

January/February 1998 Medicare Part B Update! Publication

HCFA
Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.
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Balanced Budget Act of 1997

The Balanced Budget Act of 1997 was signed into law by President Clinton on August 5, 1997. Several provisions of the Balanced Budget Act have direct impact to the Medicare program. The following information highlights some of the major changes to the Medicare program:

- Expansion of coverage for screening mammograms, screening pap smears and pelvic exams.
- New coverage for prostate cancer screening tests.
- Coverage for colorectal cancer screening services.
- National coverage policy for bone mass measurement studies.
- Several new anti-fraud and abuse provisions.
- Use of private contracts between Medicare recipients and their physicians.
- Expansion of coverage for nurse practitioners, clinical nurse specialists and physician assistants who furnish physician services.
- Provision of diagnostic information by non-physician practitioners and by practitioners who order diagnostic services.

Many of the Balanced Budget Act provisions are effective for services furnished on and after January 1, 1998. Coverage and claim filing instructions for some of these provisions of law may have been published either in this Update! or in the December 1997 Update!

Special Issue: 1998 HCPCS and MPFSDB Update. However, final coverage and claim filing instructions for the remaining provisions have not yet been completed. Information regarding these changes will be published in future issues of the Update! as they become available.

What's New

1998 HCPCS/Balanced Budget Act Policy Revisions

Coverage policies have been established or revised as a result of the 1998 HCFA Common Procedure Coding System (HCPCS) update and the Balanced Budget Act of 1997. Specific information on these policies, such as the proper reporting of Routine Foot Care services, begins on page 13. In addition, our Medical Director, Sidney Sewell, M.D., has provided a brief overview of the BBA on page 3.

Questions and Answers on Private Contracts Between Beneficiaries and Providers

Section 1802 of the Social Security Act, as amended by 4507 of the BBA of 1997, permits a physician or practitioner to enter into private contracts with Medicare beneficiaries to provide covered services, if specific requirements are met. See page 36 for details.

Provision of Diagnosis Information

A provision of the BBA of 1997 now requires diagnosis information (i.e., ICD-9-CM codes) to be reported on claims for non-physician practitioner services. In addition, physicians and non-physician practitioners who order diagnostic services will be required to provide diagnosis information to the entity providing the service. See page 36 for more details.

CLIA Compliance

Beginning January 1, 1998, the CLIA number must be included on all claims for laboratory services, including purchased tests. This information applies to both clinical diagnostic laboratory services and surgical anatomical pathology services. If the CLIA number is omitted from the claim, it will be returned as unprocessable. See page 43 for additional information.

Highlights

- 1998 Medifest Schedule (p. 5)
- Standing Orders for Clinical Consultations (p. 35)
- Routine Screening/ Noncovered Diagnosis Codes (p. 41)
- Purchased Diagnostic Tests (p. 46)

- Remittance Format Changes (p. 56)
- Medicare Registration Information (p. 75).

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Medicare B Update!

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A Physician's Focus

A Physician's Focus

As most of you have probably heard, Congress made sweeping changes in Medicare coverage in the Balanced Budget Act of 1997. This is officially known as PL 105-33 and was enacted August 5, 1997. A detailed account of these changes appears on page 13 of this issue of the Medicare B Update!

A brief synopsis of the changes under "Subtitle B-Prevention Initiatives" are as follows:

A. Section 4101 provides enhanced screening mammography. The effective date is January 1, 1998. This section provides coverage for annual screening mammograms for asymptomatic women over 39 years of age. As of January 1, 1998, screening mammograms are no longer subject to the Part B deductible. There is no change in coverage of mammograms for women in other age groups. Payment may be made for one screening between a woman's 35th and 40th birthdays. No payment may be made for a woman under age 35.

B. Section 4102 provides increased coverage for screening pap tests and pelvic exams (including clinical breast exams). The effective date is January 1, 1998. This section of the BBA provides coverage every three years for a screening Pap smear and pelvic examination (including a clinical breast examination) or annual coverage for women (1) at high risk of cervical or vaginal cancer, or (2) of childbearing age who have had a Pap smear during the preceding three years indicating the presence of cervical or vaginal cancer or other abnormality. The Part B deductible for screening Pap smear and pelvic examinations is waived. Pelvic examinations will be paid under the physician fee schedule.

C. Section 4103 provides coverage for screening tests for prostate cancer. The effective date is January 1, 2000.

D. Section 4104 provides coverage for colorectal screening. The effective dates are January 1, 1998, and January 1, 1999. This section provides specific coverage of the following screening tests for colorectal cancer effective January 1, 1998: screening fecal-occult blood tests, screening flexible sigmoidoscopy, and screening colonoscopy. A comprehensive article on colorectal screening was published on page 84 of the December 1997 Medicare B Update! Special Issue: 1998 HCFA Common Procedure Coding System Update and Medicare Physician Fee Schedule Database Update.

E. Section 4105 provides diabetes self-management benefits. The effective date is July 1, 1998. In establishing payment amounts, HCFA will consult with appropriate organizations representing individuals or Medicare beneficiaries with diabetes, e.g., American Diabetes Association. Medicare coinsurance and deductibles will apply.

F. Section 4106 provides standardization of Medicare coverage of bone mass measurements. The effective date is July 1, 1998.

G. Section 4107 extends the Influenza and Pneumococcal Vaccination Campaign through fiscal year 2002. The effective date is October 1, 1997.

F. Section 4108 funds a study on preventive and enhanced benefits. The report is due within two years of enactment.

That is about the extent of the Medicare coverage changes for this year. There are many additional provisions of the Act dealing with the technical details of administering the Medicare program. All providers are urged to carefully read the articles beginning on page 13, and/or obtain a copy of the Balanced Budget Act for further details. This information was also contained in the 1998 Fact Sheet that was included in the 1998 participation packages.

Sidney R. Sewell, M.D.
Medical Director

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Advance Notice Requirement

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

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

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

- The notice must be given in writing, in advance of furnishing the service or item.
- The notice must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., service in not covered based on the diagnosis of the patient, the frequency of the service was furnished in excess of the utilization screen, etc.).
- The notice must be signed and dated by the patient indicating that he assumes financial responsibility for the service if it is denied payment as not medically reasonable and necessary for the reason(s) indicated on the advance notice. 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.

General Information About the Medicare B Update!

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

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

Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. If additional copies are needed, there are two options: purchase a separate annual subscription for \$75 (order form in FYI section), or download the text version from our on-line service, the B LINE BBS (see this issue for more information).

Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, a HCFA 855-C must be completed in the event of relocation. See page 53 of the September/October 1997 Medicare B Update! for a copy of this form.

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MEDIFEST

Medicare Part A and B Seminars for 1998

Medifest is a symposium of seminars where you can receive the latest and most accurate Medicare A and B information. You can take classes to understand ICD-9-CM and CPT coding, Fraud and Abuse, Medicare Secondary Payer, Claims Filing, Partial Hospitalization Program, and much more!

What's New for 1998?

Medifests will now last for two days, and specialty seminars will be offered the day after Medifest. There are a number of package deals

that are offered for attendees of Medifest and specialty seminar(s). See page 8 for pricing information.

FREE Exhibit Area

Everyone is invited to our free exhibit area to learn about office automation options available from vendor representatives, or to speak with Medicare and Medicaid staff.

Continuing Education Units Available!

You can receive Continuing Education Units (CEUs) for most Medifest classes. Details are available at each Medifest.

Tips for Registrants

- Some courses require the use of current CPT and/or ICD-9-CM books. Check the course descriptions for more details; if in doubt, bring both books.
- Pre-registration and pre-payment are required!
- We have new registration policy guidelines. See registration form for more details.
- Be sure to register for only one course per time slot.
- FAX YOUR REGISTRATION to (904) 791-6035 as early as possible, and no later than the deadline for registration, to help ensure your space in the classes you want.

1998 Medifest Schedule

Orlando
March 3-4
Orange County Convention Center

Miami
April 7-8
Radisson Mart Plaza Hotel

Tampa
May 5-6
Camberly Plaza Hotel

Orlando
June 30-July 1
Orlando Airport Marriott

Miami
August 18-19
Radisson Mart Plaza Hotel

Tampa
September 15-16
Camberly Plaza Hotel

Specialty seminars will be held the day after each Medifest. See inside for more information!

For more information about Medifest, see future editions of the Medicare A Bulletin and the Medicare B Update! Medifest dates, locations, schedules, and registration forms are run in both the Bulletin and the Update!

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Courses for Both Medicare Part A and B Billers

Beneficiary Education and Outreach: This course will help attendees address their patients' health insurance questions and learn where to refer their patients for additional assistance. Participants will also gain insight of issues affecting the beneficiary community. Each attendee will be introduced to educational/outreach information available for free to all providers and beneficiaries.

- Computer-Based Training (CBT)/Bulletin Board System (BBS): This course is designed to introduce attendees to Medicare's information superhighway, the BBS A step-by-step demonstration on how to access the BBS will be provided. The BBS allows its users to access information such as medical policy, fee schedules, Medicare B Updates!, Medicare A Bulletins, Medigap listings, and much, much, more! The course will also cover Computer-Based Training (CBT), an interactive training program located on the BBS. UB-92 claim filing, HCFA-1500 Claim Filing, Evaluation and Management Documentation Guidelines, and ICD-9-CM modules are only a few of the top quality modules available to you free of charge when you access the Medicare BBS. Specific computer and modem set-up information will be provided during this session.

- CPT for Beginners: This session is designed to provide the beginning coder with valuable techniques necessary to perform concise and accurate coding. The participants of this session will review basic medical terminology to include common "root" words, suffixes, prefixes and combining forms. We will review step-by-step the format of the CPT book, including structure and usage of the appendices. Participants will learn how to identify additions, deletions, and revisions and identify the appropriate procedure code(s) via practical applications. Be sure to bring the latest edition of the CPT manual to this course; it's a hands-on session! Note: For information relating to specific coverage and medical policy issues, please attend our specialtyseminars.

- Fraud and Abuse: Fraud in the health care industry is a sensitive and important issue which has gained national attention over the past few years. This course will detail the impact of fraud and abuse on the health care system, discuss scams/schemes found in Florida and define the problem and contractor actions. Participants will gain an understanding of what constitutes fraud, how to detect it, and ways to protect themselves from becoming a victim of fraud and abuse. Reporting methods will also be discussed.

- ICD-9-CM: This half-day course will provide attendees with an introduction to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) manual, including a brief overview of Volume III coding for Part A providers. Volume I is discussed and special emphasis is placed on the coding tables located in Volume II. Attendees will learn how to code to the "highest level of specificity" using practical examples. Attendees will also understand the key differences in reporting diagnoses for diagnostic versus surgical services. Also, a review of the claim completion requirements for reporting diagnoses and advance notification will be discussed. Finally, each attendee will leave understanding the importance of diagnosis coding as it relates to medical documentation. Be sure to bring the latest edition of the ICD-9-CM manual to this course; it's a hands-on session!

- Home Health Care (HHC) Benefit: This course will provide an overview of the Health Care Financing Administration (HCFA) and Regional Home Health Intermediary (RHHI) guidelines as they pertain to the home health benefit for HHC providers and referring physicians. A discussion of the coverage guidelines/criteria, HCFA initiatives, and fraud and abuse implications will take place.

- Local Medical Review Policy (LMRP): The class will outline why the local carrier/contractor creates medical policy and direct providers on how to access these policies. An overview of the process by which medical policies are developed and implemented will also be discussed. This course will also discuss local medical policies which were developed and implemented during the previous two quarters of the year. Finally, special emphasis will be placed on how to protect your practice from being heavily affected by new policies, and the benefits of the policy development process.

- Medicaid: An overview of the Medicaid program, including third party insurer information.

- Medicare Secondary Payer (MSP): This course is designed to provide you with everything you ever wanted to know about Medicare as the secondary payer. The information provided in this session will help you identify circumstances and situations that may lead to filing Medicare as the secondary payer. Information regarding MSP filing requirements, payment calculations and patient liability will also be provided.

Finally, practical examples of deductible calculations and payment calculations will help your practice avoid incorrect payments/collections.

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Courses Helpful to Medicare Part A Billers

Note: These courses are designed for providers serviced by Blue Cross Blue Shield of Florida Medicare Part A and may not prove effective for providers serviced by other Part A intermediaries!

- Comprehensive Outpatient Rehabilitation Facility (CORF)/Outpatient Rehabilitation Facility (ORF): This course provides an overview of the Health Care Financing Administration (HCFA) guidelines as they pertain to CORF/ORF providers and services. The course includes a high-level discussion of key UB-92 form locators and billing elements.

- Part A Medical Review/AI: This course provides an overview of the Artificial Intelligence (AI) system, including a discussion of medical applications contained in the AI system and the HCFA regulations that apply. A high-level overview of the Focused Medical Review (FMR), Comprehensive Medical Review (CMR) programs, and the Reconsideration and Review process will be provided.

- Part A Process Improvement: This course provides an overview of key UB-92 (HCFA-1450) form locators as they pertain to billing deficiencies. There will be a discussion on some key return-to-provider (RTP) and reject/duplicate reason codes. This course is designed to help billing staff with claims processing issues resulting from rejected and/or RTP claims. Also, the session will include a review of the current HCFA initiatives.

- Partial Hospitalization Program (PHP): This course provides an in depth review of HCFA's clarification of the Medicare outpatient partial hospitalization benefit, eligibility, and scope of services. This course incorporates a general discussion of key billing elements and documentation requirements. This course is designed for hospital and Community Mental Health Center providers only, including billing and clinical staff.

- Skilled Nursing Facility (SNF): This course provides an overview of the Health Care Financing Administration (HCFA) guidelines as they pertain to skilled nursing facility (SNF) providers and services. The course includes a high-level discussion of key UB-92 form locators and billing elements.

- UB-92 Beginning Billing: This course offers an individual review of each of the eighty-six form locators on the UB-92 (HCFA-1450) claim form and allowable billing entries. Specific billing situations will be discussed, including when to submit adjustments and/or cancel

transactions, and a high-level discussion of revenue code application. This course does not provide detailed billing instructions for each specific bill type or provider (e.g., hospital, SNF, CORF/ORF, ESRD, etc.). This course is designed for individuals who have little or no UB-92 billing experience and will help billers understand the information that should be reported via the UB-92 claim format.

Courses Helpful to Medicare Part B Billers

- Electronic Media Claims: This course is designed to educate existing and new electronic senders with specific information on the EMC process. It will also benefit providers interested in submitting electronic claims. An overview of the software formats and the cycle of an electronic claim is given. You will learn specifics about EMC reports, rejects and duplicate transmissions, and crossover information. A review of various electronic applications and their requirements will be provided. Participants will also learn the steps necessary to improve office efficiency.

- Evaluation and Management Coding Guidelines: This course will provide comprehensive instructions for coding office, hospital and nursing home visits. The course will focus on Medicare's billing guidelines for preventative services, critical care, care plan oversight, concurrent care and hospital observations. Attendees will also understand the key differences in reporting consultations verses referrals. Special emphasis will be made on reporting covered and non-covered services rendered during the same office visit. This course is designed to allow both new and experienced billers to benefit from its basic, yet in-depth outline.

- Evaluation and Management Documentation Guidelines: This course will provide an in-depth explanation of the latest Medicare guidelines for selecting and documenting the appropriate level of evaluation and management (E/M) code (office, hospital, nursing home visits, etc.). We will focus on the three key components of an evaluation and management visit - history, examination and medical decision making and how they should be documented. The course is designed for physicians as well as medical coders. Note: The documentation guidelines discussed in this course are only applicable to E/M procedure codes.

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- Global Surgery Modifiers: This course will focus on global surgery rules, including theory and practical application of modifiers 22, 24, 25, 57, 58, 59, 78, 79 for services rendered during the pre, intra, and post-operative period of surgery. This includes how to apply modifiers to evaluation and management services rendered prior to, in conjunction with or following minor and major surgeries. Attendees will also understand how to apply modifiers when other surgeries occur during the global period. Medicare rules and modifiers for multiple and bilateral surgery, surgical assistant and surgical teams will also be covered. The topics discussed in this course are applicable to all physician specialties.

- Inquiries/Appeals/Waiver: The inquiry section of this course will provide attendees with information relating to the different areas within the Medicare program and what they offer. It includes, but is not limited to, claim filing, coverage and reimbursement information. The appeals section will provide participants with the steps necessary for requesting telephone or written reviews. This course has also been designed to provide attendees with a sneak preview of how medical policies and claim filing guidelines impact the appeals process. Special emphasis will be placed on determining physician, supplier and patient liability when services are not considered reasonable and necessary.

- Medicare Part B Claim Filing: This course will provide comprehensive instructions for completing the HCFA-1500 claim form (items 1-33). Both new and experienced billers will benefit from the basic, yet in-depth approaches used, and from the discussion of the latest changes to the HCFA-1500 claim form. This course was designed for everyone who submits claims to Medicare Part B. Students will experience both instruction and practical examples. (Note: For specific information involving electronic applications, please attend the EMC course).

- Primary Care: This course will provide comprehensive instructions regarding radiology, pathology, allergy testing, and preventative services. We will focus on special reimbursement regulations such as psychiatric payment reductions, the incident to provision and limitations for screening procedures. Diagnosis criteria for injections and the documentation required for unlisted injections will also be discussed. Note: For information relating to specific coverage and medical policy issues, please attend our specialty workshops.

- Program Change: This session focuses on upcoming changes to the Medicare Program. We will review proposed changes and explain how these changes affect you. Some of the topics for 1998 include, Payer Identification Numbers (PAYERID), National Provider Identifier (NPI), changes to the HCFA-1500 claim completion requirements, new Medicare enrollment forms, and the Balanced Budget Act (BBA) of 1997. This session is designed with change in mind, so we will provide you with the most current information available at each Medifest seminar.

- Reimbursement/Office Efficiency: This course is designed to provide attendees with information regarding traditional Medicare Part B reimbursement (e.g., fee schedule development, Health Professional Shortage Area-HPSA, participation, etc.). During the interactive session, attendees will be provided with their own personal profiles, (Medicare Part B report cards) to evaluate their office effectiveness. Our focus is to provide you with valuable information to reduce the impact(s) to your daily office operations. Each participant is guaranteed to depart with at least one valuable tool to improve his/her office's efficiency.

Medifest and Specialty Seminar Prices

Price per person:

One day at Medifest \$149.00
Two days at Medifest \$199.00
One Specialty seminar \$99.00
Two Specialty seminars \$198.00

Package deals per person:

Package deals apply only to specialty seminars held the day after a Medifest. For example, if you attend the Miami April 7-8 Medifest, you may only attend an April 9 specialty seminar at the package deal price.

One day at Medifest and one Specialty seminar \$199.00
One day at Medifest and two Specialty seminars \$249.00
Two days at Medifest and one Specialty seminar \$249.00
Two days at Medifest and two Specialty Seminars \$299.00

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Medifest Class Schedule and Registration Forms

----Aavailable in BBS Menu selection "FAX Yourself Something".

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1998 HCPCS/Balanced Budget Act

The articles in this section of the Update! provide information regarding the effects of the 1998 HCPCS update and the Balanced Budget Act on the procedure codes listed in the December 1997 special issue of the Update! Providers' offices should pay close attention to the information in this section as it will affect their billing practices.

Policy Changes Relating to the 1998 HCPCS Update

The HCPCS update for 1998 is effective for services furnished January 1, 1998, and after. Lists of procedure codes added, revised and deleted as part of the update were published in the December 1997 Medicare B Update! Special Issue: 1998 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update. While there is a grace period during which deleted or invalid procedure codes may still be used for 1998 services dates (received before April 1, 1998), we encourage all providers to complete the transition to the new 1998 codes as soon as possible to prevent possible delays in claim payment. The coverage for the following procedures, which have been either added or revised for 1998, have been incorporated into existing policies. To assist providers in adjusting to the new coding structure, a reference to publications outlining Medicare's coverage requirements is outlined:

Added/Revised Codes: G0101

Related Code(s) or Policy: Screening Pelvic Examination
Publication: See page 15.

Added/Revised Codes: J0207
Related Code(s) or Policy: Amifostine (Ethyol)
Publication: October 1996, Special Issue, pg 6November/December 1996,
pg. 8

Added/Revised Codes:
Related Code(s) or Policy:
Publication:

Added/Revised Codes: J9170, J9201
Related Code(s) or Policy: Off-label Use of Chemotherapy Drugs
Publication: See page 52.

Added/Revised Codes: R0076
Related Code(s) or Policy: Transportation of portable EKG to facility
or location, per patient
Publication: December 1997; Special Issue, pg 3

Added/Revised Codes: 11055, 11056, 11057, 11719
Related Code(s) or Policy: Routine Foot Care (M0101)
Publication: See page 17.December 1997; Special Issue, pg 3

Added/Revised Codes: 17000, 17003, 17004
Related Code(s) or Policy: Benign or Premalignant Skin Lesion
Removal/Destruction (G0051-G0053)
Publication: See page 19.

Added/Revised Codes: 53850 (Documentation must accompany claim)
Related Code(s) or Policy: Prostatron (55899)
Publication: May/June 1997, pg 22

Added/Revised Codes: 67027
Related Code(s) or Policy: Vitrasert Implant
Publication: October 1996, Special Issue, pg 6November/December 1996,
pg. 8

Added/Revised Codes: 76075, 76076
Related Code(s) or Policy: Bone Mineral Density Studies
Publication: See page 22.December 1997; Special Issue, pg 2

Added/Revised Codes: 76092
Related Code(s) or Policy: Screening Mammography
Publication: See page 25.

Added/Revised Codes: 80049, 80051, 80054, 80058
Related Code(s) or Policy: Automated Panel Codes
Publication: December 1997; Special Issue, pg 4

Added/Revised Codes: 87536
Related Code(s) or Policy: HIV-1 Quantification (G0100)
Publication: November/December 1997, pg. 25

Added/Revised Codes: 88141, 88142, 88152, 88158
Related Code(s) or Policy: Pap Smear

Publication: See page 26.

Added/Revised Codes: 93303, 93304, 93307, 93308, 93320-93325
Related Code(s) or Policy: Transthoracic and Doppler Echocardiography
and Doppler Color Flow Velocity Mapping
Publication: See page 28.

Added/Revised Codes: 93501, 93508, 93510-93514, 93524, 93530-93533
Related Code(s) or Policy: Cardiac catheterization
Publication: See page 31.

Added/Revised Codes: 95805-95808, 95810, 95811also 54250
Related Code(s) or Policy: Sleep Testing
Publication: See page 36

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Use of HCPCS Modifier QR

Effective for services furnished on and after January 1, 1998, the following modifier may be used to indicate that a test was performed more than once (separate encounters) on the same day for the same patient, only when it is necessary to obtain multiple results in the course of treatment. This modifier may not be used when tests are re-run to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.

This modifier may not be used when there are standard HCPCS codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.). This modifier may only be used for laboratory tests paid under the clinical diagnostic laboratory fee schedule.

QR

Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test value(s) (separate specimens taken in separate encounters)

Improper use of this modifier is likely to indicate a fraudulent or abusive circumstance. Use of the QR modifier has very narrow applications; any evidence of excessive use may be referred to the carrier program integrity unit for further review.

To allow providers adequate time to begin use of the QR modifier, a 90-day grace period applies. Effective April 1, 1998, the 76 modifier (Repeat procedure) will not be allowed for clinical lab procedures. After that time, if the 76 modifier is billed with clinical laboratory procedures, the services will be subject to denial.

Note: Although modifier 76 may be used for services other than clinical laboratory tests, it is expected that the same requirements for the QR modifier apply to the 76 modifier.

A9270: Coding Guidelines for Noncoverage

As a result of the 1998 HCPCS update, the following procedure codes have been added to Medicare Part B of Florida's "Coding Guidelines for Noncoverage". 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.

For more information on this policy, refer to pages 31-33 of the September/October 1997 Medicare B Update! The coding guidelines are developed under an iterative process and will be updated as national and local coverage decisions change.

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:

83019; Urea Breath Test for H-Pylori
89250-89261; Culture and fertilization of oocyte(s) and other artificial insemination procedures

Procedures:

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

53852*; Transurethral Needle Ablation (TUNA)
92997-92998; Percutaneous transluminal pulmonary artery balloon angioplasty
95806; Sleep Study unattended by a technologist

National Noncoverage Decisions:

Procedures:

G0121; Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122; Colorectal cancer screening; barium enema

78351*; Dual Photon Absorptiometry, one or more sites (CIM 50-44)
97780-97781*; Acupuncture (CIM 35-8)

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

Advance Notice Requirement

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. See page 4 for additional information on Advance Notice Requirements.

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.

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G0101, Q0091, P3000, P3001: Screening Pap Smears and Pelvic Exams

Section 4102 of the Balanced Budget Act of 1997 (P.L. 105-33) amends 1861 (nn) of the Social Security Act (42 USC 1395x(nn)) to include coverage every three years for a screening Pap smear or more frequent coverage for women (1) at high risk for cervical or vaginal cancer, or (2) of childbearing age who have had a Pap smear during any of the preceding three years indicating the presence of cervical or vaginal cancer or other abnormality.

Coverage and Payment

Screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy (as defined in 1861(r)(1) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under state law to perform the examination) under one of the following conditions:

- The beneficiary has not had a screening Pap smear test during the preceding 3 years (use ICD-9-CM code V76.2, special screening for malignant neoplasm, cervix) or

- There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; or that she is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health). The high risk factors for cervical and vaginal cancer are:

Cervical Cancer High Risk Factors:

Early onset of sexual activity (under 16 years of age) (use ICD-9-CM code: V69.2 High Risk Sexual Behavior)

Multiple sexual partners (five or more in a lifetime)

History of a sexually transmitted disease (including HIV infection)

Fewer than three negative Pap smears within the previous seven years

Vaginal Cancer High Risk Factors:

DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

- The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening Pap smear for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening Pap smear covered by Medicare was performed.

The Part B deductible for screening Pap smear services paid for under the physician fee schedule is being waived effective January 1, 1998.

HCPCS Coding

The following HCPCS codes can be used for screening Pap smear:

Q0091; Screening Pap smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.

This service is paid under physician fee schedule and, therefore, the Part B deductible for this service is waived because of the specific waiver provision in the BBA legislation.

P3000; Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision, and

P3001; Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician.

These two services (codes P3000 and P3001) are paid under the clinical diagnostic laboratory fee schedule.

P3001(26); Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician.

This service is paid under the physician fee schedule only when provided to hospital inpatients. The Part B deductible for this service is waived because of the specific waiver provision in the BBA legislation.

Screening Pelvic Examination

Section 4102 of the Balanced Budget Act of 1997 (P.L. 105-33) amends 1861 nn) of the Social Security Act (42 USC 1395x(nn)) to include coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998. A screening pelvic examination should include at least seven of the following eleven elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- Pelvic examination (with or without specimen collection for smears and cultures) including:
 - External genitalia (for example, general appearance, hair distribution, or lesions);
 - Urethral meatus (for example, size, location, lesions, or prolapse);
 - Urethra (for example, masses, tenderness, or scarring);
 - Bladder (for example, fullness, masses, or tenderness);
 - Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
 - Cervix (for example, general appearance, lesions or discharge)
 - Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
 - Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and

- Anus and perineum.

Coverage and Payment

Medicare Part B pays for a screening pelvic examination if it is performed by a doctor of medicine or osteopathy (as defined in 1861(r)(1) of the Act), or by a certified nurse midwife (as defined in 1861 gg) of the Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in 1861 (aa) of the Act) who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Payment may be made for a screening pelvic examination performed on an asymptomatic woman only if the individual has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare-covered screening pelvic examination was performed except as provided in the bullets below.

- Payment may be made for a screening pelvic examination performed more frequently than once every 36 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer, or vaginal cancer. (Use ICD-9-CM code V15.89, other specified personal history presenting hazards to health.) The high risk factors for cervical and vaginal cancer are:

Cervical Cancer High Risk Factors:

- Early onset of sexual activity (under 16 years of age) (use ICD-9-CM code: V69.2 High Risk Sexual Behavior)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease (including HIV infection)
- Fewer than three negative Pap smears within the previous seven years

Vaginal Cancer High Risk Factors:

- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Payment may also be made for a screening pelvic examination performed more frequently than once every 36 months if the examination is performed by a physician or other practitioner, for a woman of childbearing age, who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years. The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a

screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

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The Part B deductible for screening pelvic examinations is being waived effective January 1, 1998. Pelvic examinations will be paid under the physician fee schedule.

HCPCS Coding

A new HCPCS code has been established to code for the pelvic and clinical breast examinations. Use code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination). This service is paid under the physician fee schedule.

Carrier Billing Requirements

A screening Pap smear and a screening pelvic examination can be done during the same encounter. When this happens both procedure codes should be shown as separate line items on the claim.

An evaluation and management visit and code G0101 should not be reported by the same physician for the same date of service. The evaluation and management visit includes payment for the G0101 service.

As a reminder, an evaluation and management visit and code Q0091 should not be reported by the same physician for the same date of service. The evaluation and management visit includes payment for the Q0091 service.

Reimbursement

Reimbursement for procedure code G0101 is based on the physician fee schedule. The fees are:

Participating:

Loc. 1/2 - 25.50

Loc. 3 - 27.02

Loc. 4 - 28.26

Nonparticipating:

Loc. 1/2 - 24.23

Loc. 3 - 25.67

Loc. 4 - 26.85

Limiting charge:

Loc. 1/2 - 27.86

Loc. 3 - 29.52

Loc. 4 - 30.88

Advance Notice

Advance notice applies to frequency (see page 4) for high risk patients.

11055-11057, 11719: Routine Foot Care

Description

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.

Therefore, Routine Foot Care is generally considered a noncovered service; however, there may be instances in which the statutory exclusion would not apply.

In addition, there are certain metabolic, neurologic, or peripheral vascular diseases that may require Routine Foot Care by a podiatrist or other physician.

Policy Type

Local medical necessity policy

An operational statement of national coverage policy

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will consider Routine Foot Care medically necessary and reasonable when performed under the following circumstances:

- When a patient presents with an ulcer, wound or infection, and the service, which would normally be considered routine, is a necessary and integral part of an otherwise covered service;

- 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, two other criteria must be met and included on the claims when the complicating condition on the list is asterisked(*):

- When the service is performed by a podiatrist, then the name of the attending physician (M.D. or D.O.) who is actively treating the patient's condition and

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- 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 name of the M.D. or D.O. who diagnosed the complicating condition when the service is performed by a podiatrist:

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 disease 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

Other Indications and Limitations of 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

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*

HCFA National Coverage Policy

Medicare Carrier's Manual, Sections 2323.C., 4120.1 and 7506.5.A.

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 and 11719) 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 and 11719 (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 if the visit was medically necessary and was for a significant, separately identifiable service, and the modifier -25 is used.

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 indicated one Class B and two Class C findings for Routine Foot Care.

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

Modifier -25 should be used to indicate that a significant, separately identifiable evaluation and management services was performed by the same physician on the day of a procedure, following the initial visit.

Procedure code 11719 encompasses 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 nails and paring and curettement of four lesions were performed, then procedure codes 11719 and 11057 should be billed. If only trimming of 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.

17000: Benign or Premalignant Skin Lesion Removal and/or Destruction

Description

Benign or premalignant skin lesion removal/destruction.

Policy Type

Local medical necessity policy.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare B will consider the destruction of a benign or premalignant skin lesion medically necessary under the following circumstances:

- When the patient presents with an actinic keratosis that has changed in size, has developed erythema, has thickened, has ulcerated, has eroded, has developed changes at the tumor margins, has become markedly hyperkeratotic, in which pain has developed and/or a cutaneous horn has developed;

- When the patient presents with an actinic keratosis on the nose, ear, or eyelids;

- When the patient presents with a actinic keratosis and has a history of one of the following:

chronic immunosuppression such as that associated with organ transplantation, particularly renal transplantation, and other disease processes such as Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and/or chronic lymphocytic leukemia or lymphoma;

treatment of psoriasis with psolaren-ultraviolet A (PUVA) therapy;

xeroderma pigmentosum, albinism, or discoid lupus erythematosus;and/or,

previous treatment of a biopsy-proven Squamous Cell Carcinoma (SCC) or other skin malignancy.

- When the patient has multiple actinic keratoses and has self-administered 2 percent to 5 percent Fluorouracil (Efudex) topical cream for two to four weeks and the actinic keratoses have not responded to this treatment one to two months following treatment*, or

*It should be noted that the natural response to fluorouracil (Efudex) is erythema, usually followed by vesiculation, desquamation, erosion and reepithelialization. Therefore, during and immediately following fluorouracil treatment these signs and symptoms would be considered part of the response/healing process and would not be considered as meeting the criteria for removal. There are contraindications for the use of topical fluorouracil which include pregnancy, use on mucous membranes, use on mouth, and use around eyes or on nose. If after two months, the actinic keratoses have not responded, they may be removed or destroyed.

- When the patient presents with an actinic cheilitis (actinic keratosis of the lower lip) or an actinic keratosis of the upper lip;

- When the patient presents with an actinic conjunctivae (actinic keratosis on the bulbar conjunctivae);

- When a patient presents with an arsenical keratosis (due to arsenic exposure);

- When a patient presents with a keratosis and has a history of significant exposure to therapeutic or occupational radiation therapy (chronic radiation keratosis); and/or

- When a patient presents with a keratosis which arises from an old scar (chronic cicatrix keratosis).

If none of the aforementioned conditions exist, Medicare B of Florida would consider the removal of an actinic keratosis as medically unnecessary and, therefore, not reimbursable by Medicare.

In addition, chemical or cryogenic peels of the face, even in the presence of actinic keratoses, are considered medically unnecessary in nature because the technique is used to improve the appearance of photodamaged skin, and is, therefore, not reimbursable by Medicare.

The total number of services billed utilizing procedure codes 17000, 17003, and 17004 which exceed the number that would be considered medically necessary and reasonable according to established parameters will be reviewed on a prepayment basis using the criteria in this section of the policy.

Generally, the removal of benign lesions such as seborrheic keratoses, sebaceous cysts, and warts are done for cosmetic reasons, however, in rare instances it may be necessary to remove these types of lesions. Medicare B of Florida will consider the removal of these lesions as medically necessary for any of the following reasons:

The lesion is in an area such as the neck, bra line or waist and is constantly irritated and/or is located in an anatomical location of recurrent trauma and that such trauma has in fact occurred;

- The lesion obstructs an orifice or clinically obstructs vision (this would include any lesion);
- The patient presents with condylomata acuminata (venereal warts) and/or is immunosuppressed; and/or,
- Plantar warts or other lesions on the sole of the foot which impede the patient's ability to ambulate or which meet any of the aforementioned criteria.

If the aforementioned signs and symptoms are not present, further treatment would be considered medically unnecessary and, therefore, not reimbursable by Medicare B of Florida.

HCPCS Codes

11300; Shaving of epidermal or dermal lesion, single lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less

11301; lesion diameter 0.6 to 1.0 cm

11302; lesion diameter 1.1 to 2.0 cm

11303; lesion diameter over 2.0 cm

11305; Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

11306; lesion diameter 0.6 to 1.0 cm

11307; lesion diameter 1.1 to 2.0 cm

11308; lesion diameter over 2.0 cm

11310; Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

11311; lesion diameter 0.6 to 1.0 cm

11312; lesion diameter 1.1 to 2.0 cm

11313; lesion diameter over 2.0 cm

11400; Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 0.5 cm or less

11401; lesion diameter 0.6 to 1.0 cm

11402; lesion diameter 1.1 to 2.0 cm

11403; lesion diameter 2.1 to 3.0 cm

11404; lesion diameter 3.1 to 4.0 cm

11406; lesion diameter over 4.0 cm

11420; Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

11421; lesion diameter 0.6 to 1.0 cm

11422; lesion diameter 1.1 to 2.0 cm

11423; lesion diameter 2.1 to 3.0 cm

11424; lesion diameter 3.1 to 4.0 cm

11426; lesion diameter over 4.0 cm

11440; Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

11441; lesion diameter 0.6 to 1.0 cm

11442; lesion diameter 1.1 to 2.0 cm

11443; lesion diameter 2.1 to 3.0 cm

11444; lesion diameter 3.1 to 4.0 cm

11446; lesion diameter over 4.0 cm

17000; Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (e.g., actinic keratoses), other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion

17003; second through 14 lesions, each (list separately in addition to code for first lesion)

17004; 15 lesions or more (includes 17000 and 17003; that is, 17004 may not be reported in addition to 17000 and 17003)

17110; Destruction by any method of flat warts, molluscum contagiosum or milia, up to 14 lesions

17111; 15 or more lesions

17999; Unlisted procedure, skin, mucous membrane, and subcutaneous tissue

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ICD-9 Codes That Support Medical Necessity

N/A

HCFA National Coverage Policy

Medicare Carrier's Manual (MCM) 4826

Reasons for Denial

Benign skin lesions and premalignant skin lesions (actinic keratosis) removals which do not meet the criteria as outlined in "Indications and Limitations" are considered medically unnecessary and will not be reimbursed by Medicare B of Florida.

Coding Guidelines

CPT coding is based on the type of lesion (benign or premalignant), method of destruction or removal, and the number of lesions removed for any of the procedure codes within the following ranges: 11300-11313; 11400-11446; 17110-17111; 17999; or 17000-17004

If a lesion is destroyed or removed for any reason other than one listed under the "Indications and Limitations" section of this policy, the procedure is considered medically unnecessary and is, therefore, not reimbursable by Medicare and should be billed utilizing procedure code A9270 (noncovered service).

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

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

Procedure code 17000 and 17004 may only be billed once per day. Procedure code 17003 may be billed no more than thirteen (13) times in one day because the descriptor reads "second through fourteen (14) lesions, each lesion". It is not appropriate to use modifier -76 (repeat procedure) with these codes.

Procedure code 17004 includes 17000 and 17003. Therefore, it is not appropriate to bill procedure code 17004 on the same day as 17000 and 17003 for the same patient by the same provider.

When the patient is seen for purposes of prescribing fluorouracil and providing instruction on how to use this medication, the appropriate level of evaluation and management service may be reimbursed.

Documentation Requirements

If the patient presents with an actinic keratosis(es) and its appearance has changed, (i.e., size, erythema, thickening, ulceration, and/or erosion in the tumor or tumor margins) or if the patient has developed pain within the lesion, this should be clearly documented in the physician's progress/office notes to substantiate removal of the lesion.

If the patient presents with an actinic keratosis(es) and has a history of chronic immunosuppression; treatment of psoriasis with PUVA therapy; xeroderma pigmentosum, discoid lupus erythematosus or albinism; and/or a previous treatment of a biopsy-proven SCC, this should clearly be documented in the physician's progress/office notes. The approximate starting date and duration of radiation therapy or PUVA therapy should be documented, if applicable. In addition, the date of organ transplantation should be documented, if applicable. Any other immunosuppressive disorder should be documented with the date or approximate date of diagnosis.

If the patient presents with multiple actinic keratoses, the self-administration of topical 2 percent to 5 percent fluorouracil (Efudex) cream or solution for a period of no less than two weeks and unresponsiveness to the drug after two months should be documented. If the patient has a condition in which fluorouracil is contraindicated such as pregnancy or actinic keratosis(es) around the eyes, on the nose, on the mouth, or on mucous membranes, the physician's office/progress note should reflect this. The location of this lesion(s) should be documented in the office/progress notes as well.

If the patient presents with an actinic cheilitis (actinic keratosis of the lower lip) or an actinic keratosis on the ear or conjunctiva, the exact location and a description of the lesion(s) appearance should be documented in the physician's progress/office notes.

Also, if the patient has had a previous biopsy-proven SCC or other skin malignancy, the location of that lesion, the date of removal, and a pathology report for the previous lesion, if available, should be documented. In addition, for the aforementioned conditions/treatments, the exact location and a description of the lesion should be documented.

For cicatrix keratoses, the location of the scar, the type of the scar, the approximate date the scar developed, and a description of the size, location and appearance of the lesion should be documented in the physicians progress/office notes.

Although not required at this time, a photograph of the lesion with an indication of the size and location would be an excellent documentation tool for the size, location, and appearance of the lesion. If the physician is not able to take a photograph or make a sketch in his/her notes regarding size, location, and appearance of the lesion, a very clear description of the lesion must be included in the progress/office notes.

For those benign lesions that are located in areas which subject the lesion to constant irritation and/or trauma and need to be removed because of constant or frequent traumatization, the exact location and size of the lesion and type of irritation and/or trauma should be documented in the physician's progress/office notes.

In addition, to the above, the method of destruction or removal should be described in the physician's progress/office notes for any type of lesion destroyed or removed.

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76070, 76075, 76076, 76078, 78350: Bone Mineral Density Studies

Description

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

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

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

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

A stationary bone densitometer is a device that is permanently located in an office.

A mobile densitometer is one that is transported by vehicle from site to site.

A portable densitometer is one that can be picked up and moved from one site to another.

Indications and Limitations of Coverage and/or Medical Necessity

Peripheral Bone Density Study

In general, it appears that a peripheral bone density study is useful in screening for osteoporosis, however, Medicare is prevented by statute from paying for screening for osteoporosis.

A peripheral bone density study is covered for the patient with a Colles' fracture or other distal radius or ulnar fracture when the study is done because of suspicion that osteoporosis is a component of the cause of the fracture. If the diagnosis of osteoporosis is already established, this would not be covered. You would not expect to see this test performed for Colles' or other fracture more than once.

HCPCS Codes

76070

Computerized Tomography Bone Mineral Density Study, one or more sites

76076

Dual Energy X-Ray absorptiometry (DEXA), Bone Density Study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

76078

Radiographic absorptiometry (Photodensitometry), one or more sites

78350

Bone Density (Bone Mineral content) Study, one or more sites; single photon absorptiometry

ICD-9 Codes That Support Medical Necessity

813.40-813.44

813.50-813.54

Central Bone Density Study

A central bone density study is covered for the following indications:

- A patient with a recent fracture of the spine, long bone, hip or pelvis, when the fracture is suspected to be associated with osteoporosis; code with the appropriate ICD-9 code for the fracture.
- Radiographic Osteopenia: For this indication, the test is covered to verify and quantify osteoporosis and to determine if the patient is to be treated with medication to increase bone density. For this indication use ICD-9 code 733.02, idiopathic osteoporosis.
- A patient with documented osteoporosis on therapy with drugs known to increase bone mineral density when the test is done to determine response to therapy; ICD-9 code 733.00 for unspecified osteoporosis, ICD-9 code 733.01 for postmenopausal osteoporosis, ICD-9 code 733.02 for idiopathic osteoporosis.

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- A patient with known hyperparathyroidism when the test result is being used to determine if the patient requires a parathyroidectomy. Use ICD-9 code 252.0 for hyperparathyroidism.
- A patient on long-term corticosteroid therapy (greater than 3 months), on the equivalent dose of 30 mg cortisone [or 7.5 mg prednisone] or greater per day. For this indication, the test is covered only if the result is being used to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 code 733.09 for drug-induced osteoporosis and E932.0 for adrenal cortical steroids.

- A patient on long-term (greater than 1 month) heparin therapy. For this indication, the test is covered only when the result is being used to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 code 733.09 for drug-induced osteoporosis and E934.2 for heparin.

- A patient on long-term (greater than 3 months) phenytoin therapy. For this indication, the test is covered only when the result is being used to determine if the phenytoin is to be discontinued and or to determine if the patient is to be treated with drugs to increase bone density. Use ICD-9 code 733.09 for drug-induced osteoporosis and E936.1 for phenytoin.

- A patient on excessive doses of thyroid replacement. For this indication, the test is covered only if the patient has a subnormal TSH level while on thyroid replacement. For this indication, the test is covered only when the results is being used to determined if the patient is to be treated with drugs to increase bone density. Use ICD-9 codes 244.0-244.9 for hypothyroidism and E932.7 for the excessive thyroid medication.

- A woman with primary ovarian failure or post-ablative ovarian failure before the age of 40, who is suspected of having osteoporosis, and for whom a decision to treat with estrogen or bone mineral enhancing drugs is being made. A letter describing the medical necessity may be required if the test is done more than once.

- For a woman who is estrogen deficient and has a personal history of breast and/or uterine cancer if diagnostic information is needed to determine appropriate "nonestrogen" treatment for osteoporosis.

For the last two indications noted above, use ICD-9 code 256.2 (postablative ovarian failure) for secondary estrogen deficiency or 256.3 (other ovarian failure) for primary estrogen deficiency.

Medicare does not cover routine screening procedures or protocols, including the routine screening for osteoporosis through the use of bone mineral density studies. It is expected that these procedures should only be rendered when medically reasonable and necessary for the patient's condition. Therefore, a patient's therapy should be individualized; testing or retesting for each patient should not be performed automatically. This test should not be repeated more often than medically necessary.

A bone densitometry study (76075) code should be billed only once regardless of the number of sites being tested or included in the study (i.e., if the spine and hip are performed as part of the same study only one 76075 can be billed).

HCPCS Codes

76070; Computerized Tomography Bone Mineral Density Study, one or more sites

76075; Dual Energy X-Ray absorptiometry (DEXA), Bone Density Study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)

78350; Bone Density (Bone Mineral content) Study, one or more sites; single photon absorptiometry

ICD-9 Codes That Support Medical Necessity:

244.0-244.9
252.0
256.2
256.3
733.00
733.01
733.02
733.09
733.11-733.16
805.2
806.4
808.0-808.9
820.0-820.9
E932.0
E932.7
E934.2
E936.1

HCFA National Coverage Policy

Title XVIII of the Social Security Act, section 1862(a)(7). This section excludes payment for screening procedures (tests) performed in the absence of signs or symptoms.

Title XVIII of the Social Security Act, section 1862(a)(7). This section allows coverage and payment for only those services that are considered medically reasonable and necessary.

Coverage Issues Manual 50-44 precludes Medicare payment for dual photon absorptiometry.

Code of Federal Regulations 410.32 A(3).

Reasons for Denial

Medicare is prevented by statute from paying for screening for osteoporosis (e.g., bone densitometry would be noncovered (a) if done because the patient is or has been a tobacco user, (b) the individual is or has been a consumer of alcoholic products, (c) if the individual is 65 and over but does not have any of the conditions described under Coverage").

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Medical data is lacking that demonstrates that routine bone densitometry testing results in benefit to individuals in the following

categories, and therefore testing would be considered medically unnecessary:

- Perimenopausal women who are otherwise asymptomatic and who decide to take estrogen replacement for other reasons;
- Patients with end-stage renal disease;
- Elderly individuals who are otherwise well, do not have the conditions mentioned under indications for coverage;
- Patients who have been partially or completely immobilized and are likely to remain partially or completely immobilized from a chronic disease process.

Bone Ultrasound Densitometry (no CPT or HCPCS code) is considered screening until more data is available to determine its appropriateness.

Bone density studies of any type including dexa scans are not covered under the portable x-ray benefit. The benefit allows for x-ray films of the skeleton, chest or abdomen. Although bone density studies are radiology procedures, they are not x-ray films. Also, to be a benefit of portable x-ray services the equipment must be portable to provide services in the home. Bone density studies done by portable units are considered investigational until more data is available to determine its accuracy, precision and benefit in predicting bone density.

Peripheral DEXA or p-DEXA except in the case of distal ulna/radius or Colles' fractures is considered screening.

The value of bone density studies to improve the outcomes of patients with end-stage renal disease is considered investigational.

Bone mineral density studies for patients with a history of depression is considered investigational.

Any ICD-9-CM diagnosis not listed in the indications for coverage category.

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

Coding Guidelines

Effective January 1, 1998, HCPCS codes G0062 and G0063 will no longer be recognized for Medicare payment and have been assigned a "D" (deleted codes) status indicator. The following new CPT codes have been established for reporting of peripheral and central DEXA studies.

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

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

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

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

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

When performing this procedure for screening purposes bill ICD-9 code V72.5 (Special investigations and examinations: Radiological examination, not elsewhere classified).

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly document the medical necessity for the ordering of the services. The documentation may be included in any of the following:

- history and physical;
- office/progress notes;
- test results with written interpretation;
- x-ray/radiology with written interpretation.

Advance Notice Requirement

Applies to diagnosis (see page 4).

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76092: Screening Mammography Coverage Changes

As a result of legislation included in the Balanced Budget Act (BBA) of 1997, Medicare's guidelines for screening mammography have changed

effective for services rendered on or after January 1, 1998. The changes as a result of the BBA are:

- Mammographies are covered annually for women over age 39;
- The Medicare B deductible is waived; and
- Providers only need to use diagnosis code V76.12 (Other screening mammogram).

Screening Mammography Policy

The following information addresses current policy (effective for services rendered on or after January 1, 1998) on screening mammography. For coverage information on services rendered before January 1, 1998, see the following issues of the Medicare B Update:

Sept/Oct 1997, page 28

Jan/Feb 1996, page 4

Sept/Oct 1996, page 43

Screening mammography is a radiologic procedure for women for the early detection of breast cancer. It is conducted for preventative purposes, when there are no clinical indications or symptoms. Screening mammographies include a physician's interpretation of the results. A screening mammogram, at a minimum, is a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast. On occasion, supplementary views may be required to visualize breast tissue optimally (e.g., augmented breast, large breast, patient with depressed sternum or pronounced ribs). The need to do additional images (more than two views each breast) does not have any effect on the payment amount because payment is prescribed by statute.

A physician's order is not required for coverage of a screening mammogram (procedure code 76092). The determination for coverage is made based on the woman's age and statutory frequency parameter. Effective for services after January 1, 1998, risk factors are no longer considered for this benefit. The new age/frequency guidelines are:

Age: 35-39

Screening Period: Baseline (only one allowed for this age group)

Age: Over age 39

Screening Period: Annual*

Screening mammographies are not covered for women under the age of 35.

*For women who are age 39 or over, "annual" frequency is determined this way: 11 full months must have elapsed since the last screening;

begin counting with the month after the last exam. For example, if a woman had an exam on January 11, 1998, you would begin counting on February 1, 1998. She would next be eligible for a screening mammogram in January 1999. For services rendered prior to January 1, 1998, this rule still applies. For example, if a woman received an exam on October 1, 1997, you would begin counting on November 1, 1997. She would be eligible for a screening mammogram in October 1998.

Coding Guidelines

Effective January 1, 1998, every screening mammography claim must be billed using procedure code 76092 and diagnosis code V76.12.

As a reminder, all mammography facilities (both screening and diagnostic) require a certification number. The certification number should be placed in FAO record, field 31, field positions 142-151 (electronic claims submission_National Standard Format) or Block 32 of the HCFA-1500 form (paper claim submission). Services performed by a non-certified center or by a facility whose certificate is suspended or revoked, or if the certification number is omitted from the claim, the claim will be denied payment.

Interpretations of screening mammograms are to be performed only by physicians who are certified under the certification number of the screening center. Two exceptions now exist: when the beneficiary requests a transfer of the films from one facility to another for a second opinion, or because the patient has moved to another part of the country where the next screening mammography will be performed.

Documentation Requirements

Although a physician's order is not necessary, providers who refer a patient for screening mammography must include the following information in the order:

- the type of test (screening);
- the date of the last screening mammogram.

If you perform the mammography test, obtain the following information:

- if the test is ordered/referred by a physician, an order/referral that specifically prescribes a screening mammogram;
- the date of the last screening mammogram;
- maintain on file the radiology report;
- if the interpreting physician is not certified under the certification of the screening center, the documentation must clearly contain information to support the exception when billing the Medicare program.

Reimbursement

The Medicare Part B deductible does not apply to procedure code 76092, but coinsurance does. Reimbursement, which is based on a statutory amount, is as follows:

Global amount: \$64.73
Professional component only: \$20.71
Technical component only: \$44.02

Advance Notice Statement

Advance notice applies to the center's certification. If the center is not certified by the Food and Drug Administration, an advance notice of Medicare's denial of payment must be provided to the patient.

88141: New Procedure Codes for Diagnostic Pap Smears

As a result of the 1998 HCPCS update, several procedure code changes have affected the policy for diagnostic pap smears. The revised policy follows and affects the following procedure codes. New procedure codes are marked with an asterisk.

*88141; Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service)

*88142; Cytopathology, cervical or vaginal (any reporting system); collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision

88150; Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision

*88152; with manual cytotechnologist screening and automated rescreening under physician supervision

88155; with definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index)

88156; Cytopathology, smears, cervical or vaginal, (the Bethesda System (TBS)), up to three smears; screening by technician under physician supervision

*88158; with manual cytotechnologist screening and automated rescreening under physician supervision

Diagnostic pap smears are covered by Medicare Part B when they are medically reasonable and necessary for the patient's condition/illness.

To ensure that payment is made only for medically reasonable and necessary conditions/illnesses, only the following diagnoses are covered for diagnostic pap smears. Refer to the most recent edition of the ICD-9-CM for descriptors.

016.70-016.76

054.10

054.11

054.12

078.0

078.10-078.19

090.0-099.9

112.1

112.2

131.00-131.9

170.6

171.6

179

180.0-180.9

181

182.0-182.8

183.0-183.8

184.0-184.9

198.6

198.82

218.0-218.9

219.0-219.9

220

221.0-221.9

233.0-233.3

233.9

236.0-236.3

239.5

256.0-256.9

616.0

616.10-616.11

616.2

616.50-616.51

616.8

616.9

617.0

617.9

620.0

620.1

620.2

620.8

621.0

621.1

621.2

621.8

622.0

622.1

622.7

622.8

623.0

623.5

623.7
623.8
624.6
624.8
626.2
626.6
626.7
626.8
626.9
627.1
627.2
627.3
627.8
627.9
628.0-628.9
654.10-654.14
795.0

Advance Notice Requirement
Applies to medical necessity (see page 4).

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90804-90809, 90810-90815, 90816-90822, 90823-90829: New Individual
Psychotherapy and Interactive Psychotherapy Codes

As a result of the 1998 HCPCS update, last year's psychotherapy codes have been replaced with CPT codes. The new codes directly replace last year's G-codes, and are subject to the same medical policy guidelines. To help providers choose the correct new CPT procedure code for the services they render, the following table has been developed:

G-Code: G0071
New CPT Code: 90804
Descriptor: individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient

G-Code: G0072
New CPT Code: 90805
Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient, with medical evaluation and management services

G-Code: G0072
New CPT Code: 90805
Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

G-Code: G0073
New CPT Code: 90806

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

G-Code: G0074

New CPT Code: 90807

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or in an office or outpatient facility, approximately 45 to 50 minutes face-to

G-Code: G0075

New CPT Code: 90808

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient

G-Code: G0076

New CPT Code: 90809

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient, with medical evaluation and management services

G-Code: G0077

New CPT Code: 90810

Descriptor: Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

G-Code: G0078

New CPT Code: 90811

Descriptor: with medical evaluation and management services

G-Code: G0079

New CPT Code: 90812

Descriptor: Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

G-Code: G0080

New CPT Code: 90813

Descriptor: with medical evaluation and management services

G-Code: G0081

New CPT Code: 90814

Descriptor: Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;

G-Code: G0082

New CPT Code: 90815

Descriptor: with medical evaluation and management services

G-Code: G0083

New CPT Code: 90816

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient

G-Code: G0084

New CPT Code: 90817

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services

G-Code: G0085

New CPT Code: 90818

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient

G-Code: G0086

New CPT Code: 90819

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services.

G-Code: G0087

New CPT Code: 90821

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient.

G-Code: G0088

New CPT Code: 90822

Descriptor: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services

G-Code: G0089

New CPT Code: 90823

Descriptor: Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;

G-Code: G0090

New CPT Code: 90824

Descriptor: with medical evaluation and management services

G-Code: G0091

New CPT Code: 90826

Descriptor: Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms

of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;

G-Code: G0092

New CPT Code: 90827

Descriptor: with the patient; with medical evaluation and management services

G-Code: G0093

New CPT Code: 90828

Descriptor: Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;

G-Code: G0094

New CPT Code: 90829

Descriptor: with medical evaluation and management services

To ensure that providers have adequate time to adjust their billing patterns, a grace period has been established, during which either the G-codes for psychotherapy or the new 908XX codes may be used. This grace period lasts until March 31, 1998. The G-codes for psychotherapy should continue to be used for all dates of service prior to January 1, 1998.

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93303, 99304, 99307, 99308,93320-93325: Echocardiography

Description:

Echocardiography is used to image cardiac structures and function and also flow direction and velocities within cardiac chambers and vessels. Usually these images are obtained from several positions on the chest wall and abdomen using a hand-held transducer. The direction of flow of the red blood cells within the heart is displayed with the use of a doppler transducer. The direction of the flow of the blood is depicted by using color coding of velocity shifts and the red blood cell velocity is measured through the use of doppler color flow velocity mapping.

Medicare Part B of Florida has not previously published a specific policy concerning echocardiography (procedure code 93307). The purpose of this policy is to define the circumstances for which this service will be considered medically necessary by Medicare Part B of Florida.

Policy Type:

Local medical necessity policy

Indications and Limitations of Coverage and/or Medical Necessity

Transthoracic Echocardiography for Congenital Cardiac Anomalies

Medicare Part B will consider transthoracic echocardiography for congenital cardiac anomalies (procedure codes 93303, 93304) medically necessary when they are specifically performed for congenital cardiac anomalies.

HCPCS Codes

93303; Transthoracic echocardiography for congenital cardiac anomalies; complete

93304; follow-up or limited study

ICD-9 Codes That Support Medical Necessity

N/A

Transthoracic Real Time Echocardiography

Medicare Part B will consider resting real time echocardiography (procedure codes 93307, 93308) medically necessary under any one of the following circumstances:

- The patient has a prosthetic heart valve and echocardiography is needed to monitor response to therapy or investigate a change in the patient's clinical condition.
- The patient has clinical findings which suggest the presence of valvular heart disease; i.e., the patient has a heart murmur which is felt to be clinically significant.
- The patient has proven endocarditis or clinical findings suggestive of endocarditis.
- The patient has clinical findings diagnostic of or suggestive of acute myocardial ischemia or infarction, or the patient has complications of acute myocardial infarction such as valvular incompetency, ventricular septal rupture or aneurysm of heart.
- The patient has documented cardiomyopathy, or the patient has clinical findings which suggest possible cardiomyopathy, or the patient has unexplained cardiomegaly.

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- The patient has pericardial disease or the patient has clinical findings suggestive of pericardial disease (e.g., friction rub, pericarditis, pericardial effusion, cardiac tamponade, pericardial tumor or cyst) and echocardiography is necessary for evaluation and/or follow-up.

- The patient has an intracardiac mass (tumor, thrombus, vegetation).
- The patient has a thoracic aortic aneurysm or dissection, or the patient has clinical findings suggestive of aortic dissection or aneurysm.
- The patient has confirmed or suspected abnormality of the vena cava or other large intrathoracic venous structure.
- The patient has hypertension along with other clinical evidence of heart disease.
- The patient had dyspnea of suspected cardiac origin based on clinical findings.
- The patient has chest pain with clinical findings which suggest a possible cardiac origin for the pain.
- The patient exhibits signs or symptoms of cerebral embolism and a cardiac etiology for the embolus is suspected.
- The patient has syncope and a cardiac etiology is suspected based on clinical findings.
- The patient has experienced peripheral embolism and a cardiac origin of embolus is suspected.
- The patient has documented, clinically significant, arrhythmia (paroxysmal tachycardia, atrial fibrillation or flutter, or ventricular fibrillation or flutter, sinoatrial node dysfunction) and echocardiography is being done to evaluate the patient for associated heart disease.
- The patient has unexplained edema and a cardiac etiology is suspected.
- The patient has sustained chest trauma and cardiac injury is suspected.
- The patient has undergone heart transplantation.
- The patient has cardiac dysfunction, such as post-cardiology syndrome or congestion failure, following surgery or other procedure.
- The patient is under treatment, or being considered for treatment, with a cardiotoxic medication.
- The patient has suspected or confirmed pulmonary hypertension and/or cor pulmonale and echocardiography is necessary for evaluation and/or follow-up.
- Echocardiography would be considered appropriate as part of the initial evaluation of a patient with suspected or confirmed chronic ischemic heart disease.

HCPCS Codes

93307; Echocardiography, transthoracic, real time with image documentation (2D) with or without M-mode recording; complete

93308; follow-up or limited study

ICD-9 Codes That Support Medical Necessity

164.1
212.7
391.0-391.9
394.0-394.9
395.0-395.9
396.0-396.9
397.0-397.9
402.00-402.01
402.10-402.11
402.90-402.91
403.00-403.91
404.00-404.93
410.00-410.92
411.0
411.1
411.81
411.89
412
413.0-413.9
414.00
414.01
414.02
414.03
414.04
414.05
414.10-414.19
416.0
416.8
416.9
421.0-421.9
423.0-423.9
424.0-424.3
424.90
424.91
424.99
425.0-425.9
427.0-427.5
427.81
429.3
429.4
429.5
429.6
429.7
429.71
429.79
429.81
434.10-434.11

444.21-444.22
444.81-444.89
453.2
745.0
745.10-745.19
745.2
745.3
745.4
745.5
745.60-745.69
745.7
745.8
745.9
746.00-746.09
746.1
746.2
746.3
746.4
746.5
746.6
746.7
746.81-746.89
746.9
747.0
747.10-747.11
747.3
780.2
782.3
785.2
785.3
786.02
786.09
786.50-786.59
861.00-861.03
861.10-861.13
963.1

996.02
996.03
997.1
V42.1
V42.2
V43.3
V67.51

Doppler Echocardiography and Doppler Color Flow Velocity Mapping

Medicare Part B will consider doppler echocardiography (procedure code 93320-93321) and doppler flow velocity mapping (procedure code 93325) medically necessary under any one of the following circumstances:

- The patient has valvular heart disease or congenital heart disease and echocardiography is needed to define the condition, monitor response to therapy, or to investigate a change in the patient's clinical condition.

- The patient has a prosthetic heart valve and echocardiography is needed to monitor response to therapy or investigate a change in the patient's clinical condition.

- The patient has clinical findings which suggest the presence of valvular heart disease, i.e., the patient has a heart murmur which is felt to be clinically significant.

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- The patient has proven endocarditis or clinical findings suggestive of endocarditis.

- The patient has clinical findings diagnostic of or suggestive of acute myocardial ischemia or infarction, or the patient has complications of acute myocardial infarction such as valvular incompetency, ventricular septal rupture or aneurysm of heart.

- The patient has a thoracic aortic aneurysm or dissection, or the patient has clinical findings suggestive of aortic dissection or aneurysm.

- The patient has undergone heart transplantation.

- The patient has suspected or confirmed pulmonary hypertension and/or cor pulmonale and echocardiography is necessary for evaluation and/or follow-up.

Routine performance of resting echocardiography, doppler echocardiography, or doppler color flow velocity mapping on patients with stable chronic coronary artery disease is not considered medically necessary unless the patient has had a change in clinical status which makes repeat procedures necessary. Also, the performance of procedures on patients with simple hypertension without other evidence of heart disease is considered not medically necessary.

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

HCPCS Codes

93320; Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging: 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350); complete

93321; follow-up or limited study

93325; Doppler color flow velocity mapping (List separately in addition to code for echocardiography 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350)

ICD-9 Codes That Support Medical Necessity:

391.0-391.9
394.0-394.9
395.0-395.9
396.0-396.9
397.0-397.9
410.00-410.92
411.0
411.1
411.81
411.89
412
413.0-413.9
414.00
414.01
414.02
414.03
414.04
414.05
414.10-414.19
416.0
416.8
416.9
421.0-421.9
424.0-424.3
424.90
424.91
424.99
429.5
429.6
429.7
429.71
429.79
429.81
745.0
745.10-745.19
745.2
745.3
745.4
745.5
745.60-745.69
745.7
745.8
745.9
746.00-746.09
746.1
746.2
746.3
746.4
746.5
746.6
746.7
746.81-746.89
746.9
747.0
747.10-747.11

747.3
780.2
785.2
786.50-786.59
996.02
996.03
V42.1
V42.2
V43.3

Documentation Requirements

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

If the provider of echocardiographic 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 echocardiographic studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the echocardiographic studies in his order for the test(s).

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93501, 93510-93514, 93524, 93530-93533: Cardiac Catheterization

Description

Cardiac catheterization is a technique in which a flexible catheter is passed along veins or arteries into the heart and associated vessels for the measurement of physiological data and imaging of the heart and great vessels. This technique is utilized when there is a need to confirm the presence of a clinically suspected condition, define its anatomical and physiological severity, and determine the presence of associated conditions. This need most commonly arises when clinical assessment suggests that the patient may benefit from an interventional procedure (e.g., coronary angioplasty, balloon valvuloplasty) or heart surgery.

Policy Type

Local medical necessity policy

Indications and Limitations of Coverage and/or Medical Necessity

Left Heart Catheterization

A left heart catheterization will be considered medically necessary for asymptomatic patients with any of the following situations/conditions:

- There is evidence of high risk on non-invasive testing.

- Exercise ECG testing documents an abnormal ST segment depression (magnitude equal to or greater than 1.5mm depression, persistent post-exercise changes, depression in multiple leads)

OR

- An abnormal systolic blood pressure response during progressive exercise, with sustained decrease of greater than 10mmHg or flat blood pressure (less than or equal to 130mmHg); associated with ECG evidence of ischemia

OR

- Other potentially important determinant such as exercise induced ST segment elevation in leads other than aVR or exercise induced ventricular tachycardia.

- Myocardial perfusion scintigraphy documents an abnormal blood flow distribution in the anterior wall or more than one vascular region at rest or with exercise, or an abnormal distribution (ischemia) associated with increased lung uptake produced by exercise in the absence of severely depressed left ventricular function at rest.

- Radionuclide ventriculography documents a fall in ventricular ejection fraction of greater than or equal to 10 percent during exercise, or left ventricular ejection fraction of less than 50 percent at exercise or rest when suspected to be due to coronary artery disease.

- After successful resuscitation from cardiac arrest that occurred without obvious precipitating cause, when a reasonable suspicion of coronary artery disease exists.

- The presence of two or more major risk factors and a positive exercise test in patients without known coronary heart disease.

- The presence of prior myocardial infarction with normal left ventricular function at rest, and evidence of ischemia by non-invasive testing

- After coronary bypass surgery or percutaneous transluminal angioplasty when there is evidence of ischemia by non-invasive testing.

- Before high risk noncardiac surgery in patients who have evidence of ischemia by non-invasive testing.

- Periodic evaluation of patients after cardiac transplantation.

A left heart catheterization will be considered medically necessary for symptomatic patients with any of the following situations/conditions:

- Angina pectoris that has proven inadequately responsive to medical treatment, percutaneous transluminal angioplasty, thrombolytic therapy or coronary bypass surgery. "Inadequately responsive" is taken to mean that patient and physician agree that angina significantly interferes with a patient's occupation or ability to perform his or her usual activities.

- Unstable angina pectoris defined as:

- Increased severity and frequency of chronic angina pectoris within the past two months, despite medical management, including onset of angina at rest.

- New onset (within two months) of angina pectoris which is severe or increases despite medical treatment.

- Acute coronary insufficiency, with pain at rest usually of greater than or equal to 15 minutes duration, associated with ST-T wave changes, within the preceding two weeks.

- Prinzmetal's or variant angina pectoris (pain experienced at rest).

- Any angina pectoris in association with any of the following:

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- Evidence of high risk as manifested by exercise ECG testing in addition to failure to complete Stage II of Bruce protocol or equivalent workload (less than or equal to 6.5 METS with other protocols) due to ischemic cardiac symptoms.

OR

- Exercise heart rate at onset of limiting ischemia symptoms of less than 120/minute (without beta blockers).

OR

- Evidence of high risk as manifested by radionuclide exercise testing (myocardial perfusion scintigraphy, radionuclide ventriculography, or focal metabolic abnormality or mismatch).

- The coexistence of a history of myocardial infarction, a history of hypertension and ST segment depression on the baseline ECG.

- Intolerance to medical therapy because of uncontrollable side effects.

- Episodic pulmonary edema or symptoms of ventricular failure without obvious cause

- Any angina pectoris associated with a series of progressively more abnormal exercise ECG or other non-invasive stress test.

- Any angina pectoris in a patient that cannot be risk stratified by other means as a result of an inability to exercise because of an amputation, arthritis, limb deformity, or severe peripheral vascular disease.

A left heart catheterization will be considered medically necessary for atypical chest pain* of uncertain etiology with any of the following situations/conditions:

*(For the purpose of this policy, atypical chest pain is defined as single or recurrent episodes of chest pain suggestive, but not typical, of the pain of myocardial ischemia. This discomfort may have some features of ischemic pain together with features of noncardiac pain. Chest pain that has no features of cardiac pain, as well as typical chest pain of myocardial ischemia or angina as determined by a careful medical history, is excluded from definition.)

- Atypical chest pain when ECG or radionuclide stress test indicates that high risk coronary disease may be present.

- When the presence of atypical chest pain due to coronary artery spasm is suspected.

- When there are associated symptoms or signs of abnormal left ventricular function or failure.

- Atypical chest pain when non-invasive studies are questionable or cannot be adequately performed.

- When non-invasive tests are negative but symptoms are severe and management requires that significant coronary artery disease be excluded.

A left heart catheterization will be considered medically necessary after a myocardial infarction (greater than 10 days up to eight weeks) with any of the following situations/conditions:

- Angina pectoris occurring at rest or with minimal activity.

- In selected patients, heart failure during the evolving phase, or left ventricular ejection fraction 45 percent, primarily when associated with some manifestation of recurrent myocardial ischemia or with significant ventricular arrhythmias.
- Evidence of myocardial ischemia on laboratory testing: exercise induced ischemia (with or without exercise-induced angina pectoris), manifested by greater than or equal to 1 mm of ischemic ST segment depression or exercise induced reversible thallium perfusion defect or defects, or exercise induced reduction in the ejection fraction or wall motion abnormalities on radionuclide ventriculographic studies.
- Non-Q-wave myocardial infarction.
- Mild angina pectoris.
- A past history of documented myocardial infarction or unstable angina pectoris, or both present greater than six months before the current infarction.
- Thrombolytic therapy during the evolving phase, particularly with evidence of reperfusion.

A left heart catheterization will be considered medically necessary for valvular heart disease with any of the following situations/conditions:

When valve surgery is being considered in a patient with chest discomfort or ECG changes, or both, suggesting coronary artery disease.

- When valve surgery is being considered in female patients who are postmenopausal.
- When aortic or mitral valve surgery is being considered.
- When one or more major risk factors for coronary artery disease are present: heavy smoking history, diabetes mellitus, hypertension, hyperlipidemia, strong family history of premature coronary artery disease.

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- When reoperation for aortic or mitral valve disease is being considered in patients who have not had coronary angiography for one year or more.
- In the presence of infective endocarditis when there is evidence for coronary embolism.

A left heart catheterization will be considered medically necessary for any of the following conditions:

- In disease affecting the aorta when knowledge of the presence or extent of coronary artery involvement is necessary for management (for

example, the presence of aortic aneurysm or ascending aortic dissection), arteritis or homozygous type II hypercholesterolemia in which coronary artery involvement is suspended.

- The presence of left ventricular failure without obvious cause and adequate left ventricular systolic function.
- When patients with hypertrophic cardiomyopathy have angina pectoris uncontrolled by medical therapy, or are to undergo surgery for outflow obstruction.
- The presence of dilated cardiomyopathy.
- Recent blunt trauma to the chest and evidence of acute myocardial infarction in patients who have no evidence of preexisting coronary artery disease.
- When patients are to undergo other cardiac surgical procedures, such as pericardiectomy or removal of chronic pulmonary emboli.

HCPCS Codes

93510; Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous

93511; Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown

93514; Left heart catheterization by left ventricular puncture

93524; Combined transseptal and retrograde left heart catheterization

ICD-9 Codes That Support Medical Necessity

N/A

Right Heart Catheterization

Right heart catheterization is not routinely part of coronary angiography, but is an associated procedure in a significant number of patients. This procedure should be performed under the following circumstances:

- Patients with known history of congestive heart failure.
- Patients with cardio-myopathy documented by non-invasive workup.
- Patients with known or suspected valvular heart disease.
- Patients with known or suspected intracardiac shunt (i.e., ASD, VSD).
- Patients with previous myocardial infarction.

- Patients with unexplained symptoms (i.e., shortness of breath), suspected to have cardiac origin.

- Patients in whom pulmonary artery disease is known or suspected (i.e., pulmonary hypertension, S/P pulmonary emboli).

HCPCS Codes

93501; Right heart catheterization

ICD-9 Codes That Support Medical Necessity

N/A

Combined Heart Catheterization:

In conjunction with left heart catheterization, right heart catheterization can be useful in providing cardiac output and hemodynamics that may be important therapeutic directives (see Covered ICD-9 Codes).

HCPCS Codes

93526; Combined right heart catheterization and retrograde left heart catheterization

93527; Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)

93528; Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)

93529; Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)

ICD-9 Codes That Support Medical Necessity:

410.00-410.92

412

415.11

415.19

416.0

416.8

420.0

420.90-420.99

422.0

422.90-422.99

424.0-424.3

425.0-425.9

428.0-428.9
429.71
745.4

Appropriate ICD-9 codes for combined heart catheterization (procedure codes 93526, 93527, 93528, 93529) include the following:

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HCFA National Coverage Policy
MCM 4630

Reasons for Denial

Medicare Part B cannot provide coverage for cardiac catheterization procedures done as a screening test.

Coding Guidelines

Effective January 1, 1998, to report coronary angiography without left heart catheterization, use code 93508 (Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization). 93508 is to be used only when left heart catheterization (93510, 93511, 93524, 93526) is not performed. 93508 is to be used only once per procedure.

Effective January 1, 1998 these four new codes can be used to report cardiac catheterization for congenital cardiac anomalies:

93530; Right heart catheterization, for congenital cardiac anomalies

93531; Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies

93532; Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies

93533; Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies

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

21 - Inpatient Hospital

22 - Outpatient Hospital

99 - Free Standing Cardiac Catheterization Facility

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of cardiac catheterization covered by the Medicare Program. Also, the hard copy test results and interpretation of the catheterization must be included in the patient's medical record.

If the provider of the cardiac catheterization 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 study.

54250, 95805-95808, 95810, 95811, 95822: Diagnostic Services Provided
in Sleep Disorder Clinics

As a result of the 1998 HCPCS update, several procedure code changes have affected the policy for diagnostic services covered in a sleep disorder clinic. The revised policy follows and affects the procedure codes listed below. New and revised procedure codes are marked with an asterisk.

54250; Nocturnal penile tumescence and/or rigidity testing

*95805; Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

*95806; Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist (95806 is noncovered by Medicare)

*95807; Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist

95808; Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist

95810; Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

*95811; Polysomnography; sleep staging with 4 or more additional parameters of sleep, initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

95822; Electroencephalogram (EEG); sleep only

Medical Policy

Medicare Part B of Florida will cover diagnostic testing for narcolepsy and sleep apnea in a sleep disorder clinic if:

- The clinic is affiliated with a hospital or is a freestanding facility under the direction and control of physicians,
- The patient is referred by an attending physician,
- The clinic maintains a record of the attending physician's orders.

Diagnostic testing routinely performed in a sleep disorder clinic may be covered when performed in the absence of direct supervision by a physician.

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Patients who undergo diagnostic testing in a sleep disorder clinic are not considered inpatients. The overnight stay is considered an integral part of the test.

More than one night in a sleep lab may be necessary for the diagnosis and evaluation of obstructive sleep apnea. If the patient is having frequent obstructive apneas early in the study, the second half of the study is frequently performed with titration of nasal CPAP. However, if it is unclear during the initial half of the study that there will be sufficient abnormal sleep events to make a diagnosis of obstructive sleep apnea, it is necessary to get a full 7-8 hour study to make this determination. In this situation, a second overnight study with titration of nasal CPAP would therefore be considered medically necessary.

A polysomnography may be performed the night before a multiple sleep latency test to ensure that the patient has had a good night sleep. A false diagnosis of narcolepsy can be made in patients who are sleep-deprived or have had insufficient REM sleep for a variety of reasons the preceding night.

Polysomnography, multiple sleep latency or maintenance of wakefulness testing is considered reasonable and necessary for narcolepsy when the patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), amnesiac episodes or continuous disabling drowsiness.

Standard or prolonged sleep EEG studies are considered reasonable and necessary for parasomnia when seizure disorders are the suspected cause of the parasomnia.

Polysomnography is considered reasonable and necessary for parasomnia when seizure disorders have been ruled out and in cases that present a history of repeated violent or injurious episodes.

The use of polysomnography for the diagnosis of patients with chronic insomnia is a noncovered service under Medicare Part B.

A diagnosis of narcolepsy can ordinarily be confirmed with three sleep trials to assess sleepiness. Medical evidence justifying the medical necessity for additional tests must be submitted.

A diagnosis of sleep apnea can ordinarily be confirmed with a single polysomnogram and EEG. Medical evidence justifying the medical necessity for additional tests must be submitted.

A diagnosis of impotence can ordinarily be confirmed with two nights maximum diagnostic testing. Medical evidence justifying the medical necessity for additional tests must be submitted.

Reimbursement for nocturnal penile tumescence and/or rigidity test (procedure code 54250) is considered medically reasonable and necessary for impotence when performed to confirm the treatment to be given (surgical, medical, or psychotherapeutic).

Claims submitted for nocturnal penile tumescence and/or rigidity tests performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable and necessary.

Advanced Notice Requirement

Applies to medical necessity (see page 4).

Standing Orders for Clinical Consultations

The following rule was published in the Federal Register, Volume 62, number 211, dated October 31, 1997:

"The regulations set forth at 415.130 (Conditions for payment: Physician pathology services), paragraph (b) (Clinical consultation services), require that a clinical consultation meet four criteria before it can be paid. One of these criteria is that the clinical consultation must be requested by the patient's attending physician. We have allowed a standing order policy to be used as a substitute for the individual request by the patient's attending physician. However, effective January 1, 1998, we will not accept a standing order as a substitute for the individual request by the attending physician. We will instruct the Medicare carriers to enforce 415.130(b) as it is presently written."

Based on the above new rule, the Clinical Pathology Consultation Policy (procedure codes 80500 and 80502) has been revised to state that standing orders are not a substitute for the individual request made by the attending physician. For additional coverage requirements, please refer to the May/June 1997 Medicare Part B Update!.

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Provision of Diagnosis Information by Physicians and Practitioners

The Balanced Budget Act of 1997 requires that non-physician practitioners provide diagnostic codes for physician services they furnish on or after January 1, 1998. Currently, all physician specialties must use ICD-9-CM codes and must code to the highest level

of specificity. Effective January 1, 1998, the same requirement is being expanded to include non-physician practitioners. For purposes of this provision, non-physician practitioners include: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists and clinical social workers.

Although this requirement is effective for services furnished on and after January 1, 1998, claims for services furnished by non-physician practitioners which are missing ICD-9-CM codes will be processed until March 31, 1998. After that date, Medicare may begin denying payment for such claims.

In addition, effective for services furnished on and after January 1, 1998, this provision also requires that physicians and non-physician practitioners provide diagnostic information when ordering certain items or services furnished by another entity. Services affected by this provision include: diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests; durable medical equipment; prosthetic devices (other than dental); and leg, arm, back, and neck braces, and artificial legs, arms, and eyes.

Physicians and non-physician practitioners will be required to provide diagnosis information (i.e., ICD-9-CM diagnosis codes) when ordering services that are furnished by another entity when there is a Local Medical Review Policy in place requiring such diagnosis information from the entity performing the service. In the past, physicians ordering such services were not required by law to provide diagnosis information to the entity billing Medicare. Medicare took the position that the requirement to provide diagnosis information was part of the business relationship between suppliers/providers and their physician clientele; furthermore, this was a relationship into which Medicare had no right to intervene on behalf of either party. With the passing of the Balanced Budget Act, physicians and non-physician practitioners will now be required to provide this information to the entity furnishing the service at the time the service is ordered, if a policy exists requiring such diagnosis information from the entity performing the service.

Questions and Answers on Private Contracts Between Beneficiaries and Providers

Q

What is a "private contract" and what does it mean to a Medicare beneficiary who signs it?

A

As provided in section 4507 of the Balanced Budget Act of 1997, a "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has "opted out" of Medicare for two years for all covered items and services he or she furnishes to

Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

Q

What has to be in a private contract and when must it be signed?

A

The private contract must be signed by both parties before services can be furnished under its terms and must state plainly and unambiguously that by signing the private contract, the beneficiary or the beneficiary's legal representative:

- Gives up all Medicare coverage of, and payment for, services furnished by the "opt out" physician or practitioner;
- Agrees not to bill Medicare or ask the physician or practitioner to bill Medicare;
- Is liable for all charges of the physician or practitioner, without any limits that would otherwise be imposed by Medicare;
- Acknowledges that Medigap will not pay towards the services and that other supplemental insurers may not pay either;
- Acknowledges that he or she has the right to receive services from physicians and practitioners for whom Medicare coverage and payment would be available.

The contract must also indicate whether the physician or practitioner has been excluded from Medicare.

Also, a contract is not valid if it is entered into by a beneficiary or by the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health situation.

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Q

Who can "opt out" of Medicare under this provision?

A

Physicians and practitioners can "opt out" of Medicare. For purposes of this provision, physicians include doctors of medicine and of osteopathy. Practitioners include physician assistants, nurse

practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, and clinical psychologists.

The law does not define "physician", for purposes of this provision, to include optometrists, chiropractors, podiatrists, dentists, and doctors of oral surgery; therefore, they may not opt out of Medicare and provide services under private contract. Also, physical therapists in independent practice and occupational therapists in independent practice cannot opt out because they are not within the law's definition of either a "physician" or "practitioner".

Q

Can physicians or practitioners who are suppliers of durable medical equipment (DME), independent diagnostic testing facilities, clinical laboratories, etc., opt out of Medicare for only these services?

A

No. If a physician or practitioner chooses to opt out of Medicare, it means that he or she opts out for all covered items and services he or she furnishes, even if those items or services are covered under a different benefit. Physicians and practitioners cannot have private contracts that apply to some covered services they furnish but not to others. For example, if a physician or practitioner provides laboratory tests or durable medical equipment and chooses to opt out of Medicare, then he or she has opted out of Medicare for payment of lab services and DME as well as for professional services. If a physician who has opted out refers a beneficiary for medically necessary services, such as laboratory, DME or inpatient hospitalization, those services would be covered.

Q

How can participating physicians and practitioners opt out of Medicare?

A

To opt out of Medicare, a participating physician must first terminate his or her Medicare Part B participation agreement. Practitioners do not have participation agreements since the statute requires that assignment be accepted for all items and services they furnish.

At this point, the Part B participation agreement may be terminated only effective with the beginning of the year. Hence, a physician who participates in Part B of Medicare in 1997 would need to terminate the agreement during the Part B participation enrollment period for 1998 to be able to opt out of Medicare at any point in 1998. However, HCFA is exploring whether it would be administratively possible to permit

physicians to terminate their participation agreement at times other than the annual enrollment period. A decision on this issue will be made before February 2, 1998, which is the end of the extended enrollment period for 1998.

Q

What happens if a physician who is a member of a group practice opts out?

A

A member of a group practice may enter into a private contract under section 4507 and opt out of Medicare, without affecting the ability of the other members of the group practice to provide and bill for services they furnish to Medicare beneficiaries. No Medicare payment may be made to the group directly or through an organization paid on a capitated basis for services furnished by the physician or practitioner who has opted out.

Q

Can organizations that furnish physician or practitioner services opt out?

A

No. Corporations, partnerships, or other organizations that bill and are paid by Medicare for the services of physicians or practitioners who are employees, partners or have other arrangements that meet the Medicare reassignment-of-benefits rules cannot opt out since they are neither physicians nor practitioners.

Physicians and practitioners who reassign benefits to organizations that participate in Medicare may not opt out because they are bound by the participation agreement signed by the organization that bills and is paid for their services. If a physician or practitioner has reassigned benefits to an organization that participates in Medicare and wants to opt out, either the organization should terminate its participation agreement or the physician or practitioner should terminate the reassignment of Medicare benefits to the organization.

Q

Can a physician or practitioner have "private contracts" with some beneficiaries but not others?

A

No. The physician or practitioner who chooses to opt out of Medicare may provide covered care to Medicare beneficiaries only through private agreements, regardless of who bills and is paid for the services.

To have a "private contract" with a beneficiary, the physician or practitioner has to opt out of Medicare and file an affidavit with all Medicare carriers to which he or she would submit claims, advising that he or she has opted out of Medicare. The affidavit must be filed within 10 days of entering into the first "private contract" with a Medicare beneficiary. Once the physician or practitioner has opted out, such physician or practitioner must enter into a private contract with each Medicare beneficiary to whom he or she furnishes covered services (even where Medicare payment would be on a capitated basis or where Medicare would pay an organization for the physician's or practitioner's services to the Medicare beneficiary), with the exception of a Medicare beneficiary needing emergency or urgent care.

Physicians who provide services to Medicare beneficiaries enrolled in the new Medical Savings Account (MSA) demonstration created by the BBA of 1997 are not required to enter into a private contract with those beneficiaries and opt out of Medicare for two years under section 4507.

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Q

What has to be in the "opt out" affidavit?

A

To be valid, the affidavit must:

Provide that the physician or practitioner will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the 2 year period beginning on the date the affidavit is signed;

Provide that the physician or practitioner will not receive any Medicare payment for any items or services provided to Medicare beneficiaries;

Identify the physician or practitioner sufficiently that the carrier can ensure that no payment is made to the physician or practitioner during the opt out period. If the physician has already enrolled in Medicare, this would include the physician or practitioner's Medicare uniform provider identification number (UPIN) if one has been assigned.

If the physician has not enrolled in Medicare, this must include the information necessary to be assigned a UPIN;

Be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare and must be filed no later than 10 days after the first private contract to which the affidavit applies is entered into; and

Be in writing and be signed by the physician or practitioner.

Q

Where and when should the "opt out" affidavit be filed?

A

The "opt out" affidavit must be filed with each carrier that has jurisdiction over the claims that the physician or practitioner would otherwise file with Medicare and must be filed within 10 days after the first private contract to which the affidavit applies is entered into.

In Florida, all affidavits must be mailed to the following address: Medicare Registration PO Box 44021 Jacksonville, FL 32231-4021

Q

How often can a physician or practitioner "opt out" or return to Medicare?

A

Pursuant to the statute, once a physician or practitioner files an affidavit notifying the Medicare carrier that he or she has opted out of Medicare, he or she is out of Medicare for two years from the date the affidavit is signed. After those two years are over, a physician or practitioner could elect to return to Medicare or to "opt out" again.

Q

Can a physician or practitioner "opt out" for some carrier jurisdictions but not others?

A

No. The opt out applies to all items or services the physician or practitioner furnishes to Medicare beneficiaries, regardless of the location where such item or service is furnished .

Q

What is the effective date of the "opt out" provision?

A

A physician or practitioner may enter into a private contract with a beneficiary for services furnished no earlier than January 1, 1998. The physician or practitioner must submit the affidavit to all pertinent Medicare carriers within 10 days of the date the first private contract is signed by a Medicare beneficiary.

Q

Does the statute preclude physicians from treating Medicare beneficiaries if they treat private pay patients?

A

No. Medicare does not preclude physicians from treating Medicare beneficiaries if they treat private pay patients, whether they are persons under age 65 or seniors who choose not to enroll in Part B.

Q

Do Medicare rules apply for services not covered by Medicare?

A

If Medicare does not cover a service, Medicare rules, including opt-out rules, do not apply to the furnishing of the noncovered service. For example, Medicare does not cover hearing aids; therefore, there are no limits on changes for hearing aids and beneficiaries pay completely out of their own pocket if they want hearing aids.

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Q

Is a private contract needed for services not covered by Medicare?

A

No. Since Medicare rules do not apply for services not covered by Medicare, a private contract is not needed. A private contract is needed only for services that are covered by Medicare and where Medicare may make payment if a claim were submitted.

A physician or practitioner may furnish a service that Medicare covers under some circumstances but which the physician anticipates would not be deemed "reasonable and necessary" by Medicare in the particular case (e.g., multiple nursing home visits, some concurrent care services, two mammograms within a twelve month period, etc.). If the beneficiary receives an "Advance Beneficiary Notice" that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, a private contract is not necessary to bill the beneficiary if the claim is denied.

Q

What rules apply to urgent or emergency treatment?

A

The law precludes a physician or practitioner from having a beneficiary sign a private contract when the beneficiary is facing an urgent or emergency health care situation.

Where a physician, or a practitioner who has opted out of Medicare, treats a beneficiary with whom he does not have a private contract in an emergency or urgent situation, the physician or practitioner may not charge the beneficiary more than the Medicare limiting charge for the service and must submit the claim to Medicare for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare covered services furnished to the beneficiary.

Q

Will Medicare make payment for services that are ordered by a physician or practitioner who has opted out of Medicare?

A

Yes, provided the opt out physician or practitioner ordering the service has acquired a Unique Provider Identification Number (UPIN).

Q

Clinical psychologists and clinical social workers are currently not recognized by and enrolled by Medicare unless they meet certain criteria specified by HCFA, some of which are voluntary. Are the requirements for opting out of Medicare different for these practitioners?

A

No. A clinical psychologist or clinical social worker must meet the affidavit and private contracting rules to opt out of Medicare.

Q

What is the relationship between an Advance Beneficiary Notice and a private contract?

A

A physician or practitioner may furnish a service that Medicare covers under some circumstances but which the physician anticipates would not be deemed "reasonable and necessary" under Medicare program standards in the particular case (such cases are also referred to as "medical necessity" denials). If the beneficiary receives an "Advance Beneficiary Notice" that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, a private contract is not necessary to bill the beneficiary if the claim is denied.

Q

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

A

Yes. A physician who has not opted out of Medicare must submit a claim to Medicare for services that may be covered by Medicare unless the beneficiary, for reasons of his or her own, declines to authorize the physician or practitioner to submit a claim or to furnish confidential medical information to Medicare that is needed to execute a proper claim. Examples would be where the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone. The balance billing limits applicable to the physician or practitioner would still apply. Moreover, if the beneficiary or their legal representative later decides to authorize the submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so.

Q

How do the private contracting rules work when Medicare is the secondary payer?

A

When Medicare is the secondary payer, and the physician has opted out of Medicare, the physician has agreed to treat Medicare beneficiaries only through private contract. The physician or practitioner must

therefore have a private contract with the Medicare beneficiary, notwithstanding that Medicare is the secondary payer. Under this circumstance, no Medicare secondary payments will be made for items and services furnished by the physician or practitioner under the private contract.

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Revisions to 1998 Fee Schedule Allowances

The following fees are revisions to 1998 fee schedule allowances which have been previously published.

Code: 11055

Participating - Loc 1/2 =18.39 , Loc 3 =19.56 , Loc 4 =20.43
NonParticipating - Loc 1/2 =17.47 , Loc 3 =18.58 , Loc 4 =19.41
Limited Charge - Loc 1/2 =20.09 , Loc 3 =21.37 , Loc 4 =22.32

Code: 11055*

Participating - Loc 1/2 =13.88 , Loc 3 =14.64 , Loc 4 =15.27
NonParticipating - Loc 1/2 =13.19 , Loc 3 =13.91 , Loc 4 =14.51
Limited Charge - Loc 1/2 =15.16 , Loc 3 =15.99 , Loc 4 =16.68

Code: 11056

Participating - Loc 1/2 =25.96 , Loc 3 =27.66 , Loc 4 =28.99
NonParticipating - Loc 1/2 =24.66 , Loc 3 =26.28 , Loc 4 =27.54
Limited Charge - Loc 1/2 =28.36 , Loc 3 =30.22 , Loc 4 =31.67

Code: 11056*

Participating - Loc 1/2 =19.89 , Loc 3 =21.04 , Loc 4 =22.04
NonParticipating - Loc 1/2 =18.90 , Loc 3 =19.99 , Loc 4 =20.94
Limited Charge - Loc 1/2 =21.73 , Loc 3 =22.99 , Loc 4 =24.08

Code: 11057

Participating - Loc 1/2 =27.14 , Loc 3 =28.70 , Loc 4 =29.97
NonParticipating - Loc 1/2 =25.78 , Loc 3 =27.27 , Loc 4 =28.47
Limited Charge - Loc 1/2 =29.65 , Loc 3 =31.35 , Loc 4 =32.74

Code: 11057*

Participating - Loc 1/2 =22.28 , Loc 3 =23.41 , Loc 4 =24.41
NonParticipating - Loc 1/2 =21.17 , Loc 3 =22.24 , Loc 4 =23.19
Limited Charge - Loc 1/2 =24.34 , Loc 3 =25.58 , Loc 4 =26.67

Code: 11719

Participating - Loc 1/2 =12.44 , Loc 3 =13.44 , Loc 4 =14.17
NonParticipating - Loc 1/2 =11.82 , Loc 3 =12.77 , Loc 4 =13.46
Limited Charge - Loc 1/2 =13.59 , Loc 3 =14.68 , Loc 4 =15.48

Code: 11719*

Participating - Loc 1/2 =6.20 , Loc 3 =6.63 , Loc 4 =7.02
NonParticipating - Loc 1/2 =5.89 , Loc 3 =6.30 , Loc 4 =6.67
Limited Charge - Loc 1/2 =6.77 , Loc 3 =7.24 , Loc 4 =7.67

Code: 76076

Participating - Loc 1/2 =39.21 , Loc 3 =43.08 , Loc 4 =46.24
NonParticipating - Loc 1/2 =37.25 , Loc 3 =40.93 , Loc 4 =43.93

Limited Charge - Loc 1/2 =42.84 , Loc 3 =47.06 , Loc 4 =50.52

Code: 76076TC

Participating - Loc 1/2 =27.51 , Loc 3 =30.58 , Loc 4 =32.99

NonParticipating - Loc 1/2 =26.13 , Loc 3 =29.05 , Loc 4 =31.34

Limited Charge - Loc 1/2 =30.05 , Loc 3 =33.41 , Loc 4 =36.04

* Represents the fee schedule allowance based on the SOS differential.

1998 Radiopharmaceutical Pricing

The following fees are for two new procedure codes developed as a result of the 1998 HCPCS update.

Code: A9502

Descriptor: Tetrofosmin

Fee: \$88.00

Code: A9600

Descriptor: Strontium-89 Chloride

Fee: \$2032.80

Note: These services are not subject to limiting charges.

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Routine Screening/Noncovered Diagnosis Codes

ROUTINE SCREENING DIAGNOSIS CODES

Medicare Part B covers services which are reasonable and necessary for the patient's condition. Except for those services which are regulated under Medicare law (i.e., Screening Pelvic Examination - G0101, Screening Pap Smears - Q0091, P3000-P3001, Influenza Vaccinations - G0008, 90724, Pneumococcal Vaccinations - G0009, 90732, Screening Mammography - 76092, Hepatitis B Vaccine - G0010, 90731), services performed for screening purposes are noncovered. This includes services performed when there is no symptomatology to warrant the service.

The following diagnoses are considered screening because their descriptors denote that a screening service was performed. Services billed with any of these diagnoses will be denied payment. The patient may be held financially liable for any denied charges.

NOTE: When only a three digit diagnosis code is specified in the "ICD-9 DX CODE" column, all four and/or five digit codes beneath that designation will be denied for the same reason.

Note: All of the following DENIAL REASON's are "SCREENING"

ICD-9 DX CODE: V16

DESCRIPTION: Family history of malignant neoplasm

ICD-9 DX CODE: V17
DESCRIPTION: Family history of certain chronic disabling diseases

ICD-9 DX CODE: V18
DESCRIPTION: Family history of certain other specific conditions

ICD-9 DX CODE: V19
DESCRIPTION: Family history of other conditions

ICD-9 DX CODE: V20
DESCRIPTION: Health supervision of infant or child

ICD-9 DX CODE: V21
DESCRIPTION: Constitutional states in development

ICD-9 DX CODE: V28
DESCRIPTION: Antenatal screening

ICD-9 DX CODE: V29
DESCRIPTION: Observation and evaluation (without signs or symptoms) of newborns for conditions not found

ICD-9 DX CODE: V30-V39
DESCRIPTION: Liveborn infants who are consuming health care (e.g., crib or bassinet occupancy)

ICD-9 DX CODE: V69
DESCRIPTION: Problems related to lifestyles

ICD-9 DX CODE: V70
DESCRIPTION: General medical examination

ICD-9 DX CODE: V71
DESCRIPTION: Observation and evaluation for suspected conditions not found

ICD-9 DX CODE: V72-V72.7
DESCRIPTION: Routine investigations and exams (eyes, ears, dental, gynecological, skin, pregnancy test, radiology exam, lab exam)

ICD-9 DX CODE: V72.8
DESCRIPTION: Other specified examinations

ICD-9 DX CODE: V72.85
DESCRIPTION: Other specified examination

ICD-9 DX CODE: V72.9
DESCRIPTION: Unspecified examination

ICD-9 DX CODE: V73-V82
DESCRIPTION: Special screening examinations

NONCOVERED DIAGNOSIS CODES

The following diagnoses are considered noncovered because their descriptors denote that a noncovered service was performed. Services

billed with any of these diagnoses will be denied payment. The patient may be held financially liable for any denied charges.

NOTE: When only a three digit diagnosis code is specified in the "ICD-9 DX CODE" column, all four and/or five digit codes beneath that designation will be denied for the same reason.

Note: All of the following DENIAL REASON's are "NON-COVERED"

ICD-9 DX CODE: V03

DESCRIPTION: Need for prophylactic vaccination and inoculation against bacterial diseases (i.e., cholera, typhoid, tuberculosis, plague, tularemia, diphtheria, pertussis, tetanus toxoid, hemophilus influenza B, pneumococcus, etc)

ICD-9 DX CODE: V04

DESCRIPTION: Need for prophylactic vaccination and inoculation against certain viral diseases (i.e., polio, smallpox, measles, rubella, yellow fever, rabies, mumps, common cold, influenza)

ICD-9 DX CODE: V05

DESCRIPTION: Need for other prophylactic vaccination and inoculation against single diseases (i.e., encephalitis, other arthropod-borne viral diseases, leishmaniasis, hepatitis, varicella, etc)

ICD-9 DX CODE: V06

DESCRIPTION: Need for prophylactic vaccination and inoculation against combinations of diseases (i.e., cholera & TAB, DTP, DTP & TAB, DTP & polio, measles/mumps/rubella, tetanus/diphtheria, pneumonia, etc)

ICD-9 DX CODE: V25

DESCRIPTION: Encounter for contraceptive management

ICD-9 DX CODE: V26

DESCRIPTION: Procreative management

ICD-9 DX CODE: V50

DESCRIPTION: Elective surgery for purposes other than remedying health states

ICD-9 DX CODE: V53.2

DESCRIPTION: Fitting and adjustment of hearing aid

ICD-9 DX CODE: V60

DESCRIPTION: Housing, household and economic circumstances

ICD-9 DX CODE: V61

DESCRIPTION: Other family circumstances

ICD-9 DX CODE: V62

DESCRIPTION: Other psychosocial circumstances

ICD-9 DX CODE: V63

DESCRIPTION: Unavailability of other medical facilities for care

ICD-9 DX CODE: V65

DESCRIPTION: Other persons seeking consultation without complaint or sickness

ICD-9 DX CODE: V68

DESCRIPTION: Encounters for administrative purposes

ICD-9 DX CODE: 302.50-302.53

DESCRIPTION: Trans-sexualism

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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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Don't forget!!! Effective January 1, 1998, All Claims for Clinical Diagnostic Laboratory Services Will Require the CLIA Number.

The Clinical Laboratory Improvements Amendments of 1988 (CLIA), Public Law 100-578, amended 353 of the Public Health Service Act (PHSA) to extend jurisdiction of the Department of Health and Human Services to regulate all laboratories that examine human specimens to provide information to assess, diagnose, prevent, or treat any disease or impairment. CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable Federal

requirements and have a CLIA certificate in order to receive reimbursement from Federal programs. CLIA also lists requirements for laboratories performing only certain tests to be eligible for a certificate of waiver or a certificate for Physician Performed Microscopy Procedures (PPMP). In 1992, carriers were instructed to deny clinical laboratory services billed by independent laboratories which did not meet the CLIA requirements. POLs were excluded from the 1992 instruction. However, that is being changed.

HCFA has undertaken an initiative to monitor CLIA compliance for all laboratories. Several tasks have already begun in HCFA and others are to be phased in through January 1, 1998 by HCFA and Medicare Part B carriers. These are the instructions to implement changes bringing POLs into compliance with CLIA.

The major change is a requirement for the CLIA number to be included on each Form HCFA-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. While this number will be required in October 1997, claims without the CLIA number will not be denied until January 1, 1998. Medicare Part B will continue processing independent laboratories' claims as they currently do except that remittance advice notices will warn that claims will not be paid beginning January 1, 1998, where no CLIA number appears on the claim. Beginning in January 1998, the CLIA number must be on all claims for laboratory services or the service(s) will be returned as unprocessable.

For paper claims, this information must be entered in Item 23 of the HCFA-1500 claim form.

Electronic claim filers must enter this information in the FA0 record, field 34, positions 164-178, of the National Standard Format.

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Physicians Who Perform Surgery and Anesthesia

Through a claims history review, we have determined that one or more physicians are providing surgical services as well as anesthesia services and they are billing for both services. In these instances, payment for the anesthesia service is included in the payment for the surgical service and, therefore, should not be reimbursed as a separate service. For example, there is no additional reimbursement for a surgeon who performs his own anesthesia; i.e., it is included in the reimbursement for the surgical procedure.

Anesthesiology Services

Effective January 1, 1998, HCFA is revising its billing procedures for anesthesiology services where a CRNA and the anesthesiologist are involved in a single procedure and the physician is performing medical direction. The revised procedures are based upon a change in the payment policy for a medically directed service. Prior to December 31, 1997, HCFA did not permit some level of payment to both the CRNA and

the physician when only one service was supervised. Effective January 1, 1998, HCFA payment policy allows payment for medically directed services when only one service was supervised.

In situations where the CRNA and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction submit the claims using the following procedures:

- 1) For the single medically directed service, the physician uses the modifier QY.
- 2) For the anesthesia service, furnished by the medically directed CRNA, the CRNA uses the current modifier, QX.

Modifier 53: Terminated Surgical Procedures

This is a clarification to the article "Use New 53 Modifier to Indicate Discontinued Services" on page 16 of the December 1996 Special Update!

The 53 modifier applies to the Ambulatory Surgical Center's facility fee and to the physician's charges. The modifier may also be used for physician services rendered in a hospital if the patient is prepped for surgery and the surgery is discontinued.

All procedure codes billed with the 53 modifier for the facility fee require documentation.

19340: Breast Reconstruction Covered Bilaterally

Following a medically necessary mastectomy, reconstruction of the affected breast and the contralateral unaffected breast are covered. This affects the following procedure codes:

19340; Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19342; Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19350; Nipple/areola reconstruction

19357; Breast reconstruction, immediate or delayed, With tissue expander, including subsequent expansion

19361; Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant

19364; Breast reconstruction with free flap

19366; Breast reconstruction with other technique

19367; Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;

19368; Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharge)

19369; Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

19380; Revision of reconstructed breast

19396; Preparation of moulage for custom breast implant

19499; Unlisted procedure, breast

65760-65767, 65771: Refractive Keratoplasty Not Covered

Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include the following procedure codes:

65760; Keratomileusis

65765; Keratophakia

65767; Epikeratoplasty

65771; Radial keratotomy

Because radial keratotomy and/or keratoplasty is considered a substitute or alternative to eyeglasses or contact lenses, it is specifically excluded from coverage.

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61711: Noncoverage Information for EC-IC

Procedure code 61711 (Anastomosis, arterial, extracranial-intracranial (EC-IC) (e.g., middle cerebral/cortical) arteries) for the treatment of strokes is a noncovered service. EC-IC arterial bypass surgery is not considered reasonable and necessary when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries.

Reasons for Denial

Extracranial-intracranial (EC-IC) surgery is noncovered for the following diagnoses.

430

431

433.00-433.01

433.10-433.11
433.20-433.21
433.30-433.31
433.80-433.81
433.90-433.91
434.00-434.01
434.10-434.11
434.90-434.91
435.0
435.1
435.2
435.3
435.8
435.9
436
437.0
437.1
437.2
437.3
437.4
437.5

Documentation Requirements

Request for a review of charges denied as "not payable for the diagnosis as reported" should include a narrative statement of medical necessity clearly documenting why the physician feels the service(s) was medically necessary.

Documentation Guidelines for Blepharoplasty Procedures

On June 2, 1997, the carrier sent a special notice to all ophthalmologists to clarify the documentation requirements for upper eyelid and brow surgeries. Since that time, we have been asked to clarify several key points. The following Question and Answer section has been developed to further clarify the current documentation requirements. If you did not receive a copy of the June 2, 1997 notice, contact our Provider Customer Service department at (904) 634-4994 to obtain a copy.

Q

What documentation is required to establish that a Blepharoplasty and/or Ptosis Repair was performed as a functional surgery?

A

Ocular history; surgery report or evidence that the surgical procedure was performed as billed; and the level of visual impairment supported by photographs or visual field interpretation.

Q

Is the visual field test required documentation?

A

No, only the interpretation.

Q

What must be documented in the visual field interpretation?

A

The visual field interpretation must clearly document a minimum of 12 degrees or 30 percent loss of upper field vision with upper lid skin and/or upper lid margin in repose and elevated by taping of the lid to demonstrate potential correction (see the July/August 1996 Medicare B Update!).

Q

If evidence of visual impairment is substantiated only by photographs and is not supported by visual field interpretations what are the requirements for a photograph?

A

The photographs must be of sufficient clarity to show a light reflex on the cornea. The frontal photograph must be canthus to canthus with the head perpendicular to the plane of the camera and must demonstrate that the eyelid margin approaches to within 2.5mm (1/4th of the diameter of the visible iris) of the corneal light reflex.

Q

Are additional photographs ever necessary?

A

Yes. Additional photographs are needed if no visual field interpretation is submitted when an upper lid blepharoplasty (15822-15823) and repair of blepharoptosis (67901-67908) are performed at the same time. Additional photographs must be taken with the upper lid skin retracted to show the actual position of the true lid margin.

Q

Are oblique photographs ever needed?

A

Yes. When no visual field interpretation is submitted and redundant skin on the upper eyelashes is the only indication for surgery oblique photographs are needed.

Q

Are photographs necessary for brow ptosis?

A

Yes. If evidence of visual impairment is only substantiated by photos and not visual fields, the photos must include before and after taping, or other means of showing the functional effect of surgery.

Q

If the claim is for chronic dermatitis are visual field interpretations needed?

A

No. The documentation must include the physical description of the dermatitis and evidence of any prior treatment.

Q

Can we create a form for our office that would allow us to capture all the documentation requirements on one form?

A

Yes. We have already seen many different types of forms that capture the necessary documentation. Some providers have added the ocular history and visual fields interpretation to the operative report.

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Guidelines for Purchased Diagnostic Tests

Effective for services rendered January 1, 1998, and after, the following, all-inclusive list of procedure codes will be subject to the purchased diagnostic tests rules (see next page).

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

Personally Performed Diagnostic Tests

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

Purchased Diagnostic Tests

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

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

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

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

- Portable x-ray suppliers
- Independent laboratories
- Independently practicing audiologists
- Independent physiological laboratories

Procedures Subject to Purchased Test Rules

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

**Procedure codes added for 1998

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

G0005*	G0006*	G0015*	G0030	G0031	G0032	G0033	G0034
G0035	G0036	G0037	G0038	G0039	G0040	G0041	G0042
G0043	G0044	G0045	G0046	G0047	G0062	G0063	G0106**
G0120**	Q0035	Q0092*	70010	70015	70030	70100	70110
70120	70130	70134	70140	70150	70160	70170	70190
70200	70210	70220	70240	70250	70260	70300	70310
70320	70328	70330	70332	70336	70350	70355	70360
70370	70371	70373	70380	70390	70450	70460	70470
70480	70481	70482	70486	70487	70488	70490	70491
70492	70540	70541	70551	70552	70553	71010	71015
71020	71021	71022	71023	71030	71034	71035	71036
71038	71040	71060	71090	71100	71101	71110	71111
71120	71130	71250	71260	71270	71550	72010	72020
72040	72050	72052	72069	72070	72072	72074	72080
72090	72100	72110	72114	72120	72125	72126	72127
72128	72129	72130	72131	72132	72133	72141	72142
72146	72147	72148	72149	72156	72157	72158	72170
72190	72192	72193	72194	72196	72200	72202	72220
72240	72255	72265	72270	72285	72295	73000	73010
73020	73030	73040	73050	73060	73070	73080	73085
73090	73092	73100	73115	73120	73130	73140	73200
73201	73202	73220	73221	73500	73510	73520	73525
73530	73540	73550	73560	73562	73564	73565	73580
73590	73592	73600	73610	73615	73620	73630	73650
73660	73700	73701	73702	73720	73721	74000	74010
74020	74022	74150	74160	74170	74181	74190	74210
74220	74230	74235	74240	74241	74245	74246	74247
74249	74250	74251	74260	74270	74280	74283	74290
74291	74300	74301	74305	74320	74327	74328	74329
74330	74340	74350	74355	74360	74363	74400	74405
74410	74415	74420	74425	74430	74440	74445	74450
74455	74470	74475	74480	74485	74710	74740	74742
74775	75552	75553	75554	75555	75600	75605	75625
75630	75650	75658	75660	75662	75665	75671	75676
75680	75685	75705	75710	75716	75722	75724	75726
75731	75733	75736	75741	75743	75756	75774	75790
75801	75803	75805	75807	75809	75810	75820	75822
75825	75827	75831	75833	75840	75842	75860	75870
75872	75880	75885	75887	75889	75891	75893	75898
75945	75946	75970	75992	75993	75994	75995	75996
76000	76001	76003	76010	76020	76040	76061	76062
76065	76066	76076**	76078**	76080	76086	76088	

76090	76091	76093	76094	76095	76096	76098	76100
76101	76102	76120	76125	76150*	76350*	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	76945	76970	
76975	76986	76999	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
78399	78414	78428	78445	78455	78457	78458	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	78655	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	78999	86485*	86490*	86510*	86580*	86585*	
86586*	88104	88106	88107	88108	88125	88160	88161
88162	88170	88171	88172	88173	88180	88182	88199
88300	88302	88304	88305	88307	88309	88311	88312
88313	88314	88318	88319	88342	88346	88347	88348
88349	88355	88356	88358	88362	88365	88399	89350*
89360*	91000	91010	91011	91012	91020	91030	91032
91033	91052	91055	91060	91065	92552*	92553*	92555*
92556*	92557*	92561*	92562*	92563*	92564*	92565*	
92567*	92568*	92569*	92571*	92572*	92573*	92574*	
92575*	92576*	92577*	92578*	92579*	92580*	92582*	
92583*	92584*	92585	92587	92588	92589*	92596*	
93005*	93012*	93017*	93024	93041*	93225*	93226*	
93231*	93232*	93236*	93270*	93271*	93278	93303	
93304	93307	93308	93312	93314	93315	93317	93320
93321	93325	93350	93508**	93530**	93531**	93532**	
93533**	93555	93556	93721*	93724	93731	93732	93733
93734	93735	93736	93737	93738	93740	93770	93799
93875	93880	93882	93886	93888	93922	93923	93924
93925	93926	93930	93931	93965	93970	93971	93975
93976	93978	93979	93980	93981	93990	94010	94060
94070	94150	94200	94240	94250	94260	94350	94360
94370	94375	94400	94450	94620	94680	94681	94690
94720	94725	94750	94760*	94761*	94762*	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	95933	95934	95935

95936 95937 95950 95951 95953 95954 95955 95956
95957 95958 95961 95962

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82947: Blood Glucose Testing

Blood glucose testing is covered by Medicare Part B for certain conditions/illnesses. This policy affects the following procedure codes:

82947; Glucose; quantitative

82948; Blood, reagent strip

82962; Glucose, blood by glucose monitoring device(s) cleared by the FDA Specifically for home use.

To ensure that claims are paid only for medically necessary services, blood glucose testing is covered only when it is performed for the following diagnoses:

- 112.0
- 112.1
- 112.2
- 157.0-157.8
- 194.0
- 211.6
- 211.7
- 227.0
- 250.00-250.93
- 251.0
- 251.1
- 251.3
- 251.4
- 251.8
- 252.0
- 253.0
- 253.2
- 253.7
- 255.0
- 255.4
- 276.5
- 356.8
- 357.8
- 571.0
- 571.2
- 571.49
- 571.5
- 571.6
- 571.8
- 577.0
- 577.1
- 648.80-648.84
- 780.01

780.1
780.2
780.31-780.39
780.4
780.8
783.2
783.5
783.6
788.41
788.42
790.2
791.5
V67.51

Blood glucose testing will not be covered by Medicare Part B when performed on a routine screening basis in the absence of abnormal signs or symptoms.

Advance Notice Requirement

Applies to diagnosis (see page 4).

Coding Guidelines

Bill the service with CPT procedure code 82947 for glucose; quantitative, and CPT procedure code 82948 for blood glucose, reagent strip. Include the appropriate ICD-9 code which describes the symptom or condition. CPT code 82947 should not be billed on the same day as a Basic metabolic panel (80049), General health panel (80050), or Comprehensive metabolic panel (80054), unless the blood is obtained at different encounters. (These blood panels were all included in automated profiles [80002-80019, G0058-G0060] prior to January 1, 1998.)

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

1998 Gap-Filled Clinical Laboratory Procedures:

Code: G0100
Fee: 64.38

Code: 80201
Fee: 20.90

Code: 83019
Fee: NC

Code: 84512
Fee: 7.50

Code: 86148
Fee: 22.87

Code: 86361
Fee: 5.80

Code: 87472
Fee: 64.38

Code: 87477
Fee: 64.38

Code: 87482
Fee: 64.38

Code: 87487
Fee: 64.38

Code: 87492
Fee: 64.38

Code: 87497
Fee: 64.38

Code: 87512
Fee: 64.38

Code: 87517
Fee: 64.38

Code: 87522
Fee: 64.38

Code: 87527
Fee: 64.38

Code: 87530
Fee: 64.38

Code: 87533
Fee: 64.38

Code: 87536
Fee: 64.38

Code: 87539
Fee: 64.38

Code: 87542
Fee: 64.38

Code: 87552
Fee: 64.38

Code: 87557
Fee: 64.38

Code: 87562
Fee: 64.38

Code: 87582
Fee: 64.38

Code: 87592
Fee: 64.38

Code: 87622
Fee: 64.38

Code: 87652
Fee: 64.38

Code: 87799
Fee: IC

Code: 88142
Fee: 7.29

88342: Correction to Immunocytochemistry Article

In the November/December 1997 issue of the Medicare B Update!, an article describing billing guidelines for procedure code 88342 (immunocytochemistry [including tissue immunoperoxidase], each antibody) indicated that if the procedure is being performed as a repeat procedure, it should be billed with a 76 modifier. This is incorrect.

Providers should not bill the 76 modifier with procedure code 88342. If 88342 is billed with the 76 modifier, the service will be denied payment.

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93640-93642, 93737, 93738: Electrophysiological Evaluation of Cardioverter-Defibrillator

Electrophysiologic evaluation of cardioverter-defibrillator and/or leads (93640, 93641, 93642) and electronic analysis of cardioverter/defibrillator only (93737, 93738) is covered only when due to:

- a documented episode of life threatening ventricular tachyarrhythmia;
or
- cardiac arrest not associated with myocardial infarction

HCPCS Codes

93640; Electrophysiologic evaluation of cardioverter-defibrillator leads (includes defibrillation threshold testing and sensing function) at time of initial implantation or replacement;

93641; with testing of cardioverter-defibrillator pulse generator

93642; Electrophysiologic evaluation of cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)

93737; Electronic analysis of cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); without reprogramming

93738; with reprogramming

ICD-9 Codes That Support Medical Necessity

427.1

427.5

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

Coding Guidelines

Bill with the CPT code which describes the services rendered and the ICD-9 code which describes the medical symptom or condition.

It is inappropriate to bill a separate service for insertion of a temporary pacemaker. If, at the same session as an electrophysiological study, a permanent pacemaker is placed, it can be billed as a separate service.

Documentation Requirements

Medical records must contain sufficient information to show the medical necessity of the service. If there has been a denial due to medical necessity or there is a question of medical necessity with original billing, include history and physical, progress notes and any other information needed to show medical necessity.

Referring Physician's UPIN Required on Consultation Claims

Consistent with the Physicians' Current Procedural Terminology (CPT), a consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

There are four subcategories of consultations: office (99241-99245); initial inpatient (99251-99255); follow-up inpatient (99261-99263) and confirmatory (99271-99275 *)

In order for a service to qualify as a consultation, there must be a formal request by the attending physician documented in the patient's medical record. Furthermore, the purpose of the attending doctor's request must be to obtain an opinion or advice regarding the evaluation and/or management of a specific problem. The name and Unique Physician Identification Number (UPIN) of the referring physician must be included on the consulting physician's claim (Items 17 and 17a), OR the equivalent Electronic Media Claim (EMC) field.

* A consultation initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultations or office visits. In such cases, the attending physician may use his own UPIN.

92525, 92526: Otorhinolaryngo- logic Services

Procedure codes 92525 (Evaluation of swallowing and oral function for feeding) and 92526 (Treatment of swallowing dysfunction and/or oral function for feeding) are not payable as repeat procedures. Therefore, procedure code modifier 76 (repeat procedure) may not be billed in conjunction with these services. In addition, the "DAYS or UNITS" field should never exceed "1".

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95819, 95930-95951, 95953, 95956: Coverage Guidelines for EEG Testing

Electroencephalography (EEG) (procedure codes 95819, 95930-95951, 95953, and 95956) is a covered service when medically necessary for the patient's condition/illness. To ensure that payment is made only for medically necessary services, EEG is covered only for the following conditions/illnesses. These codes have been updated to the highest level of specificity.

Covered Diagnosis Codes for Electroencephalography (EEG) (Procedure code 95819)

- 291.0
- 293.0
- 294.0
- 294.9
- 296.00-296.06
- 296.10-296.16
- 296.20-296.26
- 296.30-296.36
- 296.40-296.46
- 296.50-296.56

296.60-296.66
296.7
296.80-296.82
296.89
296.90
296.99
300.10-300.11
306.9
310.1
310.2
322.9
323.0
324.0
331.0
331.1
331.2
332.0
333.6
342.00-342.02
342.10-342.12
342.80-342.82
342.90-342.92
345.00-345.01
345.10-345.11
345.2-345.3
345.40-345.41
345.60-345.61
345.70-345.71
345.80-345.81
345.90-345.91
346.00-346.01
346.10-346.11
346.20-346.21
346.80-346.81
346.90-346.91
348.1
348.3
349.0
349.82
379.40
379.50
386.2
430
431
433.20-433.21
435.0-435.3
435.8-435.9
437.1-437.2
780.1
780.2
780.31-780.39
780.4
780.9
781.0
781.2
784.3
852.00-852.09

852.10-852.19
852.20-852.29
852.30-852.39
852.40-852.49
852.50-852.59
853.00-853.09
853.10-853.19
854.00-854.09
854.10-854.19

Long-term (24-hour)/Ambulatory EEG Monitoring (Procedure codes 95950, 95951, 95953, 95956)

Ambulatory or 24-hour EEG monitoring is covered for patients in whom a seizure diathesis is suspected but not defined by history, physical, or resting EEG. Ambulatory EEG can be used in the differential diagnosis of syncope and transischemic attacks if not elucidated by conventional studies. Ambulatory EEG should always be preceded by a resting EEG (procedure codes 95819, 95822, and 95827).

Covered Diagnosis Codes Long-term (24-hour)/Ambulatory EEG Monitoring (Procedure codes 95950, 95951, 95953, 95956)

006.5
013.00-013.06
013.10-013.16
013.20-013.26
013.30-013.36
013.40-013.46
013.50-013.56
013.60-013.66
013.80-013.86
013.90-013.96
036.0-036.1
045.00-045.03
045.10-045.13
045.20-045.23
045.90-045.93
053.0
053.10-053.19
054.72
056.00-056.09
062.0-062.9
063.0-063.9
064
071
072.1
072.2
191.0-191.9
192.0
192.1
225.0
225.2
228.00-228.09
292.0

292.11-292.12
292.81-292.89
293.0-293.1
293.81-293.89
294.0-294.1
295.20-295.24
296.10-296.16
296.20-296.26
296.30-296.36
296.40-296.46
296.50-296.56
296.60-296.66
296.7
296.80-296.89
296.90-296.99
298.9
303.90-303.92
310.0-310.9
326
331.0-331.7
332.0-332.1
333.0-333.5
334.0-334.9
335.10-335.19
335.20-335.29
335.8-335.9
337.0-337.1
337.20-337.29
337.9
340
341.0-341.9
343.0-343.9
345.00-345.01
345.10-345.11
345.2-345.3
345.40-345.41
345.50-345.51
345.60-345.61
345.70-345.71
345.80-345.81
345.90-345.91
346.00-346.01
346.10-346.11
346.20-346.21
346.80-346.81
346.90-346.91
348.3
349.0
350.1-350.9
352.0-352.9
430
431
432.1
433.00-433.01
433.10-433.11
433.20-433.21
433.30-433.31

433.80-433.81
433.90-433.91
434.00-434.01
434.10-434.11
434.90-434.91
435.0-435.9
436
437.1
437.2
572.2
767.0
780.2
780.31-780.39
780.4
780.50-780.59
781.6
784.3
803.00-803.09
803.10-803.19
803.20-803.29
803.30-803.39
803.40-803.49
803.50-803.59
803.60-803.69
803.70-803.79
803.80-803.89
803.90-803.99
851.00-851.09
851.10-851.19
851.20-851.29
851.30-851.39
851.40-851.49
851.50-851.59
851.60-851.69
851.70-851.79
851.80-851.89
851.90-851.99
852.00-852.09
852.10-852.19
852.20-852.29
852.30-853.39
852.40-852.49
852.50-852.59
853.00-853.09
853.10-853.19
854.00-854.09
854.10-854.19
950.0-950.9
951.0-951.2
951.3-951.9
997.00-997.09
V10.85
V12.4

Advance Notice Requirement

Applies to diagnosis (see page 4).

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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 (FMR) initiatives. Both the LMR and FMR initiatives are designed to ensure the appropriateness of medical care and that the Carrier's medical policies and review guidelines are consistent with the accepted standards of medical practice.

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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Noncoverage Coding Guidelines

New Coverage Guidelines for Electrostimulation for the Treatment of Wounds

Effective immediately, Electrostimulation for the Treatment of Wounds (listed as A9270) will be removed from the Noncoverage Coding Guidelines.

This procedure will now be reviewed for coverage on a case by case basis. Providers should bill the service using procedure code 96999 (Unlisted special dermatological service or procedure) and include documentation (History and Physical and/or office notes) to support the medical necessity and rationale for using this procedure.

Providers are not to bill this service using Physical Medicine and Rehabilitation codes 97001-97799.

A9270: Motor Function Studies Considered Investigational

Page 31 of the September/October 1997 Medicare B Update! featured an article on Medicare Part B of Florida's Coding Guidelines for Noncovered Services.

Treatment of motor function disorders with electrical nerve stimulation (procedure code A9270) is a noncovered service due to its investigational status. The asterisk "*" used to identify investigational services was inadvertently left off of this procedure. Therefore, 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. For additional information on advance notice requirements, refer to page 4.

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J9170, J9201: Off-Label Use of Chemotherapy Drugs

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

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

Indications and Limitations of Coverage and/or Medical Necessity

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

effects of the treatment regimen when the drugs are administered incident to a chemotherapy treatment.

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

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

Phase III clinical trials.

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

Use peer reviewed medical literature appearing in the following publications:

- American Journal of Medicine;
- Annals of Internal Medicine;
- The Journal of the American Medical Association;
- Journal of Clinical Oncology;
- Blood;
- Journal of the National Cancer Institute;
- The New England Journal of Medicine;
- British Journal of Cancer;
- British Journal of Hematology;
- British Medical Journal;

-Cancer;

-Drugs;

-European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);

-Lancet; or

-Leukemia.

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

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

Gemcitabine (Gemzarr)

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.

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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. 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

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, an antineoplastic agent belonging to the taxoid family, acts by disrupting cell replication. It is a derivative of 10-deacetylbaccatin III, 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 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. 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

Squamous cell carcinoma of the head and neck

Ovarian carcinoma

Gastric carcinoma

Melanoma

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

Coding Guidelines

For service dates prior to January 1, 1998

When billing for Gemcitabine 200mg, use HCPCS code J9999 and the appropriate ICD-9 diagnosis code which indicates the medical condition being treated. The name, strength and dosage of the drug must be indicated in Item 19 of the HCFA-1500 claim form. EMC senders should report this information in HA0 field 05.0

When billing for either Taxotere 80mg or Taxotere 20mg , use HCPCS code J9999 and the appropriate ICD-9 diagnosis code which indicates the medical condition being treated. The name, strength and dosage of the drug must be indicated in Item 19 of the HCFA-1500 claim form. EMC senders should report this information in HA0 field 05.0.

For service dates on or after January 1, 1998

When billing for Gemcitabine 200mg, use HCPCS code J9201, adjusting the "Days or Units" field for every 200 mgs administered.

When billing for Taxotere, use HCPCS code J9170, adjusting the "Days or Units" field for every 20 mgs administered.

Reasons for Denial

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

Documentation Requirements

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

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

51784, 51785: Coverage for Anal or Urethral Sphincter Electromyography

Analysis of January through June 1996 claims data indicated that Anal or Urethral Sphincter Electromyography (EMG) (procedure codes 51784 and 51785) has been billed substantially more in Florida than at the national level for specialty 34 (Urology). These procedure codes were selected for 1997 Focused Medical Review (FMR). As a result of this aberrancy, a local medical review policy was developed to establish the conditions/illnesses for which Medicare Part B of Florida will consider

the service to be medically reasonable and necessary. This policy includes procedure codes 51784 (Electromyography of anal or urethral sphincter, other than needle, any technique) and 51785 (Needle electromyography studies of anal or urethral sphincter, any technique). This policy is effective for services processed on or after February 16, 1998.

Electromyography (EMG) of the anal or urethral sphincter is a urodynamic study that assesses the neuromuscular function of the external sphincter and assesses the functional balance between bladder and striated sphincter muscle activity.

EMG alone gives useful information about sphincteric function, but it is most valuable when done in conjunction with cystometry to determine whether the striated sphincter appropriately increases its activity in a gradual fashion during bladder filling and whether rest occurs normally before and during bladder contraction. According to a vast majority of urologists, the study of the activity of one group of muscles (in this case, the striated musculature of the outlet) with respect to another (in this case, bladder) is termed Kinesiologic electromyography. Kinesiologic EMG can be performed with either needle electrodes or surface or patch electrodes. Surface electrode recordings can be obtained either from the lumen of the urethra in the region of the voluntary sphincter or, preferably, from the anal sphincter by using an anal plug electrode. Recording via needle electrodes can be obtained from the anal sphincter, from the bulk of the musculature of the pelvic floor, or from the external sphincter itself, though in the latter case the placement is difficult and the accuracy of the results is questionable.

Direct needle EMG of the urethral sphincter provides the most accurate information. However, the technique is difficult, therefore simpler approaches are generally used. The anal sphincter is readily accessible for EMG testing, and testing of any area of the pelvic floor musculature generally reflects the overall electrical activity of the pelvic floor, including the external sphincter.

Another type of electromyography that involves the study of the bioelectric potentials generated by skeletal muscle is called a Motor unit EMG. Motor unit EMG is a very accurate way of detecting evidence of denervation or myopathy in the striated pelvic floor musculature. This procedure must be performed using the needle electrodes and requires the performer of the service to have considerable experience for interpreting the various parameters recorded during a motor unit EMG, and, therefore is normally performed by a neurologist.

Currently, the International Continence Society doesn't specify normal findings for sphincter EMG. However, the EMG should show increased muscle activity when the patient tightens the external urinary sphincter and decreased muscle activity when he relaxes it. If EMG and cystometrography are done together, results show that muscle activity of the normal sphincter increases as the bladder fills. During voiding and with bladder contraction, muscle activity decreases as the sphincter relaxes. This comparison aids assessment of external sphincter efficiency and functional balance between bladder and sphincter muscle activity.

An abnormal EMG results from: (1) the failure of the sphincter to relax; or (2) increased muscle activity during voiding demonstrates detrusor-external sphincter dyssynergia. Confirmation of such muscle activity by EMG may indicate neurogenic bladder, spinal cord injury, multiple sclerosis, Parkinson's disease, or stress incontinence.

Medicare Part B will consider an anal or urethral electromyogram medically reasonable and necessary as a diagnostic test for the initial evaluation of patients with a voiding dysfunction such as urinary incontinence, neuropathic disorder, etc. if the cause of the patient's disorder cannot be determined after clinical evaluation (history and physical). In addition, it is expected that other urodynamic testing consisting of cystometry, urethral profilometry, and uroflowmetry are performed with an EMG.

Once a diagnosis of a voiding dysfunction has been confirmed or ruled out, it is not considered medically necessary to repeat the test unless the patient presents with new symptomatology suggestive of a voiding dysfunction and the cause cannot be determined by clinical evaluation.

Coding Guidelines

When EMG is performed as part of a biofeedback session, CPT code 51784 or 51785 is not to be billed unless a significant, separately identifiable diagnostic EMG service is provided. If the CPT code 51784 or 51785 is to be used for a diagnostic EMG, a separate report must be available in the medical records to indicate this service was performed.

Biofeedback therapy differs from EMG, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An EMG device may be used to provide feedback with certain types of biofeedback. Biofeedback (anorectal) performed for fecal incontinence includes an EMG, and therefore, should be billed utilizing procedure code 90911. Both procedure code 51784/51785 and 90911 should not be billed together when only biofeedback training is being performed.

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Documentation Requirements

Medical record documentation should demonstrate that the patient had signs and symptoms of a voiding dysfunction and the cause cannot be determined after clinical evaluation. In addition, documentation that the service was performed including the results of the EMG should be available. This information is normally found in the office notes, progress notes, history and physical, and the hard copy test results.

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

Retraction Of Policy: Certification and Accreditation Requirements Of
Diagnostic Ultrasound, Echocardiography and Noninvasive Vascular
Studies

The Health Care Financing Administration (HCFA) has recently informed carriers of a change related to Independent Physiological Laboratories (IPLs). Between January 1, 1998, and July 1, 1998, a new entity referred to as Independent Diagnostic Testing Facilities (IDTFs) will replace IPLs as a type of facility to which Medicare reimbursement may be made. The operational aspects regarding provider registration and the issuance of billing numbers for this new type of facility are currently under development. It is anticipated that issues related to IDTF accreditation and non-physician personnel certification requirements will be addressed at the time an entity requests consideration for IDTF status. Therefore, we are retracting policy 00001- Certification and Accreditation Requirements of Diagnostic Ultrasound, Echocardiography and Noninvasive Vascular Studies published in the November/December 1997 Medicare B Update! (pgs. 30-31), as we anticipate that these requirements will be set forth by HCFA.

85651, 85652: Sedimentation Rate, Erythrocyte

On page 17 of the November/December 1994 Medicare B Update!, the coverage criteria for Sedimentation Rate, Erythrocyte (procedure codes 85651 and 85652) were published. Since the publication of that article, the following diagnoses have been added to be used when billing for an erythrocyte sedimentation rate performed in the assessment of medication adjustment for rheumatoid arthritis patients:

E933.1

(antineoplastics and immunosuppressives [such as methotrexate])

E935.6

(antirheumatics [such as gold salts])

E947.2

(antidotes and chelating agents [such as penicillamine])

These E diagnosis codes are not appropriate for any other diagnoses than those described above.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

86430: Rheumatoid Factor

In the November/December 1997 Medicare B Update! the diagnoses for which coverage is provided for procedure code 86430 were published. Due to a typographical error, ICD-9-CM 719.49 was incorreccted listed as 714.49.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4)

95999: Current Perception Threshold Testing

On page 35 of the November/December 1997 Medicare B Update!, it was published that Current Perception Threshold testing (neurometer CPT) was no longer a covered service by Medicare Part B of Florida. The article incorrectly stated that this policy was effective for claims processed December 15, 1997, and after. Please note that this policy is effective for services rendered December 15, 1997, and after.

CPT testing is considered part of the evaluation and management aspect of the physician's service and should not be billed separately. Additionally, it is inappropriate to report this service as nerve conduction studies (95900, 95903, 95904).

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A CLOSER LOOK

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Implementation of 835 Version 3051.4B and NSF/RA Version 2.01 and Standard Paper Remittance Advice Revisions

Effective Date of Change March 5, 1998

Because of unacceptable variations in some of the current shared system/carrier implementations of the 835 version 3051.3B and the National Standard Format/Remittance Advice (NSF/RA) version 2.0 for Medicare, the Health Care Financing Administration has upgraded the implementation guides to limit the opportunity for misinterpretation. The new guides are identified as 3051.4B and 2.01 respectively and may

be downloaded via modem from either the B Line BBS or the HCFA web page (<http://www.hcfa.gov/medicare/edi/edi.htm>).

Medicare Part B of Florida will continue to support 835 versions 3030M and 3051.3B and NSF/RA versions 1.04 and 2.0 after March 5, 1998.

Also, based on requests from the provider community, adjustments have been made to the standard paper remittance notice format. These format changes are noted below. A sample of the revised paper remittance notice can be found on pages 57-59.

Changes In Paper Remittance Format

- The PROV PD column has been moved to the end of the line at the request of many providers. Clerks who manually post from the paper remittance notices indicated that this is the most important column on the paper notice to them and that it is difficult for them to read the PROV PD amount in its current location. They requested it be moved to the end for legibility.

- A total has been added, also at the request of many providers, at the claim and provider levels for the sum of RC-AMT adjustments.

- The NET payment for the claim field has been moved to make space for the above changes.

- The MODS column has been changed from a maximum of 4 modifiers to 3 possible modifiers to correspond to the NSF and current usage of the 835.

- The section at the end of the notice for definition of codes has been named "GLOSSARY: Group, Reason, MOA and Remark Codes," and the order for reporting of the codes is now group codes (XX), followed by reason codes (XXX), followed by line level remark codes (Mxx), followed by claim level remark codes (MAXx).

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Understanding the Provider Remittance Notice

Reason codes and the text messages that define those codes are used to explain why a claim may not have been paid in full. Although reason codes and Health Care Financing Administration (HCFA) message codes will appear in the body of the remittance advice, the text of each code that is used will be printed at the end of the notice to facilitate interpretation.

An ANSI X12.835 group code will always be shown with a reason code to indicate when you may or may not bill a beneficiary for the non-paid balance of the services or equipment you furnished. This corresponds to payment information already being sent to beneficiaries in the Explanations of Medicare Benefits. All denials or reductions from your billed amount with a group code of PR (patient responsibility) are the financial responsibility of the beneficiary or his/her supplemental

insurer (if it covers that service). Due to their frequency of use, separate columns have been set aside for reporting of deductible and coinsurance, both of which are also patient responsibility.

CO is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial liability, such as participation agreement violation amounts, assignment amount violations, late filing penalties, or amounts for services not considered to be reasonable and necessary.

Group code OA (other adjustment) will be used when neither PR nor CO applies, such as with the reason code message that indicates the bill is being paid in full. A final group code, CR (correction or reversal to a prior decision), will be used whenever there is a change to the decision on a previously adjudicated claim, perhaps as a result of a subsequent reopening. CR explains the reason for a change and would always be used in tandem with a PR, CO, or OA to show revised information.

Note: Medicare Part B of Florida does not supply providers with duplicate Provider Claims Summaries except in unusual circumstances (e.g., the original PCS was destroyed, original was missing pages, etc.). Medicare Part B of Florida will send an Explanation of Medicare Benefits to a provider only if written consent is provided by the patient.

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Sample of new paper Provider Remittance Notice.

..... UNABLE TO PROVIDE IN THIS FORMAT.....

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Standard Claim Adjustment (CAS) Reason Codes

Any reference to procedures or services in the Claim Adjustment Reason Codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs). An "*" after a code value denotes that the code value is inactive as of release of version 3040 of the 835. An "^" after a code value denotes that the code value is inactive as of release of version 3050 of the 835. Codes with either of these symbols may not be used in post 3040 and/or 3050 versions of the 835 or versions of the NSF 2.0 or later.

This list supersedes earlier CAS reason code lists. The indicated wording may not be modified without approval of the X12 Claim Reason and Status Code Task Group. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare. These are the only CAS reason codes approved for use in Medicare 835, National Standard Format (NSF) and standard Medicare paper remittance advice transactions.

These reason codes report the reasons for any claim financial adjustments, such as denials, reductions or increases in payment. CAS reason codes may be used at the service or claim level, as appropriate.

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-Payment Amount

4 = The procedure code is inconsistent with the modifier used, or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's sex.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's sex.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = The date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service denied because the submitted authorization number is missing or invalid.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service denied because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury and thus the liability of the Worker's Compensation carrier.

20 = Claim denied because this injury is covered by the liability carrier.

21 = Claim denied because this injury is the liability of the no-fault carrier.

22 = Claim denied because this care may be covered by another payer per coordination of benefits.

23 = Claim denied/reduced because charges have been paid by another payer as part of coordination of benefits.

24 = Payment for charges denied. Charges are covered under a capitation agreement.

25 = Charges denied. Your stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time service was provided.

29 = The time limit for filing has expired.

30 = Benefits are not available for these services until the patient has met the required waiting or residency period.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 * = Balance does not exceed co-payment amount.

37 * = Balance does not exceed deductible.

38 = Services are not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/precertification was requested.

40 = Charges do not meet qualifications for emergency/urgent care out-of-area.

41 * = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is (are) not covered.

47 = This (these) diagnosis (es) are not covered.

48 = This (these) procedure(s) is (are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a "medical necessity" by the payer.

51 = These are non-covered services because this is a pre-existing condition.

52 = The referring/prescribing provider is not eligible to refer/prescribe/order the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by the payer.

57 = Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service denied/reduced because treatment was deemed by the payer to have been entered in an inappropriate or invalid place of service.

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59 = Charges are reduced based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with this proximity to inpatient services are not covered.

61 = Charges reduced as penalty for failure to obtain second surgical opinion.

62 = Penalty taken for absence of or exceeded pre-certification authorization.

63 * = Correction to a prior claim.

64 * = Denial reversed per Medical Review.

65 * = Procedure code was incorrect. This payment reflects the correct code.

66 = Blood deductible.

67 * = Lifetime reserve days. (Handled in QTY, QTY01=LA)

68 * = DRG weight. (Handled in CLP12)

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary payer amount.

72 * = Coinsurance day. (Handled in QTY, QTY01=CD)

73 ^ = Administrative days.

74 = Indirect medical education adjustment.

75 = Direct medical education adjustment.

76 = Disproportionate share adjustment.

77 * = Covered days. (Handled in QTY, QTY01=CA)

78 = Non-covered days/Room charge adjustment.

79 ^ = Cost report days. (Handled in MIA15)

80 ^ = Outlier days. (Handled in QTY, QTY01=OU)

81 * = Discharges.

82 * = PIP days.

83 * = Total visits.

84 ^ = Capital adjustment. (Handled in MIA)

85 = Interest amount.

86 = Statutory adjustment.

87 = Transfer amount.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.

90 = Ingredient cost adjustment.

91 = Dispensing fee adjustment.

92 * = Claim paid in full.

93 = No claim level adjustments.

94 = Processed in excess of charges.

95 = Benefits reduced. Plan procedures not followed.

96 = Non-covered charges.

97 = Payment is included in the allowance for the basic service/procedure.

98 * = The hospital must file the Medicare claim for this inpatient non-physician service.

99 * = Medicare Secondary Payer adjustment amount.

100 = Payment made to patient/insured/responsible party.

101 = Predetermination, anticipated payment upon completion of services.

102 = Major medical adjustment.

103 = Provider promotional discount (i.e. Senior citizen discount)

104 = Managed care withholding.

105 = Tax withholding.

106 = Patient payment option/election not in effect.

107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

108 = Claim/service denied/reduced because rent/purchase guidelines were not met.

109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

110 = Billing date predates service date.

111 = Not covered unless the provider accepts assignment.

112 = Claim/service denied/reduced as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside of the United States or as result of war.

114 = Procedure/product not approved by the Food and Drug Administration.

115 = Claim/service denied/reduced as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan.

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payor refund amount due to overpayment.

124 = Payor refund amount_not our patient.

125 = Claim/service denied/reduced due to a submission/billing error(s).

126 = Deductible_major medical.

127 = Coinsurance_major medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied_prior processing information appears incorrect.

130 = Paper claim submission fee. (Not Medicare)

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

A0 = Patient refund amount.

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met.

A4 = Medicare claim PPS day capital outlier amount.

A5 = Medicare claim PPS cost capital outlier amount.

A6 = Prior hospitalization or 30-day transfer requirement not met.

A7 = Presumptive payment adjustment.

A8 = Claim denied. Ungroupable DRG.

B1 = Non-covered visits.

B2 * = Covered visits.

B3 * = Covered charges.

B4 = Late filing penalty.

B5 = Claim/service denied/reduced because coverage guidelines were not met or were exceeded.

B6 = This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.

B7 = This provider was not certified for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.

B9 = Services are not covered because the patient is enrolled in a hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patient's medical records.

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B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service denied/reduced because this procedure/service is not paid separately.

B16 = Claim/service denied/reduced because "New Patient" qualifications were not met.

B17 = Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

B19 = Claim/service denied/reduced because of the finding of a review organization.

B20 = Charges denied/reduced because procedure/service was partially or fully furnished by another provider.

B21 * = The charges were reduced because the service/care was partially furnished by another physician.

B22 = This claim/service is denied based on the diagnosis.

B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.

D1 = Claim/service denied. Level of subluxation is missing or inadequate.

D2 = Claim lacks the name, strength or dosage of the drug furnished.

D3 = Claim,/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.

D4 = Claim/service does not indicate the period of time for which this will be needed.

D5 = Claim/service denied. Claim lacks individual lab codes included in the test.

D6 = Claim/service denied. Claim did not include patient's medical record for the service.

D7 = Claim/service denied. Claim lacks date of patient's most recent physician visit.

D8 = Claim/service denied. Claim lacks indicator that "X-ray is available for review."

D9 = Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts, or the type of intraocular lens used.

D10 = Claim/service denied. Completed physician financial relationship form not on file.

D11 = Claim lacks completed pacemaker registration form.

D12 = Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.

D13 = Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.

D14 = Claim lacks indication that the plan of treatment is on file.

D15 = Claim lacks indication that service was supervised or evaluated by a physician. For demonstration program use only:

D97 = Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.

D98 = Part B coinsurance. (Part B Center of Excellence Demonstration)

D99 = Adjustment to the pre-demonstration rate.

Medicare Line Level Remark Codes

Remark codes must be used to relay service-specific Medicare informational messages that cannot be expressed with a reason code. Medicare remark codes are maintained by HCFA.

M1 = X-ray not taken within the past 12 months or near enough to the start of treatment.

M2 = Not paid separately when the patient is an inpatient.

M3 = Equipment is the same or similar to equipment already being used.

M4 = This is the last monthly installment payment for this durable medical equipment.

M5 = Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.

M6 = You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.

M7 = No rental payments after the item is purchased.

M8 = We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.

M9 = This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.

M10 = Equipment purchases are limited to the first or the thirteenth month of medical necessity.

M11 = DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code.

M12 = Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.

M13 = No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.

M14 = No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.

M15 = Separately billed services/tests have been bundled under a single procedure code as they are considered components of that same procedure. Separate payment is not allowed.

M16 = Please see the letter or bulletin of (date) for further information. [Note: Contractor must enter the date of the letter/bulletin.]

M17 = Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.

M18 = Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.

M19 = Oxygen certification/recertification (HCFA-484) is incomplete.

M20 = HCPCS needed.

M21 = Claim for services/items provided in a home must indicate the place of residence.

M22 = Claim lacks the number of miles traveled.

M23 = Invoice needed for the cost of the material or contrast agent.

M24 = Claim must indicate the number of doses per vial.

M25 = Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 = Payment has been (denied for the/made only for less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

If you did not know, and could not have reasonably been expected to know, that we would not pay for this service: or

If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(1) of the Social Security Act and 42CFR411.408 . The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

M27 = The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

M28 = This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.

M29 = Claim lacks the operative report.

M30 = Claim lacks the pathology report.

M31 = Claim lacks the radiology report.

M32 = This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.

M33 = Claim lacks the UPIN of the ordering/referring or performing physician, or the UPIN is invalid.

M34 = Claim lacks the CLIA certification number.

M35 = Claim lacks pre-operative photos or visual field results.

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M36 = This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.

M37 = Service not covered when the beneficiary is under age 35.

M38 = The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.

M39 = The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.

M40 = Claim must be assigned and must be filed by the practitioner's employer.

M41 = We do not pay for this as the patient has no legal obligation to pay for this.

M42 = The medical necessity form must be personally signed by the attending physician.

M43 = Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary.

M44 = Incomplete/invalid condition code.

M45 = Incomplete/invalid occurrence codes and dates.

M46 = Incomplete/invalid occurrence span code and dates.

M47 = Incomplete/invalid internal or document control number.

M48 = Medicare payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.

M49 = Incomplete/invalid value code(s) and/or amount(s).

M50 = Incomplete/invalid revenue code(s).

M51 = Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes. Refer to the HCFA Common Procedure Coding System.

(Add to message for carriers only: If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.)

M52 = Incomplete/invalid "from" date(s) of service.

M53 = Did not complete or enter the appropriate number (one or more) of days or units(s) of service.

M54 = Did not complete or enter the correct total charges for services rendered.

M55 = Medicare does not pay for self-administered anti-emetic drugs that are not administered with a Medicare-covered oral anti-cancer drug.

M56 = Incomplete/invalid payer identification.

M57 = Incomplete/invalid provider number.

M58 = Please resubmit the claim with the missing/correct information so that it may be processed.

M59 = Incomplete/invalid "to" date(s) of service.

M60 = Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.

M61 = We cannot pay for this as the approval period for the FDA clinical trial has expired.

M62 = Incomplete/invalid treatment authorization code.

M63 = Medicare does not pay for more than one of these on the same day.

M64 = Incomplete/invalid other diagnosis code.

M65 = Only one technical component can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each technical component code.

M66 = Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.

M67 = Incomplete/invalid other procedure code(s) and/or date(s).

M68 = Incomplete/invalid attending or referring physician identification.

M69 = Paid at the regular rate as you did not submit documentation to justify modifier 22.

M70 = NDC code submitted for this service was translated to a HCPCS code for Medicare processing, but please continue to submit the NDC on future claims for this item.

M71 = Total payment reduced due to overlap of tests billed.

M72 = Did not enter full 8-digit date (MM/DD/CCYY).

M73 = The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.

M74 = This service does not qualify for a HPSA bonus payment.

M75 = Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.

M76 = Incomplete/invalid patient's diagnosis(es) and condition(s).

M77 = Incomplete/invalid place of service(s).

M78 = Did not complete or enter accurately an appropriate HCPCS modifier(s).

M79 = Did not complete or enter the appropriate charge for each listed service.

M80 = We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.

M81 = Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.

M82 = Service is not covered when beneficiary is under age 50.

M83 = Service is not covered unless the beneficiary is classified as at high risk.

M84 = Old and new HCPCS cannot be billed for the same date of service.

M85 = Claim/service(s) subjected to the prepayment review of physician E/M services.

M86 and following = Reserved for future use

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Medicare Claim Level Remarks Codes

A maximum of 5 of these claim level Medicare Inpatient Adjudication (MIA) and 5 of these claim level Medicare Outpatient Adjudication (MOA) remarks codes may be used per claim.

Medicare MIA/MOA remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. An appropriate appeal, limitation of liability or other message must be used whenever applicable.

MA01 = (Initial Part B determination, carrier or intermediary)_If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under 1879 of the Social Security Act, and the patient chooses not to appeal.)

(NOTE: Carriers who issue telephone review decisions must add: If you meet the criteria for a telephone review, phone this office if you wish to request a telephone review.)

MA02 = (Initial Part A determination)_If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under 1879 of the Social Security Act, and the patient chooses not to appeal.)

MA03 = (Hearing)_If you do not agree with the Medicare approved amounts and \$100 or more is in dispute (less deductible and coinsurance) , you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under 1879 of the Social Security Act, and the patient chooses not to appeal.)

MA04 = Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05 = Incorrect admission date, patient status or type of bill entry on claim.

(NOTE: See MA30, MA40 and MA43 also.)

MA06 = Incorrect beginning and/or ending date(s) on claim.

MA07 = The claim information has also been forwarded to Medicaid for review.

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

MA09 = Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

MA10 = The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.

MA11 = Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.

MA12 = You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).

MA13 = You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.

MA14 = Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.

MA15 = Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.

MA16 = The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

MA17 = We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

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

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

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MA20 = SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.

MA21 = SSA records indicate mismatch with name and sex.

MA22 = Payment of less than \$1.00 suppressed.

MA23 = Demand bill approved as result of medical review.

MA24 = Christian Science Sanitorium/ SNF bill in the same benefit period.

MA25 =A patient may not elect to change a hospice provider more than once in a benefit period.

MA26 = Our records indicate that you were previously informed of this rule.

MA27 = Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.

MA28 = Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.

MA29 = Incomplete/invalid provider name, city, state, and zip code.

MA30 = Incomplete/invalid type of bill.

MA31 = Incomplete/invalid beginning and ending dates of the period billed.

MA32 = Incomplete/invalid number of covered days during the billing period.

MA33 = Incomplete/invalid number of noncovered days during the billing period.

MA34 = Incomplete/invalid number of coinsurance days during the billing period.

MA35 = Incomplete/invalid number of lifetime reserve days.

MA36 = Incomplete/invalid patient's name.

MA37 = Incomplete/invalid patient's address. (Note: When used, a Medicare contractor must verify that an address, with city, State, and zip code, and a phone number are present.)

MA38 = Incomplete/invalid patient's birth date.

MA39 = Incomplete/invalid patient's sex.

MA40 = Incomplete/invalid admission date.

MA41 = Incomplete/invalid type of admission.

MA42 = Incomplete/invalid source of admission.

MA43 = Incomplete/invalid patient status.

MA44 = No appeal rights on this claim. Every adjudicative decision based on Medicare law.

MA45 = As previously advised, a portion or all of your payment is being held in a special account.

MA46 = The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.

MA47 = Reserved for future use

MA48 = Incomplete/invalid name and/or address of responsible party or primary payer .

MA49 = Incomplete/invalid six-digit Medicare provider number of home health agency or hospice for physician(s) performing care plan oversight services.

MA50 = Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.

MA51 = Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.

MA52 = Did not enter full 8-digit date.

MA53-MA57 = Reserved for future use

MA58 = Incomplete release of information indicator.

MA59 = The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.

MA60 = Incomplete/invalid patient's relationship to insured.

MA61 = Did not complete or enter correctly the patient's social security number or health insurance claim number.

MA62 = Telephone review decision

MA63 = Incomplete/invalid principal diagnosis code.

MA64 = Our records indicate that Medicare should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.

MA65 = Incomplete/invalid admitting diagnosis.

MA66 = Incomplete/invalid principal procedure code and/or date.

MA67 = Correction to a prior claim.

MA68 = We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PAYERID of the insurer to assure correct and timely routing of the claim.

MA69 = Incomplete/invalid remarks.

MA70 = Incomplete provider representative signature.

MA71 = Incomplete/invalid provider representative signature date.

MA72 = The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the beneficiary on this notice.

MA73 = Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.

MA74 = This payment replaces an earlier payment for this claim that was either lost, damaged or returned.

MA75 = Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.

MA76 = Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.

MA77 = The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the beneficiary's

payment less the total of Medicare and other payer payments and the amount shown as patient responsibility on this notice.

MA78 = The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the Medicare allowed amount total and the amount paid by the beneficiary.

MA79 = Billed in excess of interim rate.

MA80 = Informational notice. No payment issued for this claim with this notice. Medicare payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.

MA81 = Our records indicate neither a physician or supplier signature is on the claim or on file.

MA82 = Did not complete or enter the correct physician/supplier's Medicare number or billing name, address, city, state, zip code, and phone number. (Substitute "NPI" for "Medicare number" when effective.)

MA83 = Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.

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MA84 = Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.

MA85 = Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the primary payer's plan or program name. (Substitute "PAYERID" for "their plan or program name" when effective.)

MA86 = Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group or policy number of the insured.

MA87 = Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.

MA88 = Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.

MA89 = Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.

MA90 = Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employment status code of the primary insured.

MA91 = This determination is the result of the appeal you filed.

MA92 = Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information.

(NOTE: Carriers must also add: Refer to the HCFA-1500 instructions on how to complete MSP information.)

MA93 = Reserved for future use.

MA94 = Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.

MA95 = A "not otherwise classified" or "unlisted" procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.

MA96 = Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.

MA97 = Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan.

MA98 = Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.

MA99 = Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.

MA100 = Did not complete or enter accurately the date of current illness, injury or pregnancy.

MA101 = Reserved for future use

MA102 = Did not complete or enter accurately the referring/ordering/supervising physician's name and/or UPIN. (Substitute "NPI" for "UPIN" when effective.)

MA103 = Reserved for future use

MA104 = Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. (Substitute "NPI" for "UPIN" when effective.)

MA105-109 = Reserved for future use.

MA110 = Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.

MA111 = Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.

MA112 = Our records indicate that the performing physician/supplier is a member of a group practice; however, you did not complete or enter accurately their carrier assigned PIN. (Substitute "NPI" for "PIN" when effective.)

MA113 = Reserved for future use.

MA114 = Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute "NPI" for "PIN" when effective.)

MA115 = Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute "NPI" for "PIN" when effective.)

MA116 = Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.

MA117-119 = Reserved for future use

MA120 = Did not complete or enter accurately the CLIA number

MA121 = Did not complete or enter accurately the date the X-Ray was performed.

MA122 = Did not complete or enter accurately the initial date "actual" treatment occurred.

MA123-127 = Reserved for future use

MA128 = Did not complete or enter accurately the six digit FDA approved, identification number.

MA129 = This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to payment for such procedures. Please contact _____ to correct or obtain CLIA certification. (Claim processor must insert the name and phone number of the State agency to be contacted.)

MA130 = Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit the correct information to the appropriate fiscal intermediary or carrier.

MA131and higher = Reserved for future use

WHAT'S NEW FOR EMC?

Host Consolidation to Occur

During the next few months, Blue Cross Blue Shield of Florida, Inc. (BCBSF) will eliminate one of its EDI host systems. This system, known by various names, including Non-JES, PC HOST, and Async Host, has been in operation since the National Standard Format was first introduced and asynchronous communications were first offered by BCBSF.

To determine if you will be affected by this change, check if your systems use any of the following phone numbers to transmit claims or receive remittance.

904-355-7884; Asynchronous toll line for claim submission and acknowledgment

1-800-477-2792; Asynchronous toll-free line for claim submission and acknowledgment

904-353-3506; Synchronous (3780) toll line for claim submission and acknowledgment

1-800-934-7029; Synchronous (3780) toll-free line for claim submission and acknowledgment

904-355-7886; Asynchronous toll line for remittance and claim status retrieval

If you dial these numbers to communicate with BCBSF, you may have some upcoming modifications to your system. The majority of users should require no changes to their systems. However, you will notice format changes in the acknowledgment received for claim submission. If your systems contact these numbers to receive remittance, or if you use 3780 BSC protocol on one of the above numbers, then it will be necessary for you to convert all applications to the mail Box. Most users have at least one application running through Mail box, and the additional effort to add new applications should not be too great.

BCBSF will do everything possible to minimize the effects of this change on your business operations. We will continue to keep you informed of our plans in this regard through direct mailings, broadcast messages (on acknowledgments) and future bulletins. If you have any questions or concerns, please call (904) 791-8608. If no one is available to take your call, please leave a voice mail message with your name, phone number, and your question or concern.

New EDI Form is Mandatory for Electronic Claims Filers

The Health Care Financing Administration (HCFA) developed this form and mandated each carrier and/or intermediary to implement its use. This form is solely between Medicare Part B and providers, suppliers, or PA groups and is required to be signed prior to submitting electronic claims.

This form must be signed by all providers, suppliers or PA groups currently submitting electronic claims. It also replaces any previously signed agreement forms. If you have not completed the EDI Enrollment Form, you are out of compliance with the HCFA's EDI guidelines. There have been numerous extensions granted for completion of the form. Noncompliance will cause interruption of your electronic claims processing ability at any given time.

Only original signatures will be processed; if facsimiles (faxes) or copies are received they will be returned to the sender. (Note: you can copy a blank form but not the signatures.)

Completion Requirements

Complete and forward the signed EDI Enrollment Form (found on pages 70-73) to one of addresses listed below (NOTE: The entire form must be returned including the first two pages that start with "EDI Enrollment Form" section "A. 1-10" and section " A.11-B.6)

Mailing Address:

Blue Cross Blue Shield of Florida
Medicare EDI
P.O.. 44071 - 6 Tower
Jacksonville, FL 32231-4071

Physical Address
(for Federal Express, etc.):

Blue Cross Blue Shield of Florida
Medicare EDI
532 Riverside Ave. - 6 Tower
Jacksonville, FL 32202

Send to the attention of:

- For existing senders; Marnita Howard or,
- When applying for new sender number (include "EDI Enrollment Form" with "New Installation Form"); Anna Wehner

Not Sure You Have Completed the Form?

If you are not sure if you have completed the new EDI Enrollment Form, you may contact the Medicare EDI Area at (904) 791-6379. If we are not available when you call, leave a voice mail with your name, phone number, provider number, and sender number. Your call will be returned in the order it was received.

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EDI ENROLLMENT FORM

..... CANNOT BE PROVIDED IN THIS FORMAT

..... REFER TO "FAX YOURSELF SOMETHING" AT THE MAIN MENU OF THE BLINE
BBS

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Where Has EMC Support Gone?

Effective October 21, 1997, EMC phone support has been re-routed to the Medicare EDI department at 904-354-5977. Medicare EDI will be providing assistance regarding questions or problems with the NSF and ANSI specifications only. This includes interpretation of the specifications and mapping instructions of the HCFA 1500 vs. NSF/ANSI formats. All other calls will be re-routed to the following appropriate area(s).

All billing and status inquiries should continue to be addressed by the provider lines at 904-634-4994 or the ARU status lines at 904-353-3205. If you need assistance when transmitting or if you are unable to retrieve your confirmation, please call the Help Desk at 904-791-9880. For assistance regarding an EMC Error report, please contact the Provider Electronic Services Marketing department at 904-791-8767. If you have problems regarding your Electronic Remittance Notification, please call 904-791-6895. For Medicare Registration related issues or problems, please contact 904-634-4994.

Where Are My Medfacs Software Updates?

Beginning the first quarter of 1997, Medicare Part B of Florida began offering a new software product called PC-ACETM. This product is replacing the current MEDFACS software, therefore, you have not received any updates to MEDFACS in over a year.

What Does This Mean To You?

Currently there may be no impact to you. But, as HCFA releases new billing guidelines, this could make your MEDFACS software obsolete. So don't be caught without a means to transmit your claims electronically. The forms necessary to obtain the PC-ACETM software were originally included in your October 1996 MEDFACS release. If you need these forms, or wish to receive more information about PC-ACETM, contact the PC-ACETM Customer Support staff at (904) 355-0313.

Scheduled Maintenance For Mail Box System

The Mail Box maintenance schedule has been modified. It is now the first and third Sunday of each month, from 6:00 p.m. to 10:00 p.m. On some Sundays, this could be extended to 12:00 a.m. Monday morning.

As always, if you are having trouble communicating with Mail Box, you should contact the Customer Support Help Desk at 904-791-9880 for information and assistance.

Medicare Registration Information

The Medicare Registration Department processes all applications and/or correspondence in order of receipt date. If information is sent to us express mail, Federal Express etc., it will reach our office earlier than if sent first class, third class or priority mail. However, it will not be given processing preference. Incomplete applications and/or correspondence will be returned to the provider and the processing time will begin again. To receive timely processing of correspondence and applications, all providers must ensure that all information and documentation is received with the initial request.

When a provider decides to open a solo practice and has previously practiced only as a group member, the General Enrollment Application (HCFA 855) must be completed.

Satellite Offices (Additional Practice Locations)

If a provider is an established provider with the Medicare Program (i.e., has an existing Florida Medicare Part B provider number) and opens additional office(s), Medicare Registration must be notified by completing the appropriate sections of the General Enrollment Application (HCFA 855). See the matrix on page 77 to identify the appropriate sections.

Services rendered in different payment localities require the assignment of a number for each locality. Services must be billed under the appropriate number in order to receive correct reimbursement.

Clarification On Completing The General Enrollment Application (HCFA 855)

Page 79 of this Update! furnishes a matrix showing which sections(s) of the application must be completed based on what the applicant is applying for.

If you are a new provider completing a General Enrollment Application (HCFA 855) and are unsure if a particular section should be completed for your specific provider type, complete it. It is best to furnish too much information instead of not furnishing enough. Indicate NA in each field of the application that does not apply. If the section has a block which indicates "check here only if this entire section does not apply to the applicant", check the applicable block. If the section does not have a block which indicates "check here only if this entire section does not apply to applicant", the section must be completed. Any section left entirely blank will result in the application being returned as incomplete. Processing time will start over when the application is resubmitted.

Section 7 - Practice Location(s) - This section is for indicating the practice address where services are rendered. If a provider has more than one address at which services are rendered, this section should be copied and completed for each address.

Section 9 - Managing/Directing Employees - The information given in this section should indicate any managing/directing employees pertaining to that practice location. If applicant is an individual and practices only in a group practice, the information given in this section should be based on the managing/directing employees of the group.

Section 10 - Ownership Information - Information regarding owners having 5 percent or more interest in the entity should be noted in this section. If the applicant is an individual and practices only in a group practice, the information given in this section should be based on ownership information for the group. Nonprofit organizations should indicate the officers/directors of the business.

Section 13 - Contractor Information (Physicians and Non-Physician Individuals) - The information contained in this section should consist of any individuals the applicant contracts with to have services performed. For example, if the applicant is John Doe, M.D., and John Doe, M.D. is applying for a Medicare Part B provider number and contracts with John Smith, M.D. to perform radiology services, John Doe, M.D. should complete section 13 listing information pertaining to John Smith M.D. All individuals with whom John Doe, M.D. contracts, regardless of the amount of reimbursement, should be indicated in this section. If John Doe, M.D. contracts with more than one individual, he must copy and complete this section for each individual. If John Doe, M.D. does not contract with any individuals, the block indicating "check here only if this entire section does not apply to the applicant" must be checked.

Section 14 - Contractor Information (Business Organizations) - The information contained in this section should consist of any business/organization that the applicant contracts with to have services performed. For example, if John Doe, M.D. is applying for a provider number and contracts with MRI Physicians to perform MRI services, John Doe, M.D. should complete section 14 listing information pertaining to MRI Physicians. All businesses/organizations with which John Doe, M.D. contracts, regardless of the amount of reimbursement, should be indicated in this section. If John Doe, M.D. does not contract with any business/organization, the block indicating "check here only if this entire section does not apply to the applicant" must be checked.

Section 15 - Billing Agency/Management Service Organization Address - If the applicant uses a billing agency or management service organization which submits the Medicare Part B claims, this section should consist of information regarding the company. A copy of the

billing agreement must accompany the application. If the applicant is not using a billing company or management service organization, the block stating "check here only if this entire section does not apply to the applicant" must be checked. See page 79 for information regarding billing agreements.

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Section 18 - Reassignment of Benefits Statement - This section must be completed by contractors who want payment for their services generated in a name other than their own. The HCFA 855G may not be used for contractors. The HCFA 855G should be completed if the applicant is applying to become a group member. The entity in which payment will be generated must complete a General Enrollment application (HCFA 855) if they have not done so. This section should also be completed for sole proprietors who want payments issued in the name of their entity (e.g. John Doe MD wants payments generated to John Doe MDPA.) The employer identification number must match the name in which payment will be generated.

Section 19 - Certification Statement - All individual applicants must sign the certification statement in the section labeled "Applicant Signature". If the applicant is an organization or group, an authorized representative must sign the certification statement in the section labeled "For Groups and Organizations; Authorized Representative Signature". An authorized representative is an officer, CEO, or general partner. If there is more than one authorized representative, furnish names and signatures of those who will be directly involved with the Medicare contractor.

To expedite the processing of applications, each provider should submit a copy of their W9 or CP575 showing the entity name in which payment will be generated. Copies of occupational licenses and billing agreements should also be attached (if applicable).

All applications must be submitted with original signatures. It is sometimes difficult to determine if signatures submitted are originals when signed in black ink. We suggest that applications be signed in a color other than black.

Group Provider Information & Group Membership

New groups (never obtained a Florida Medicare Part B provider number) that want to bill Medicare, must complete the General Enrollment application (HCFA 855).

To obtain a Medicare Part B group provider number, the entity applying must employ two or more physicians and/or non-physician practitioners or have one employee which is a physician and/or non-physician practitioner and have at least one owner which is a physician.

If individual providers who are joining the group are also new providers (i.e., never obtained a Florida Medicare Part B provider number), they must complete the General Enrollment application (HCFA

855) and the Individual Group Member Enrollment application (HCFA 855G). If the group member has an existing Florida Medicare Part B provider number they should complete only the HCFA 855G. Only W-2 employees and/or owners may be added as group members.

Entities employing two or more physicians and/or non-physician practitioners meet the Health Care Financing Administration's (HCFA's) definition of a group and will be assigned a group provider number. If the entity has not completed a HCFA 855, one must be completed before Medicare Part B can assign a provider number to the group.

The Medicare Change of Information Application (HCFA 855C) may not be used to add group members or locations at which they practice.

If a group member leaves a group and then returns to practice with that same group, a new HCFA 855G must be completed.

Clarification On Completing The Individual Group Membership Enrollment Application (HCFA 855G)

Section 1 - Group Identification - If adding or deleting a group member, this section should be completed indicating the date the member joined and/or the date the member left.

Section 3 - Group Member Practice Location (s) - This section of the HCFA 855G should be copied and completed for each practice location in which the group member renders services or for each location in which the group member no longer practices. If at a later date the group member starts practicing at another location(s), all sections of the 855G should again be completed showing the new practice location(s).

The practice location submitted on the 855G must have been enrolled by the group. If the practice location has not been submitted on a group application, the 855G will be returned with a request for the group to update their file by completing the appropriate sections of the HCFA 855 (sections 1C, 1D, 2, 3, 7, 9, 10, 11, 12, 15, 16, 17, 18, and 19). The HCFA 855G should be resubmitted along with the HCFA 855. Processing time will start over.

The bottom of section 3 asks if all patient records are stored at this practice location. If not, the name of the storage location must be indicated. The top of page 2 should contain the address of the storage location. This section should not be utilized for additional practice locations.

Section 4 - Reassignment of Benefits Statement - The individual applicant must sign this section and submit original signatures. It is sometimes difficult to determine if signatures submitted are originals when signed in black ink. We suggest that applications be signed in a color other than black.

Section 6 - Certification Statement - The applicant applying for group membership and a group authorized representative must sign and submit original signatures. If original signatures are not submitted the application will be returned and processing time will start over when resubmitted. It is sometimes difficult to determine if signatures submitted are originals when signed in black ink. We suggest that applications be signed in a color other than black.

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To expedite the processing of applications each new group member should submit a copy of the group's W9 or CP575 in addition to the occupational license (if required by the city and/or county). The occupational license should show the address which the group member is practicing.

Changes

When changes occur to information regarding a provider's practice, Medicare Registration should be notified immediately. Changes to any practice may be submitted on the General Enrollment application (HCFA 855); however, the Change of Information application (HCFA 855C) may be used to update information listed below.

- Name
- Specialty
- E-Mail Address
- Practice Location Address
- Billing Agency Address
- Pay To Address
- Mailing Address
- Pricing Locality
- Cancellation of a Medicare Billing Number
- Telephone Number
- Fax Number

The General Enrollment application HCFA 855 must be used to update information not listed above such as managing/directing employees, ownership, etc.

If you are an individual (sole proprietor) and want your file changed from a social security number to an employer identification number, this may be accomplished by completing the appropriate sections of the HCFA 855 (sections 1A, 1B, 1D, 7, and 19) if the name matches IRS documentation exactly. If the name is different, for example John Smith M.D. versus John Smith M.D.P.A., completion of the entire HCFA 855 is required. The name in which payment will be generated must match the IRS documentation (W9, CP575 etc.).

Any provider which is changing from one employer identification number to another must complete the entire HCFA 855.

Any time ownership information changes on an existing provider, completion of a new HCFA 855 is required.

If an existing provider purchases another existing provider, a new HCFA 855 is required. A copy of the purchase agreement should be attached to expedite the process. The purchase price may be whited out.

A certification statement and/or attestation statement with an original authorized signature must be signed and submitted with each notification of change. The certification and/or attestation statement is found on page 2 of the HCFA 855C and on page 11 of the HCFA 855.

The Medicare Change of Information Application (HCFA 855C) may not be used to add group members or locations at which they practice.

Billing Agreements

The primary purpose of the guidelines listed below is to permit computer and other billing services to claim and receive Medicare payment in the name of a provider. The conditions for payment are designed to ensure that the billing agent has no financial interest in how much is billed or collected and is not acting on behalf of someone who has such an interest, other than the provider.

Medicare Part B may make payment in the name of a provider to an agent who furnishes billing or collection services if all of the conditions listed below exist:

- The agent receives the payment under an agency agreement with the provider;
- The agent's compensation is not related in any way to the dollar amount billed or collected;
- The agent's compensation is not dependent on the actual collection of payment;
- The agent acts under payment disposition instructions which the provider may modify or revoke at any time; and
- In receiving payment, the agent acts only on behalf of the provider (except insofar as the agent uses part of that payment to compensate the agent for the agent's billing and collection services).

The billing agreement should clearly indicate all of these conditions. If we are unable to determine if all the conditions are present, the application will be returned requesting modification to the billing agreement.

Completion of The Participation Agreement

If you elect to become a participating provider in the Medicare Part B Program, the participation agreement must be completed, mailed and received by the Medicare Registration Department within 90 days of your

request for a provider number or additional practice location. Participation agreements received more than 90 days after receipt of the request for a provider number or establishment of an additional practice location will not be made retroactive. The following elements of the participation agreement must be completed.

- Name
- Complete Street Address
- Phone Number
- Provider Number (if assigned)
- Signature (must be original)

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Clarifications Regarding Participation Election

Effective January 1, 1995, the "Byrd Bill" was enacted, which requires certain practitioners to accept assignment for all covered services rendered to Medicare beneficiaries. The following practitioners are subject to mandatory assignment. If your specialty is one of the following you are not required to complete a participation agreement. Your participation is automatic.

- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Certified Nurse Midwife
- Physician Assistant
- Clinical Social Worker
- Clinical Psychologist

A group member is not required to complete a participation agreement. The participation status is based on the group's decision. However, if the group member has offices which are not part of a group practice (solo practice) and the provider wishes to be a participating provider, a participation agreement must be submitted.

If you are in solo practice at multiple locations, it is not necessary to submit a participation agreement for each practice location. If you are in solo practice at multiple locations, you may not elect to be participating at one location and not the other(s). All solo practice locations will be bound by the agreement.

If two or more independently practicing providers decide to form a group practice and the group wishes to be participating, an agreement must be submitted on behalf of the group. Participation agreements from the independently practicing providers are not transferred to the group practice.

When a participating group makes the decision to terminate its group status, the participation agreement for the group will also be terminated. A new participation agreement must be completed on behalf of each individual physician if they elect to participate in a solo practice. The participation decision from the group is not transferable. A new participation agreement must be completed by each individual if going into solo practice.

If ownership of an established entity changes, a HCFA 855 enrollment application should be completed to indicate that ownership has changed. When submitting the application, a participation agreement should be submitted if the new owner wishes to be participating. Participation agreements are not transferable from one Medicare provider number to another when ownership has changed.

Remember: A provider is not considered a participating provider just because claims are filed as assigned claims. A participation agreement must be completed for a provider to become a participating provider.

Listed on page 79 is a matrix which will help providers complete enrollment applications. The matrix outlines which sections must be completed based on the type of application.

Remember: All required sections must be completed and appropriate documentation submitted or the application will be returned. The processing time will start over again when resubmitted.

If you have additional questions about completing applications or if applications are needed, call the Provider Customer Service department at (904) 634-4994. Completed applications should be returned to:

MEDICARE REGISTRATION
P O BOX 44021
JACKSONVILLE, FLORIDA 32231-4021

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COMPLETING THE HCFA 855 NON-CERTIFIED PROVIDERS

..... UNABLE TO PROVIDE IN THIS FORMAT

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Medicare Part B Premium Unchanged for 1998

The Department of Health and Human Services has announced that Medicare beneficiaries will not see an increase in the Part B premium in 1998. The Part B premium will stay at the 1997 rate of \$43.80. This is the

first time it has not gone up in over eight years. Last year it rose by only \$1.30. This is good news for Medicare beneficiaries. "In addition to not increasing the Part B premium, there is only a slight increase in the Part A deductible," said the Deputy Administrator of the Health Care Financing Administration, which runs Medicare.

The Medicare Part A deductible for inpatient hospital care is rising by \$4 _- only 0.52 percent. The 1998 Part A deductible will be \$764. The small increase largely reflects savings from a freeze on Medicare hospital payment and other important structural changes signed into law that help to protect and preserve the Medicare Hospital Trust Fund. Last year, the deductible rose by \$24.

For more information on the Medicare Part B premium, 1998 deductibles, or to order free Medicare educational materials for distribution to Medicare patients, please call the Provider Customer Service department at (904) 634-4994.

1998 Participation Enrollment Information

All physicians, practitioners and suppliers must make their 1998 Medicare participation decisions by February 2, 1998. Although these decisions have usually been required to be made by December of the preceding calendar year, we are allowing an extra month this year because of all of the changes made in the recently enacted Balanced Budget Act of 1997.

Participation Agreements Received Prior to January 1, 1998

Physicians and practitioners who submit their participation enrollment or withdrawal forms prior to January 1, 1998, should submit claims for 1998 dates of service in accordance with the decision made.

Participation Agreements Received After December 31, 1997

Although the participation enrollment period will run through February 2, 1998, the participation agreement is effective January 1, 1998. Physicians and practitioners who submit their 1998 participation election or withdrawal forms after December 31, 1997, must bill in accordance with their decision once it is submitted to Medicare Part B of Florida.

Note: Until the 1998 participation election or withdrawal form is processed by Medicare Part B of Florida, all claims for 1998 service dates will be processed under the provider's 1997 participation status.

Correction: UPIN Directory Available on CD-ROM

In the November/December issue of the Medicare B Update!, an article was published about the availability of a CD-ROM version of the UPIN

directory. In the article, the cost of the directory was incorrect: the correct costs for the CD-ROM version of the UPIN directory are \$14 plus \$5 for shipping and handling.

The directory contains a complete national UPIN listing, current through August 1996; updates will be issued at a later date. The system requirements for the CD-ROM are:

- An IBM PC/AT or PS/2 or compatible with 640 KB of RAM (520 KB base memory available after CD-ROM drive installed);
- MS-DOS version 3.1 or later, and Windows 95
- CD-ROM drive with Microsoft MS-DOS CD-ROM extensions, version 2.0 or later, capable of reading ISO 9660 format.

To order the CD-ROM, make checks payable to Blue Cross Blue Shield of Florida, Account # 754-250, and mail the request and payment to:

Medicare Registration
532 Riverside Ave., 14 Tower
Jacksonville, FL 32207
Attn: Tawny Stewart, UPIN Coordinator

The CD-ROM UPIN directory is also available through the Government Printing Office (GPO) for \$28. The contact person for GPO sales is Esther Edmonds at (202) 512-1530. When requesting your CD-ROM UPIN directory from GPO, refer to stock number 017-060-00601-3.

There are a limited number of directories available, so order yours today!

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Updates To The Medigap Insurer Listing

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

Medigap Insurer Address Changes:

Number: 33051
Insurer Name: ALLIANZ LIFE INSPO BOX 523MINNEAPOLIS MN 55440

Number: 46026
Insurer Name: BCBS OF OKLAHOMAPO BOX 3283TULSA OK 74102

Number: 54007
Insurer Name: BLUE SHIELD OF UTAHPO BOX 30270SALT LAKE CITY UT 84130

Number: 23205
Insurer Name: LEAHY & ASSOCIATES310 S RACINECHICAGO IL 60607

Number: 53005
Insurer Name: TRANSPORT LIFEPO BOX 66953CHICAGO IL 60666

Medigap Insurer Name/Address Change:

Number: 22003
Former Name: BLUE SHIELD OF IDAHO
Changed To: REGENCE BLUE SHIELD OF IDAHO PO BOX 1106LEWISTON ID 83501

Number: 15006
Former Name: MASS INDEMITY LIFE
Changed To: PENNSYLVANIA LIFE INSPO BOX 130009RALEIGH NC 27605

Number: 33056
Former Name: PAUL BERK & ASSOCIATES
Changed To: DRIASIPO BOX 523MINNEAPOLIS MN 55440

Medigap Insurer Numbers Changed to Exempt

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

Number: 52030
Insurer Name: ADMINISTRATIVE RISK MGMT

Number: 19683
Insurer Name: AMERICAN LIFE INS

Number: 32067
Insurer Name: BLUE CARE NETWORK

Number: 19269
Insurer Name: FCCI

Number: 19793
Insurer Name: GAINSVILLE HLTH OPTIONS

Number: 23201
Insurer Name: HEALTH CLAIMS ADMIN

Number: 15040
Insurer Name: MAXI CARE

Number: 56032
Insurer Name: NALAC HEALTH BENE PLAN

Number: 19790
Insurer Name: NALAC

Number: 19534
Insurer Name: NAT'L CITIZENS GRP

Number: 40067

Insurer Name: NY STATE HLTH BENE

Number: 23151

Insurer Name: UNITED CHAMBERS

Number: 19486

Insurer Name: UNITED INSURANCE CO

Number: 19491

Insurer Name: UNITED INSURANCE CO

Number: 19702

Insurer Name: UNITED INSURANCE CO

Number: 19723

Insurer Name: UNITED INSURANCE CO OF AMERICA

Number: 19834

Insurer Name: UNITED INSURANCE CO

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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 100141Columbia, 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 2537Jacksonville, 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 10066Augusta, GA 30999-0001

Provider Change of Address:

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109Jacksonville, 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

Medicare Registration Applications:

The Health Care Financing Administration (HCFA) has issued three new
types of enrollment applications. Given below are the three types of
applications and their appropriate use. Providers should obtain these
applications and start using them immediately.

- HCFA 855 General Enrollment
- HCFA 855C Change of Enrollment Information
- HCFA 855G Individual Group Member Enrollment

Copies of the HCFA 855C and 855G can be found on pages 53-65 of the September/October 1997 issue of the Medicare B Update! In addition, all three forms may be obtained by calling our Provider Customer Service department at (904) 634-4994, or downloaded from the Florida B-Line Bulletin Board System (BBS).

HCFA 855 General Enrollment

The HCFA 855 is a Medicare General Enrollment Application for providers to obtain a Medicare provider number or a satellite office for providers already enrolled. This application should also be used to update information. If the updates to a providers practice are items included on the HCFA 855C, that application may be used instead of the HCFA 855. This application should also be used for providers to inform Medicare of additional practice settings.

This application replaces one which is very similar and is currently in use. The new HCFA 855 shows HCFA (5/97) in the lower left corner. Where the one currently in use shows OMB Approval No 0938-0685 in the lower left corner. Providers should request, become familiar with and start using the new application. No other application is acceptable.

HCFA 855C Change of Enrollment Information

The new HCFA 855C should be utilized when providers need to make changes to their existing Medicare files. If providers need to update their name, specialty, E-Mail address, practice location address, billing agency address, pay to address, mailing address, pricing locality, telephone number, fax number, or deactivate (cancel) a Medicare billing number, they should complete the HCFA 855C. If information is being updated which is not listed above, the provider should complete the appropriate section(s) which contains the changed information) of the HCFA 855 (general enrollment application) and sign the certification statement.

If a provider does not wish to complete the HCFA 855C and has one or more of the changes listed above, they may request the change(s) in writing. The letter requesting the change(s) must be on letterhead with the provider's (or authorized representative's) original signature. If requesting a change to a physical address, the request must include a copy of the city and/or county occupational license. The signature on the letter will be compared to the signature we have in the provider's file. If it does not match or if we do not have a signature on file, the request will be returned requesting that the HCFA 855C be completed prior to making the change.

HCFA 855G Individual Group Member Enrollment

The HCFA 855G should be used when an individual provider is joining a group practice. If an individual provider is joining a group and both the group and the individual are currently enrolled in the Medicare Program, the individual must complete only the HCFA 855G. If the individual is not currently enrolled in the Medicare Program and is joining an existing group practice, they must complete the HCFA 855 AND the HCFA 855G.

Important Note: Effective immediately Medicare Part B of Florida will no longer accept the Florida Reassignment of Benefits (the green and white form). Providers must complete the HCFA 855G.

Completed forms must be sent to the following address:

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

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MEDICARE B - MATERIALS ORDER FORM

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BLINE BBS

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COMPUTER BASED TRAINING

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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

Participating Providers:
1-800-838-8859

Nonparticipating Providers:
904-791-6991
904-791-8474

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 phone 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

End Of File