

May/June 1998 Medicare Part B Update! Publication

HCFA

Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.

A HCFA Contracted Carrier and Intermediary

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Millennium Update: Changes to the HCFA-1500 Instructions

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

HCFA-1500 Fields Affected by New Reporting Requirement

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

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

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

3. Patient's Birth Date		
MM	DD	YY
01	21	1935

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

HCFA-1500 Fields Not Affected by New Reporting Requirement

Item 11b - Employer's Name or School Name

Item 12 - Patient or Authorized Person's Signature Date

Item 14 - Date of Current Illness, Injury, or Pregnancy

Item 16 - Dates Patient Unable to Work in Current Occupation

Item 18 - Hospitalization Dates Related to Current Illness

Item 19 - Reserved for Local Use

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What's New

New Provider Applications

The Health Care Financing Administration (HCFA) has revised the provider enrollment applications. Carriers have been instructed to utilize these revised applications effective May 1, 1998 and to return any other applications received after May 31, 1998. The General Enrollment (HCFA 855), Change of Enrollment Information (HCFA 855C) and the Individual Group Member Enrollment (HCFA 855G) applications have all changed. For identification purposes, the previous applications have the form number and (5/97) in the lower left corner of the application where the newer version has the form number and (1/98). The HCFA 855G has been replaced with the HCFA 855R (Individual Reassignment of Benefits Application).

If you are in the process of enrolling a new provider, updating information on an existing provider, or adding a group member and are unsure if the information can be completed and received by the carrier before May 31, 1998, please call the Customer Service Department at (904) 634-4994 for a new application. Carriers should receive their supply of new applications by May 4, 1998.

Oral Anti-Emetics

The Balanced Budget Act of 1997 provides coverage for oral anti-emetics when used as part of a cancer chemotherapeutic regimen. Effective for services rendered on or after April 1, 1998, several changes have been made to the provision, including claim filing guidelines and covered medications. Additionally, a new

electronic remittance message has been developed. See page 34 for more information.

Highlights

- Seminars (p. 5)
- Consolidated Billing for SNFs (p. 14)
- CLIA Services (p. 25)
- PET Lung Imaging (p. 30)
- Calculating Payment for Automated Multichannel Tests (p. 39)
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Publications Staff:

Michael Atcherson

Cynthia Moore

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

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Fraud and Abuse: If It Seems Too Good To Be True, It Probably Is

News stories on Medicare fraud, waste, and abuse are very prevalent, and Florida seems to get more than its share of attention. Unfortunately, a small percentage of providers are inadvertently or deliberately failing to comply with the program in submitting their claims. They thereby become subject to repayment requests, at best, or being charged with criminal behavior, at worst.

For starters, most reasonable people would assume that when medical treatments are rendered in a doctor's office and claims are submitted, a physician is performing or directing and ordering the treatments. However, our experience is that, in many cases, no physician is on the premises when services are being rendered.

In other instances, we have groups of physicians who have never met the other physicians in their group. A group is, by definition, more than one physician. If you are offered a position in a group and find yourself consistently alone in the clinic, you should make inquiries to see if the clinic is being operated in accordance with Medicare rules and regulations.

Another red flag is when clinic owners or managers restrict access to certain parts of the clinic or restrict access to certain medical charts. Physicians are responsible for the care of their patients and should have access to all medical charts and treatment plans. Restrictions of access to certain parts of the facility is a good reason to ask questions and reassess whether you want to be a part of that clinic.

Physicians should be careful of part-time positions. Many physicians typically work in more than one facility and part-time work, in many cases, is the norm. However, if you are working on a part-time basis, you should demand to review all services rendered on your behalf. Medicare requires that the physician must be present and immediately available for services or supplies to be covered as "incident to a physician's services."

Some clinic owners hire physicians on a part-time basis with the understanding that they will utilize the physician's Medicare number on a full-time basis. Should you be offered such a position, you should report it to Medicare immediately.

There are no free lunches. If it seems too good to be true, it probably is. Some Florida physicians have told us they were offered very good positions and paid very good wages but saw very few patients. When we investigated the situation, we found that the clinic was filing claims for numerous services that the physician did not perform, order, supervise, or approve. Again, the physician should demand to review all of the claims filed on her or his behalf.

The signing of charts should be a routine function for physicians. However, the signing of charts of patients who have never been seen or attended by the physician is a symptom of

possible fraud. Physicians should refuse to sign such charts. If you do so, you may be charged with participating in fraud and/or abuse of the Medicare program.

One thing we learned from our first day in medical school is to never pre-sign a prescription or a medical order form. Owners who ask you to do so may use the pre-signed documents to submit inappropriate claims. A physician may be fined, suspended, and/or lose his or her license for engaging in this practice.

The bottom line is that physicians can play a key role in limiting fraud and abuse by being aware of their employment situation and verifying only those services which they know to be legitimate benefits under the Medicare program. Should you be confronted with one of these questionable situations, protect yourself by reporting it to a Medicare Part B of Florida Provider Customer Service representative at (904) 634-4994.

Sincerely,

Sid Sewell, MD, FAAFP
Medicare 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.

(continued on page 4)
Millennium Update (continued from cover)

Item 24a - Date(s) of Service

Item 31 - Signature of Physician/Supplier

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

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

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

- Form HCFA-1500 does not have to be revised to capture 8-digit dates for the above fields.
- All date fields, except for item 24a, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On Form HCFA-1500, the space between month, day, and year is delineated by a dotted, vertical line.
- Item 24a must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24a will penetrate the dotted, vertical lines used to separate month, day, and year. Our claims processing system will be able to process your claim if you penetrate these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24a.
- Do not compress or change the font of the "year" field in item 24a to keep the date within the confines of item 24a. If you enter a continuous number in item 24a with no spaces between month, day, and year, you will not need to compress the "year" field to remain within the confines of item 24a.
- The "from" date in item 24a must not run into the "to" date field, and the "to" date must not run into item 24b.
- Dates reported in item 24a must not be reported with a slash between month, day, and year.
- If you decide to enter 8-digit dates for items 11b, 12, 14, 16, 18, 19, 24a, or 31, you must enter 8-digit dates for all these fields. For instance, you are not permitted to enter 8-digit dates for items 11b, 12, 14, 16, 18, 19, 31 and a 6-digit date for item 24a. The same applies to those who wish to submit 6-digit dates for these fields.

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

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Medifest, Specialty and Medicare-101 Seminar, Information, Schedule and Registration See Seminar Section Main Menu of BBS

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INTRODUCTION TO MEDICARE 101:
A Medicare Seminar Designed For The New Provider Or New Billing Staff

INTRODUCTION TO MEDICARE 101: A Medicare Seminar Designed For The New Provider Or New Billing Staff

We realize there is a constant flow of new providers entering into the Medicare Program. Additionally, new staff are hired in physician offices who may have limited knowledge of Medicare rules and processing guidelines. Therefore, we have developed for the first time, a seminar designed specifically for the "new" provider and "new" office staff who desires to understand the basic rules and guidelines of the Medicare Program.

This newly-designed seminar is not specific to any one specialty so, any provider office may attend. INTRODUCTION TO MEDICARE (101) is designed to provide the basic fundamentals of the Medicare Program on issues such as who to call, where to write and "what does this mean?" are just a few of the items that will be discussed.

Listed below are some additional curriculum topics that will be discussed:

- Roles of the Medicare staff (Who to call, where to write)
- Discussion of MUST-HAVE reference materials
- Claim filing rules, time limits, penalties
- What's covered, what's not, and how do I know the difference?
- Preventative medicine services (billable or not?)
- Using the appropriate modifier and discussion of their importance
- National Correct Coding Initiatives
- Medicare Provider and Beneficiary Remittance Notices
- Provider Enrollment Process
- Appeals Process
- Overpayment Recoveries
- Patient Waiver of Liability, when does the patient need to sign?
- Focused Medical Review Initiatives - Am I at risk of an audit?

This seminar is packed with must-have information if you or your staff are new to billing the Medicare Program. The session lasts a full day (8:30 am - 4:30 pm). The cost is \$149.00 which includes a continental breakfast and all seminar material. Lunch will be on your own. Only four sessions are currently planned throughout the state so, hurry and register now before classes fill up. Limited seating will be available.

To attend the INTRODUCTION TO MEDICARE (101) seminar, complete and FAX the registration form provided below to (904)791-6035.

For registration, payment methods, cancellations, confirmations, and mailing address, the same guidelines apply as for Medifest and other seminars; see page 9 for more information.

Introduction To Medicare 101 Seminar Registration Form

Use one registration form per person. Photocopy forms are acceptable. Keep a copy for your records.

Registrant's Name

Provider's Name _____ Medicare billing
provider number _____

Address _____ City, State, ZIP
code _____

Phone () _____ Fax ()

PLEASE BRING YOUR CONFIRMATION FORM TO THE SEMINAR.

_____ June 23: Orlando

Adams Mark Hotel
1500 Sand Lake Rd.
(At the Florida Mall)
407/438-0520

_____ July 21: Ft. Lauderdale

Wyndham
1825 Griffin Road
Ft. Lauderdale Airport
954/920-3500

_____ August 20: Miami

Hotel Sofitel
5800 Blue Lagoon Dr.
305/264-4888

_____ September 17: Tampa

Marriott Westshore
1001 Westshore Blvd.
813/287-2555

Please indicate the city location and date of the seminar you will be attending:

Amount enclosed (\$149 per person) \$ _____

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Consolidated Billing for Skilled Nursing Facilities (SNFs)

Consolidated Billing - General

Section 4432(b) of the BBA requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive (both Part A and Part B services), except for certain excluded services listed below. An SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF (or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF), regardless of whether Part A covers the stay. Whenever such a beneficiary leaves the facility, the beneficiary's status as an SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends when one of the following events occurs:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary receives services from a Medicare-participating home health agency under a plan of care;
- The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or comprehensive care plan [see 42CFR 483.20]); o
- The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF within 24 consecutive hours.

NOTE: This instruction only applies to Medicare fee-for-service beneficiaries residing in a participating SNF or in the nonparticipating remainder of a nursing home that also includes a participating distinct part SNF.

These claims shall be submitted to the Part A intermediary on Form HCFA-1450. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of an SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF still bills for all the services not specifically excluded. The provision requires that effective for services and items furnished on or after July 1, 1998, payment is to be made directly to the SNF. SNFs will no longer be able to "unbundle" services to an outside supplier that can then submit a separate bill directly to the Part B carrier. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier in which the SNF (rather than the supplier) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. (See 42 CFR 424.73.) As a result, the outside supplier must look to the SNF (rather than to the Part B carrier) for payment.

In terms of facilities, consolidated billing applies to:

- A participating SNF;
- Any part of a nursing home that includes a participating distinct part SNF. In this situation, place of service must always be coded as "SNF" even if the beneficiary was in a nursing facility (NF) for part of the time;

But does not apply to:

- A nursing home that has no Medicare certification, such as:
 - A nursing home that does not participate at all in either the Medicare or Medicaid programs; and
 - A nursing home that exclusively participates only in the Medicaid program as a nursing facility.

In terms of services, consolidated billing applies to:

- All services furnished to an SNF resident (other than the excluded service categories described below). Examples of services that are subject to consolidated billing include:
 - Physical, occupational, and speech-language therapy services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional (see 1888(e) (2)(A)(ii) of the Social Security Act).
 - Psychological services furnished by a clinical social worker; and

- Services furnished as an "incident to" the professional services of a physician or other excluded category of health care professional described below.

But does not apply to:

- The excluded service categories listed on the following page.

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Services Excluded From Consolidated Billing:

- Physician's services furnished to SNF residents are not subject to the consolidated billing requirement and are still billed separately to the Part B carrier. Section 4432 (b)(4) of the BBA requires bills for these particular services to include the SNF's Medicare provider number;
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Erythropoietin (EPO) for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR 405.2163(g) and (h));
- Hospice care related to a beneficiary's terminal condition;
- An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge; and
- FOR 1998 ONLY - The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS code R0076) furnished during 1998. This reflects 4559 of the BBA which temporarily restores separate Part B payment for the transportation of portable electrocardiogram equipment used in furnishing tests during 1998.

General Billing Information - Transition

SNFs Not on PPS Prior to January 1, 1999

A transition period from July 1, 1998 through December 31, 1998 is available for those SNFs that will not have the systems and billing capability to submit claims to the intermediary for all the services that their residents receive effective for services and supplies rendered on or after July 1, 1998. Intermediaries will use this transition period to educate their providers regarding these new requirements through December 31, 1998. Beginning January 1, 1999, suppliers will no longer be permitted to bill the Part B carrier or the DMERC for supplies and services rendered to residents of an SNF. The SNF must bill the intermediary. This is not a "phase in" period where SNFs may gradually begin billing for those services usually billed to the DMERC or the Part B carrier, e.g., additional services beginning to come to the intermediary in October and gradually more billed in November and so on. For those SNFs utilizing the transition period, all claims for all services and supplies rendered on or after January 1, 1999, that the resident of an SNF receives, must be billed to the intermediary. There will be no extensions beyond January 1, 1999. During this transition period, suppliers may continue to bill the Part B carrier or the DMERC as appropriate for the services and supplies rendered to the residents of an SNF not in a covered Part A stay (Part A benefits exhausted or level of care requirements not met) and to residents in a Part A stay if the stay is not yet reimbursed under the prospective payment system (PPS) and only if the SNF is not currently billing for these services and supplies to the intermediary.

These services and supplies include prosthetics and orthotics, surgical dressings and supplies, ostomy and miscellaneous supplies, parenteral and enteral nutrition (PEN), and independent laboratory and independent radiology services. In the case of PEN, the SNF may not bill these to the intermediary until January 1, 1999. HCFA will check for duplicate billings and payments during this transition period.

SNFs on PPS Prior to January 1, 1999

Part A Stay

SNFs that go on PPS prior to January 1, 1999, must submit line item billing to the best of their ability for all of the ancillaries that the resident receives. Suppliers may not bill the DMERC or the Part B carrier for ANY service or supply rendered to residents in a Part A stay (21X bill type) because payment for the ancillaries is included in the PPS rate.

Inpatient Part B

If a resident of an SNF is no longer in a covered Part A stay (Part A benefits exhausted or level of care requirements not met _ 22X bill type) the billing guidelines stated above for SNFs not on PPS prior to January 1, 1999, are to be followed during the transition period.

Part B Claim Filing Instructions

Effective July 1, 1998, physicians must include the Medicare facility provider number of the SNF on Form HCFA-1500 in Item 32 when they provide services covered under 2255 of the Medicare Carriers Manual, to a beneficiary residing in an SNF, if the SNF is the location where the services were rendered. If the services were rendered to an SNF beneficiary outside of the SNF, the physician should enter the Medicare facility provider number of the SNF in Item 23. For electronic submissions, the Medicare facility number of the SNF should be reported in record EA1, field EA1.04 (Facility/Lab ID) of the National Standard Format and in Table 2, Position 250, segment/element NM109 (Facility ID) of the ANSI X12 837 transaction set.

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Physician Services for SNF Residents Billable to Medicare Part B

To identify physician services for SNF residents that are billable to Medicare Part B, the Health Care Financing Administration (HCFA) has instructed carriers to use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule Database. To assist providers in understanding these changes, listings of codes affected by this change are provided.

Physician Services

Physician services provided to beneficiaries residing in an SNF may be billed to Medicare Part B. Examples of physician services include visits, consultations, and surgical procedures. See Appendix I (page 18) for a list of procedure codes for which physician services may be covered when provided to beneficiaries residing in an SNF.

Diagnostic Tests and Radiology Services

These are procedure codes which describe diagnostic tests (e.g., pulmonary function tests) or therapeutic radiology procedures (e.g., radiation therapy). These procedures include both professional and technical components. See AppendixII (page 24).

SNF Payment Policy

- Professional component (procedure code modifier 26) -
Considered a billable physician service.

- Technical component (procedure code modifier TC) - Only billable to the intermediary by the SNF. Claims submitted to Medicare Part B of Florida will be denied payment.

- Global procedure (both components are performed by the same provider) - The professional component should be billed with the procedure code modifier 26. The technical component should be billed to the intermediary by the SNF. Claims submitted to Medicare Part B for technical components will be denied payment.

Claims for global procedures will be returned as unprocessable, and the provider will be instructed to rebill for the professional component (billed with the "26" modifier).

Professional Component Only Procedures

These are procedure codes which describe professional component only procedures (e.g., interpretation and report only). They are stand-alone procedure codes which identify the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component only and another that describes the global test. The payment for professional component only procedures includes the physician work, practice expense and malpractice expense. See Appendix III (page 25).

SNF Payment Policy

- Professional Component Only - Considered a billable physician service. To report professional component only procedures, bill only the procedure code which describes the service. The use of procedure code modifier 26 is not required.

Technical Component Only Procedures

These are stand-alone procedure codes which describe technical component only procedures (e.g., staff and equipment costs) of diagnostic tests for which there is an associated code that describes the professional component only. They also identify procedures that are covered only as diagnostic tests and, therefore, do not have a related professional component. The payment for technical component only procedures includes the practice and malpractice expenses. See Appendix IV (page 25).

SNF Payment Policy

- Technical Component Only - Billable only to the intermediary by the SNF. Claims submitted to Medicare Part B of Florida will be denied payment.

Global Test Only Procedures

These are stand-alone procedure codes which describe global test only procedures of diagnostic tests for which there are associated codes that describe the professional component only and the technical component only. Neither procedure code modifier 26 nor TC can be used with these procedures. See Appendix V (page 25).

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SNF Payment Policy

Global Test Only - Only the professional component of this service qualifies for payment as a physician service to an SNF patient. The technical component may only be paid to the SNF by the SNF's intermediary. Claims for "Global Tests Only" will be returned as unprocessable, and the provider will be instructed to rebill the professional component code.

Global Test Only Codes and Associated Procedure Codes:

Global Test Only: G0004
Professional Component: G0007
Technical Component: G0005 OR G0006

Global Test Only: 93000
Professional Component: 93010
Technical Component: 93005

Global Test Only: 93015
Professional Component: 93016 OR 93018
Technical Component: 93017

Global Test Only: 93040
Professional Component: 93042
Technical Component: 93041

Global Test Only: 93224
Professional Component: 93227
Technical Component: 93225 OR 93226

Global Test Only: 93230
Professional Component: 93233
Technical Component: 93231 OR 93232

Global Test Only: 93235
Professional Component: 93237
Technical Component: 93236

Global Test Only: 93268
Professional Component: 93272
Technical Component: 93270 OR 93271

Global Test Only: 93720
Professional Component: 93722
Technical Component: 93721

Incident to Codes

SNF Payment Policy

Incident to codes - These services represent services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. These services are not considered physician services in an SNF setting. See Appendix VI (page 25).

Laboratory Physician Interpretation Codes

SNF Payment Policy

Laboratory physician interpretation codes - These services represent clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. These services are considered a physician service in an SNF setting. See Appendix VII (page 25).

Physical, Speech and Occupational Therapy Services

SNF Payment Policy

Physical, speech and occupational therapy services - These services are billable only to the intermediary by the SNF for an SNF patient. See Appendix VIII (page 25).

Physician Interpretation Codes

SNF Payment Policy

Physician interpretation codes - These services represent the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a hospital inpatient. This applies to codes 85060, 88151-26, 88157-26, G0124-26 and P3001-26. These services are considered physician services in an SNF setting.

Independent Laboratory and Independent Radiology Claims

During the transition period from July 1, 1998 through December 31, 1998, Medicare Part B will continue to process claims from independent laboratory and radiology suppliers for residents of an SNF. Claims received on or after January 1, 1999, for laboratory/ radiology services for a resident of an SNF shall be rejected. These claims must be submitted to the intermediary by the SNF. In the event that an SNF acts as an independent laboratory for non-resident Medicare beneficiaries, the SNF is required to obtain all the necessary certifications.

Ambulance Claims

Effective July 1, 1998, all claims submitted to Medicare Part B for ambulance services for a resident of an SNF shall be rejected.

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Appendix I - Physician Services

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

A4890	D0150	D0240	D0250	D0260	D0270	D0272	D0274
D0460	D0471						
D0501	D0502	D0999	D1510	D1515	D1520	D1525	D1550
D2970	D2999						
D3460	D3999	D4250	D4260	D4263	D4264	D4270	D4271
D4273	D4355						
D4381	D5911	D5912	D5951	D5983	D5984	D5985	D5987
D6920	D7110						
D7120	D7130	D7210	D7220	D7230	D7240	D7241	D7250
D7260	D7291						
D7940	D9110	D9230	D9630	D9930	D9940	D9950	D9951
D9952	G0002						
G0051	G0052	G0053	G0064	G0065	G0071	G0072	G0073
G0074	G0075						
G0076	G0077	G0078	G0079	G0080	G0081	G0082	G0083
G0084	G0085						
G0086	G0087	G0088	G0089	G0090	G0091	G0092	G0093
G0094	G0101						
G0104	G0105	G0110	G0111	G0112	G0113	G0114	G0115
G0116	G0127						
J3370	M0064	Q0068	Q0091	R0070	R0075	R0076	V5299
V5362	V5363						
V5364	10040	10060	10061	10080	10081	10120	10121
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11308	11310						
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11406	11420						
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28735	28737						

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52647	52648						

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65285	65286						

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67825	67830	67835	67840	67850	67875	67880	67882
67900	67901						
67902	67903	67904	67906	67908	67909	67911	67914
67915	67916						
67917	67921	67922	67923	67924	67930	67935	67938
67950	67961						
67966	67971	67973	67974	67975	67999	68020	68040
68100	68110						
68115	68130	68135	68200	68320	68325	68326	68328
68330	68335						
68340	68360	68362	68399	68400	68420	68440	68500
68505	68510						
68520	68525	68530	68540	68550	68700	68705	68720
68745	68750						
68760	68761	68770	68801	68810	68811	68815	68840
68850	68899						
69000	69005	69020	69100	69105	69110	69120	69140
69145	69150						
69155	69200	69205	69210	69220	69222	69300	69310
69320	69399						
69400	69401	69405	69410	69420	69421	69424	69433
69436	69440						
69450	69501	69502	69505	69511	69530	69535	69540
69550	69552						
69554	69601	69602	69603	69604	69605	69610	69620
69631	69632						
69633	69635	69636	69637	69641	69642	69643	69644
69645	69646						
69650	69660	69661	69662	69666	69667	69670	69676
69700	69711						
69720	69725	69740	69745	69799	69801	69802	69805
69806	69820						
69840	69905	69910	69915	69930	69949	69950	69955
69960	69970						
69979	80500	80502	85095	85097	85102	86077	86078
86079	88141						
88299	88321	88325	88329	89100	89105	89130	89132
89135	89136						
89140	89141	90749	90799	90801	90802	90804	90805
90806	90807						
90808	90809	90810	90811	90812	90813	90814	90815
90816	90817						

90818	90819	90820	90821	90822	90823	90824	90826
90827	90828						
90829	90835	90842	90843	90844	90845	90846	90847
90849	90853						
90855	90857	90862	90865	90870	90871	90880	90899
90901	90911						
90918	90919	90920	90921	90922	90923	90924	90925
90935	90937						
90945	90947	90997	90999	91100	91105	92002	92004
92012	92014						
92018	92019	92020	92070	92100	92120	92130	92140
92225	92226						
92230	92260	92287	92311	92312	92313	92315	92316
92317	92330						
92335	92502	92504	92506	92507	92508	92510	92511
92512	92516						
92520	92525	92526	92597	92598	92950	92953	92960
92970	92971						
92975	92980	92981	92982	92984	92986	92987	92990
92992	92993						
92995	92996						

92997	92998	93313	93316	93503	93536	93539	93540
93541	93542						
93543	93544	93545	93650	93651	93652	93797	93798
94656	94657						
94660	94662	95010	95015	95075	95144	95145	95146
95147	95148						
95149	95165	95170	95180	95199	95830	95831	95832
95833	95834						
95851	95852	95857	95999	96100	96105	96110	96111
96115	96117						
96405	96406	96440	96445	96450	96542	96549	96999
98925	98926						
98927	98928	98929	98940	98941	98942	99082	99183
99199	99201						
99202	99203	99204	99205	99211	99212	99213	99214
99215	99217						
99218	99219	99220	99221	99222	99223	99231	99232
99233	99234						
99235	99236	99238	99239	99241	99242	99243	99244
99245	99251						
99252	99253	99254	99255	99261	99262	99263	99271
99272	99273						
99274	99275	99281	99282	99283	99284	99285	99291
99292	99295						
99296	99297	99301	99302	99303	99311	99312	99313
99315	99316						
99321	99322	99323	99331	99332	99333	99341	99342
99343	99344						
99345	99347	99348	99349	99350	99351	99352	99353
99354	99355						
99356	99357	99375	99378	99431	99432	99433	99435
99436	99440						
99455	99456	99499					

Appendix II - Diagnostic Tests and Radiology Services

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

G0030	G0031	G0032	G0033	G0034	G0035	G0036	G0037
G0038	G0039						
G0040	G0041	G0042	G0043	G0044	G0045	G0046	G0047
G0062	G0063						
G0106	G0120	G0122	G0125	G0126	Q0035	51725	51726
51736	51741						
51772	51784	51785	51792	51795	51797	54240	54250
59020	59025						
62367	62368	70010	70015	70030	70100	70110	70120
70130	70134						
70140	70150	70160	70170	70190	70200	70210	70220
70240	70250						
70260	70300	70310	70320	70328	70330	70332	70336
70350	70355						
70360	70370	70371	70373	70380	70390	70450	70460
70470	70480						
70481	70482	70486	70487	70488	70490	70491	70492
70540	70541						
70551	70552	70553	71010	71015	71020	71021	71022
71023	71030						
71034	71035	71036	71038	71040	71060	71090	71100
71101	71110						
71111	71120	71130	71250	71260	71270	71550	71555
72010	72020						
72040	72050	72052	72069	72070	72072	72074	72080
72090	72100						
72110	72114	72120	72125	72126	72127	72128	72129
72130	72131						
72132	72133	72141	72142	72146	72147	72148	72149
72156	72157						
72158	72159	72170	72190	72192	72193	72194	72196
72198	72200						
72202	72220	72240	72255	72265	72270	72285	72295
73000	73010						
73020	73030	73040	73050	73060	73070	73080	73085
73090	73092						
73100	73110	73115	73120	73130	73140	73200	73201
73202	73220						
73221	73225	73500	73510	73520	73525	73530	73540
73550	73560						
73562	73564	73565	73580	73590	73592	73600	73610
73615	73620						
73630	73650	73660	73700	73701	73702	73720	73721
73725	74000						

74010	74020	74022	74150	74160	74170	74181	74185
74190	74210						
74220	74230	74235	74240	74241	74245	74246	74247
74249	74250						
74251	74260	74270	74280	74283	74290	74291	74300
74301	74305						
74320	74327	74328	74329	74330	74340	74350	74355
74360	74363						
74400	74405	74410	74415	74420	74425	74430	74440
74445	74450						
74455	74470	74475	74480	74485	74710	74740	74742
74775	75552						
75553	75554	75555	75600	75605	75625	75630	75650
75658	75660						
75662	75665	75671	75676	75680	75685	75705	75710
75716	75722						
75724	75726	75731	75733	75736	75741	75743	75746
75756	75774						
75790	75801	75803	75805	75807	75809	75810	75820
75822	75825						
75827	75831	75833	75840	75842	75860	75870	75872
75880	75885						
75887	75889	75891	75893	75894	75896	75898	75900
75940	75945						
75946	75960	75961	75962	75964	75966	75968	75970
75978	75980						
75982	75984	75989	75992	75993	75994	75995	75996
76000	76001						
76003	76010	76020	76040	76061	76062	76065	76066
76070	76075						
76076	76078	76080	76086	76088	76090	76091	76093
76094	76095						
76096	76098	76100	76101	76102	76120	76125	76355
76360	76365						
76370	76375	76380	76390	76400	76499	76506	76511
76512	76513						
76516	76519	76529	76536	76604	76645	76700	76705
76770	76775						
76778	76800	76805	76810	76815	76816	76818	76825
76826	76827						
76828	76830	76831	76856	76857	76870	76872	76880
76885	76886						
76930	76932	76934	76936	76938	76941	76942	76945
76946	76948						
76950	76960	76965	76970	76975	76986	76999	77280
77285	77290						
77295	77299	77300	77305	77310	77315		

77321	77326	77327	77328	77331	77332	77333	77334
77399	77470						
77499	77600	77605	77610	77615	77620	77750	77761
77762	77763						
77776	77777	77778	77781	77782	77783	77784	77789
77790	77799						

78000	78001	78003	78006	78007	78010	78011	78015
78016	78017						
78018	78070	78075	78099	78102	78103	78104	78110
78111	78120						
78121	78122	78130	78135	78140	78160	78162	78170
78172	78185						
78190	78191	78195	78199	78201	78202	78205	78215
78216	78220						
78223	78230	78231	78232	78258	78261	78262	78264
78270	78271						
78272	78278	78282	78290	78291	78299	78300	78305
78306	78315						
78320	78350	78399	78414	78428	78445	78455	78457
78458	78459						
78460	78461	78464	78465	78466	78468	78469	78472
78473	78478						
78480	78481	78483	78491	78492	78499	78580	78584
78585	78586						
78587	78591	78593	78594	78596	78599	78600	78601
78605	78606						
78607	78610	78615	78630	78635	78645	78647	78650
78660	78699						
78700	78701	78704	78707	78708	78709	78710	78715
78725	78726						
78727	78730	78740	78760	78761	78799	78800	78801
78802	78803						
78805	78806	78807	78810	78890	78891	78999	79000
79001	79020						
79030	79035	79100	79200	79300	79400	79420	79440
79999	88104						
88106	88107	88108	88125	88160	88161	88162	88170
88171	88172						
88173	88180	88182	88199	88300	88302	88304	88305
88307	88309						
88311	88312	88313	88314	88318	88319	88323	88331
88332	88342						
88346	88347	88348	88349	88355	88356	88358	88362
88365	88399						
89399	91000	91010	91011	91012	91020	91030	91032
91033	91052						
91055	91060	91065	91122	91299	92060	92065	92081
92082	92083						
92235	92240	92250	92265	92270	92275	92283	92284
92285	92286						
92499	92541	92542	92543	92544	92545	92546	92548
92585	92587						
92588	92599	92978	92979	93024	93278	93303	93304
93307	93308						
93312	93314	93315	93317	93320	93321	93325	93350
93501	93505						
93508	93510	93511	93514	93524	93526	93527	93528
93529	93530						
93531	93532	93533	93555	93556	93561	93562	93600
93602	93603						
93607	93609	93610	93612	93615	93616	93618	93619
93620	93621						

93622	93623	93624	93631	93640	93641	93642	93660
93724	93731						
93732	93733	93734	93735	93736	93737	93738	93740
93770	93799						
93875	93880	93882	93886	93888	93922	93923	93924
93925	93926						
93930	93931	93965	93970	93971	93975	93976	93978
93979	93980						
93981	93990	94010	94060	94070	94150	94200	94240
94250	94260						
94350	94360	94370	94375	94400	94450	94620	94680
94681	94690						
94720	94725	94750	94770	94772	94799	95805	95806
95807	95808						
95810	95811	95812	95813	95816	95819	95822	95824
95827	95829						
95858	95860	95861	95863	95864	95867	95868	95869
95870	95872						
95875	95900	95903	95904	95920	95921	95922	95923
95925	95926						
95927	95930	95933	95934	95936	95937	95950	95951
95953	95954						
95955	95956	95957	95958	95961	95962		

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Appendix III - Professional Component Only Codes

G0007	G0016	77261	77262	77263	77419	77420	77425
77430	77431	77432	93010	93014	93016	93018	93042
93227	93233	93237	93272	93722			

Appendix IV - Technical Component Only Codes

G0005	G0006	G0015	Q0092	76150	76350	77336	77370
77401	77402	77403	77404	77406	77407	77408	77409
77411	77412	77413	77414	77416	77417	79900	86485
86490	86510	86580	86585	86586	89350	89360	92547
92552	92553	92555	92556	92557	92561	92562	92563
92564	92565	92567	92568	92569	92571	92572	92573
92575	92576	92577	92579	92582	92583	92584	92589
92596	93005	93012	93017	93041	93225	93226	93231
93232	93236	93270	93271	93721	94760	94761	94762
95027	95028	95060	95065	95070	95071	95078	

Appendix V - Global Test Only Procedures

G0004	93000	93015	93040	93224	93230	93235	93268
93720							

Appendix VI - "Incident to" Procedures

G0050	36430	37195	90780	90781	90782	90783	90784
90788	92325	92326	92977	94640	94642	94650	94651
94652	94664	94665	94667	94668	95004	95024	95044
95052	95056	95115	95117	96400	96408	96410	96412
96414	96420	96422	96423	96425	96520	96530	96900
96910	96912	96913	99175	99185	99186	99195	

Appendix VII - Laboratory Physician Interpretation Procedures

8302026	8391226	8416526	8418126	8418226	8539026
8557626	8625526	8625626	8632026	8632526	8632726
8633426	8716426	8720726	8837126	8837226	8906026

Appendix VIII - Physical Therapy Procedures

Q0103	Q0104	Q0109	Q0110	97001	97002	97003	97004
97012	97014	97016	97018	97020	97022	97024	97026
97028	97032	97033	97034	97035	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	97799	

CPT-4 and HCPCS Codes Subject to CLIA Edits

In addition to the pathology and laboratory services (80000-89399*), the following CPT-4 and HCPCS codes are subject to CLIA edits.

HCPCS	MOD	DESCRIPTION
G0058		Auto multichannel 20 tests
G0059		Auto multichannel 21 tests
G0060		Auto multichannel 22 tests
G0107		Colorectal cancer screening
P3000		Screen pap by tech w md supv
P3001		Screening pap smear by phys
P3001	26	Screening pap smear by phys
P7001		Culture bacterial urine
78110		"Plasma volume, single"
78110	TC	"Plasma volume, single"
78111		"Plasma volume, multiple"

78111	TC	" Plasma volume, multiple"
78120		"Red cell mass, single"
78120	TC	"Red cell mass, single"
78121		"Red cell mass, multiple"
78121	TC	"Red cell mass, multiple"
78122		Blood volume
78122	TC	Blood volume
78130		Red cell survival study
78130	TC	Red cell survival study
78160		Plasma iron turnover
78160	TC	Plasma iron turnover
78162		Iron absorption exam
78162	TC	Iron absorption exam
78191		Platelet survival
78191	TC	Platelet survival
78270		Vit B-12 absorption exam
78270	TC	Vit B-12 absorption exam
78271		"Vit B-12 absorp exam, IF"
78271	TC	"Vit B-12 absorp exam, IF"
78272		"Vit B-12 absorp, combined"
78272	TC	"Vit B-12 absorp, combined"

* A complete list of pathology and laboratory services excluded from the CLIA edits can be found on the following page.

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CPT Modifier Description

80103 Tissue preparation for drug analysis

80500 Clinical pathology consultation; limited, without review of patient's history and medical records

80502 Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records

81050 Volume measurement for timed collection, each

82075 Alcohol (ethanol); breath

83019 Helicobacter pylori, breath test

84061 Phosphatase, acid; forensic examination

85095 Bone marrow; aspiration only

85102 Bone marrow biopsy, needle or trocar

86077 Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report

86078 Blood bank physician services; investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report

86079 Blood bank services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report

86485 Skin test; candida

86490 Skin test coccidioidomycosis

86510 Skin test histoplasmosis

86580 Skin test tuberculosis, intradermal

86585 Skin test tuberculosis, tine test

86586 Skin test; unlisted antigen, each

86891 Autologous blood or component, collection processing and storage; intra- or postoperative salvage)

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

86911 Blood typing, for paternity testing, per individual, ABO, Rh and MN; each additional antigen system

86927 Fresh frozen plasma, thawing, each unit

86930 Frozen blood, preparation for freezing, each unit

86931 Frozen blood, preparation for freezing, each unit; with thawing

86932 Frozen blood, preparation for freezing, each unit; with freezing and thawing

86945 Irradiation of blood product, each unit

86950 Leukocyte transfusion

86965 Pooling of platelets or other blood products

86985 Splitting of blood or blood products, each unit

86999 Unlisted transfusion medicine procedure

88040 Necropsy (autopsy); forensic examination

88045 Necropsy (autopsy); coroner's call

88125 Cytopathology, forensic (eg, sperm)

88170 Fine needle aspiration with or without preparation of smears; superficial tissue

88171 Fine needle aspiration with or without preparation of smears; deep tissue under radiologic guidance

88304 TC Level III - Surgical pathology, gross and microscopic examination

88305 TC Level IV - Surgical pathology, gross and microscopic examination

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

88312 TC Special stains; Group I for microorganisms, each

88313 TC Special stains; Group II, all other, except Immunocytochemistry and immunoperoxidase stains, each

88314 TC Special stains; histochemical staining with frozen section(s)

88329 Pathology consultation during surgery

89100 Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure

89105 Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube

89130 Gastric intubation and aspiration,
diagnostic, each specimen, for chemical analyses or cytopathology

89132 Gastric intubation and aspiration,
diagnostic, each specimen, for chemical analyses or
cytopathology; after stimulation

89135 Gastric intubation, aspiration, and
fractional collections; one hour

89136 Gastric intubation, aspiration, and
fractional collections; two hours

89140 Gastric intubation, aspiration, and
fractional collections; two hours including gastric stimulation

89141 Gastric intubation, aspiration, and
fractional collections; three hours, including gastric
stimulation

89250 Culture and fertilization of oocyte(s)

89251 Culture and fertilization of oocyte(s); with
co-culture of embryos

89252 Assisted oocyte fertilization, microtechnique
(any method)

89253 Assisted embryo hatching, microtechniques
(any method)

89254 Oocyte identification from follicular fluid

89255 Preparation of embryo for transfer (any
method)

89256 Preparation of cryopreserved embryos for
transfer (includes thaw)

89257 Sperm identification from aspiration (other
than seminal fluid)

89258 Cryopreservation; embryo

89259 Cryopreservation; sperm

89260 Sperm isolation; simple prep for insemination
or diagnosis with semen analysis

89261 Sperm isolation; complex prep for
insemination or diagnosis with semen analysis

89350 Sputum, obtaining specimen, aerosol induced
technique (separate procedure)

CLIA Services

Effective January 1, 1998, the CLIA number must be included on all claims for laboratory services. This includes tests granted waived status under CLIA and tests covered under provider performed microscopy procedures (PPMP) certificates.

Tests Granted Waived Status Under CLIA

Pages 68-70 of the December 1997 Medicare B Update! Special Issue: 1998 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update and page 18 of the March/April 1998 Medicare B Update! featured a list of tests granted waived status under CLIA. Providers issued a certificate for waived CLIA tests may only perform services listed in the waived CLIA tests category. The following tests have been added to the list of tests granted waived status under CLIA:

Test Name: Bayer Clinitek 50 Urine Chemistry Analyzer - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes - automated

Manufacturer: Bayer
CPT Code(s): 81003QW
Use: Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections

Test Name: Bayer DCA 2000-glycosylated hemoglobin (Hgb Alc)
Manufacturer: Bayer
CPT Code(s): 83036QW
Use: Measures the percent concentration of hemoglobin Alc in blood, which is used in monitoring the long-term care of people with diabetes

Test Name: Wampole Mono-Plus WB
Manufacturer: Wampole
CPT Code(s): 86308QW
Use: Qualitative screening test for the presence of heterophil antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis

Test Name: LXN Duet Glucose Control Monitoring System
Manufacturer: LXN
CPT Code(s): 82962, 82985QW
Use: Monitoring of blood glucose levels and measures fructosamine which is used to evaluate diabetic control over a 2-3 week period

Test Name: ENA C.T. Total Cholesterol Test
Manufacturer: ActiMed Laboratories
CPT Code(s): Pending
Use: Cholesterol monitoring

Test Name: Genzyme Contrast Mono(whole blood)
Manufacturer: Genzyme Diagnostics
CPT Code(s): Pending
Use: Qualitative screening test for the presence of heterophil antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis

Test Name: Applied Biotech SureStep Strep A (II)(direct from throat swab)
Manufacturer: Applied Biotech Inc.
CPT Code(s): Pending
Use: Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever

Note: Entities performing waived tests are required to report the procedure code for the test plus procedure code modifier QW (CLIA waived test) where applicable (e.g., 81003QW). Such CLIA waived tests submitted without procedure code QW will be denied payment.

Provider Performed Microscopy Procedures (PPMP) Certificates

This certificate has been established to address specific microscopy procedures, which are classified as moderately complex tests. Under this certificate the laboratory may also conduct waived tests. The following is a list of PPMP tests.

Code

Descriptor

Q0111 - Wet mounts, including preparation of vaginal, cervical or skin specimens

Q0112 - All potassium hydroxide (KOH) preparations

Q0113 - Pinworm examinations

Q0114 - Fern tests

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

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

81001 - Urinalysis; by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy (Note: May only be used when the lab

is using an automated dipstick urinalysis instrument approved as waived.)

81015 - Urinalysis; microscopic only

81020 - Urinalysis; two or three glass test

89190 - Nasal smears for eosinophils

G0026 - Fecal leukocyte examinations

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

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Ordering a National Correct Coding Policy Manual

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

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

- If requesting a paper copy of the manual for each quarter, use order # SUB-9576 (\$65.00 plus handling fee). A subscription may be purchased for \$260.00.

- If you are requesting the CD-ROM version, use order # SUB-5407 (\$80.00 plus handling fee).

- If you are requesting the ASCII version (raw data), use order # SUB-5408 (\$140.00 plus handling fee).

Individual Chapters of the Correct Coding Manual

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

CHAP: 2
DESCRIPTION: Anesthesia Services (00000-09999)
ORDER #: SUB-9902

CHAP: 3
DESCRIPTION: Surgery: Integumentary System (10000-19999)
ORDER #: SUB-9903

CHAP: 4

DESCRIPTION: Surgery: Musculoskeletal System (20000-29999)
ORDER #: SUB-9904

CHAP: 5
DESCRIPTION: Surgery: Respiratory, Cardiovascular, Hemic, and
Lymphatic System (30000-39999)
ORDER #: SUB-9905

CHAP: 6
DESCRIPTION: Surgery: Digestive System (40000-49999)
ORDER #: SUB-9906

CHAP: 7
DESCRIPTION: Surgery: Urinary, Male & Female Genital, Maternity
Care, and Delivery System (50000-59999)
ORDER #: SUB-9907

CHAP: 8
DESCRIPTION: Surgery: Endocrine, Nervous, Eye and Ocular Adnexa,
Auditory System (60000-69999)
ORDER #: SUB-9908

CHAP: 9
DESCRIPTION: Radiology Services (70000-79999)
ORDER #: SUB-9909

CHAP: 10
DESCRIPTION: Pathology and Laboratory Services (80000-89999)
ORDER #: SUB-9910

CHAP: 11
DESCRIPTION: Medicine, Evaluation, and Management Services
(90000-99999)
ORDER #: SUB-9911

Additional Ordering Information

- To receive ordering information via NTIS FAX Direct , call
(703) 487-4140 and enter code 8657.
- To receive ordering information by mail, call (703) 487-4630.
- To order a single copy, call (703) 487-4650.
- Ordering and product information is also available via the
World Wide Web at www.ntis.gov/cci.

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A9170, A9270, 97010: Appropriate use of Codes by Chiropractors

This article contains information on when chiropractors should
use procedure codes A9170 (Noncovered service by chiropractor),
A9270 (Noncovered item or service), and 97010 (application of a
modality to one or more areas; hot or cold packs).

A9170: Noncovered Service by Chiropractor

This service by a chiropractor is not covered by Medicare. In this case, the beneficiary is liable for payment.

This procedure code should only be used when a chiropractor performs a service that is not covered when rendered by a chiropractor (specialty 35).

Example: X-ray service or a spinal manipulation service when the patient refuses to have x-rays taken.

A9270: Noncovered Item or Service

This is a non-covered service. In this case, the beneficiary is liable for payment.

This procedure code should only be used when the service the chiropractor is rendering is noncovered under Medicare Part B (for example, dispensing vitamin supplements).

97010: Application of a Modality to One or More Areas; Hot or Cold Packs

In this case, the beneficiary is not liable for payment.

The reimbursement for this procedure is included in any other service the provider renders (also known as a "bundled" service). Spinal manipulation services (98940 - 98942) are considered physician services; therefore, reimbursement for procedure code 97010 is bundled into the spinal manipulation service.

Note: Some providers are billing procedure code A9170 or A9270 for this service instead of 97010 to circumvent the patient's liability. The provider should not bill codes A9170 or A9270 for this service.

E1230: Medicare Durable Medical Equipment Regional Carrier
Physician Information Sheet: Power Operated Vehicles (POVs)

Power Operated Vehicles (POVs) are billed to the DMERC using the HCPCS code, E1230. This type of vehicle is primarily meant to function inside the home, and is characterized as being a "non-highway" vehicle. It may have three or four wheels.

The E1230 reimburses approximately \$2,000. Physicians should remember that reimbursements made for durable medical equipment are drawn from the same Part B Medicare pool of funds available for payment of physician services. No claims for durable medical equipment may be reimbursed without there being an order or certificate of medical necessity completed by a physician.

Indications

A power operated vehicle (POV) is covered when all of the following criteria are met:

The patient's condition is such that a wheelchair is required for the patient to get around in the home,

The patient is unable to operate a manual wheelchair,

The patient is capable of safely operating the controls for the POV, and

The patient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV.

Coverage and Payment Rules

Most POV's are ordered for patients who are capable of ambulation within the home but require a power vehicle for movement outside the home. POV's will be denied as not medically necessary in these circumstances.

A POV that is beneficial primarily in allowing the patient to perform leisure or recreational activities will be denied as not medically necessary.

If a POV is covered, a wheelchair provided at the same time or subsequently will usually be denied as not medically necessary.

A POV is usually covered only if it is ordered by a physician who is one of the following specialties: Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology. When such a specialist is not reasonably accessible, e.g. more than one day's round trip from the beneficiary's home, or the patient's condition precludes such travel, a prescription from the beneficiary's attending or other consulting physician may be acceptable.

Documentation

AN ORDER FOR A POV, SIGNED AND DATED BY THE PHYSICIAN, MUST BE RECEIVED BY THE SUPPLIER PRIOR TO DELIVERY OF THE ITEM TO THE PATIENT.

The supplier of your patient's equipment must submit a Certificate of Medical Necessity (CMN) (DMERC 07) with the claim in order to obtain Medicare reimbursement. Section B of the CMN contains questions pertaining to the medical necessity of the equipment which may not be completed by the supplier. The physician or another health care clinician may complete Section B, BUT ONLY THE PATIENT'S PHYSICIAN MAY SIGN THE CMN, INDICATING THAT HE/SHE HAS REVIEWED SECTION B OF THE CMN FOR ACCURACY AND COMPLETENESS.

The physician's medical record of the patient must contain documentation substantiating that the patient's condition meets the above coverage criteria and the answers given in Section B of the CMN. These records may be requested by the DMERC to confirm concurrence between the medical record and the information submitted to the DMERC.

Prior Authorization

The POV is one of three items of DME which is available for prior authorization (PA). This allows a beneficiary and his or her physician to determine before purchase whether Medicare will approve reimbursement based upon medical necessity criteria (it is always possible that, subsequent to a PA approval, a claim may be denied for other technical reasons such as Medicare ineligibility, the discovery of Medicare's having paid for duplicate equipment, an invalid supplier number, etc).

In order to participate in the PA process, the physician completes the CMN prior to the supplier's submission of the claim for reimbursement. The DMERC will respond directly to the physician's office and the beneficiary with a decision to pay or deny, or to further develop the claim for information.

Whether or not the PA process is chosen, if the prescribing physician is not one of the four specialists required in the medical review policy (physiatrist, neurologist, rheumatologist, or orthopedic surgeon), it is essential that extra documentation in the form of a physician's letter accompany the CMN, explaining why the prescribing physician believes the patient requires a POV. The letter should also explain why the patient was not seen by one of these specialists for the purpose of ordering a POV.

G0123, G0124, 88142: Revised Fees for Pap Smears

Effective for services rendered on or after April 1, 1998, the fee for the following pap smear procedure codes has been revised to \$13.92:

G0123

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer

preparation, screening by cytotechnologist under physician supervision,

G0124

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, requiring interpretation by physician.

Additionally, effective for services rendered on or after January 1, 1998, procedure code 88142 (Cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision) has a revised fee of \$9.36.

All of these codes are clinical laboratory procedures, so limiting charge does not apply.

G0125, G0126: Medical Policy for Positron Emission Technology (PET) Lung Imaging

Page 28 of the March/April issue of the Medicare B Update! contained an article that introduced two new procedure codes for Positron Emission Technology (PET) lung imaging, which are effective for services rendered on or after December 18, 1997. The codes are:

G0125 - PET lung imaging of solitary pulmonary nodules, using 2-[fluorine-18]-fluoro-2-deoxy-D-glucose (FDG), following CT (71250/71260 or 71270)

G0126 - PET lung imaging of solitary pulmonary nodules, using 2-[fluorine-18]-fluoro-2-deoxy-D-glucose (FDG), following CT (71250/71260 or 71270); initial staging of pathologically diagnosed non-small cell lung cancer

G0125 Coverage Guidelines - Procedure code G0125 (PET scans using FDG) is covered when used for the characterization of suspected solitary pulmonary nodules (SPNs). The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient.

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Characterizing SPNs with PET using FDG must meet the following conditions:

- Evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other

detection method, indicating an indeterminate or possibly malignant lesion, not exceeding four centimeters (cm.) in diameter.

- Evidence of a concurrent thoracic CT, which is necessary for anatomic information, to ensure that the PET scan is properly coordinated with other diagnostic modalities.

NOTE: A Tissue Sampling Procedure (TSP) will not be routinely covered in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. Claims for TSP after a negative PET scan must be submitted with documentation for review to determine if the TSP is reasonable and necessary in spite of a negative PET scan. Claims submitted for a TSP after a negative PET without documentation will be denied.

In cases of serial evaluation of SPNs using both CT and regional PET chest scanning, such PET scans will not be covered if repeated within 90 days following a negative PET scan.

G0126 Coverage Guidelines

Procedure code G0126 (PET scans using FDG for staging non-small cell lung carcinoma) are covered only when used for the initial staging of suspected metastatic non-small cell lung carcinoma (NSCLC) in thoracic (mediastinal) lymph nodes in patients who have a confirmed primary lung tumor, but whose extent of disease has not yet been established. The primary purpose of such staging should be to determine the progress and extent of the disease, as well as the probable rate of its progression, in order to plan future management for the patient.

NOTE: Multiple stagings using PET is considered monitoring of the progress of the disease, rather than staging, and is not covered at this time.

Initial staging of NSCLC with PET scan using FDG must meet the following conditions:

- Evidence that a primary cancerous lung tumor has been confirmed. This should include, but is not limited to, a surgical pathology report which documents the presence of an NSCLC.

- Evidence of both (1) performance of a concurrent thoracic CT, which is necessary for anatomic information, and (2) performance of any lymph node biopsy to finalize whether the patient will be a surgical candidate.

NOTE: A lymph node biopsy will not be covered in the case of a negative CT and negative PET, where the patient is considered a surgical candidate, given the presumed absence of metastatic NSCLC unless medical review supports a determination of medical necessity of a biopsy. A lymph node biopsy will be covered in all other cases (i.e., positive CT and positive PET, negative CT and positive PET, positive CT and negative PET).

Coding Guidelines

- HCPCS Codes G0030 through G0047, G0125, and G0126 represent the global service, so providers performing just the technical or professional component of the test should use modifier TC or 26, respectively.

- In addition to the standard modifiers, a two-digit modifier will be used to indicate the results of the PET scan and the previous test. (The modifier is not required for technical component-only billings.) The first alpha character should indicate the result of the PET scan; the second alpha character should indicate the results of the prior test. The test result modifiers and their descriptions are listed below:

Modifier: N
Description: Negative

Modifier: E
Description: Equivocal

Modifier: P
Description: Positive, but not suggestive of extensive ischemia or not suggestive of malignant single pulmonary nodule

Modifier: S
Description: Positive and suggestive of extensive ischemia (20% of the left ventricle) or malignant single pulmonary nodule

These modifiers may be used in any combination.

Claims submitted without the two-digit modifier indicating the results of the PET scan and previous test will be returned as unprocessable.

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G0127: Trimming Dystrophic Nails

Effective for services rendered on or after April 1, 1998, procedure code G0127 (Trimming of dystrophic nails, any number) has been developed to report the trimming of dystrophic nails.

Procedure code G0127 is subject to the standard multiple procedure rules when performed on the same day or during the same session by the same physician. The allowances for procedure codes subject to multiple procedures rules are calculated as follows:

- 100 percent of the fee schedule amount for the primary procedure (highest relative value);
- 50 percent of the fee schedule for the second through fifth procedures; and
- "By report" for the sixth and subsequent procedures.

See Appendix V (page 36) of the December 1997 Medicare B Update! Special Issue: 1998 HCPCS/MPFSDB Update for a list of procedure codes subject to the multiple procedures rules. For additional information on routine footcare, refer to page 46 of this Update! The fees for procedure code G0127 can be found on page 29 of the March/April 1998 Medicare B Update!

Please note that this code cannot be billed with the 50 modifier (bilateral procedure). Also, there are no follow-up days for procedure code G0127.

K0001-K0009, K0011: Medicare Durable Medical Equipment Regional Carrier Physician Information Sheet: Manual and Motorized Wheelchairs & Accessories

Manual Wheelchairs

A wheelchair is covered if the patient's condition is such that without the use of it, the patient would otherwise be bed or chair confined.

There are different grades of wheelchairs based upon their lightness or upon their capacity to accommodate obese patients. These are classified according to HCPCS codes. If a higher grade wheelchair (lighter or heavier capacity) is prescribed primarily to allow a patient to perform leisure or recreational activities, it will be reimbursed at the level of the least costly medically necessary level, or possibly denied totally. Following are the categories of manual wheelchairs with some of their more significant features, indications and costs to the Medicare Program:

K0001: Standard Wheelchair: chair weighs greater than 36 lbs.

Approximate Medicare Reimbursement = \$492

K0002: Standard Hemi-wheelchair: chair weighs greater than 36 lbs, but the seat is lower to the floor in order to accommodate

shorter stature or for a patient who self-propels with their feet on the floor.

Approximate Medicare Reimbursement = \$664

K0003: Lightweight Wheelchair: chair weighs less than 36 lbs. It is covered for a patient who cannot self-propel in a standard weight wheelchair, but can self-propel in this weight chair.

Approximate Medicare Reimbursement = \$816

K0004: High strength, lightweight wheelchair: chair weighs less than 34 lbs., and there is a lifetime warranty on the side frames and cross braces. Covered for a patient who self-propels while engaging in frequent activities (not recreational or leisure) that cannot be performed in a standard or lightweight chair. It is also covered if the patient requires seat dimensions that cannot be accommodated in a standard, hemi, or lightweight chair, and the patient spends at least 2 hours per day in the wheelchair. It would not be covered if the patient would need it for less than 3 months (e.g., post-operative recovery).

Approximate Medicare Reimbursement = \$1,213

K0005: Ultra lightweight wheelchair: chair weighs less than 30 lbs., and there is a lifetime warranty on the side frames and cross braces. The need for these is rare and require individual consideration of additional documentation submitted with the Medicare claim.

Approximate Medicare Reimbursement = \$1,763

K0006: Heavy duty wheelchair: chair can accommodate and support a patient weighing greater than 250 lbs., or who has severe spasticity.

Approximate Medicare Reimbursement = \$1,148

K0007: Extra heavy duty wheelchair: chair can accommodate and support a patient weighing greater than 300 lbs.

Approximate Medicare Reimbursement = \$1,682

K0008: Custom manual wheelchair base: chair base is uniquely constructed for the individual patient and is like no other. It is not customized merely by the assemblage of modular components, nor the addition of various accessories to a base which could otherwise be classified into one of the other above codes. It would only be covered if it offered features not otherwise available on already manufactured chair bases.

Approximate Medicare Reimbursement = Individually priced

K0009: Other manual wheelchair base: because of modular construction to accommodate unusual patient measurements or requirements, the base cannot be adequately classified using one of the above codes.

Approximate Medicare Reimbursement = Individually priced

Motorized Wheelchairs

There are various classifications of motorized wheelchairs paralleling the division existing among manual wheelchairs, based upon weight of the chair, customization or modular construction. The standard and lightweight motorized wheelchairs are reimbursed by Medicare at approximately \$3,600 and \$3,000 respectively. The customized and modularly constructed chairs are individually priced. One particular model, coded K0011 represents models that have additional programmable controls that allow for speed adjustment, limits on acceleration and braking, and control dampeners for patients with tremors or poor coordination. These models reimburse at approximately \$5,000.

There has been a significant increase in the ordering of K0011 models. Interestingly, many of the K0011s being sold look very similar to power operated vehicles (or scooters), coded E1230, which normally reimburse at approximately \$2,000. While these models do furnish the control features allowing them to be properly coded as K0011, it is important for physicians to ascertain that these motorized wheelchairs are being prescribed for the indications listed below, and not being used by patients who would otherwise be sufficiently served by the ordering of scooters (see PHYIS on Power Operated Vehicles).

A power wheelchair is covered when all of the following criteria are met:

1. The patient's condition is such that without the use of a wheelchair the patient would otherwise be bed or chair confined, and
2. The patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate a wheelchair manually, and
3. The patient is capable of safely operating the controls for the power wheelchair.

Usually, a patient who requires a power wheelchair is totally nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular condition.

Similar to a power wheelchair (K0011), a power operated vehicle (or scooter) (E1230) is not covered by Medicare if the patient does not require it for mobility within the home. However, the physician should try to determine if a power operated vehicle (E1230) will serve the needs of the patient (who might have the upper trunk stability and neurologic or muscular ability to operate a scooter), as opposed to a power wheelchair (K0011).

The K0011 reimburses \$5,000; the E1230 reimburses \$2,000. Physicians should remember that reimbursements made for durable medical equipment are drawn from the same Part B Medicare pool of funds available for payment of physician services. No claims for durable medical equipment may be reimbursed without there being an order or certificate of medical necessity completed by a physician.

Wheelchair Options and Accessories

There are some underlying principles which apply to all options and accessories for wheelchairs:

1. In order to cover accessories, the patient must have a wheelchair base which meets Medicare coverage criteria,
2. The accessory must be necessary for the patient to function in the home environment, and
3. The accessory must be necessary to enable the patient to perform an activity of daily living.

There are three accessories which have related questions on the wheelchair certificate of medical necessity, and for which there are indications specified in our published policy:

Fully reclining back:

To justify this feature, the patient should have one or more of the following conditions: quadriplegia, fixed hip angle, trunk or lower extremity casting or bracing requiring reclining back for positioning, excessive extensor tone of trunk muscles, or the need to rest in a recumbent position 2 or more hours during the day with transfer between wheelchair and bed being very difficult.

Adjustable arm height:

Patient requires an arm height that is different than that available using nonadjustable arms and the patient spends a least 2 hours per day in the wheelchair.

Elevating leg rests:

Patient has a musculoskeletal condition or has a cast or brace which prevents 90 degree flexion at the knee, or has significant edema of the lower extremities that requires leg elevation, or meets the criteria for and has a reclining back on the wheelchair.

There are many other options and accessories that may be added to wheelchairs to accommodate the individual needs of patients. These are also listed in the DMERC medical policy, a copy of which you may obtain from a supplier of wheelchairs or directly from the Region C DMERC by contacting: Professional Relations, PGBA DMERC Region C, P.O. Box 100141, Columbia, SC, 29202-3141.

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Certificate Of Medical Necessity (CMN)

The supplier of your patient's equipment must submit a Certificate of Medical Necessity (CMN) (DMERC 02) with the claim in order to obtain Medicare reimbursement. Section B of the CMN contains questions pertaining to the medical necessity of the equipment which may not be completed by the supplier. The physician or another health care clinician may complete Section B, BUT ONLY THE PATIENT'S TREATING PHYSICIAN MAY SIGN THE CMN, INDICATING THAT HE/SHE HAS REVIEWED SECTION B OF THE CMN FOR ACCURACY AND COMPLETENESS.

The patient's medical records must contain documentation substantiating that the patient's condition meets the above coverage criteria and the answers given in Section B of the CMN. These records may be requested by the DMERC to confirm concurrence between the medical record and the information submitted to the DMERC.

Q0163-Q0181: Revised Guidelines for Oral Anti-Nausea Drugs When Used as Part of a Cancer Chemotherapeutic Regimen

Section 4557 of the Balanced Budget Act (BBA) of 1997 provides coverage for oral anti-emetic (anti-nausea) drugs as full therapeutic replacements for intravenous anti-nausea drugs when prescribed as part of a chemotherapeutic regimen. Effective for services rendered on or after April 1, 1998, follow the guidelines published in this article. (See page 31 of the March/April 1998 issue of the Medicare B Update! for services rendered between January 1 and March 31, 1998.)

The drug must be administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent. The allowable covered period is up to 48 hours after the date of chemotherapy administration.

Note that if the patient fails on oral anti-nausea treatment, intravenous anti-nausea medication may be covered.

Covered Medications

The following chart outlines anti-nausea drugs that are covered for oral administration and their reimbursement amounts:

Code: Q0163

Descriptor: DIPHENHYDRAMINE HYDROCHLORIDE 50mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen.
Allowance: .06/capsule

Code: Q0164

Descriptor: PROCHLORPERAZINE MALEATE 5mg, oral, FDA approved prescription anti-, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .51/tablet

Code: Q0165

Descriptor: PROCHLORPERAZINE MALEATE 10mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .77/tablet

Code: *Q0166

Descriptor: GRANISETRON HYDROCHLORIDE 1mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.
Allowance: 40.61/tablet

Code: Q0167

Descriptor: DRONABINOL 2.5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: 3.27/capsule

Code: Q0168

Descriptor: DRONABINOL 5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: 6.42/capsule

Code: Q0169
Descriptor: PROMETHAZINE HYDROCHLORIDE 12.5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .19/tablet

Code: Q0170
Descriptor: PROMETHAZINE HYDROCHLORIDE 25mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .04/tablet

Code: Q0171
Descriptor: CHLORPROMAZINE HYDROCHLORIDE 10mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .05/tablet

Code: Q0172
Descriptor: CHLORPROMAZINE HYDROCHLORIDE 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .08/tablet

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Code: Q0173
Descriptor: TRIMETHOBENZAMIDE HYDROCHLORIDE 250mg, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .35/capsule

Code: Q0174
Descriptor: THIETHYLPERAZINE MALEATE 10mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: 60/tablet

Code: Q0175
Descriptor: PERPHENAZINE 4mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
Allowance: .61/tablet

Code: Q0176
Descriptor: PERPHENAZINE 8mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hours dosage regimen.

Allowance: 74/tablet

Code: Q0177

Descriptor: HYDROXYZINE PAMOATE 25mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Allowance: .19/capsule

Code: Q0178

Descriptor: HYDROXYZINE PAMOATE 50mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Allowance: 20/capsule

Code: Q0179

Descriptor: ONDANSETRON HYDROCHLORIDE 8mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Allowance: 21.50/tablet

Code: *Q0180

Descriptor: DOLASETRON MESYLATE, 100mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.

Allowance: 62.70/tablet

Code: **Q0181

Descriptor: UNSPECIFIED ORAL DOSAGE FORM, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Allowance: I.C.

*Note: The 24 hour maximum drug supply limitation noted for procedure codes Q0166 and Q0180 has been established to ensure conformity with the "Indications and Usage" section of current FDA-approved product labeling for these drugs.

**Note: Q0181 should be used when billing for liquid or syrup forms of oral anti-nausea drugs (procedure codes Q0163-Q0180).

Claim Submission/Billing Guidelines

The chemotherapy drug must be billed on the same day as the oral anti-emetic drug procedure code (Q0163 to Q0181) reported. If an oral anti-emetic drug is billed but no chemotherapy code is reported for the same claim, the claim will be denied payment.

Additionally, the oral anti-emetic must be billed with a diagnosis of cancer (ICD-9-CM diagnosis codes 140-239.9, or V58.0) in block 24E of the HCFA-1500 claim form, FA0 records 14-17 for electronic claims.

In addition to standard claim filing guidelines, follow these instructions when billing for oral anti-nausea drugs:

- When billing for procedure code Q0181, providers should note the name and strength of the drug in block 19 of the HCFA-1500 claim form, or in the HA0 narrative record for electronic claims.

- The date of service should be the date the prescription was filled.

- When billed by a supplier, such as a pharmacy, include the ordering physician's name in block 17 of the HCFA-1500 claim form, or in the following fields for electronic claims:

Last name: EA0 22, positions 120-139

First name: EA0 23, positions 140-151

Initial: EA0 24, positions 152-152

- When billed by a supplier, such as a pharmacy, include the Unique Provider Identification Number (UPIN) in block 17a of the HCFA-1500 claim form, or in the EA0 20 field, position 80-94 for electronic claims.

- The number billed should reflect the number of units dispensed. Report this in item 24G on the HCFA-1500, or FA0 18, positions 82-85 for electronic claims.

Remittance Messages (ANSI X12.835)

If a claim for an oral anti-emetic drug is submitted, but there is no chemotherapy drug reported on the same claim, or the verified date of the oral anti-emetic drug exceeds the date of service of the chemotherapy drug plus two additional calendar days, the oral anti-emetic will be denied payment. In this case, ANSI REASON/REMARK CODE M100 will be generated. The message generated will be "We do not pay for an oral anti-emetic drug that is not administered for use immediately before, after or within 48 hours after administration of a covered chemotherapy drug."

Advance Notice Statement

Advance notice applies to medical necessity and non-FDA-approved drugs (see page 4).

Note: Medicare Part B of Florida is anticipating additional information on the oral anti-emetic benefit. Watch for further information in upcoming issues of the Medicare B Update!

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Certificate of Medical Necessity
EPO Administered by a Physician for Patients with Anemia Caused
by Chronic Renal Failure.

Form not available in this format.
Contact the Customer Service area (904)6344994.

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R0070, R0075: Revised Fees for Transportation of Portable X-ray
Equipment

Effective for services rendered on or after January 1, 1998, the
fees for the following procedure codes have been revised:

R0070 - Transportation of portable x-ray equipment and personnel
to home or nursing home, per trip to facility of location, one
patient seen

R0075 - Transportation of portable x-ray equipment and personnel
to home or nursing home, per trip to facility or location, more
than one patient seen, per patient

The revised fees for R0070 and R0075 are:

Loc 01/02	Loc 03	Loc 04
53.78	57.83	57.21

Please note that affected providers' claims will be adjusted by
the carrier. Providers do not need to request a review.

17260-17286: Destruction of Malignant Lesions

Effective for claims processed on or after April 6, 1998, the
following diagnosis codes have been added to the list of covered
diagnoses for which destruction of malignant lesions (procedure
codes 17260-17286) are covered:

176.0
176.1
176.2
176.8

Medical policy and a complete list of diagnoses for which
destruction of malignant lesions (procedure codes 17260-17286) is
covered were published on page 25 of the July/August 1997
Medicare B Update!

Advance Notice Requirement

Applies to diagnosis (see page 4).

78460-78465, 78478, 78480: Myocardial Perfusion Imaging

Description

Myocardial perfusion imaging is a cardiac radionuclide imaging procedure that is usually performed with exercise ECG testing for detecting coronary artery disease and determining prognosis. The SPECT (single-photon emission computed tomographic) technique is utilized to obtain multiple-angle images.

Medicare Part B of Florida has not previously published a specific coverage policy concerning myocardial perfusion imaging. This policy is being developed in order to define the circumstances for which myocardial perfusion imaging will be considered medically necessary by Medicare Part B.

Policy Type

Local medical necessity policy

Indications and Limitations of Coverage and/or Medical Necessity

- Myocardial perfusion imaging will be considered medically reasonable and necessary, and therefore covered, by Medicare Part B of Florida if any one of the following circumstances is present (see Covered ICD-9 Codes):

- The patient has chest pain, other symptoms, or signs suggestive of coronary artery disease, and the patient has an abnormal baseline EKG (RBBB, LBBB, IVCD, LVH, Atrial fibrillation, marked resting ST segment changes) which would make interpretation of a standard exercise test inaccurate.

- The patient has chest pain, other symptoms, or signs suggestive of coronary artery disease, and the patient is on a cardiac glycoside (digoxin) or other medication which would impair the accuracy of interpretation of a standard exercise test.

- The patient has an abnormal or non-diagnostic standard exercise test and myocardial perfusion imaging is being performed in order to determine if the patient has myocardial ischemia.

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- The patient has a condition, such as mitral valve prolapse, which would likely result in a non-diagnostic or inaccurate standard stress test.

- Patient has known coronary artery disease (or recent myocardial infarction) and myocardial perfusion imaging is being done to

determine the significance of/or the extent of myocardial ischemia (or scar) resulting from coronary artery disease or to assess myocardial viability.

- The patient has undergone cardiovascular re-perfusion (CABG, PTCA, thrombolysis) and perfusion imaging is being done to evaluate the effectiveness of the intervention.
- The patient has developed congestive heart failure and a silent MI is suspected.
- The patient has a ventricular wall motion abnormality demonstrated by another imaging modality and perfusion imaging is needed to further evaluate the abnormality.
- The patient has severe peripheral vascular disease and is a candidate for peripheral vascular reperfusion by balloon angioplasty or bypass surgery and myocardial perfusion imaging is being done pre-operatively because of concern about possible significant coronary artery disease.

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

HCPCS Codes

- 78460 - Myocardial perfusion imaging; single
- 78461 - Myocardial perfusion imaging; multiple
- 78464 - SPECT, single
- 78465 - SPECT, multiple

- 78478 - Myocardial perfusion with wall motion
- 78480 - Myocardial perfusion with ejection fraction

ICD-9 Codes That Support Medical Necessity

- 411.0
- 411.1
- 411.81
- 411.89
- 412
- 413.0
- 413.1
- 413.9
- 414.00
- 414.01
- 414.02

414.03
414.04
414.05
414.10
414.11
414.19
414.8
414.9
424.0
426.2
426.3
426.4
426.50
426.51
426.52
426.53
426.54
426.6
426.7
427.31
428.0
428.1
428.9
440.21-440.24
794.31
960.7
995.2
E942.0
E942.1
V67.0
V67.51
V67.59

HCPCS Section and Benefit Category

Nuclear Medicine

HCFA National Coverage Policy

MCM 4630

Reasons for Denial

Medicare Part B cannot provide coverage for myocardial perfusion imaging performed as a screening test for coronary artery disease.

Noncovered ICD-9 Code(s)

N/A

Sources of Information

CPT

ICD-9-CM

Coding Guidelines

Thallous Chloride, Cardiolite, and CardioTec (A4641, A9500, A9503, A9505, Q0142, Q0143) are myocardial imaging agents for cardiac perfusion studies both at rest and at stress and are covered when billed with CPT codes (78460-78465, 78478, 78480). Procedure code A4641 (supply of radiopharmaceutical diagnostic imaging agent) can be billed when a specific code does not exist for the agent used. Use code 93015 or 93016 as appropriate when billing for ECG (stress test supervision and interpretation) by a physician.

These procedures can be performed in the following places of service:

- 11 Office
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room-Hospital
- 51 Inpatient Psychiatric Facility
- 61 Comprehensive Inpatient Rehabilitation Facility

Documentation Requirements

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

If the provider of myocardial perfusion imaging studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. When ordering myocardial perfusion imaging studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the myocardial perfusion studies in his order for the test.

Other Comments

The most common specialties one would expect to see performing these services are:

- 06 Cardiovascular Disease
- 11 Internal Medicine
- 30 Radiology
- 36 Nuclear Medicine
- 95 Independent Physiological Laboratory

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Reimbursement for Automated Lab Panels and Individual Automated Tests

Page 35 of the March/April 1998 issue of the Medicare B Update! contains an article describing the new payment method used for panel codes in addition to individual automated tests. The procedure codes that represent automated lab panels are 80049-80054, 80058, 80061, and 80072.

Claims for automated lab tests will be reimbursed based on the total number of tests allowed. To help providers calculate Medicare Part B's reimbursement when multiple automated tests are allowed, refer the following chart:

Number of Tests:	1 or 2
Reimbursement Amount:	\$7.20
Number of Tests:	3
Reimbursement Amount:	\$9.18
Number of Tests:	4
Reimbursement Amount:	\$9.69
Number of Tests:	5
Reimbursement Amount:	\$10.81
Number of Tests:	6
Reimbursement Amount:	\$10.84
Number of Tests:	7
Reimbursement Amount:	\$11.29
Number of Tests:	8
Reimbursement Amount:	\$11.70
Number of Tests:	9-10
Reimbursement Amount:	\$12.00
Number of Tests:	11
Reimbursement Amount:	\$12.21
Number of Tests:	12

Reimbursement Amount: \$12.48

Number of Tests: 13-16
Reimbursement Amount: \$14.61

Number of Tests: 17-18
Reimbursement Amount: \$14.71

Number of Tests: 19
Reimbursement Amount: \$15.28

Number of Tests: 20
Reimbursement Amount: \$15.78

Number of Tests: 21
Reimbursement Amount: \$16.27

Number of Tests: 22
Reimbursement Amount: \$16.77

Individual Automated Tests

The following procedure codes are considered automated for the purpose of this provision:

82040
82250
82251
82310
82374
82435
82465
82550
82565
82947
82977
83615
84075
84100
84132
84155
84295
84450
84460
84478
84520
84550

Note that individual automated multichannel tests will, like the lab panel tests, be reimbursed based on the total number of tests ordered. When an individual automated test is performed in addition to a panel code, Medicare will check for duplicate tests, and will reimburse based on the number of allowed tests as noted in the chart.

If You Have Questions....

If you have further questions regarding lab panels, please call the Medicare Part B Provider Customer Service Department at (904) 634-4994.

88314: Histochemical Staining with Frozen Section

Medicare Part B of Florida has recently received questions about the billing of histochemical staining with frozen section (procedure code 88314) when performing a pathology consultation during surgery; with frozen section(s) (procedure codes 88331-88332).

Hematoxylin and Eosin (H and E) is not considered a special stain, but a "routine stain, and does not qualify for the billing of procedure code 88314. If the pathologist applies H and E, the pathology consult; frozen section (procedure codes 88331-88332) would be the only code billed.

Histochemical staining of the frozen section can only be billed in addition to the pathology consultation during surgery; with frozen section(s) (procedure codes 88331-88332) when the pathologist applies a "special" stain.

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93307, 93308: Real Time Echocardiography

Page 24 of the November/December 1996 issue of the Medicare B Update! contained a list of diagnoses for which real time echocardiography (procedure codes 93307, 93308) is considered medically reasonable and necessary. That list contained an error; diagnosis codes 424.0-425.9 should have been 425.0-425.9.

Advance Notice Statement

Applies to diagnosis requirements (see page 4).

93797, 93798: Cardiac Rehabilitation Programs

The following is a comprehensive list of the diagnoses/conditions for which cardiac rehabilitation programs (procedure codes 93797, 93798) are covered:

- 410.00-410.92
- 411.0
- 412
- 413.9
- V45.81

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

For additional information on this policy (except diagnoses), please refer to the October 1996 Medicare B Special Issue (page 45).

Routine Exams with Evaluation and Management Services

A physician who furnishes both a routine physical examination and a covered E/M visit on the same day should bill as follows:

- The covered E/M service should be billed using the appropriate E/M procedure code. Payment will be made at the lower of the fee schedule or actual billed charges.

- The routine physical examination should be billed using the appropriate preventive medicine E/M procedure code (99381-99397). Physicians should deduct their normal charge for the covered E/M service from their normal charge for the routine physical examination and bill this amount to Medicare Part B as the charge for this service. Physicians may collect this amount from the patient, and are not required to provide advance notice of this denial since coverage for routine physical examinations is excluded under statutory, rather than medical necessity, provisions of Medicare law.

For example, a physician who provides both 99214 and a routine physical examination on the same day should bill as follows:

- Bill the standard charge for 99214 - \$70.00

- Deduct this amount from the standard charge for the routine physical examination $-\$125.00 - 70.00 = \55.00 .

- Bill \$55.00 as the charge for procedure code 99397 (established patient preventative medicine, 65 years and over). This amount is collectible from the patient.

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Local and Focused Medical Review Policies

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

Effective Dates

The policies contained in this section are effective for claims processed June 22, 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 B Line BBS.

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A9270: Noncoverage Coding Guidelines

The purpose of these coding guidelines is to create a working list of medical services and procedures that are never covered by the Medicare program. Such services and procedures are always denied either because:

- a national decision to noncover the service/procedure exists, or
- the service/procedure is included on the list of services determined by this contractor to be excluded from coverage.

The coding guidelines are developed under an iterative process and will be updated as national and local coverage decisions change.

Indications and Limitations of Coverage and/or Medical Necessity

A service or procedure on the "national noncoverage list" may be noncovered for a variety of reasons. It may be noncovered based on a specific exclusion contained in the Medicare law; for example, acupuncture; it may be viewed as not yet proven safe and effective and, therefore, not medically reasonable and necessary; or it may be a procedure that is always considered cosmetic in nature and is denied on that basis. The precise basis for a national decision to noncover a procedure may be found in references cited in this policy.

A service or procedure on the "local" list is always denied on the basis that we do not believe it is "medically reasonable and necessary." Our list of local medical review policy exclusions contains procedures that, for example, are:

- experimental
- not yet proven safe and effective
- not yet approved by the FDA

It is important to note that the fact that a new service or procedure has been issued a CPT code or is FDA approved does not, in itself, make the procedure "medically reasonable and necessary." It is our policy that new services, procedures, drugs, or technology must be evaluated and approved either nationally or by our local medical review policy process before they are considered Medicare covered services.

Local Noncoverage Decisions

Laboratory Procedures

82172 - Apolipoprotein, each

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

86911 - each additional antigen system

82523* - Collagen cross links, any method

89250-89261 - Culture and fertilization of oocyte(s) and other artificial insemination procedures

88349 - Electron microscopy: scanning

84999*+ - Lymphocyte mitogen response assays used to monitor the treatment of cancer

88000-88099 - Necropsy (autopsy)

Drugs and Biologicals

J3520 Edetate disodium, per 150 mg (chemical endarterectomy)

A9270 Muse

J3530 Nasal vaccine inhalation

Procedures

01990 Physiological support for harvesting of organs from brain-dead patients

01995 Regional I.V. administration of local anesthetic agent or other medication (upper or lower extremity)

11975 Insertion, implantable contraceptive capsules

11977 Removal with reinsertion, implantable contraceptive capsules

15820-15821 Blepharoplasty, lower lid

15824-15829 Rhytidectomy

15831-15839 Excision, excessive skin and subcutaneous tissue (including lipectomy)

15876-15879 Suction assisted lipectomy

17380 Electrolysis epilation, each < hour

43999*+ Gastric Electrical Stimulation

53852* Transurethral Needle Ablation (TUNA)

55899* T3 system

58321 Artificial insemination; intra-cervical

58322 Artificial insemination; intra-uterine

58323 Sperm washing for artificial insemination

58970 Follicle puncture for oocyte retrieval, any method

58974 Embryo transfer, intrauterine

58976 Gamete, zygote, or embryo intrafallopian transfer, any method

59012 Cordocentesis (intrauterine), any method

76499*+ MRI for use in measuring the blood flow, spectroscopy imaging of corticalbone and calcification, and procedures involving resolution of bone or calcification

92548* Computerized dynamic posturography

92970* Cardioassist-method of circulatory assist; internal

92997-92998 Percutaneous transluminal pulmonary artery balloon angioplasty

93720-93722* Plethysmography, total body

93799*+ Metaiodobenzylguanidine (MIBG) imaging

95999*+ Biothesiometry

95999+ Current Perception Threshold Testing (CPT)

97799+ Low vision rehabilitation

99360 Stand-by anesthesia

A9270* Autologous Chondrocyte Transplantation

A9270* Meniscal Allograft Transplantation]

A9270* Cellular Therapy

A9270 High Voltage Pulsed Current (HVPC) Therapy

A9270* Light reflecting rheography

A9270* Pelvic floor stimulator

A9270 Politzer Procedure

95806 Sleep Study unattended by a technologist

95999*+ Surface electromyography

27599*+ Tidal knee irrigation

83019* Urea Breath Test for H-Pylori

A9270* Neurocybernetic Prosthesis System (NCP) for Vagus Nerve Stimulation (VNS)

A9270* Large and Small Bowel Transplants

A9270* Fiberoptic Endoscopy Evaluation of swallowing with sensory testing (FEEST)

A9270* ZStat flu Influenza Test Kits

A9270* Matrix Pro Elect/Matrix Elect DT

National Noncoverage Decisions

Devices

33999*+ Artificial hearts and related devices (CIM 65-15)

A9270* Intrapulmonary percussive ventilator for home use (CIM 60-21)

Laboratory Procedures

80050 General Health Panel

86999*+ Cytotoxic leukocyte tests for food allergies (CIM 50-2)

88399*+ Human tumor stem cell drug sensitivity assays (CIM 50-41)

Drugs and Biologicals

J3570* Laetrile (Amygdalin, Vit B17) (CIM 45-10)

A4260* Levonorgestral (contraceptive) implants system, including implants and supplies (Statute 1862 [a][1][a])

J7140-J7180 Oral Medication (MCM 2049)

A9270 Oral Medication (MCM 2049)

J8499+ Oral Medication (MCM 2049)

J8499*+ Sublingually administered antigens (CIM 45-28)

Procedures

97780-97781* Acupuncture (CIM 35-8)

93784-93790* Ambulatory blood pressure monitoring (CIM 50-42)

59899*+ Ambulatory home monitoring of uterine contractions (MCM 2005.1)

90908 (prior to 1/1/97) (prior to Biofeedback (psychiatric only) (CIM 35-27)

53899*+ Bladder Stimulator (CIM 65-11)

A9270 Carbon Dioxide Therapy (CIM 35-29)

A9270* Cardiac output monitoring by electrical bioimpedance (CIM 50-54)

A9270* Cardiointegram (CIG) as an alternative to stress test or thallium stress test (CIM 50-47)

A9270* Carotid body resection to relieve pulmonary symptoms, including asthma (CIM 35-7)

A9270* Carotid sinus nerve stimulator for treatment of paroxysmal supraventricular tachycardia (CIM 65-4)

A9270* Chelation Therapy (EDTA) for treatment of arteriosclerosis (CIM 35-64)

56805 Clitoroplasty for intersex state (CIM 35-61)

69949** Cochleostomy with neurovascular transplant for Meniere's Disease (CIM 35-50)

A9270* Colonic irrigation (CIM 35-1)

G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

G0122 Colorectal cancer screening; barium enema

A9270 Cosmetic surgery (MCM 2329)

A9270* Cryosurgery of the prostate (CIM 35-96)

A9270* Diathermy or ultrasound treatments performed for respiratory conditions or diseases (CIM 35-41)

48550* Donor pancreatectomy (CIM 35-82)

78351* Dual Photon Absorptiometry, one or more sites (CIM 50-44)

A9270* Ear/carbon therapy (CIM 35-29)

A9270* Electrical aversion therapy for treatment of alcoholism (CIM 35-23.1)

A9270* Electrical continence (CIM 65-2)

95999* EEG monitoring during open heart surgery and in immediate post-op period (CIM 35-57.1)

A9270* Electrosleep therapy (CIM 35-18)

A9270 Electrotherapy for the treatment of facial nerve paralysis (Bell's Palsy) (CIM 35-72)

92971* Enhanced External Counterpulsation (EECP) (CIM 35-74)

A9270 Eye exam, routine (MCM 2320)

A9270* Fabric wrapping of abdominal aneurysms (CIM 35-34)

A9270* Gastric balloon for treatment of obesity (CIM 35-86)

M0100* Gastric freezing (CIM 35-65)

A9270* Hair analysis (CIM 50-24)

V5010 Hearing exam for the purpose of a hearing aid (MCM 2320)

A9270* Hemodialysis for treatment of schizophrenia (CIM 35-51)

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A9270* Indirect Calorimetry used to assess nutritional status as a respiratory therapy]

90875-90876 Individual psychophysiological therapy incorporating biofeedback (CIM 35-27)

55970-55980* Intersex surgery (CIM 35-61)

A9270 Intestinal bypass for obesity (CIM 35-33)

A9270* Intravenous histamine therapy (CIM 35-19)

A9270* Investigational IOLS in FDA Core Study or Modified Core Study (MCM 2020.25)

32491*+ Lung volume reduction surgery (CIM 35-93)]

A9170 Noncovered service by chiropractor (MCM 2026.26)

A9160 Noncovered service by podiatrist (MCM 2020.4)

A9270 Osteopathic cranial manipulation (MCM 2020.2)

A9270 Osteopathic pulmonary manipulation (MCM 2020.2)

48160* Pancreatectomy, total, with transplantation (CIM 35-82)

A9270* Partial ventriculectomy (also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery) (CIM 35-95)

92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

92314 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia

A9270* Platelet-derived wound healing formula (Procuren) (CIM 45-26)

A9270* Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (CIM 35-13)

15775-15776 Punch graft for hair transplant (MCM 2329)

65760-65767, 65771* Refractive keratoplasty to correct refractive error (CIM 35-54)

32491 Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous), for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure (prior to 1/1/97 HCPCS code G0061) (CIM 35-93)

95199+ Repository antigen (MCM 2005.2)

90760 Routine physical exam (MCM 2320)

A9270 Speech therapy by pathologist/speech therapist (MCM 2206.2)

64999** Stereotactic cingulotomy as a means of psychosurgery (CIM 35-84)

A9270* Sweat test as predictor of efficacy of sympathectomy in PVD (CIM 50-3)

11920-11922 Tattooing (MCM 2329)

A9270* Thermogenic therapy (CIM 35-6)

A9270* Tinnitus masking (CIM 35-63)

90899** Transcendental meditation (CIM 35-92)

A9270* Transfer factor for treatment of multiple sclerosis (CIM 45-17)

A9270* Transilluminator light scanning or diaphanography (CIM 50-46)

35452* Transluminal balloon angioplasty (PTA) in treatment of obstructive lesions of aortic arch (CIM 50-32.3)

A9270* Transmyocardial Revascularization (TMR) (CIM 35-94)

48554* Transplantation of pancreatic allograft (CIM 35-82)

A9270* Transvenous (catheter) pulmonary embolectomy (CIM 35-55)

A9270* Treatment of decubitus ulcers by ultraviolet light, low intensity directcurrent, topical application of oxygen and topical dressings with balsam of Peru in castor oil (CIM 35-31)

A9270* Treatment of motor function disorders with electrical nerve stimulation (CIM 35-20)

78810* Tumor Imaging, Positron Emission Tomography (PET), metabolic evaluation

A9270* Ultrafiltration independent of conventional dialysis (CIM 55-3)

57335 Vaginoplasty for intersex state (CIM 35-61)

A9270* Vertebral Axial Decompression (VAX-D) (CIM 35-97)

A9270 Vitamin B12 injections to strengthen tendons, ligaments of the foot (CIM 45-4)

These lists of noncovered services are not all inclusive.

*Services which are noncovered due to their being investigational/experimental

+Claims for these services will always be reviewed, as they must currently be billed with an unlisted procedure code .

Reasons for Denial

See criteria for noncoverage.

An 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 a service that is considered investigational/experimental, or is not approved by the FDA, or because there is a lack of scientific and clinical evidence to support the procedure's safety and efficacy.

Documentation Requirements

National noncovered services may not be covered by the local carrier.

In order for noncovered services to be evaluated for coverage, the following documentation must be submitted to the local carrier:

- Peer-reviewed articles from appropriate medical journals
- Statements from authorities within the field
- FDA approval
- Appropriate CPT/HCPCS code

Rationale for Creating Coding Guidelines

These coding guidelines are created to publish a list of noncovered services and to establish the parameters by which

Medicare Part B of Florida will consider services for noncoverage, and to ensure that reimbursement is made only for those services which are medically reasonable and necessary.

CAC Notes

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from numerous societies.

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J3490: Viscosupplementation Therapy for Knee

Indications and Limitations of Coverage and/or Medical Necessity

Medicare B will consider Synvisc or Hyalgan medically necessary in the following situations:

- The patient must have mild to moderate osteoarthritis of the knee, and
- The patient must have an intolerance to non-steroidal anti-inflammatory drugs (NSAIDs) with a condition such as peptic ulcer disease, and
- Mild analgesics such as acetaminophen have not been effective in pain reduction, and/or
- The patient has failed other conservative treatment, and
- The patient must not have large effusions of the knee, which is characterized by a tense, bulging knee, and/or
- The patient should not be markedly obese, and
- The joint(s) injected must be the knee(s), and
- The patient has not had a previous reaction to an earlier administration of one of these medications.

HCPCS Codes:

J3490 Unclassified Drugs

20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)

ICD-9 Codes That Support Medical Necessity

715.96 Osteoarthritis, whether generalized or localized,
multiple sites

Reasons for Denial

Any reason not stated in the "Indications and Limitations" section of this policy.

Also, when the patient receives more than one injection per week times 3 weeks with Synvisc and more than one injection per week times 5 weeks with Hyalgan, the additional dosage(s) may be denied. In addition, a sequence of either of these medications should be given no more than once every six months.

When the patient has severe osteoarthritis and/or has large effusions, the claim will be denied on a prepayment basis.

When there is no indication in the documentation that the patient cannot take NSAIDs and/or that NSAIDs or acetaminophen and/or other conservative treatment has not been effective in treating the patient's osteoarthritis, the claim will be denied.

Noncovered ICD-9 Code(s)

All other diagnosis codes not listed in the "Covered ICD-9" list are noncovered for the administration of viscosupplementation drugs for the knee.

Coding Guidelines

For each injection given, J3490 (Unclassified drugs) and 20610 (Arthrocentesis, aspiration and/or injection major joint or bursa [e.g., shoulder, hip, knee joint, subarcromial bursa]) may be billed when viscosupplementation of the knee is performed.

Because procedure code J3490 will be used to bill Synvisc or Hyalgan, documentation related to medical necessity as described below must be submitted for prepayment review.

Documentation Requirements

The physician should indicate in the patient's medical documentation; the severity of the osteoarthritis; the inability to take NSAIDs and for what reason; the lack of pain relief with mild analgesics such as acetaminophen and/or the failure of other conservative treatment; presence of effusions and the size of the effusions; and the height and weight of the patient should all be documented. The dosage and specific drug given (Synvisc, Hyalgan) should also be documented. In addition, if the patient receives more injections in a certain timeframe that exceeds the recommended use of these drugs, the claim may be reviewed and denied on a prepayment basis. The physician should also indicate which knee is being injected or if both knees are being injected

by appropriate modifiers, i.e., LT and/or RT, on the claim form and in the documentation.

Rationale for Creating Policy

Due to the recent FDA approval of Synvisc and Hyalgan and because the carrier has received several inquiries on this subject, medical policy was deemed necessary to define the service, its medically necessary and appropriate indications and limitations of usage.

CAC Notes

This policy does not express the sole opinion of the carrier or the Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee which includes representatives from the Florida Society of Rheumatology, The Florida Society of Physical Medicine and Rehabilitation, and the Florida Orthopaedics Society.

Advance Notice Requirement

Applies to diagnosis (see page 4).

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J9201: Off- Label Use of Chemotherapy Drugs

Gemcitabine (Gemzar)

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 200mg of powder to be reconstituted, and should be administered by intravenous infusion at a dose of 1000mg/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 (157.0 - 157.9). Phase II and Phase III clinical trials have also demonstrated the efficacy of Gemzar treatment in an additional carcinoma, and this off-label use is supported by the United

States Pharmacopeial Convention, Inc. (USP DI). Medicare Part B will now cover Gemzar for its FDA-approved use, as well as for treatment of the following neoplasm:

- Non-small cell lung carcinoma (162.2-162.9)

HCPCS Code

For service dates prior to January 1, 1998
J9999 Gemcitabine HCL (Gemzar)

For service dates on or after January 1, 1998
J9201 Gemcitabine HCL, 200 mg

Docetaxel (Taxotere)

Docetaxel (Taxotere), an antineoplastic agent belonging to the taxoid family, acts by disrupting cell replication. It is a derivative of 10-deacetylbaecatin 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 frontline agent in the treatment of metastatic breast cancer (174.0-174.9, 175.0, and 175.9) 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 (176.0-176.9). Phase II 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 (162.2-162.9)
- Squamous cell carcinoma of the head and neck (195.0)
- Ovarian carcinoma (183.0)
- Gastric carcinoma (151.0-151.9)
- Melanoma (172.0-172.9)

HCPCS Code

For service dates prior to January 1, 1998
J9999 Docetaxel

For service dates on or after January 1, 1998
J9170 Docetaxel, 20 mg.

Documentation Requirements

Claims submitted for Gemzar and Taxotere given for diagnoses not indicated above must be submitted with medical record documentation to substantiate the medical necessity for the use of these chemotherapy drugs by clearly indicating the condition for which these drugs are being used.

Advance Notice Requirements

Advance notice applies to medical necessity requirements (see page 4).

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11055, 11056, 11057, 11719, G0127: Routine Foot Care

As mentioned in the March/April 1998 Medicare B Update!, procedure code G0127 is effective April 1, 1998 for trimming of dystrophic nails. Since numerous changes have taken place with this service, including new CPT codes and the additional information around the billing of Evaluation & Management services with routine foot care, the policy is being republished in its entirety to reflect the changes to date.

Routine foot care generally includes the cutting or removal of corns and calluses; the trimming, cutting, clipping of nails; and other hygienic and preventative maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the feet.

Routine foot care is generally considered a noncovered service; however, there may be instances in which, under certain circumstances, coverage may be extended.

Certain metabolic, neurologic, or peripheral vascular diseases may require routine foot care by a podiatrist or other physician.

The purpose of this policy is to describe the circumstances under which routine foot care may be covered.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will consider routine foot care as medically necessary and reasonable when performed under the following circumstances:

Services ordinarily considered to be routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.

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

Diabetes mellitus*;

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

Buerger's disease (thromboangitis obliterans);

Chronic thrombophlebitis*;

Peripheral neuropathies involving the feet such as those

associated with malnutrition and vitamin deficiency*,

associated with carcinoma*,

associated with diabetes mellitus*,

associated with drugs and toxins*,

associated with multiple sclerosis*,

associated with uremia (chronic renal disease)*,

associated with traumatic injury,

associated with leprosy or neurosyphilis, or

associated with hereditary disorders

Hereditary sensory radicular neuropathy

Angiokeratoma corporis diffusum (Fabry's)

Amyloid neuropathy;

In addition, when the service is being performed and qualifies for coverage by one of the conditions listed above with an asterisk, the following must be met and indicated on the claim form:

Services performed by a podiatrist require the name of the attending physician (M.D. or D.O.) who is actively treating the patient's condition and

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

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

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

In addition to the complicating condition, the following medical information is required which describes the sign(s) and/or symptom(s) of the underlying systemic diseases which are categorized in classes A, B, or C. To fulfill the medical necessity requirements for routine foot care there must be:

One Class A finding, or

Two Class B findings, or

One Class B and two Class C findings.

Class A

Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B

Absent posterior tibial pulse, or

Absent dorsalis pedal pulse, or

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

Hair growth (decrease or absence)

Pigmentary changes (discoloration)

Skin color (rubor and redness or blueness)

Nail changes (thickening)

Skin texture (thin, shiny)

Class C

Claudication (pain in calf when walking)

Temperature changes in the feet

Edema

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

Burning

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Coverage and/or Medical Necessity

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

HCPCS Codes

11055 Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion

11056 two to four lesions

11057 more than four lesions

11719 Trimming of nondystrophic nails, any number

G0127 Trimming of dystrophic nails, any number

ICD-9 Codes That Support Medical Necessity

030.0-030.9

094.0

094.1

094.9

250.60-250.63*

250.70-250.73*

263.9*

265.0*

265.2*

266.1*

266.2*

272.7

277.3

281.0*

281.3*

334.0
340*
356.0-356.9
357.0*
357.1*
357.2*
357.3*
357.4*
357.5*
357.6*
357.7*
358.1*
358.2*
440.20-440.24
443.0
443.1
444.22
446.0
446.7*

451.0*
451.1*
451.11*
451.19*
579.0*
579.1*
579.2*
579.3*
579.4*
585*
586*

Reasons for Denial

Any service billed with a diagnosis code(s) other than the ones listed under the "ICD-9 Codes That Support Medical Necessity" will be denied as noncovered by Medicare for routine foot care services.

Routine foot care (11055-11057,11719, and G0127) would not be reimbursed by Medicare when performed in the following places of service:

41

Ambulance - Land

42

Ambulance - Air or Water

81

Independent Laboratory

Noncovered ICD-9 Code(s)

All other codes not listed under the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Coding Guidelines

In order for 11055-11057, 11719, and G0127 (Routine foot care) to be a covered service, the patient must have one or more of the diagnoses listed under the "ICD-9 That Supports Medical Necessity" section in this policy. Otherwise, the service is noncovered and should be coded as A9160 (noncovered service by a podiatrist) or A9270 (noncovered item or service). On all claims for routine foot care, except for peripheral neuropathy involving the feet associated with traumatic injury, the name of the M.D. or D.O. who diagnosed the problem must be indicated.

In addition, for those diagnoses which are asterisked (*), the M.D. or D.O. must be actively treating the condition and the date the patient was last seen by the actively treating M.D. or D.O. must be included on the claim.

Medicare will pay for a visit on the same day as routine foot care only if the visit was medically necessary and was for a significant, separately identifiable service, and the modifier -25 is used.

Hygienic services such as cleaning and soaking of the feet and/or the application of skin creams to maintain skin tone of either ambulatory or bedfast patients, performed in the absence of paring or cutting of benign hyperkeratotic lesions (11055-11057), trimming of nondystrophic nails (11719), and/or trimming of dystrophic nails (G0127) should be billed using an evaluation and management service. In this case, a -25 modifier would not be necessary.

Hygienic services, as described above, performed in conjunction or preparation for paring or cutting of benign hyperkeratotic lesions (11055-11057), trimming of nondystrophic nails (11719), and/or trimming of dystrophic nails (G0127) should not be billed separately. They are included in the services indicated by 11055-11057, 11719, and/or G0127.

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

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

Procedure codes 11719 and G0127 encompass any number of nails and would therefore be reported only once for any number of nails trimmed.

It is expected that the provider bill only for the service performed and not all HCPCS codes applicable to routine foot care. For example, if trimming of nondystrophic nails and paring and curettement of four lesions were performed, then procedure codes 11719 and 11057 should be billed. If only trimming of nondystrophic nails is performed, then code 11719 should be billed.

Documentation Requirements

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

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

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17304: MOH's Micrographic Surgery

An article was printed in the March/April 1998 Medicare B Update! regarding Moh's Micrographic Surgery (MMS). The first paragraph of that article made a general statement regarding what was involved in the surgery. However, a physician may bill for MOH's surgery and a repair/closure code and be reimbursed. The article may have inadvertently led physicians to believe that the repair/closure was included in the basic allowance of MMS. It is not. The repair codes describe separate procedures which are reimbursed separately.

***** 36533: Billing of Tesio Catheters

Numerous inquiries have been received regarding the proper billing and documentation requirements when Tesio Catheters are inserted.

When these catheters are inserted, procedure code 36533 (Insertion of implantable venous access port, with or without subcutaneous reservoir) should be billed twice, one with procedure code modifier 76 (repeat procedure) and one without modifier 76. Documentation does not have to be submitted at the time the claim is filed, however, it must be available on file in case of a postpayment audit. These services may be submitted electronically.

***** 20974, 20975: Osteogenic Stimulation

Electrical stimulation to augment bone repair can be attained either invasively or noninvasively. Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. The power pack for the latter device is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. The power supply for the former device is externally placed and the leads connected to the inserted cathodes. With the noninvasive device, opposing pads, wired to an external power supply, are placed over the cast. An electromagnetic field is created between the pads at the fracture site.

Both non-invasive and invasive electrical stimulation (procedure codes 20974 and 20975) are covered by Medicare when the service meets the requirements as identified in the Medicare Carriers Manual.

Noninvasive Stimulator:

The noninvasive stimulator device is covered only for the following indications:

Nonunion of long bone fractures;

Failed fusion, where a minimum of nine months has elapsed since the last surgery;

Congenital pseudarthroses; and

As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Nonunion, for all types of devices, is considered to exist only after six or more months have elapsed without healing of the fracture.

Invasive Stimulator:

The invasive (implantable) stimulator device is covered only for the following indications:

Nonunion of long bone fractures;

As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Nonunion, for all types of devices, is considered to exist only after six or more months have elapsed without healing of the fracture.

Reasons for Denial

There is insufficient evidence to support the medical necessity of using an ultrasonic osteogenic stimulator. Therefore, the device is not a covered service.

Documentation Requirements

Documentation must support that this service meets the requirements as listed in the indication section of the policy. This information is normally found in the office/progress notes and/or operative report.

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86316: CA 27.29

The cancer antigen CA 27.29 is a mucinous glycoprotein that can be detected by monoclonal antibodies. The CA 27.29 marker is a tumor-associated serum marker available for monitoring the treatment and recurrence of carcinoma of the breast.

Medicare of Florida will consider CA 27.29 (CPT code 86316) to be medically reasonable and necessary for the following conditions:

- CA 27.29 is used as an aid to predict recurrent breast cancer in patients with previously treated Stage II or Stage III disease; or
- CA 27.29 is used as an aid in monitoring response to therapy in patients with Stage IV breast cancer. A partial or complete response to treatment will be confirmed by declining levels. Likewise, a persistent rise of CA 27.29 levels despite therapy strongly suggests progressive disease.
- Additionally, only those tests which are FDA approved are covered by Medicare. Currently, the Truquant BR RIA is the only FDA approved device indicated for the quantitative determination of the CA 27.29 antigen.
- CA 27.29 is not indicated as a screening test.

ICD-9 Codes That Support Medical Necessity

174.0-174.9 Malignant neoplasm of the female breast

175.0-175.9 Malignant neoplasm of the male breast

V10.3 Personal history of malignant neoplasm, breast

Coding Guidelines

When billing for a tumor antigen which is not FDA approved or is considered investigational or experimental, use code A9270 which represents a noncovered item or service.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test, including the appropriate ICD-9 codes. This information can usually be found in the history and physical, office/progress notes, and/or laboratory results.

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of the 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 Requirements

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

82947, 82948, 82962: Blood Glucose Testing

On pages 32 and 33 of the July/August 1997 Medicare B Update, the coverage criteria for Blood Glucose Testing were published. Since the publication of that article, the following diagnosis has been added:

790.6 Other abnormal blood chemistry

When billing for the diagnosis of elevated blood sugar, as evidenced by a laboratory result, use ICD-9 code 790.6. ICD-9 code 790.6 is indicated for "other abnormal blood chemistry;" however, for blood glucose testing it is only covered when the test is being performed for an elevated blood sugar.

Advance Notice Requirement

Applies to diagnosis (see page 4).

95900: Nerve Conduction Studies

Electrodiagnostic studies can be used to determine whether a disease process is limited to a particular peripheral nerve, nerve root, portion of the brachial or lumbosacral plexus, or muscle.

The purpose of these tests is to determine any changes in NCV in various disease states. These may consist of "single nerve" conditions or conditions involving "multiple nerves." Nerves may be predominantly sensory, motor, or mixed.

Single Nerve Syndrome

- mononeuropathy

Multiple Nerve Syndrome

- inflammatory and toxic neuropathy
- postlaminectomy syndrome
- brachial neuritis or radiculitis
- thoracic or lumbosacral neuritis or radiculitis, unspecified
- diabetes with neurological manifestations*
- hereditary and idiopathic peripheral neuropathy*

* In diabetic polyneuropathy code first the underlying disease but add the specific neurological code.

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

Nerve conduction measurements involve stimulating a nerve at one point and recording the response, either at the muscle (motor nerve) or at some distance along the nerve (sensory nerve). The results of nerve conduction studies usually include latency of response, conduction velocity, and amplitude of response. The latency of response refers to the time elapsed between the start of the stimulus and the muscle response (muscle fiber depolarization) or nerve response (sensory nerve action

potential). The conduction velocity between two points along the nerve is expressed in meters per second.

Indications and Limitations of Coverage and/or Medical Necessity

Nerve Conduction Studies:

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

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

The carrier is cognizant of the fact that patients are not always referred with a definite diagnosis in mind. Often, pain or numbness in an extremity is the reason for a nerve conduction study. Therefore, symptom-based diagnoses such as "pain in limbs" (729.5), "disturbance in skin sensation" or "paresthesia" (782.0), or "weakness" (780.7) are acceptable provided the clinical history unequivocally supports the need for a study.

Only a limited number of nerves can be tested, in practicality, and the examination must be tailored to clinical impression. Commonly evaluated nerves include:

- upper extremity- median, ulnar, radial nerve
- lower extremity- peroneal, tibial, superficial peroneal, sural nerves

Less accessible nerves in the upper extremity include the brachial plexus and shoulder girdle nerves. In the lower extremity the lumbosacral plexus, saphenous nerve, and lateral femoral cutaneous nerve are relatively difficult to test and are usually used for patients whose clinical symptoms lead you to these areas.

Generally, the following diagnoses may be established without exceeding the motor and sensory nerve conduction unit limits given below:

Conditions: Carpal Tunnel (unilateral)
Motor NCV 95900: 3
Sensory NCV 95904: 4

Conditions: Carpal Tunnel (bilateral)
Motor NCV 95900: 4
Sensory NCV 95904: 4

Conditions: Radiculopathy (i.e., sciatica)
Motor NCV 95900: 3
Sensory NCV 95904: 2

Conditions: Mononeuropathy
Motor NCV 95900: 3
Sensory NCV 95904: 3

Conditions: Polyneuropathy
Motor NCV 95900: 4
Sensory NCV 95904: 4

Conditions: Myopathy- muscle disease
Motor NCV 95900: 2
Sensory NCV 95904: 2

Conditions: ALS- motor neuron disease
Motor NCV 95900: 4
Sensory NCV 95904: 2

Conditions: Plexopathy
Motor NCV 95900: 4
Sensory NCV 95904: 6

Conditions: Neuromuscular Junction disorder
Motor NCV 95900:
Sensory NCV 95904:

Repeating nerve conduction studies should be based on clinical justification. There should be evidence-based documentation for any repeat study. However, you could see nerve conduction studies repeated after the initial diagnosis has been made for the following conditions:

- for a patient with worsening signs and symptoms;
- for new trauma or injury to the affected area;
- for a patient who is being managed medically for a condition and who is not showing signs of improvement using current prescribed modalities.

Repeat testing should only be performed for conditions that require medical management and meet the coverage criteria listed in this policy.

Reimbursement for (NCV) studies 95900, 95903, 95904 is limited to certain diagnosis criteria for all specialties. See Covered ICD-9 Codes.

HCPCS Codes

95900 Nerve conduction, amplitude and latency/velocity study, each nerve, any/all site(s), along the nerve: motor, without F-wave study

95903 Nerve conduction, amplitude and latency/velocity study, each nerve, any/all site(s), along the nerve: motor, with F-wave study

95904 Nerve conduction, amplitude and latency/velocity study, each nerve, any/all site(s), along the nerve: sensory

ICD-9 Codes That Support Medical Necessity

- 250.61-250.63
- 337.20-337.29
- 354.0-354.9

- 355.0-355.6
- 355.71-355.79
- 355.8-355.9
- 356.0-356.9
- 357.0-357.9
- 359.0-359.9
- 722.80-722.83
- 723.1
- 723.4
- 724.4
- 729.5
- 780.7
- 782.0

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Reasons for Denial

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

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

Noncovered ICD-9 Code(s)

Any ICD-9 diagnosis code not listed as a covered diagnosis in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

Claims for nerve conduction studies should be billed using procedure codes 95900, 95903, and 95904.

Current perception threshold testing (neurometer CPT) is considered part of an evaluation and management service and should not be billed separately. Any claim reporting CPT testing as nerve conduction and/or latency studies would not be appropriate and will be denied.

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

Segmental testing of a single nerve will not be reimbursed on a multiple unit basis. For instance, testing the ulnar nerve at the wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will all be considered as a one unit test of 95900 or 95904. Different methods of measuring the conduction in the same nerve will not be reimbursed as separate services. For instance, even if two or more methods of testing are used (as orthodromic and antidromic testing) to obtain results from a single nerve, only one unit of charge will be paid.

Documentation Requirements

The clinical history and examination, carried out before the study, must always describe and document clearly and comprehensibly the need for the planned test. Documentation should include patient history for sensory and/or motor nerve dysfunction.

The patient's medical records must clearly document the medical necessity of the test and the type of test to be performed. This information along with the nerve conduction study results is usually found in the office/progress notes and/or history and physical. The performing provider, in addition to the referring provider, is responsible for determination of the appropriateness of a study .

99183: Hyperbaric Oxygen Therapy

On pages 54-57 of the March/April 1998 Medicare B Update!, the coverage criteria for hyperbaric oxygen therapy were published. Since the publication of that article, the following diagnosis has been added:

686.09 Other pyoderma

The only condition covered for hyperbaric oxygen therapy (procedure code 99183) under ICD-9 codes 686.01 (Pyoderma gangrenosum) or 686.09 (Other pyoderma) is Meleney's ulcer.

Other pyodermas and skin ulcers are not covered for hyperbaric oxygen therapy under Medicare Part B.

Advance Notice Requirements

Advance notice applies to medical necessity requirements (see page 4).

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What's New for EMC?

Year 2000 Update: Will Your Practice be Ready?

The Health Care Financing Administration (HCFA) has mandated that all electronic formats be millennium-compliant by December 31, 1998. Effective October 1, 1998, all systems must be updated in accordance with the following instructions. Specifications outlined below may be obtained via the HCFA website at www.hcfa.gov/Medicare/edi/edi.htm. For additional information regarding these changes, contact the Electronic Media Claims (EMC) department at (904) 354-5977.

HCFA Eligibility Inquiry and Response Flat File

This is to inform trading partners (i.e., vendors, clearinghouses, billing services, service bureaus and in-house programmers) who request Electronic Beneficiary Eligibility via the National Standard Flat File, that it will NOT be modified to accommodate the millennium. The National Standard Flat File will continue to contain six-digit dates. The use of this flat file is optional.

To receive a response with eight-digit dates, trading partners must convert to the ANSI X12 270/271 version 3051. This is a currently existing format and specifications can be obtained from the HCFA website.

ANSI X12 835 version 3051.4b

This is to inform trading partners who receive Electronic Remittance Notices that ANSI X12 835 version 3051.4b is millennium-compliant. ANSI X12 835 versions 3030 2B and 3051 3B will continue to contain the six-digit dates and use of these versions is optional. Trading partners who wish to receive a response with eight-digit dates, must convert to version 3051 4B. This new version will become effective for use July 1, 1998 and specifications can be obtained from the HCFA website.

PC-ACE Millennium Compliance

The PC-ACE All-Payer 1500 product for Medicare Part B is currently being tested for millennium compliance. Distribution of the millennium-compliant PC-ACE product is scheduled to begin May 22, 1998, in order to meet the July 1, 1998, implementation date.

The Top 3 EMC Error Report Messages for February

The following are the top three EMC error report messages generated during February 1998.

PROV NOT IN GROUP

This error message continues to be the highest volume of rejects. Research shows that most of the errors are created by having several suffixes on a PA group number as well as the doctor being attached to multiple group locations. There are several ways to remedy this error. First, call before you transmit and verify providers to each group. Second, keep all of your confirmation letters from Medicare Registration and refer back to these letters when adding the appropriate suffixes to the group and/or to the individual provider numbers in your software.

PROV # INCONS

This error message continues to be one of the highest volume errors. Research shows that most providers are not aware that they need to fill out an EDI enrollment form when their provider number changes or they apply for a satellite office. The following are requirements for an EDI enrollment form to be completed.

- If you were assigned a new provider number, whether it is a PA group or individual physician, and plan on sending electronic claims.
- If you were assigned a suffix for satellite office(s), whether it is a PA group or individual physician.
- If you changed from filing as a group to an individual.

If you are a contractual provider and not billing with a group number.

INV PROV NUMBER

This error message continues to be a high volume of our rejects because providers are using the wrong suffix on their individual number or their group number. Research shows that most providers entered the wrong suffix or they received a letter from Blue Cross Blue Shield of Florida's Provider Registration instead of from Medicare Part B Provider Registration. If you have applied for a number with Blue Cross Blue Shield of Florida, you must

also complete a HCFA 855 form to receive a Medicare Part B provider number.

Questions?

If you have any questions regarding this article, call (904) 791-6878.

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PC-ACE(tm): Medicare's Free Software

In the last quarter of 1996, Medicare Part B of Florida began offering a new software product called PC-ACE(tm) that replaced the MEDFACS and BLUEFACS software products. In addition to Medicare Part B claims, this product contains the ability to bill Blue Cross Blue Shield, HMO and commercial claims. From a single software package, users can bill virtually every insurance claim electronically, therefore minimizing the need for paper claims. The PC-ACE(tm) software is already being used successfully by many senders.

Features Offered With PC-ACE(tm)

One of the most exciting features available in this software is the print image import capability, which will allow you to export claims from your existing system into PC-ACE(tm), eliminating the need for re-keying. Other exciting features that PC-ACE(tm) offers are:

- Patient information database
- Submitted claims tracking database
- Paid claims history database
- Extensive editing of claims prior to transmission
- Correction/update of stored claims
- HCFA-1500/UB92 print capability
- Claim re-submission capability
- Procedure code price list (HCFA-1500)
- Revenue code price list (UB92)
- National Standard and ANSI 837 formatting (future)
- Auto-posting, translation and export of ANSI x.12 835 remittance

- Help screens
- Reporting sub-system

Benefits of PC-ACE(tm)

- It's FREE!
- Reduce the cost of purchasing HCFA 1500 forms
- Reduce the cost of postage (save stamps for other uses)
- Reduce time spent completing insurance forms
- Clean electronic claims are paid on the 14th day versus 27 days for paper claims
- Electronic posting of accounts receivable (ERN) saving your office time and money
- Less administrative cost (the cost is estimated to be about fifty cents per claim)
- Confirmation report stating receipt of your claims
- Eliminate possible keying errors - You key the claims, you're in control!
- Lines are available 24 hours a day, seven days a week
- Toll-free access for sending claims for participating providers

For More Information...

To receive more information on our PC-ACE(tm) software contact the PC-ACE(tm) support area at (904)355-0313. To receive the paperwork needed to apply, contact Provider Electronic Services (PES) area at (904)791-8767.

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Ben Franklin said, "An ounce of prevention is worth a pound of cure." We could not agree more with Ben. It is far more efficient to prevent an inappropriate Medicare payment from occurring than to chase it down later for recovery.

One component of our prevention strategy is to exercise extreme care in issuing billing numbers to physicians and suppliers. The Health Care Financing Administration's new national enrollment form, implemented last summer, and provisions of the Balanced Budget Act of 1997 that raise the enrollment standards for providers, will strengthen the Medicare program's enrollment process. However, in areas that are highly susceptible to

Medicare fraud and abuse, extra precaution _or as Ben might say, another ounce of prevention_ is in order. We now visit providers in Miami who are applying for new billing numbers to validate certain aspects of their enrollment applications prior to approving them.

The results from these visits have been impressive and have prevented _there is that word again_ "bad apples" from gaining access to the Medicare trust funds. Along the way, we have also encountered a few things that are_well, odd. I thought you might find a few of them interesting:

- We visited a facility that had applied as a medical clinic specializing in rehabilitative medicine, only to find a massage therapist and no doctors. The availability of an acupuncturist was advertised in the window.
- We visited the purported address of a laboratory specializing in pulse oximetry tests, only to find a warehouse full of used clothing and shoes and an active import/export business.
- We visited a community mental health center, only to find the entrance gate padlocked. Among the dust and scattered rudimentary art were several pair of shoes waiting for their owners to return.

As one of our employees who has conducted hundreds of these visits likes to say, "You can't make this stuff up." Has anyone seen my bifocals?

Implementation of Court Order in National Medical Care v. Shalala

On January 9, 1998, the Court issued a memorandum and an interlocutory order in National Medical Care v. Shalala. Essentially, the Court barred HCFA from requiring plaintiff to apply HCFA's April 24, 1995 clarification of its interpretation of the Omnibus Budget Reconciliation Act of 1993 change in the Medicare Secondary Payer (MSP) ESRD provision to services provided on or after August 10, 1993 and prior to April 24, 1995. This bulletin advises providers and suppliers of the decision that HCFA has made regarding implementation of this interlocutory order.

HCFA had previously extended until December 31, 1997 the time period during which initial claims for services, provided between August 10, 1993 and April 23, 1995 and related to the issue in this case, must be filed. Claims related to the issue are those that involve services that were provided to Medicare beneficiaries who: (a) were entitled on the basis of ESRD as well as age or disability; (b) had GHP coverage at the time the services were provided; and (c) received the services during their first 18 months of entitlement based on ESRD.

The time period for providers and suppliers to file claims for services provided between August 10, 1993 and April 23, 1995 related to the issue in the NMC case will not be extended further at this time. (HCFA never extended timely filing for services provided after April 23, 1995.) In addition, Medicare will not reopen, at this time, any claims for services provided between August 10, 1993 and April 23, 1995 where the basis for the requested reopening is related to the issue in the NMC case. Following ultimate disposition of this case, HCFA will afford all providers and suppliers an opportunity to submit initial claims affected by the ultimate orders in this case, and will provide further guidance on reopening claims.

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What Impact Does The Health Insurance Portability And Accountability Act Of 1996 Have On You? More Than You May Have Realized.

Dear Colleague:

The Administrative Simplification provisions of the Act mandate that the Secretary of Health and Human Services adopt national standards for the electronic transmission of health care transactions. All health plans and clearinghouses and those providers who use electronic data interchange must meet these standards. That's right - not just the Medicare and Medicaid programs but all health plans. The provisions also require national standards for medical code sets; standard identifiers for providers, health plans, employers, and individuals; and security and privacy standards.

A wide range of organizations and individuals will be affected, including those that:

- Pay health care claims or coordinate benefits across payers.
- Submit claims to health plans.
- Submit medical encounter data to managed care plans.
- Enroll employees in health plans.
- Pay premiums to health plans.
- Conduct authorized referrals.
- Provide prior authorization for services.
- File first reports of injury for worker's compensation.
- Query insurance eligibility or claim status.

The standards for these health care transactions, code sets, identifiers, and security are scheduled to go into effect 2 years after they are adopted by the Secretary. (Small health plans have one extra year.) At that time, organizations will need to be able to accept standard electronic transactions from their customers. In addition, the Secretary has made recommendations to Congress for privacy legislation to protect individually identifiable health information. Standards for claims attachments will also be adopted, and will be proposed in the next year.

There will be clear benefits to those who use electronic transactions. With a national standard, the same claim can be sent to any insurance company for payment, greatly simplifying claims submission for providers. And payers will know exactly what a claim from any provider will look like - it will be the same as claims from other providers.

The Department of Health and Human Services (DHHS) and other Federal and State agencies have been hard at work since the passage of the Act in August 1996. After extensive consultation with technical and professional organizations, a series of standards is ready to be proposed. The standards to be adopted will build on the voluntary consensus standards already developed by the private sector.

We have received extensive industry input to date but are continuing to look for comments on these standards. The Notices of Proposed Rule Making (NPRMs), the first official publications of the proposed standards, are expected to be published in the Federal Register shortly. In addition, the NPRMs will be available from the Department's Administrative Simplification World Wide Web site at:

<http://aspe.os.dhhs.gov/admsimp/>

Because you will be directly affected by these standards, we urge you to carefully read the proposed rules and provide your comments to the addressees noted in the NPRMs. These comments will be critical in determining the final set of standards to be adopted. We ask that associations work with their members to provide input to us.

DHHS has arranged for the implementation guides for proposed standards to be available on the World Wide Web. The guides can be downloaded free of charge from the Washington Publishing Company Web site at::

<http://www.wpc-edi.com/HIPAA>

Additionally, now is the time for you to begin planning for implementation of these new standards. This is an opportunity to move from paper transactions to electronic transactions, to move

from proprietary systems to open systems - to move to national standards.

We urge you and your members to begin the process of implementation by discussing these transactions with your business partners and with the vendors that provide these services.

So watch the Federal Register, watch the Web site, and start the implementation process. Now is the time.

Yours truly,

Bill Braithwaite
Karen Trudel
Co-Chairs, HHS Data Council, Committee on Health Data Standards

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Additional Telephone Review Services

In the past, providers could request a telephone review for claims requiring corrections and/or changes to the following items:

- Date of service (except for change in year, i.e., 1997 to 1998; year of service changes must be made via a written request)
- Billed amount
- Procedure code
- Add, change or delete a modifier (except modifiers 22, 24, 62, 64 and 66; changes to these modifiers require a written review request)
- Place of service
- ICD-9-CM diagnosis code, and/or
- Number/quantity billed

In addition to the above-mentioned items, the Provider Customer Service department now offers telephone reviews for certain medical necessity denials on assigned claims. Telephone reviews will be granted for the following procedure codes, provided the appropriate documentation is submitted with the review request.

Procedure Code: 71020
Descriptor: Chest x-ray
Documentation Requirements: Office Records/Progress Notes, Test Results

Procedure Code: 90801
Descriptor: Psychiatric Diagnostic
Documentation Requirements: Diagnostic Interview Exam

Procedure Code: 93000
Descriptor: Electrocardiogram
Documentation Requirements: Office Records/Progress Report

Procedure Code: 93307
Descriptor: Echocardiography
Documentation Requirements: History and Physical, Test Results,
Office Records/Progress Notes

Procedure Code: 93227
Descriptor: Holter Monitoring
Documentation Requirements: Office Records/Progress Notes,
Holter Monitor Report

Procedure Code: 98940-98942
Descriptor: Spinal Manipulation
Documentation Requirements: Office Records/Progress Notes which
include the following: Initial patient history and physical for
the current condition; Patient complaint/symptom/condition must
match treatment provided; Date of onset; Response to daily
treatments; Treatment plan including beginning and ending dates
and frequency; Any changes to original treatment (either patient
or physician generated); Other treatment provided; Nature of
patient's condition; Expected prognosis; Documented evidence that
manual manipulation was performed; and X-ray report documenting
existence of subluxation for the primary condition reported

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

The Customer Service Representative will then give the provider a
confirmation number and instructions for faxing the review
request. A copy of the medical review cover sheet to be used for
the above mentioned procedure codes, can be found on page 57. A
cover sheet must accompany each claim to be reviewed. Each caller
will be limited to five review requests per call.

TO: MEDICARE PART B CUSTOMER SERVICE

FAX: (904)791-8318

FROM: _____

PHONE: _____

OF PAGES (INCLUDING COVER SHEET): _____

CONFIRMATION NUMBER: _____

HEALTH INSURANCE NUMBER (HIC): _____

NOTES: _____

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Health Professional Shortage Area Designations

Physicians are eligible for a quarterly incentive payment for services they furnish in certain medically underserved areas. These areas, known as Health Professional Shortage Areas (HPSAs), may cover an entire county, or only a portion of a county or city. They are designated as either rural or urban HPSAs.

The incentive payments are based on 10 percent of the paid amount for both assigned and nonassigned claims for services performed by the physician.

A physician is eligible for the HPSA incentive payment when the service(s) is furnished in an area designated as a HPSA, regardless of where the physician's office is located. For example, a physician's office may be located in an area not designated as a HPSA. However, the physician may treat a patient in a nursing facility which is located in a HPSA. In this case, the physician would be eligible for the HPSA incentive payment. Likewise, the physician's office may be in a HPSA; however, the physician treats a patient in his home which is not located in a HPSA. In this case, the physician is not eligible for the HPSA incentive payment.

To report services furnished in a HPSA, one of the following procedure code modifiers should be reported with the service:

QB Physician service rendered in a rural HPSA

QU Physician service rendered in an urban HPSA

In addition, Item 32 of the HCFA-1500 claim form or the equivalent fields for electronically submitted claims must be completed when either the QB or QU modifiers are billed. The physical location where the service was furnished must be indicated if it is other than the patient's home. However, if the address is the same as the billing provider's address (in Item 33), the word "SAME" may be indicated in Item 32.

As a note, only physicians are eligible for the HPSA incentive payments; there are no incentive payments for services furnished by non-physician practitioners (e.g., physician assistants, nurse practitioners, clinical psychologists, etc.).

A complete listing of the HPSAs in Florida begins below.

Florida Rural HPSAs

CALHOUN COUNTY
Effective Date: 10/31/88
Termination Date: 10/1/97
(Service dates on or after)

DIXIE COUNTY
Effective Date: 1/1/90
Termination Date: none

GILCHRIST COUNTY
Effective Date: 10/31/88
Termination Date: 10/1/97
(Service dates on or after)

GLADES COUNTY
Effective Date: 1/1/91
Termination Date: none

HAMILTON COUNTY
Effective Date: 6/1/93
Termination Date: none

HARDEE COUNTY
Effective Date: 10/31/88
Termination Date: 3/1/98
(Service dates on or after)

HENDRY COUNTY
Effective Date: 10/31/88
Termination Date: 10/1/97

(Effective for services on or after 10/1/97, only census tracts 9603 and 9604 of Labelle qualify.)

HOLMES COUNTY

Effective Date: 10/31/88
Termination Date: 10/1/97
(Service dates on or after)

JEFFERSON COUNTY

Effective Date: 10/31/88
Termination Date: 5/1/97
(Service dates on or after)

LAFAYETTE COUNTY

Effective Date: 10/31/88
Termination Date: none

LEVY COUNTY

Effective Date: 9/1/93
Termination Date: 3/1/98
(Service dates on or after)

MADISON COUNTY

Effective Date: 10/31/88
Termination Date: 5/1/98
(Service dates on or after)

PUTNAM COUNTY

Effective Date: 4/1/92
Termination Date: 8/1/97

SUMTER COUNTY

Effective Date: 10/31/88
Termination Date: 5/1/97

SUWANNEE COUNTY

Effective Date: 10/31/88
Termination Date: none

TAYLOR COUNTY

Effective Date: 5/1/93
Termination Date: none

UNION COUNTY

Effective Date: 1/31/88
Termination Date: none

WAKULLA COUNTY
Effective Date: 1/31/88
Termination Date: none

WALTON COUNTY
Effective Date: 1/31/88
Termination Date: 10/1/97
(Service dates on or after)

WASHINGTON COUNTY
Effective Date: 12/1/97
Termination Date: none

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Florida Urban HPSAs

BRADFORD COUNTY
Effective Date: 1/1/91
Termination Date: none

CLAY COUNTY
Keystone Heights/Keystone Heights Division
Effective Date: 6/1/93
Termination Date: none

COLLIER COUNTY
Everglades
Census Tracts 111.01-111.02
Effective Date: 6/1/93
Termination Date: none

COLLIER COUNTY
Imokalee
Census Tracts 112.01-112.03
Effective Date: 6/1/93
Termination Date: none
Census Tracts 113-114
Effective Date: 1/1/91
Termination Date: none

DADE COUNTY
Southern Dade (Homestead)
Census Tracts 103-105, 106.02, 107.01, 108-109
Effective Date: 1/1/91
Termination Date: none
Census Tracts 110.01-110.02

Effective Date: 7/1/94
Termination Date: none
Census Tract 111
Effective Date: 1/1/91
Termination Date: none
Census Tracts 112.01-112.02
Effective Date: 7/1/94
Termination Date: none
Census Tract 113
Effective Date: 1/1/91
Termination Date: none
Census Tract 114.98
Effective Date: 7/1/94
Termination Date: none

DADE COUNTY

Wynwood

Census Tracts 14.01-14.02, 20.01, 20.03-20.04, 21, 22.01-22.02,
25
Effective Date: 6/1/93
Termination Date: none
Census Tracts 26, 27.01-27.02, 28
Effective Date: 1/1/91
Termination Date: none
Census Tract 29
Effective Date: 6/1/93
Termination Date: none

DADE COUNTY

Model Cities

Census Tracts 4.08, 8.01-8.02,
9.01-9.02
Effective Date: 3/1/93
Termination Date: none
Census Tracts 9.03, 10.01-10.04
Effective Date: 1/1/91
Termination Date: none
Census Tract 11.03
Effective Date: 3/1/93
Termination Date: none
Census Tract 15.01-15.02
Effective Date: 1/1/91
Termination Date: none
Census Tracts 16.01-16.02
Effective Date: 3/1/93
Termination Date: none
Census Tracts 17.01-17.02, 18.01-18.03, 19.01
Effective Date: 1/1/91
Termination Date: none
Census Tracts 19.03-19.04
Effective Date: 3/1/93
Termination Date: none
Census Tract 23
Effective Date: 1/1/91

Termination Date: none

ESCAMBIA COUNTY

Century CCD/Northwest Escambia/CCD

Census Tracts 38-40

Effective Date: 9/1/94

Termination Date: none

GADSDEN COUNTY

Effective Date: 1/1/91

Termination Date: 1/1/98

(Service dates on or after)

HILLSBOROUGH COUNTY

East Tampa/Ybor City

Census Tract 10

Effective Date: 1/1/91

Termination Date: 5/1/98

Census Tract 17

Effective Date: 6/1/93

Termination Date: 5/1/98

Census Tracts 18-19, 30-44, 49-51

Effective Date: 1/1/91

Termination Date: 5/1/98

(Service dates on or after)

LEE COUNTY

Dunbar

Census Tracts 5.01-5.02, 6

Effective Date: 6/1/97

Termination Date: none

MARTIN COUNTY

Indiantown/Indiantown CCD

Effective Date: 1/1/91

Termination Date: none

NASSAU COUNTY

Callahan/Hilliard

Census Tracts 504-505

Effective Date: 1/1/91

Termination Date: 4/1/97

(Service dates on or after)

PALM BEACH COUNTY

West Palm Beach

Census Tract 20

Effective Date: 6/1/93

Termination Date: none

Census Tracts 21-26
Effective Date: 1/1/91
Termination Date: none

POLK COUNTY

Polk City/Eva
Census Tracts 116, 123, 124
Effective Date: 8/1/93
Termination Date: none

POLK COUNTY

Frostproof/Lake Wales
Census Tracts 142-144, 154-160, 161.98
Effective Date: 6/1/93
Termination Date: none

VOLUSIA COUNTY

Pierson/Seville/Deleon Springs
Census Tract 0901.00
Effective Date: 3/1/98
(Service dates on or after)
Termination Date: none

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Claims Sent Back for Review Because of Incorrect Diagnosis Cost
the Medicare Program Millions of Dollars

During the first half of fiscal year 1998 (October 1997 through
March 1998), 435,585 services filed to Medicare Part B were
denied due to the diagnosis. The Health Care Financing
Administration funds Medicare Part B carriers approximately \$8.76
for each review processed, including those denied due to an
incorrect diagnosis being submitted with the original claim.
While we understand that errors can occur from time to time, we
would expect them to be minimal.

This denial (diagnosis not payable for service billed) occurs
when the ICD-9 diagnosis code billed is not considered "covered"
for the procedure rendered. This means the Medicare carrier will
only allow the service for certain ICD-9 diagnosis codes. While
some of these denials are appropriate, many are billing errors
that can be avoided by:

- Referencing the Medicare B Update!;
- Accessing the Medicare Bulletin Board System (BBS);
- Purchasing a Procedure/Diagnosis Relationship Report booklet
(\$15.00 + tax);

- Calling the Medicare Part B Automated Response Unit at (904) 353-3205; or

- Calling the Medicare Part B Provider Customer Service Department at (904) 634-4994.

NOTE: The diagnosis/relationship booklet order form is located in all issues of the Medicare B Update!

We look forward to your support in helping us to safeguard the Medicare trust fund as we go into the twenty-first century.

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

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

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

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Florida Medicare B-Line BBS

What is the B-LINE?

The B-Line is a Bulletin Board System (BBS) available to all. It enables you to access vast amounts of important Medicare (Part A and B) information, electronically. Access can be obtained by using your office or home computer and is available 24 hours a day, 7 days a week. Toll-free access is available to participating providers one business day after initial access and registration on the toll line.

What's available on the B-LINE?

Once you've connected to the B-Line 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 things like:

Medicare Part A - Medical Policy Manual, Bulletins, Reason Codes, Computer Based Training (CBT) Modules, etc.

Medicare Part B - UPIN Directory, Medigap Listing, Publications (UPDATE!), Fee Schedules, Medical Policy Manual, EDI Format Specifications Manuals, Computer Based Training (CBT) Modules, etc.

And much more will be available in the future.

What you need to access the B-LINE

- Personal Computer (PC)
- Telephone Line
- Modem - internal or external
- Communication Software - There are dozens of programs available such as PCAnywhere, Procomm, HyperTerminal, 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 B-Line using the B-Line phone numbers.

Windows95 - comes with a built in program called HyperTerminal and can be accessed by: selecting Start, then Programs, then Accessories and then HyperTerminal. Follow the Wizard set-up instructions on screen to access the B-Line.

Free Software Available - If you are unable to use your existing software, Medicare has a communication program called Banacom, available free of charge. To obtain Banacom contact the B-Line Help Line at (904)791-8384.

Note: Banacom will not work with UNIX or APPLE computers. We suggest you contact your software support vendor for alternatives.

B-Line User-ID and Password

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

To Access the B-Line:

(904)791-6991 Jacksonville FL users

(800)838-8859 All Other users

BBS Voice Help Line: (904)791-8384

Welcome To The B-Line BBS !!!

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Windows 95 Access to the "B-Line BBS"

Using HyperTerminal

Windows 95 includes a communications program called HyperTerminal which will allow you to connect to the B-Line 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. First time users must enter area code 904 (if outside the 904 calling area) and phone number 791-6991. Users with existing accounts should enter the area code and telephone number they are now using. 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 B-Line BBS.

Signing On To The B-Line - If you are a new user to the B-Line, 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. Within 48 hours we will verify your participation status and allow you to access the B-Line via a toll-free number (see "Modifying HyperTerminal Dialing Number for Toll Free Access" below on how to change the dialing number).

That's it - when you sign off the B-Line 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 "B-Line BBS". Simply double-click on this icon to connect in the future.

Modifying HyperTerminal Dialing Number for Toll Free Access

If you are a participating physician outside the 904 calling area, you will be able to access the B-Line BBS via a toll-free number. Please remember that first time users must follow the steps above to establish an account; upon verification of your participation status (within 48 hours), you will be able to modify your account for toll-free access.

Double-click the B-Line BBS icon to open. The Connect box will appear.

Click the Modify button. Select the Phone Number tab and change the area code to 800 and the phone number to 838-8859. Click OK to save this change.

Click Dial to make your call using the new telephone number.

Need Help?

If you have any questions or problems with the B-Line BBS, contact our Voice 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 DOS based

communication software program which will enable you to access the B-Line BBS.

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New Web Site For Medicare Online Training

Jacksonville, Florida

Florida Medicare launched a Web site (www.floridamedicare.com) in early 1998 designed to capitalize on the emerging Internet-based training market.

Users of the Web site can take free training courses that help them develop their Medicare billing skills and knowledge like ICD-9-CM Coding, Office Management, etc.

The technology benefits both the Medicare contractor as well as the Medicare provider community. "Web-based training gives the Medicare contractor yet another channel to reach new audiences, build new partnerships, and deliver up-to-date materials and services," says Philip Zoller, an instructional designer at Florida Medicare. "The lure for providers is the flexibility to have control over their learning environment."

It's expensive for physicians and facilities to send workers to offsite training, and it can disrupt their operations. Training with books and CD-ROMs is convenient and cheaper, but students can get bored, and there's no easy way to get answers to questions that may arise.

Florida Medicare's Web site combines the two methods by creating free materials that can be used on the Web, 24-hours a day, seven days a week, while providing access to fellow students in real time via chatrooms, or using e-mail.

Here's How It Works:

Students can go to the Florida Medicare Web site by typing in www.floridamedicare.com in the address field of their browser, click on "Computer Based Training" and register to take a lesson. A 10-minute orientation tells students how to set up their computers, what kind of basic hardware they'll need, and how to download features such as the training plug-in software.

In almost every lesson, students will have the opportunity to practice what they've learned through quizzes and tests. After each test is taken, students are given full access to their results instantly. Students can take as long as they want to complete each lesson.

Zoller said that Florida Medicare has provided computer-based training to about 7,000 students so far. Most of the students, who are primarily Medicare providers and billing specialists,

have taken the free lessons by downloading them off of the contractor's bulletin board system (BBS). "The Web offers the ability to interact with the student much more than with the BBS," adding, "usage will explode as more people begin to use the Web."

All of these services are provided FREE of charge!

What are the System Requirements to use Medicare Online Training?

- Windows 95 or NT
- Netscape 3.0 or higher; or
- Microsoft Internet Explorer 3.01 or higher

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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

B Line BBS

Access:

1-800-838-8859

1-904-791-6991

Technical Problems:

1-904-791-8384

BENEFICIARY

Outside Duval County (in Florida):

1-800-333-7586

Duval County (or outside Florida):

904-355-3680

Hearing Impaired:

1-800-754-7820

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

EMC

EMC Billing Problems/Guidelines:

904-354-5977

EMC Start-Up:

904-791-8767

EMC Front-End Edits/Rejects:

904-791-6878

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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