March/April 1998 Medicare Part B Update! Publication
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HCFA
Health Care Financing Administration
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FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier and Intermediary
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**********Page 1

Volume 11, Number 2March/April 1998

Highlights

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Balanced Budget Act Provisions Clarified

The following provisions of the Balanced Budget Act of 1997 (BBA) are included in this issue:

Provision of Diagnosis Information by Physicians and Non-Physician Practitioners: Effective April 1, 1998, if physicians and certain non-physician practitioners do not provide ICD-9-CM codes on all claims, they will not be paid. See page 20 for more information.

NP/PA Guidelines: The Medicare contractor has developed guidelines for NPs and PAs to use when billing for their services. See page 21 for additional information.

Private Contracts: A new question and answer section is included regarding the guidelines for entering into private contracts with Medicare beneficiaries. See page 23 for more information.

Screening Pap Smears and Pelvic Exams: Clarification on diagnosis coding has been received for screening pap smears and pelvic exams, and two new codes have been developed to use when billing thin prep pap smears See pages 28 and 31 for more information.

Oral Anti-Nausea Drugs: Guidelines have been developed for the provision of the BBA that allows coverage for oral anti-nausea drugs during anti-cancer chemotherapy. See page 31 for more information.

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HCPCS Grace Period Ends April 1, 1998

The grace period for use of procedure codes deleted/invalid for 1998 ends on April 1, 1998. Claims received on or after this date billed using deleted or invalid procedure codes will be returned as unprocessable. Providers will be notified that an invalid procedure code was submitted and the claim must be resubmitted with a valid procedure code. Providers should refer to their 1998 coding manual or to the December 1997 HCPCS Special Update! for a list of deleted/invalid procedure codes and their replacements.

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What's New

1998 MEDPARD Directory

The Medicare Directory of Participating Physicians and Suppliers (MEDPARD) contains the names, address, telephone numbers and specialties of Medicare participating physicians and suppliers. Medicare participating physicians and suppliers have agreeded to accept assignment on all Medicare claims for covered items and services.

In previous years, the MEDPARD directory was mailed to all participating physicians, suppliers and practitioners. This year, the MEDPARD will be mailed to participating physicians, suppliers and practitioners only upon request. An order form for the 1998 MEDPARD can be found on page 79.

Professional Services Eligible for HPSA Payments

Effective for claims processed on or after April 1, 1998, for diagnostic and therapeutic radiology tests, Health Professional Shortage Area (HPSA) incentive payments will only be made for the professional component of the test. See page 13 for complete information and a list of affected procedure codes.

Claims Status Inquiries

Effective March 1, 1998, written claim status inquiries will no longer be accepted. Written inquiries for claim status will be returned to the provider. See page 65 for additional information.

Seminars

Two new seminars have been developed; one for new providers/offices, and one about fraud and abuse. See pages 77-78 for additional information.

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Medicare B Update!
Vol. 11 No. 2

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

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Jacksonville, FL
32231-0048

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Table Of Contents

Medicine

Local and Focused Medical Review Policies

Financial Services Department

EMC

What's New for EMC?

General EMC Information

For Your Information

MEDPARD Order Form 79

Medicare B Materials Order Form 80

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A Physician's Focus

We frequently receive requests from providers to change our Medicare coverage policies because "their claims are not getting paid." After analyzing the claim, the problem is often not with the local medical review policies, but with incorrect billing procedures. Failure to list the correct diagnoses is one of the most frequent reasons for claim rejections. When submitting claims, the patient's diagnosis code must be reported to the highest level of specificity as listed in the latest edition of the ICD-9-CM.

Physicians frequently write in their patient's records a complete list of past diagnoses (post-cholecystectomy, post M.I., etc.) as a reminder and as a matter of thoroughness. Chronic diseases treated on an on-going basis should be coded and reported on the claim as many times as the patient receives treatment and care for those conditions. Conditions which have been previously treated and no longer require treatment should not be listed on the claim.

If the diagnosis is unknown, the physician should report the signs and symptoms related to the visit. For example, if a physician sees a patient who has symptoms of "dizziness and double vision" and starts a work-up to "rule out multiple sclerosis," the reason given for the visit should be "dizziness and double vision" and not "multiple sclerosis." The same rationale holds true when referring patients for lab tests or x-rays. For example, if a physician sees a patient with "dizziness, headache and nausea" and orders a CT scan to "rule out brain tumor," the physician should report "dizziness, headache and nausea" on the request and not "brain tumor." This is true even if the CT shows a tumor.

It is important to realize that one cannot use the results of a test to justify performance of a test. For example, if during an annual exam, the patient's blood sugar is reported elevated, the claim should not be submitted with the diagnosis of diabetes, but as a screening blood glucose.

The rules for surgical procedures are different. If exploratory or screening surgical procedures are performed and a tumor or lesion is discovered during the procedure, the procedure should be billed using the ICD-9-CM code for the tumor or lesion discovered. For example, if a screening colonoscopy is performed and tumors or polyps are found and removed, the diagnoses which represent the confirmed findings should be used when submitting the claim for payment.

If you are having trouble determining the appropriate diagnosis to bill with procedures, there are multiple sources for help. Every office should have a copy of the "Procedure to Diagnosis File" which can be ordered using the form in the back of this publication. The Bulletin Board System (BBS) is also a good resource. An order form and telephone numbers for the BBS are also in the back of this issue. Help is also always available by calling the Automated Response Unit (ARU) at (904) 353-3205.

Sincerely,

Sidney R. Sewell, M.D.

Medical Director

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Advance Notice Requirement

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

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

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

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

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

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

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

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

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

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

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

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General Information About the Medicare B Update!

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

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

Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of

Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. If additional copies are needed, there are two options: purchase a separate annual subscription for $75, or download the text version from our on-line service, the B LINE BBS.

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 form must be completed in the event of relocation. See page 71 for additional information.

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Page 5 See "Seminar Schedule" at Main Menu
Page 6 See "Seminar Schedule" at Main Menu
Page 7 See "Seminar Schedule" at Main Menu
Page 8 See "Seminar Schedule" at Main Menu
Page 9 See "Seminar Schedule" at Main Menu
Page 10 See "Seminar Schedule" at Main Menu
Page 11 See "Seminar Schedule" at Main Menu
Page 12 See "Seminar Schedule" at Main Menu

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Page 13

Health Professional Shortage Area Designations

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

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

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

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

QB

Physician service rendered in a rural HPSA

QU

Physician service rendered in an urban HPSA

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

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

A complete listing of the HPSAs in Florida will be published in the next Medicare B Update!

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Professional Services Eligible for HPSA Payments

Effective for claims processed April 1, 1998, and after, for diagnostic and therapeutic radiology tests, HPSA bonus payments will only be made on the professional component. HPSA bonus payments will not be made on the technical component of such tests. Prior to this change, the HPSA bonus payment was incorrectly applied to the technical component of globally billed services. To elimate this problem, the Health Care Financing Administration has advised carriers to use the Medicare Physician Fee Schedule Database (MPFSDB) to identify professional services eligible for HPSA payments.

To assist providers in understanding these revised guidelines, a list of codes affected by this change is provided. Coding examples are also provided.

Note: This change does not affect other services which may qualify for HPSA bonus payments.

Diagnostic Tests and Radiology Services

These are procedure codes which describe diagnostic tests (e.g., pulmonary function tests) or therapeutic radiology procedures

(e.g., radiation therapy). These procedures include both professional and technical components.

HPSA Payment Policy

Professional component (procedure code modifier 26) - To receive the HPSA bonus payment, the professional component of the test must be billed with the procedure code modifier 26 and the appropriate HPSA modifier (QB or QU).

Technical component (procedure code modifier TC) - A HPSA modifier (QB or QU) should not be billed with a technical component because the HPSA bonus payment does not apply to technical components.

Global procedure (both components are performed by the same provider) - The professional component should be billed with the procedure code modifier 26, and the appropriate HPSA modifier (QB or QU) to receive the HPSA bonus payment. The technical component should be billed with procedure modifier TC. A HPSA modifier (QB or QU) should not be billed with a technical component because the HPSA bonus payment does not apply to technical components.

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Claims for global procedures billed with a HPSA modifier will be returned as unprocessable, and the provider will be instructed to rebill the service as two components with separate charges for the professional component (billed with the "26" and HPSA modifiers) and the technical component billed with the "TC" modifier but not the HPSA modifier.

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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). Applicable FARS/DFARS apply.

G0030	G0031	G0032	G0033	G0034	G0035	G0036
G0037	G0038	G0039	G0040	G0041	G0042	G0043
G0044	G0045	G0046	G0047	G0062	G0063	G0106
G0120	G0122	Q0035	51725	51726	51736	51741
51772	51784	51785	51792	51795	51797	54240
54250	59020	59025	62367	62368	70010	70015
70030	70100	70110	70120	70130	70134	70140
70150	70160	70170	70190	70200	70210	70220
70240	70250	70260	70300	70310	70320	70328
70330	70332	70336	70350	70355	70360	70370
70371	70373	70380	70390	70450	70460	70470
70480	70481	70482	70486	70487	70488	70490
70491	70492	70540	70541	70551	70552	70553
71010	71015	71020	71021	71022	71023	71030

71034 71035 71036 71038 71040 71060 71090
71100 71101 71110 71111 71120 71130 71250
71260 71270 71550 71555 72010 72020 72040
72050 72052 72069 72070 72072 72074 72080
72090 72100 72110 72114 72120 72125 72126
72127 72128 72129 72130 72131 72132 72133
72141 72142 72146 72147 72148 72149 72156
72157 72158 72159 72170 72190 72192 72193
72194 72196 72198 72200 72202 72220 72240
72255 72265 72270 72285 72295 73000 73010
73020 73030 73040 73050 73060 73070 73080
73085 73090 73092 73100 73110 73115 73120
73130 73140 73200 73201 73202 73220 73221
73225 73500 73510 73520 73525 73530 73540
73550 73560 73562 73564 73565 73580 73590
73592 73600 73610 73615 73620 73630 73650
73660 73700 73701 73702 73720 73721 73725
74000 74010 74020 74022 74150 74160 74170
74181 74185 74190 74210 74220 74230 74235
74240 74241 74245 74246 74247 74249 74250
74251 74260 74270 74280 74283 74290 74291
74300 74301 74305 74320 74327 74328 74329
74330 74340 74350 74355 74360 74363 74400
74405 74410 74415 74420 74425 74430 74440
74445 74450 74455 74470 74475 74480 74485
74710 74740 74742 74775 75552 75553 75554
75555 75600 75605 75625 75630 75650 75658
75660 75662 75665 75671 75676 75680 75685
75705 75710 75716 75722 75724 75726 75731
75733 75736 75741 75743 75746 75756 75774
75790 75801 75803 75805 75807 75809 75810
75820 75822 75825 75827 75831 75833 75840
75842 75860 75870 75872 75880 75885 75887
75889 75891 75893 75894 75896 75898 75900
75940 75945 75946 75960 75961 75962

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75964 75966 75968 75970 75978 75980 75982
75984 75989 75992 75993 75994 75995 75996
76000 76001 76003 76010 76020 76040 76061
76062 76065 76066 76070 76075 76076 76078
76080 76086 76088 76090 76091 76093 76094
76095 76096 76098 76100 76101 76102 76120
76125 76355 76360 76365 76370 76375 76380
76390 76400 76499 76506 76511 76512 76513
76516 76519 76529 76536 76604 76645 76700
76705 76770 76775 76778 76800 76805 76810
76815 76816 76818 76825 76826 76827 76828
76830 76831 76856 76857 76870 76872 76880
76885 76886 76930 76932 76934 76936 76938
76941 76942 76945 76946 76948 76950 76960
76965 76970 76975 76986 76999 77280 77285
77290 77295 77299 77300 77305 77310 77315
77321 77326 77327 77328 77331 77332 77333
77334 77399 77470 77499 77600 77605 77610
77615 77620 77750 77761 77762 77763 77776
77777 77778 77781 77782 77783 77784 77789

77790 77799 78000 78001 78003 78006 78007
78010 78011 78015 78016 78017 78018 78070
78075 78099 78102 78103 78104 78110 78111
78120 78121 78122 78130 78135 78140 78160
78162 78170 78172 78185 78190 78191 78195
78199 78201 78202 78205 78215 78216 78220
78223 78230 78231 78232 78258 78261 78262
78264 78270 78271 78272 78278 78282 78290
78291 78299 78300 78305 78306 78315 78320
78350 78399 78414 78428 78445 78455 78457
78458 78459 78460 78461 78464 78465 78466
78468 78469 78472 78473 78478 78480 78481
78483 78491 78492 78499 78580 78584 78585
78586 78587 78591 78593 78594 78596 78599
78600 78601 78605 78606 78607 78610 78615
78630 78635 78645 78647 78650 78660 78699
78700 78701 78704 78707 78708 78709 78710
78715 78725 78726 78727 78730 78740 78760
78761 78799 78800 78801 78802 78803 78805
78806 78807 78810 78890 78891 78999 79000
79001 79020 79030 79035 79100 79200 79300
79400 79420 79440 79999 88104 88106 88107
88108 88125 88160 88161 88162 88170 88171
88172 88173 88180 88182 88199 88300 88302
88304 88305 88307 88309 88311 88312 88313
88314 88318 88319 88323 88331 88332 88342
88346 88347 88348 88349 88355 88356 88358
88362 88365 88399 89399 91000 91010 91011
91012 91020 91030 91032 91033 91052

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91055 91060 91065 91122 91299 92060 92065
92081 92082 92083 92235 92240 92250 92265
92270 92275 92283 92284 92285 92286 92499
92541 92542 92543 92544 92545 92546 92548
92585 92587 92588 92599 92978 92979 93024
93278 93303 93304 93307 93308 93312 93314
93315 93317 93320 93321 93325 93350 93501
93505 93508 93510 93511 93514 93524 93526
93527 93528 93529 93530 93531 93532 93533
93555 93556 93561 93562 93600 93602 93603
93607 93609 93610 93612 93615 93616 93618
93619 93620 93621 93622 93623 93624 93631
93640 93641 93642 93660 93724 93731 93732
93733 93734 93735 93736 93737 93738 93740
93770 93799 93875 93880 93882 93886 93888
93922 93923 93924 93925 93926 93930 93931
93965 93970 93971 93975 93976 93978 93979
93980 93981 93990 94010 94060 94070 94150
94200 94240 94250 94260 94350 94360 94370
94375 94400 94450 94620 94680 94681 94690
94720 94725 94750 94770 94772 94799 95805
95806 95807 95808 95810 95811 95812 95813
95816 95819 95822 95824 95827 95829 95858
95860 95861 95863 95864 95867 95868 95869

95870	95872	95875	95900	95903	95904	95920
95921	95922	95923	95925	95926	95927	95930
95933	95934	95936	95937	95950	95951	95953
95954	95955	95956	95957	95958	95961	95962

Professional Component Only Procedures

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

HPSA Payment Policy

- Professional Component Only - To report professional component only procedures, bill only the procedure code which describes the service. The use of procedure code modifier 26 is not required. However, the appropriate HPSA modifier (QB or QU) must be billed to receive the HPSA bonus payment.

Professional Component Only Procedure Codes.

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

Technical Component Only Procedures

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

HPSA Payment Policy

Technical Component Only -To report technical component only procedures, bill only the procedure code which describes the service. The use of procedure code modifier TC is not required. Technical component only procedures are not eligible for HPSA bonus payments.

Technical Component Only Procedure Codes

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

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Global Test Only Procedures

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

HPSA Payment Policy

Global Test Only - Since only the professional component qualifies for the HPSA bonus payment, stand-alone procedure which describe global tests must be billed with the associated codes that describe the professional component only and the technical component only. Claims for "Global Tests Only" will be returned as unprocessable, and the provider will be instructed to rebill the service as separate professional and technical component procedure codes. The HPSA modifier should only be used with the professional component code.

The following is an example of a properly completed claim for a "global test only" procedure (procedure code 93000) rendered in a HPSA.

Global Test Only Codes and Associated Procedure Codes:

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

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

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

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

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

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

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

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

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

Note: As a reminder, the coding guidelines detailed in this article only apply to diagnostic and therapeutic radiology tests rendered in a HPSA.

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Changes in HPSA Designation

The following changes to Health Professional Shortage Area (HPSA) designations have occurred:

- Effective for service dates on or after December 1, 1997, Washington County is now classified as a geographic HPSA.

- Effective for service dates on or after March 1, 1998, census tract 0901.00 in the Pierson, Seville, and Deleon Springs area of Volusia County is eligible for HPSA incentive payments.

- Effective for service dates on or after January 1, 1998, Gadsden County is no longer a HPSA.

- Effective for service dates on or after March 1, 1998, Hardee and Levy County are no longer HPSAs.

If you have any questions about this information, please call the Provider Customer Service Department at (904) 634-4994.

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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: Radiology Services (70000-79999)
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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CLIA Services Clarified

In the December 1997 Medicare B Update! Special Issue: 1998 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update, pages 67-78, a comprehensive article concerning the Clinical Laboratory Improvement Act (CLIA) was published. Effective January 1, 1998, the CLIA number must be included on all claims for laboratory services. This includes tests granted waived status under CLIA and tests covered under provider performed microscopy procedures (PPMP) certificates.

Tests Granted Waived Status Under CLIA

Pages 68-70 of the December 1997 Special Issue featured a list of tests granted waived status under CLIA. Providers issued a certificate for waived CLIA tests may only perform services listed in the waived CLIA tests category. The following tests have been added to the list of tests granted waived status under CLIA:

Test Name: Bayer Clinitek 50 Urine Chemistry Analyzer - qualitative dipstick for glucose, bilirubin, ketone, specific

gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes - automated
Manufacturer: Bayer
CPT Code(s): 81003QW
Use: Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections

Test Name: Bayer DCA 2000-glycosylated hemoglobin (Hgb A1c)
Manufacturer: Bayer
CPT Code(s): 83036QW
Use: Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes

Test Name: Wampole Mono-Plus WB
Manufacturer: Wampole
CPT Code(s): Pending
Use: Pending

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

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

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

Provider Performed Microscopy Procedures (PPMP) Certificates

This certificate has been established to address specific microscopy procedures, which are classified as moderately complex tests. Under this certificate the laboratory may also conduct waived tests.

PPMP tests are performed only by a physician (an M.D., D.O. or D.P.M.), a dentist or mid-level practitioner (nurse midwife, nurse practitioner or physician assistant, under the supervision of a physician or in independent practice if authorized by the state); the microscope is the only instrument that may be used. The following is a list of PPMP tests.

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

Q0112 - All potassium hydroxide (KOH) preparations

Q0113 - Pinworm examinations

Q0114 - Fern tests

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

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

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

81015 - Urinalysis; microscopic only

81020 - Urinalysis; two or three glass test

89190 - Nasal smears for eosinophils

G0026 - Fecal leukocyte examinations

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

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

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

Important News for Pathologists

Pathologists who bill only the professional component for lab procedures performed in a CLIA certified lab may, with the approval of the lab, use the lab's CLIA number to bill. A copy of the physician's agreement with the lab must be submitted to the following address:

Medicare Registration
P.O. Box 44021

Jacksonville, FL 32231-4021

If the professional component is performed at a location other than the certified lab, the physician must obtain a CLIA certificate for that location.

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Commonly Asked Questions About CLIA

Outlined below are questions related to the Clinical Laboratory Improvement Act (CLIA). These questions are the result of inquiries from the provider community.

Q - What does a CLIA number actually look like?

A - A CLIA certification number is a 10-digit number formatted as follows: NNANNNNNNN (N - Numeric, A - Alpha).

Q - I'm an electronic claim filer. May I retransmit claims that were either denied/rejected due to an invalid or missing CLIA certification number?

A - Yes, such claims may be resubmitted electronically.

Q - Can I bill the beneficiary for clinical laboratory services denied for lack of CLIA certification?

A - No. The beneficiary should not be held financially liable for such services. In addition, having a patient sign an advance notice of Medicare's possible denial of service does not place the financial burden of such denials on the beneficiary.

Q - I have a CLIA certificate, yet my claims are still denied due to the lack of a CLIA certificate. What should I do?

A - Questions regarding CLIA certification should be addressed to the Agency for Health Care Administration. See above for the address.

Q - If I am billing for lab work performed by another laboratory, do I use my CLIA number or the CLIA number of the lab where the work was performed?

A - Always use the CLIA number assigned to the lab where the work was performed. The purpose of the CLIA is to validate that the lab is qualified and certified to perform the tests rendered. The CLIA number of the provider who only bills the test but does not perform the test is not relevant. For example, if lab work is

sent to a hospital laboratory, the CLIA number assigned to the hospital lab must be indicated on the claim.

Q - Many pathologists act as Medical Director for a hospital-based laboratory with the understanding that they may occasionally perform their own private workload within the hospital laboratory. For example, a pathologist performing his/her private workload within the hospital laboratory may decide to personally perform the professional component of a test but purchase the technical component from the hospital. How should this be billed?

A - Assuming the arrangement described above is acceptable to both the hospital and the pathologist, the claim would reflect the CLIA number assigned to the hospital-based laboratory for both the technical and professional components because both components were actually performed in the hospital-based laboratory. A comprehensive article on purchased diagnostic tests can be found on page 46 of the January/February 1998 Medicare B Update!

Q - How do I bill when some lab work was performed in-house and other tests are referred to another (reference) laboratory?

A - You must file separate claims because you must transmit your lab CLIA number on the tests you perform and the reference lab CLIA number on the tests that they perform.

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Q - What CLIA number do I submit when I have purchased a lab test?

A - Send the CLIA number assigned to the lab that performed the testing. Remember, you can only submit one purchased test per claim. Also, if you purchase more than one lab test from different laboratories, you will need to send separate claims for each CLIA number. For additional information on purchased diagnostic tests, including a list of laboratory services subject to the purchased diagnostic test rules, refer to page 46 of the January/February 1998 Medicare B Update!

Q - Will Medicare accept multiple CLIA numbers on one claim?

A - No. If more than one CLIA number is required, separate claims must be submitted.

Q - When I am billing for the professional interpretation of a surgical pathology specimen (i.e., procedure code 88305-26), do I use the CLIA number of the laboratory where the pathologist interpreted the test?

A - Yes. Even though surgical pathology and physician interpretations are professional services in nature, the CLIA number where the technical component was performed should be used.

Q - Do I need a CLIA number for every physician in my practice?

A - No. CLIA numbers are assigned to laboratories, not physicians. For example, if several physicians use an office laboratory, all claims filed by these physicians must contain the laboratory's CLIA number. In other words, the physicians will share the CLIA number.

Q - If I only do a few simple tests like urinalysis, do I need a CLIA number?

A - Yes. Even the most simple types of tests require the CLIA number. Be sure to check the various articles published about CLIA to be sure your test requires a CLIA number. Remember, there are three categories of testing, waived, non-waived and Physician Performed Microscopy Procedures (PPMP). Urinalysis fits into the PPMP category.

Q - Do I need a CLIA number if I am only drawing the blood (procedure code G0001 - Routine venipuncture for collection of specimen[s])?

A - No. This procedure code is not subject to the CLIA edits.

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Provision of Diagnosis Information by Physicians and Non-Physician 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. Beginning March 30, 1998, no payment will be made 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.

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Revised Coverage Guidelines for Nurse Practitioners and Physician Assistants

The Balanced Budget Act of 1997 has expanded the coverage of services furnished by advanced registered nurse practitioners and physician assistants effective for services furnished on and after January 1, 1998. Prior to this date, coverage for services furnished by these practitioners was limited to the following settings:

- Nurse practitioners - nursing facilities in metropolitan areas or any setting in rural areas

- Physician assistants - hospitals and nursing facilities in areas other than rural health professional shortage areas or any setting in rural health professional shortage areas.

Effective for services furnished on and after January 1, 1998, coverage may be allowed for these practitioners regardless of the setting or designation of the area (i.e., metropolitan or rural) where the services are furnished.

The following information outlines the coverage guidelines for nurse practitioners and physician assistants effective for services furnished on and after January 1, 1998.

Note: These guidelines may be temporary because Medicare contractors are awaiting clarification from the HCFA on the billing guidelines for nurse practitioners and the applicability of certain coverage guidelines relating to both ARNPs and PAs.

Eligibility Requirements for Nurse Practitioners

- Must be a registered professional nurse who is currently licensed to practice in the state in which the services are furnished;

- Must satisfy the applicable requirements for qualifications of ARNPs of the state in which the services are furnished;

- Must meet at least one of the following requirements:

Be currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioner Associates;

Have satisfactorily completed a formal one year academic educational program for preparing registered nurses to perform an expanded role in the delivery of primary care that includes supervised clinical practice and at least four months (in the aggregate) of classroom instruction, and that awards a degree, diploma, or certification for successful completion of the program; or

Have successfully completed a formal educational program (that does not qualify under the immediately preceding requirement) for preparing registered nurses to perform an expanded role in the delivery of primary care.

Note: For the state of Florida, those who are licensed as ARNPs meet the eligibility requirements for Medicare purposes.

Coverage Requirements for Nurse Practitioners

- The ARNP must be working in collaboration with a physician. (A process whereby the ARNP is working with a physician to deliver health care services within the scope of the ARNP's licensure and there is medical direction and appropriate supervision.)

- The services are the type which are within the scope of the ARNP's licensure and the services are performed by a person who meets the definition of an ARNP.

- The services are the type that are considered physician services if furnished by an MD/DO.

- The services are not otherwise precluded from Medicare coverage.

Note: The services must also meet other Medicare coverage requirements (e.g., medical necessity, utilization screens, diagnosis requirements, etc.).

Employment Relationship

Payments for services of an ARNP may be made to the employer of the ARNP or directly to the ARNP. The employer may be a physician, medical group, professional corporation, hospital or nursing facility.

The following are considered valid employer/employee relationships:

- The ARNP is directly employed by a physician, physician group, hospital or nursing facility (i.e., the employer files form W-2).

- The ARNP has a contractual arrangement or is a leased employee of a physician, physician group, hospital or nursing facility (form 1099). In these instances, the physician, physician group, hospital or nursing facility who is "leasing" the ARNP is considered the employer.

Nurse practitioners who intend to bill Medicare directly for their services must obtain a provider number in order to file their claims.

Note: An ambulatory surgical center is not an appropriate employer for these purposes. A group of ARNPs may not incorporate and bill for their services.

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Physician Supervision

The services must be rendered under the general supervision of a physician (or a physician designated by the supervising

physician, or employer as provided under state law or regulations). The ARNP physician supervisor is primarily responsible for the overall direction and management of the ARNP professional activities and for assuring that the services provided are medically appropriate for the patient.

The physician supervisor (or physician designee) need not be physically present with the ARNP when a service is being furnished to a patient, unless state law or regulations provide otherwise. However, if the physician supervisor is not physically present with the ARNP, he or she must be immediately available for consultation by telephone or other effective, reliable means of communication.

Team Concept

A team is defined as a physician and a physician assistant acting under the supervision of the physician or a physician and nurse practitioner working in collaboration with the physician or both. All services furnished by a nurse practitioner in a nursing facility must be furnished under the "team concept."

Applicable Procedure Code Modifiers

Procedure code modifiers are required on all claims for nurse practitioner services regardless of whether the nurse practitioner's services are billed by the employer or billed directly with the nurse practitioner's provider number.

AL - Nurse practitioner, non-rural area, team member

AK - Nurse practitioner, rural area, team member

AV* - Nurse practitioner, non-rural or rural area, non-team member

AM - Team visit (by a physician)

* Note the expansion of this modifier definition from rural to all areas (temporarily, until final instructions are released by HCFA.)

Reimbursement

Covered ARNP services are allowed at the lower of the billed amount or 85 percent of the physician fee schedule allowance.

How To Properly Report Services

- All services must be submitted on an assigned claim.

- All services must include the applicable procedure code modifiers.

- Services may be billed by either the ARNP or the ARNP's employer.

Note: It is expected that only those claims which are to be filed independently by the nurse practitioner are billed with the nurse practitioner's Medicare provider number. Otherwise, if a nurse practitoner is furnishing services for an employer, then the employer's Medicare provider number should be reported on the claim. In cases where a nurse practitioner is not in idependent practice, it may not be necessary for a nurse practitioner to obtain a Medicare provider number.

Eligibility Requirements for Physician Assistants

A physician assistant is an individual who meets all state requirements governing physician assistants and at least one of the following conditions:

- Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

- Has satisfactorily completed a program for preparing physician assistants that:

    - was at least one academic year in length;

    - consisted of supervised clinical practice and at least four months (total) of classroom instruction directed toward preparing students to deliver health care; and

    - was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

- Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of the second item above and has been assisting primary care physicians.

Coverage Requirements for Physician Assistants

- The physician assistant must be working under the general supervision of the physician. That is, the physician does not have to present but at least must be immediately available by telephone.

- The services are the type which are within the scope of the PA's licensure and the services are performed by a person who meets the definition of a PA.

- The services are the type that are considered physician services if furnished by an MD/DO.

- The services are not otherwise precluded from Medicare coverage.

Employment Relationship

Payments for services of a PA may be made only to the actual employer of the PA. The employer may be a physician, PA group, physician clinic, hospital or nursing facility.

Note: An ambulatory surgical center is not an appropriate employer for these purposes.

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The following are considered valid employer/employee relationships:

- The PA is directly employed by a physician, physician group, hospital or nursing facility (i.e., the employer files form W-2).

- The PA has a contractual arrangement or is a leased employee of a physician, physician group, hospital or nursing facility (form 1099). In these instances, the physician, physician group, hospital or nursing facility is considered the employer.

Currently, locum tenens pools which employ PAs and lease them to physicians as surgical assistants or as contracted employees do not meet the definition of an employer.

Physician Supervision

The services must be rendered under the general supervision of a physician (or a physician designated by the supervising physician, or employer as provided under state law or regulations). The PA's physician supervisor is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient.

The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient, unless state law or regulations provide otherwise. However, if the physician supervisor is not physically present

with the PA, he must be immediately available for consultation by telephone or other effective, reliable means of communication.

Team Concept

A team is defined as a physician and a physician assistant acting under the supervision of the physician or a physician and nurse practitioner working in collaboration with the physician or both. Nursing facility visits furnished by physician assistants may be furnished under the "team" concept.

Applicable Procedure Code Modifiers:

AN - Physician assistant services for other than assistant-at-surgery, non-team member

AS - Physician assistant services for assistant-at-surgery (non-team member)

AU - Physician assistant services for other than assistant-at-surgery, team member

Reimbursement

Covered physician assistant services are allowed at the lower of the billed amount or 85 percent of the physician fee schedule allowance.

How To Properly Report Services

- All services must be submitted on an assigned claim.

- All services must be reported with the applicable procedure code modifiers.

- All claims must be billed by the physician assistant's employer.

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Private Contracts Between Beneficiaries and Physicians/Practitioners

The purpose of this Question and Answer section is to give providers additional information on 1802 of the Social Security Act, as amended by 4507 of the BBA of 1997, which permits a physician or practitioner to "opt out" of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements are met.

The amendment made by 4507 of the Balance Budget Act (BBA) of 1997 to 1802 of the Social Security Act shall apply with respect to contracts entered into on and after January 1, 1998.

The Questions and Answers (Q's and A's) listed below differ from those previously published in the January/February 1998 Medicare B Update! because of recent policy decisions. Therefore the Q's and A's in this Update! supersede any previous Q's and A's.

The following are the most frequently asked questions and answers about private contracts.

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

A - As provided in 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.

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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 for items or services furnished by that physician or practitioner;

- 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; and

- Acknowledges that he or she has the right to receive items or 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.

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

A - Certain physicians and practitioners can "opt out" of Medicare. For purposes of this provision, physicians include doctors of medicine and of osteopathy. Practitioners permitted to opt out are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, and clinical psychologists.

The "opt out" law does not define "physician" 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 "opt out" law's definition of either a "physician" or "practitioner."

Q - Can physicians or practitioners who are suppliers of durable medical equipment (DMEPOS), 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. 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 incident to his or her professional services and chooses to opt out of Medicare, then he or she has opted out of Medicare for payment of lab services and DMEPOS as well as for professional services. If a physician who has opted out refers a beneficiary for medically necessary services, such as laboratory, DMEPOS or inpatient hospitalization, those services would be covered. (See #18.) In addition, because suppliers of DMEPOS, independent diagnostic testing facilities, clinical laboratories, etc., cannot opt out, the physician or practitioner owner of such suppliers cannot opt out as such a supplier.

Q - How can participating physicians and practitioners opt out of Medicare?

A - Participating physicians and practitioners may opt out if they file an affidavit that meets the criteria and which is received by the carrier at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e. 1/1, 4/1, 7/1,10/1). They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit.

Non-participating physicians and practitioners may opt out at any time.

Q - What happens if a physician or practitioner who opts out is a member of a group practice or otherwise reassigns his or her Medicare benefits to an organization?

A - Where a physician or practitioner opts out and is a member of a group practice or otherwise reassigns his or her rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for the services that physician or practitioner furnishes to Medicare beneficiaries. However, if the physician or practitioner continues to grant the organization with the right to bill and be paid for the services he or she furnishes to patients, the organization may bill and be paid by the beneficiary for the services that are provided under the private contract.

The decision of a physician or practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and practitioners who have not opted out of Medicare.

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-payment rules cannot opt out since they are neither physicians nor practitioners. Of course, if every physician and practitioner within a corporation, partnership or other organization opted out, then such corporation, partnership, or other organization would have, in effect, opted out

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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.

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 to opt out of Medicare under 4507.

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 or its effective date;

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 would 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 be filed no later than 10 days after the first private contract to which the affidavit applies is entered into for nonparticipating providers. For participating providers, the affidavit must be filed at least 30 days prior to the first day

of the next calendar quarter the "opt out" decision is effective; and

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

Medicare Part B of Florida will notify providers in writing whether or not the affidavit is acceptable based on the criteria listed above.

Q - Where and when must the "opt out" affidavit be filed?

A - An "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, "opt out" affidavits should be sent 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 2 years from the later of the date the affidavit is signed or its effective date. After those 2 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 items or services are furnished .

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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 on or after January 1, 1998.

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 such private pay patients are persons not eligible for Medicare under age 65 or are individuals who are entitled to Medicare benefits but have chosen not to enroll in Part B.

Q - Do Medicare rules apply for services not covered by Medicare?

A - If a service is one of a type that Medicare categorically excludes from coverage, 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 charges for hearing aids, and beneficiaries pay completely out of their own pocket if they want hearing aids.

If a service is one that is not covered because, under Medicare rules, the service is never found to be medically necessary to treat illness or injury, no claim need be submitted, but the physician or practitioner who has not opted out may charge the beneficiary for the noncovered service only if he or she gives the beneficiary an advance beneficiary notice of noncoverage.

If a service is one which Medicare has determined is medically necessary where certain clinical criteria are met, but is not medically necessary where these criteria are not met, a claim must be submitted since it is possible that the carrier may determine that the service is covered in the individual beneficiary's case, even where the physician or practitioner who has not opted out believes that it will not be covered and has given an advance beneficiary notice to that effect. In this case, if Medicare denies the claim on the basis that the service was not medically necessary, the physician or practitioner who has given the advance beneficiary notice may bill the beneficiary.

Where a physician or practitioner has opted out of Medicare and agreed to provide covered services only through private contracts with beneficiaries that meet the criteria specified in the law, the physician or practitioner who has opted out is prohibited from submitting claims for covered services.

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 contact is needed only for services that are covered by Medicare and where Medicare might make payment if a claim were submitted.

Q - What rules apply to urgent or emergency treatment?

A - The law precludes a physician or practitioner from having a beneficiary enter into 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 on behalf of the beneficiary for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare covered services furnished to the beneficiary. Medicare coverage for emergency/urgent care services is based on the patient's medical condition, not the place of service where the service was furnished.

Claims for emergency/urgent care situations must be submitted on a paper HCFA-1500 claim form. In addition, the claim must be submitted along with an attachment stating that the service was indeed an emergency or urgent care situation and that no contract exists with the beneficiary. No payment will be made for claims for emergency/urgent care situations submitted without the appropriate supporting documentation. Such denials will result in the contractor placing a "violator" status on the physician or practitioner. Only the beneficiary will have appeal rights when this situation occurs.

Where a physician or a practitioner who has opted out of Medicare treats a beneficiary with whom he does have a private contract in an emergency or urgent situation, the physician or practitioner may not submit such charges to Medicare.

****

Q - What happens if an "opt out" physician or practitioner violates the agreement not to file claims to Medicare?

A - If an "opt out" physician/practitioner violates his or her agreement to not file claims to Medicare (except for claims for emergency or urgent care services furnished to a beneficiary with

whom the physician or practitioner has not entered into a private contract) he/she must thereafter submit claims for all services to Medicare beneficiaries (for which no Medicare payment may be made) and must abide by the limiting charge rules and regulations for the duration of the "opt out" period.

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 uniform provider identification number (UPIN) and the services are not furnished by a physician or practitioner who has also opted out.

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 Advanced Beneficiary Notice and a private contract?

A - There is no relationship between these instruments. 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. 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, and payment for the service is denied as a "medical necessity denial," 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 submit a proper claim. Examples would be where

the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone. Moreover, if the beneficiary or their legal representative later decides to authorize the submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so.

The Health Care Financing Administration does not seek to limit or interfere in the right of a beneficiary to obtain medical care from the physician or practitioner of his or her choice. However, once a physician or practitioner who has not opted out of Medicare has furnished a covered item or service to a beneficiary who is enrolled in Part B of Medicare, the law requires that the physician or practitioner submit a claim to Medicare for the covered services.

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.

Q - Is a private contract needed for services provided to Medicare beneficiaries who are enrolled in a Medicare risk-based managed care plan who go out of the plan to receive services not covered by the plan?

A - No. When a beneficiary who is enrolled in a Medicare risk-based managed care plan goes out of plan to acquire a service and the plan does not cover it, the enrollee is liable for the full charge for the service and the physician or practitioner does not need to sign a private contract to collect payment for the noncovered service.

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Revisions to 1998 MPFSDB

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

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

Revised Fees

Effective for services rendered on or after January 1, 1998, the malpractice expense relative value units for the following procedures have been revised and, as a result, the fee schedule allowances have been revised:

PARTICIPATING FEES

CODE: 11055
LOC 01/02: 18.90
LOC 01/02: * SOS Differential: 14.38
LOC 03: 20.23
LOC 03: * SOS Differential: 15.31
LOC 04: 21.31
LOC 04: * SOS Differential: 16.15

CODE: 11056
LOC 01/02: 26.46
LOC 01/02 * SOS Differential: 20.39
LOC 03: 28.33
LOC 03 * SOS Differential: 21.71
LOC 04: 29.87
LOC 04 * SOS Differential: 22.92

CODE: 11057
LOC 01/02: 27.65
LOC 01/02 * SOS Differential: 22.79
LOC 03: 29.37
LOC 03 * SOS Differential: 24.07
LOC 04: 30.85
LOC 04 * SOS Differential: 25.29

CODE: 11719
LOC 01/02: 12.95
LOC 01/02 * SOS Differential: 6.70
LOC 03: 14.11
LOC 03 * SOS Differential: 7.30
LOC 04: 15.05
LOC 04 * SOS Differential: 7.90

NON-PAR FEES

CODE: 11055

LOC 01/02: 17.96
LOC 01/02 * SOS Differential: 13.66
LOC 03: 19.22
LOC 03 * SOS Differential: 14.54
LOC 04: 20.24
LOC 04 * SOS Differential: 15.34

CODE: 11056
LOC 01/02: 25.14
LOC 01/02 * SOS Differential: 19.37
LOC 03: 26.91
LOC 03 * SOS Differential: 20.62
LOC 04: 28.38
LOC 04 * SOS Differential: 21.77

CODE: 11057
LOC 01/02: 26.27
LOC 01/02 * SOS Differential: 21.65
LOC 03: 27.90
LOC 03 * SOS Differential: 22.87
LOC 04: 29.31
LOC 04 * SOS Differential: 24.03

CODE: 11719
LOC 01/02: 12.30
LOC 01/02 * SOS Differential: 6.37
LOC 03: 13.40
LOC 03 * SOS Differential: 6.94
LOC 04: 14.30
LOC 04 * SOS Differential: 7.51

LIMITING CHARGE

CODE: 11055
LOC 01/02: 20.65
LOC 01/02 * SOS Differential: 15.71
LOC 03: 22.10
LOC 03 * SOS Differential: 16.73
LOC 04: 23.28
LOC 04 * SOS Differential: 17.64

CODE: 11056
LOC 01/02: 28.91
LOC 01/02 * SOS Differential: 22.28
LOC 03: 30.95
LOC 03 * SOS Differential: 23.72
LOC 04: 32.63
LOC 04 * SOS Differential: 25.04

CODE: 11057

LOC 01/02: 30.21
LOC 01/02 * SOS Differential: 24.90
LOC 03: 32.09
LOC 03 * SOS Differential: 26.30
LOC 04: 33.70
LOC 04 * SOS Differential: 27.63

CODE: 11719
LOC 01/02: 14.15
LOC 01/02 * SOS Differential: 7.32
LOC 03: 15.42
LOC 03 * SOS Differential: 7.98
LOC 04: 16.44
LOC 04 * SOS Differential: 8.63

Effective for services rendered on or after January 1, 1998, the work relative value unit for the following procedure code has been revised and, as a result, the fee schedule allowance has been revised:

PARTICIPATING FEES

CODE: 57531
LOC 01/02: 1730.90
LOC 03: 1870.41
LOC 04: 2003.62

NON-PAR FEES

CODE: 57531
LOC 01/02: 1644.36
LOC 03: 1776.89
LOC 04: 1903.44

LIMITING CHARGE

CODE: 57531
LOC 01/02: 1891.01
LOC 03: 2043.42
LOC 04: 2188.95

Screening Pap Smears: New Codes for Thin Layer Preparation Method

Two new codes have been added for use when reporting screening pap smears performed using the automated thin layer preparation method. The new codes will be effective April 1, 1998, but providers may retroactively bill claims for these services rendered on or after January 1, 1998.

The new codes and their fees are:

G0123 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision.

G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician.

Procedure codes G0123 and G0124 are paid from the Clinical Lab Fee Schedule at 100 percent. Deductible does not apply. The reimbursement amount for G0123 and G0124 is $7.29.

Procedure code G0124 may also be billed as a "professional component only" code, billed with the 26 modifier.
****

G0124-26 is paid off the physician fee schedule, and is reimbursed at 80%. Deductible applies. The allowed amounts are:

PARTICIPATING FEES

CODE: G0124- 26
LOC 01/02: 26.91
LOC 03: 28.87
LOC 04: 30.58

NON-PARTICIPATING FEES

CODE: G0124- 26
LOC 01/02: 25.56
LOC 03: 27.43
LOC 04: 29.05

LIMITING CHARGE

CODE: G0124- 26
LOC 01/02: 29.40
LOC 03: 31.54
LOC 04: 33.41

All current guidelines for screening pap smears apply to G0123, G0124, and G0124-26. See page 15 of the January/February 1998 issue of the Medicare B Update! for information on risk

categories. For information about diagnosis coding for screening pap smears, see page 31 of this issue.

PET Lung Imaging

Effective for services rendered on or after December 18, 1997, two new procedure codes have been developed for billing of PET lung imaging of solitary pulmonary nodules. The new codes and their fees are:

G0125 - PET lung imaging of solitary pulmonary nodules, using 2-[flourine-18]-fluoro-2-deoxy-D-glucodes (FDG), following CT (procedure codes 71250, 71260, or 71270)

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

The reimbursement amounts are:

PARTICIPATING FEES

CODE: G0125
LOC 01/02: 173.58
LOC 03: 182.88
LOC 04: 191.25

CODE: G0125-TC
LOC 01/02: 104.15
LOC 03: 109.73
LOC 04: 114.75

CODE: G0125-26
LOC 01/02: 69.43
LOC 03: 73.15
LOC 04: 76.50

CODE: G0126
LOC 01/02: 222.48
LOC 03: 235.00
LOC 04: 246.35

CODE: G0126 TC
LOC 01/02: 133.49
LOC 03: 141.00
LOC 04: 147.81

CODE: G0126-26
LOC 01/02: 88.99
LOC 03: 94.00
LOC 04: 98.54

NON-PARTICIPATING FEES

CODE: G0125
LOC 01/02: 164.90
LOC 03: 173.74
LOC 04: 181.69

CODE: G0125-TC
LOC 01/02: 98.94
LOC 03: 104.24
LOC 04: 109.01

CODE: G0125-26
LOC 01/02: 65.96
LOC 03: 69.49
LOC 04: 72.68

CODE: G0126
LOC 01/02: 211.36
LOC 03: 223.25
LOC 04: 234 .03

CODE: G0126 TC
LOC 01/02: 126.82
LOC 03: 133.95
LOC 04: 140.42

CODE: G0126-26
LOC 01/02: 84.54
LOC 03: 89.30
LOC 04: 93.61

LIMITING CHARGE

CODE: G0125
LOC 01/02: 189.64
LOC 03: 199.80
LOC 04: 208.94

CODE: G0125-TC
LOC 01/02: 113.78
LOC 03: 119.88
LOC 04: 125.36

CODE: G0125-26

LOC 01/02: 75.85
LOC 03: 79.92
LOC 04: 83.58

CODE: G0126
LOC 01/02: 243.06
LOC 03: 256.74
LOC 04: 269.14

CODE: G0126 TC
LOC 01/02: 145.84
LOC 03: 154.04
LOC 04: 161.48

CODE: G0126-26
LOC 01/02: 97.22
LOC 03: 102.70
LOC 04: 107.65

Medical policy information will be published in a future issue of the Medicare B Update!

Trimming Dystrophic Nails

Effective for services rendered on or after April 1, 1998, procedure code G0127 (Trimming of dystrophic nails, any number) has been developed to use when billing for the trimming of dystrophic nails. Trimming of dystrophic nails was previously billed under procedure code M0101, which is no longer valid for Medicare purposes.

The fees for procedure code G0127 are:

PARTICIPATING FEES

CODE: G0127
LOC 01/02: 12.95
LOC 03: 14.11
LOC 04: 15.05

NON-PARTICIPATING FEES

CODE: G0127
LOC 01/02: 12.30
LOC 03: 13.40
LOC 04: 13.40

LIMITING CHARGE

CODE: G0127
LOC 01/02: 14.15
LOC 03: 15.42
LOC 04: 16.44

For additional information about foot care services, see page 3 of the December 1997 Medicare B Update! Special Issue and page 17 of the January/February 1998 Medicare B Update!, as well as page 33 of this issue of the Medicare B Update!

Physician Supervision of Diagnostic Tests

Medicare Part B of Florida has been advised that this policy, first described in the 1998 Fact Sheet, has been delayed until further notice. The Health Care Financing Administration is working with physicians to resolve issues about the level of supervision for some specific diagnostic services (such as ultrasound).

****

A4644-A4646:Reimbursement for Low Osmolar Contrast Media Items:

The 1998 maximum allowances for covered nonionic radiopaque agents are listed below and are effective for dates of service on or after March 1, 1998.

.....
.....
CODE: A4644(100-199 mg. of iodine)

Product name: Omnipaque/Iohexol
Strength: 140 mg.
Par Allowance per ML: $0.72
Non-Par Allowance per ML: $0.68

Product name: Omnipaque/Iohexol
Strength: 180 mg.
Par Allowance per ML: $2.47
Non-Par Allowance per ML: $2.35

Product name: Isovue/Iopamidol
Strength: 128 mg.
Par Allowance per ML: $0.86
Non-Par Allowance per ML: $0.82

Product name: Optiray/Iover sol
Strength: 160 mg.
Par Allowance per ML: $0.61
Non-Par Allowance per ML: $0.58

Product name: Hexabrix/Ioxaglate meglumine
Strength:
Par Allowance per ML: $0.98
Non-Par Allowance per ML: $0.93

Product name: Amipaque/Metrizamide
Strength: 13.5%

Par Allowance per ML: $3.52
Non-Par Allowance per ML: $3.34

Product name: Amipaque/Metrizamide
Strength: 18.75%
Par Allowance per ML: $2.35
Non-Par Allowance per ML: $2.23

Product name: Ul travi st/Iopromide
Strength: 150 mg.
Par Allowance per ML: $0.50
Non-Par Allowance per ML: $0.48

.....
.....
CODE: A4645(200-299 mg. of iodine)

Product name: Omnipaque/Iohexol
Strength: 210 mg.
Par Allowance per ML: $3.25
Non-Par Allowance per ML: $3.09

Product name: Omnipaque/Iohexol
Strength: 240 mg.
Par Allowance per ML: $0.84
Non-Par Allowance per ML: $0.80

Product name: Isovue/Iopamidol
Strength: 200 mg.
Par Allowance per ML: $0.99
Non-Par Allowance per ML: $0.94

Product name: Isovue/Iopamidol
Strength: 250 mg.
Par Allowance per ML: $1.02
Non-Par Allowance per ML: $0.97

Product name: Optiray/Ioversol
Strength: 240 mg.
Par Allowance per ML: $0.71
Non-Par Allowance per ML: $0.67

Product name: Ultravist/Iopromide
Strength: 240 mg.
Par Allowance per ML: $0.58
Non-Par Allowance per ML: $0.55

Product name: Visipaque/Iodixanol
Strength: 270 mg.
Par Allowance per ML: $1.04
Non-Par Allowance per ML: $0.99
.....
.....
CODE: A4646(300-399 mg. of iodine)

Product name: Omnipaque/Iohexol
Strength: 300 mg.
Par Allowance per ML: $0.99
Non-Par Allowance per ML: $0.94

Product name: Omnipaque/Iohexol
Strength: 350 mg.
Par Allowance per ML: $1.08
Non-Par Allowance per ML: $1.03

Product name: Isovue/Iopamidol
Strength: 300 mg.
Par Allowance per ML: $1.06
Non-Par Allowance per ML: $1.01

Product name: Isovue/Iopam idol
Strength: 370 mg.
Par Allowance per ML: $1.15
Non-Par Allowance per ML: $1.09

Product name: Optiray/Ioversol
Strength: 300 mg.
Par Allowance per ML: $0.88
Non-Par Allowance per ML: $0.84

Product name: Optiray/Ioversol
Strength: 320 mg
Par Allowance per ML: $0.81
Non-Par Allowance per ML: $0.77

Product name: Optiray/Ioversol
Strength: 350 mg.
Par Allowance per ML: $0.87
Non-Par Allowance per ML: $0.83

Product name: Ultravist/Iopro mide
Strength: 300 mg
Par Allowance per ML: $0.66
Non-Par Allowance per ML: $0.63

Product name: Ultravist/Iopro mide
Strength: 370 mg.
Par Allowance per ML: $0.73
Non-Par Allowance per ML: $0.6 9

Product name: Visipaque/Iodixanol
Strength: 320 mg.
Par Allowance per ML: $1.14
Non-Par Allowance per ML: $1.08

Product name:
Strength:
Par Allowance per ML:
Non-Par Allowance per ML:

Product name:
Strength:

Par Allowance per ML:
Non-Par Allowance per ML:

****

A9170: Chiropractic Services When the Beneficiary Refuses to Have an X-ray

When a chiropractor submits a claim for chiropractic treatment (procedure codes 98940-98942) to Medicare Part B, the X-ray date must be included in block 19 of the HCFA-1500 form or in the appropriate EMC field.

If the beneficiary has refused to have an X-ray, the service is not covered by Medicare Part B, and the provider should submit the claim using procedure code A9170 (Noncovered service by a chiropractor).

****

G0101, G0123-G0124, Q0091, and P3000-P3001: Revised Diagnosis Requirements for Screening Pap Smears and Screening Pelvic Exams

The following information is to clarify the diagnosis requirements for screening pap smears and pelvic exams, which are a covered benefit under the Balanced Budget Act of 1997, effective for services rendered on or after January 1, 1998. This diagnosis coding information replaces the diagnosis coding instructions published on page 15 of the January/February 1998 issue of the Medicare B Update!

The revised diagnosis coding information affects the following procedure codes:

G0101

Screening pelvic examinations

*G0123 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision.

*G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician.

Q0091 - Obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

P3000 - P3001 - Screening Pap smear

(*G0123 and G0124 are new procedure codes; see page 28 for additional information.)

Claims for pelvic examinations and screening pap smears must indicate if the patient is at high or low risk of developing cervical or vaginal cancer by referencing the appropriate ICD-9-CM diagnosis code in item 24E of the HCFA-1500 claim form, or the appropriate EMC field. For both screening pap smears and screening pelvic examinations, follow these coding guidelines:

- If the patient is at low risk for developing cervical or vaginal cancer, use diagnosis code V76.2 (Special screening for malignant neoplasms of the cervix), or

- If the patient is at high risk for developing cervical or vaginal cancer, use diagnosis code V15.89 (Other specified personal history presenting hazards to health).

Providers may, of course, use any additional diagnosis desired to describe a patient's particular condition. For example, if a patient is at high risk for cervical or vaginal cancer based on early onset of sexual activity (before age 16), the provider could indicate this situation as a secondary diagnosis by using ICD-9-CM code V69.2. However, only V76.2 or V15.89 will be recognized for coverage for screening pap smears and screening pelvic exams, and therefore must be the primary diagnosis code referenced for these services. Complete information regarding the definitions of "high risk" and "low risk" was published in the January/February 1998 issue of the Medicare B Update!

****

J3490: Coverage Guidelines for Oral Anti-Nausea Drugs

As a result of the Balanced Budget Act of 1997, oral anti-nausea drugs are covered when prescribed as full therapeutic replacements for intravenous anti-nausea drugs when prescribed as part of a cancer chemotherapeutic regimen. Coverage of oral anti-nausea drugs is effective for services rendered on or after January 1, 1998.

Oral anti-nausea drugs must either be adminstered by the treating physician or in accordance with the physician's written order as part of a cancer chemotherapy regimen. Anti-nausea drugs administered with a particular chemotherapy treatment must be initiated within two hours of administration of the chemotherapy itself. The anti-nausea drugs may be continued for up to 48 hours after the chemotherapy treatment.

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

Covered Medications

The following guidelines were used to determine which anti-nausea drugs are covered for oral administration:

- Only drugs approved by the Food and Drug Administration (FDA) for use as anti-nausea drugs are covered.

- All covered oral anti-nausea drugs must have an intravenous counterpart that would have otherwise been administered at the time of the chemotherapy treatment.

- The dispensed number of dosage units may not exceed:

  - A loading dose administered within two hours of treatment, plus

  - A supply of additional dosage units for up to 48 hours after the chemotherapy treatment.

****

Medicare Part B of Florida will recognize three oral anti-nausea drugs for use as part of a cancer chemotherapeutic regimen. All of these drugs should be reported with procedure code J3490 (Unclassified drugs). The drugs, their usual dosages, and the reimbursement amounts are listed in the three charts below:

.....
.....
Zofran (Ondansetron Hydrochloride)

How Supplied:
Tablets: 4 mg, 8 mg
Oral Solution: 4 mg/5ml
(10 ml is equivelant to 8 mg)

Total Amount Per Chemotherapy Session (Loading Dose Plus 48 Hours):
12 - 4 mg tablets
6 - 8 mg tablets
60 ml - Oral solution

Participating Reimbursement:

4 mg: $12.87
8 mg: $21.44
1 ml: $2.63

Non-Participating Reimbursement:
4 mg: $12.23
8 mg: $20.37
1 ml: $2.50

Usual dosage - 8 mg by mouth 30 minutes before start of chemotherapy, followed by 8 mg by mouth 8 hours after first dose, then 8 mg every 12 hours for one to two days.

.....
.....
Kytril (Granisetron Hydrochloride)

How Supplied:
Tablets: 1 mg

Total Amount Per Chemotherapy Session (Loading Dose Plus 48 Hours):
2 - 1 mg tablets

Participating Reimbursement:
1 mg: $40.61

Non-Participating Reimbursement:
1 mg: $38.58

Usual dosage: 1 mg tablet is given up to one hour before start of chemotherapy, and the second tablet 12 hours after the first, only on the day(s) of chemotherapy.

.....
.....
Anzemet (Dolasetron Mesylate)

How Supplied:
Tablets: 50 mg, 100 mg

Total Amount Per Chemotherapy Session (Loading Dose Plus 48 Hours):
2 - 50 mg tablets1 - 100 mg tablets

Participating Reimbursement:
50 mg: $47.31100 mg: $62.70

Non-Participating Reimbursement:
50 mg: $44.94100 mg: $59.57

Usual dosage: 100 mg given within one hour before chemotherapy. There is no indication for follow-up with oral administration.

.....
.....
Claim Submission/Billing Guidelines

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

- All supplier billings submitted before March 30, 1998, must be submitted on paper.

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

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

Last name: EAO 22, positions 120-139
First name: EAO 23, positions 140-151
Initial: EAO 24, positions 152-152

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

- For dates of service from January 1, 1998, through March 31, 1998, physicians and suppliers must report the name of the oral anti-nausea drug and its strength (ex., Zofran, 4 mg) in item 19 of the HCFA-1500 claim form (or on an attachment), or in the HAO narrative record for electronic claims.

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

- If the billing is for oral anti-nausea medication for a patient's first chemotherapy treatment, or if the patient is on oral chemotherapy, note the date and method of chemotherapy information on an attachment (paper claims), or in the HAO narrative record (electronic claims). If this information is not received on an assigned claim, no payment will be made. For nonassigned claims, Medicare will develop for the information.

Advance Notice Statement

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

****

Q0159-Q0161: New Temporary Procedure Codes for Injections

The following national temporary "Q" codes have been established for use in reporting the drugs/services listed below. Providers should use these codes to report drugs for services rendered on or after April 1, 1998.

Q0159 - Injection, Adenosine, 90 mg (not to be used to report Adenosine phosphate compounds, instead use A9270)

Q0160 - Factor IX (Antihemophilic factor, purified, non-recombinant) per I.U.

Q0161 - Factor IX (Antihemophilic factor, recombinant) per I.U.

Reimbursement

Allowances for the new procedure codes are:

Code: Q0159 (per 90 mg)
Participating: $212.56
Non-Participating: $201.93

Code: Q0160 (per I.U.)
Participating: $1.02
Non-Participating: $1.02

Code: Q0161 (per I.U.)
Participating: $1.12
Non-Participating: $1.12

****

Q0162: New Code for Catheterization for Specimen Collection

Effective April 1, 1998, procedure code P9610 (Catheterization for collection of specimen[s], single homebound, nursing home, or SNF patient) is no longer valid for Medicare. Providers must instead use procedure code Q0162 (Catheterization for collection of specimen(s), single patient, all places of service). The pricing for Q0162 is the same as P9610 ($3.00 for both participating and non-participating providers), and Q0162 is subject to all of the laboratory fee schedule requirements.

When catheterization for specimen collection is performed in the physician's office, procedure code 53670 (catheterization, urethra; simple) may not be reported; bill using procedure code Q0162.

****

11055-11057, 11719, G0127: Caution to Podiatrists Regarding Billing of Evaluation and Management Codes

In the January/February 1998 edition of the Medicare B Update! we outlined the coding changes for routine foot care that were effective for services rendered January 1, 1998, and later (see pages 17-19). In that article, we noted that in certain cases an evaluation and management (E/M) code may be properly billed in addition to surgical codes 11055-11057 and 11719. In certain cases, an E/M code may also be billed in addition to procedure code G0127 (Trimming of dystrophic nails, any number). (See page 29 for more information on procedure code G0127.)

If a provider performs and bills services in addition to services described by surgical procedure codes G0127, 11055-11057, and 11719, the E/M code must have modifier -25. If the provider's records do not document a separate service from the surgical

codes, the E/M code is not covered. (See page 22 of the December 1997 Medicare B Update! Special Issue: HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update.

We are concerned, however, that this information may influence some podiatrists to bill separate E/M codes improperly. For example, we would not expect a separate E/M code to be billed for hygienic services such as soaking the feet or the application of creams or lotions performed in addition to the trimming of nails if the hygienic services performed are related to the trimming of nails. The use of separate E/M codes is limited to situations where patient evaluation, diagnosis and treatment planning are performed. Separate billing of E/M codes must be done in accordance with the guidelines in the above referenced article and properly documented in the patient's medical record as outlined in the September 1997 Medicare B Update! Special Issue: Documentation Guidelines for Evaluation and Management Services.

If you have further questions about this article, please contact the Provider Customer Service department at (904) 634-4994.

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Inappropriate Cardiology Coding

We have noticed that providers are billing Medicare for certain additional procedures/services that are included with the primary procedure. Please pay close attention to the following inappropriately coded scenarios and the corresponding rationales. This information has been published in previous issues of the Medicare B Update!

Catheter Placement

Incorrect: Billing for a catheter placement service using procedure codes such as 36200 or 36215 during cardiac catheterizations (93501, 93510-93533).

Incorrect: Billing for a catheter placement service using procedure codes such as 36200, 36215, 93539-93545 during angioplasty, atherectomy or stent placement procedures (92980, 92982, 92995).

Rationale: The catheter placement is an integral part of the cardiac catheterization, angioplasty, atherectomy or stent placement procedure and should not be reported separately.

Supervision/Interpretation Services

Incorrect: Billing for supervision and interpretation service(s) using procedure codes such as 93555 and/or 93556 during

angioplasty, atherectomy or stent placement procedures (92980, 92982, 92995).

Rationale: Supervision and interpretation of an angioplasty, atherectomy or stent placement procedure is an integral part of the procedure and should not be reported separately. Furthermore, procedure codes 93555 and/or 93556 should only be billed when injection procedures (93539-93545) are performed during cardiac catheterization.

Billing for the Placement of a Stent

Incorrect: Billing for the placement of a stent using procedure codes such as 37205 through 37208 during an angioplasty or atherectomy procedure (92980) which includes stent.

Rationale: The placement of a stent during the angioplasty or atherectomy procedure (92980) is an integral part of the procedure and should not be reported separately.

Billing for Thrombolysis Service

Incorrect: Billing for thrombolysis service using procedure codes such as 37201 or 37202 during an angioplasty, atherectomy or stent placement procedure (92980, 92982, or 92995).

Rationale: The thrombolysis service during a Percutaneous Transluminal Coronary Angioplasty (PTCA) (92980, 92982, 92995) is an integral part of the procedure and should not be reported separately.

For more information, refer to:

- Your 1998 CPT book. This information was also published in previous CPT books.

- The July/August 1994 Medicare B Update! (You can access back issues of the Medicare B Update! via the B Line BBS system.)

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54235: Injection of Corpora Cavernosa

A test injection of a vasoactive agent into the corpora cavernosa is an office diagnostic procedure, as well as the standard of care for beginning a patient on pharmacologic injection therapy. The procedure can be used to provide diagnostic information as to the etiology of the patient's erectile dysfunction and determine if the patient is a candidate for injection therapy. It is

necessary to define the dose of medication which will give the patient a functional erection and not result in priapism (abnormal, painful and continued erection).

Medicare Part B will allow payment for the initial injection given by the physician.

Based on national coverage guidelines, the injections which are self-administered by the patient are not a benefit of Medicare.

To ensure that payment is made for only medically necessary services, injection of corpora cavernosa with pharmacologic agent(s) (54235) is covered only for the following diagnoses/conditions:

302.72
607.84

Drugs Used with the Injection of Corpora Cavernosa

The injection into the corpora cavernosa normally consists of one or any combination of the following drugs: papaverine, phentolamine and/or prostaglandin (alprostadil). Since these drugs require titration to determine the appropriate dosage, payment will be allowed one time for the following drugs:

J0270 - Injection, Alprostadil, per 1.25 mcg

J2440 - Injection, Papaverine HCL, up to 60 mg

J2760 - Injection, Phentolamine Mesylate, up to 5 mg.

Advance Notice Requirement

Applies to diagnosis requirements (see page 4).

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72192: Computed Tomography of the Pelvis

The following diagnoses for which computed tomography of the pelvis (procedure code 72192) is covered have been updated to reflect the highest level of specificity:

995.54
996.81

A complete list of diagnoses for which procedure code 72192 is covered was published on page 58 of the March/April 1997 Medicare B Update! A diagnosis update was published on page 13 of the May/June 1997 Medicare B Update!

Advance Notice

Applies to diagnosis requirements (see page 4).

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80049-80054, 80058, 80061, 80072: How to Calculate Reimbursement for Automated Multichannel Tests

The Health Care Financing Administration (HCFA) has revised the coding requirements for clinical laboratory services for claims process on or after January 1, 1998. The major changes are:

- Effective for services rendered on or after January 1, 1998, new and revised codes (80049-80054) were created for automated lab panels.

- Effecive January 1, 1998, the previous automated multichannel codes (80002-80019 and G0058-G0060) were deleted. Note: A provider can contunie to use the "old" automated multichannel codes throughout the grace period (January 1 - March 31, 1998).

- Effective for claims processed on or after January 1, 1998, a new payment methodology was implemented for automated clinical lab services.

Although a grace period (January 1 - March 31, 1998) was established to allow providers to continue to use the "old" automated multichannel codes, the new payment methodology is effective for claims processed on or after January 1, 1998.

Effective, January 1, 1998, claims received with individual automated lab codes billed will not be grouped into panel codes. However, the reimbursement for the total number of automated procedures will continue to be equivalent to the reimbursement of the deleted automated multichannel codes (80002-80019, G0058-G0060).

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Medicare Part B has received many inquiries from providers regarding how reimbursement is calculated. The following information has been developed to clarify how reimbursement is calculated.

Formula for Calculating the Pro-Rated Fee for Individual Automated Lab Tests

The following formula is used to determine the pro-rated fee for individual automated lab tests. Please note that although the grace period for deleted multichannel procedure codes 80002-80019 and G0058-G0060 ends effective March 31, 1998, pricing for these procedure codes is the basis for determining reimbursement for

multiple individual procedures. The formula Medicare uses to calculate the pro-rated fee for automated multichannel codes is:

1. Determine the procedure code that represents the total number of automated procedures that were rendered. (Excluding any code that denied for duplicate, medical necessity, or CCI).

2. Obtain the allowed amount for the procedure code in Step 1

3. Obtain the allowed amount for each automated procedure that was listed separately.

4. Divide allowed amount for automated multichannel code (step 2) by the total allowed amount for the automated tests (any automated code listed separately) to receive your Reduction Factor.

5. Multiply the allowed amount for each automated test by the reduction factor.

Note: When calculating the amount for step 4, round your number to the fourth digit (e.g. .457985 = .4580 or .74823 = .7482) for the "reduction factor".

Individual Automated Multichannel Tests

If provider submits individual automated codes, Medicare Part B will process the codes individually, and will prorate the allowed amount. The sum of the prorated allowed amounts will equal the amount that would be paid if the tests were grouped.

Use the following steps to determine reimbursement for this case:

1. Determine the procedure that represents "2" multichannel tests (80002).

2. Obtain the pricing for procedure code 80002 ($7.39)

3. Obtain the allowed amounts for each individual code.

4. Divide allowed amount for procedure code 80002 ($7.39) by total allowed amount for individual test ($13.65).
   7.39/13.65 = .5414 (Reduction Factor)

5. Multiply the allowed amount for each code by the reduction factor (.5414).
   5414 x 7.13 = 3.86 (Pro-rated fee)
   5414 x 6.52 = 3.53 (Pro-rated fee)

When you add together the results of step 5, the sum should equal the allowed amount for procedure code 80002.

Example: Individual Automated Multichannel Tests

Billed Number Codes:	Billed Pro-rated Amounts:	Fee Amount:	Allowed Amount:	of Test(s):	Amount:
82250	$10.00	$7.13	$7.13	1	$3.86
84132	$15.00	$6.52	$6.52	1	$3.53
Total:	$25.00	$13.65	$13.65	2	$7.39

Note: All tests performed are automated multichannel tests.

Individual Multichannel Test(s) Submitted with a Panel Code

If a provider submits a panel code and an individual automated test(s), the Medicare Part B will check for duplicate tests (components of panel code vs. individual tests). Then the total number of individual tests rendered will be added together to determine what multichannel code to use for pricing purposes.

Use the following steps to determine reimbursement for this case:

1. Determine the procedure code that represents "6" tests (80006)

2. Obtain pricing for procedure code 80006 ($11.13)

3. Obtain the allowed amounts for procedure codes 80058 and 84295.

4. Divide allowed amount for procedure code 80006 ($11.13) by total allowed amount for automated tests ($17.92)

    11.13/17.92 = .6211 (Reduction Factor)

5. Multiply the allowed amount for each code by the reduction factor (.6211)

    6211 x 11.10 = 6.89 (Pro-rated Fee)

    6211 x 6.82 = 4.24 (Pro-rated Fee)

When you add together the results of step 5, the sum should equal the allowed amount for procedure code 80006.

****

Example: Individual Multichannel Test(s) Submitted with a Panel Code

Billed Codes	Billed Amounts	Fee Amount	Allowed Amount	Number of Test(s)	Pro-rated Amount
80058 (82040 ,82251 ,84075 ,84450 ,84460)	$13.00	$11.10	$11.10	5	$6.89
84295	$7.00	$6.82	$6.82	1	$4.24
84295	$7.00	$6.82	$6.82	6	$11.13

Note: All tests performed are automated multichannel tests.

Automated Codes Submitted with Nonautomated Codes

If a provider submits both automated lab codes and nonautomated codes, the total allowed amount will only include the fee for the automated test.

Use the following steps to determine reimbursement for this case:

1. Determine the procedure code that represents "5" test (80005).

2. Obtain pricing for procedure code 80005 ($11.10).

3. Obtain the allowed amounts for each automated test.

4. Divide allowed amount for procedure code 80005 ($11.10) by total allowed amount for the automated tests ($32.79).

    11.10/32.79 = .3385 (Reduction Factor)

5. Multiply the allowed amount for each automated test by the reduction factor (.3385).

    .3385 x 6.52 = 2.21 (3 times) (Pro-rated Fee)
    .3385 x 6.82 = 2.31 (Pro-rated fee)
    .3385 x 6.41 = 2.17 (Pro-rated fee)

The total sum for step 5 should equal the allowed amount for procedure code 80005. In this example the sum is $0.01 greater.

Example: Automated codes submitted with nonautomated codes

Billed Number Codes	Billed Pro-rated Amounts	Fee Amount	Allowed Amount	of Test(s)	Amount
82374	$10.00	$6.52	$6.52	1	$2.21
82435	$10.00	$6.52	$6.52	1	$2.21
84132	$10.00	$6.52	$6.52	1	$2.21
84295	$10.00	$6.82	$6.82	1	$2.31
84550	$10.00	$6.41	$6.41	1	$2.17
85651*	$10.00	$5.04	$5.04	1	
86255*	$10.00	$17.11	$10.00	1	
86430*	$10.00	$8.06	$8.06	1	
total	$50.00		$32.79	5	$11.11

* Denotes nonautomated test paid as separate test.

****

87470-87799: Clarification of Antigen Billing Rules

The 1998 HCFA Common Procedure Coding (HCPCS) Update included several new procedure codes (87470-87799) designed to be billed when a test for an antigen is performed. Each of the codes for these antigen tests describe one of three techniques that may be used: direct probe, amplified probe, and quantification. The quantification technique includes both the direct and amplified probe techniques.

If the direct or amplified version of a test is billed with the quantification version of the same test on the same day, only the quantification will be allowed by Medicare Part B. For example, if a provider bills 87516 (hepatitis B virus, amplified probe technique) and 87517 (hepatitis B virus, quantification) on the same day, only procedure code 87517 will be allowed.

If the direct and amplified versions of a test are both billed on the same day, Medicare Part B will allow both tests. For example, both procedure code 87515 (hepatitis B virus, direct probe technique) and 87516 (hepatitis B virus, amplified probe technique) may be billed on the same day if both tests are performed and are medically necessary.

Finally, if a direct or amplified technique is submitted and paid before the quantification technique (for the same day, by the

same provider), the allowance for the quantification will be reduced for the amount already paid.

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90724, 90732, 90744-90747: Pricing for Immunizations

The pricing for the following immunizations was not included in the 1998 Fee Schedule. Please note that these codes are not subject to the non-par differential.

Code: 90724
Descriptor: Influenza virus vaccine
Reimbursement: $3.86

Code: 90732
Descriptor: Pneumococcal vaccine, polyvalent
Reimbursement: $13.49

Code: 90744
Descriptor: Immunization, active, hepatitis B vaccine; newborn to 11 years
Reimbursement: $21.83

Code: 90745
Descriptor: Immunization, active, hepatitis B vaccine;11-19 years
Reimbursement: $40.04

Code: 90746
Descriptor: Immunization, active, hepatitis B vaccine; 20 years and above
Reimbursement: $56.91

Code: 90747
Descriptor: Immunization, active, hepatitis B vaccine; dialysis or immunosuppressed patient, any age
Reimbursement: $103.27

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1998 Clinical Psychologist and Clinical Social Worker Fee Schedule

The Clinical Psychologist (CP) fee schedule is set at 100 percent of the physician fee schedule amount for the same service. This payment guidance applies to all CP services.

For the Clinical Social Worker (CSW) fee schedule, amounts remain set by law at 75 percent of the CP fee schedule for corresponding services. Diagnostic procedures are also reimbursed at 75 percent of the fee schedule.

Mandatory assignment is required on all covered services furnished to Medicare beneficiaries by CPs and CSWs. As a result, there is no five percent reduction in the approved amount when billing for diagnostic or therapeutic procedures. Additionally, limiting charges for these services are not applicable.

For payment purposes, approved charges for CP and CSW services are the lower of the billed amount or the fee schedule amount. Therapeutic services are subject to the outpatient services limitation of 62.5 percent. This payment limitation is not applicable for diagnostic services.

Important Note: Effective January 1, 1997, CPs must report their name in item 17 and the surrogate UPIN (OTH000) in item 17a of the HCFA-1500 claim form when billing for codes 96105-96117 (Central Nervous System Assessments/Tests).

The fee schedule rates for CPs and CSWs are listed on the next page. These fees are effective for services rendered on or after January 1, 1998. If you have any questions regarding these fees, please contact the Provider Customer Service department at: (904) 634-4994.

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** REFERTO FEE SCHEDULE SECTION AT MAIN MENU, AND OTHER FEES WITHIN SELECTION, FOR "CLINICAL PSYCHOLOGIST/CLINICAL SOCIAL WORKER FEE SCHEDULE FOR 1998".

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92015: Clarification for Determination of Refractive State

The following questions and answers were developed to clarify guidelines for procedure code 92015 (determination of refractive state).

Q - When a refraction is performed during the course of an eye exam or an evaluation/ management (E&M), are we required to use either an eye exam/E&M code and code 92015?

A - Yes. When a refraction is performed, it cannot be included in the billing for an eye exam or an evaluation and management service. Any time a refraction is performed, it must be billed as a separate component.

Q - Are we required to assign a charge to 92015 or can we charge $0.00 for the refraction? If we have to assign a charge, how do we determine a charge amount for the refraction?

A - You must charge for the refraction. Otherwise, it may be construed an incentive for Medicare patients to use you as their doctor. The decision on what amount to charge for a refraction is a physician's decision. We would recommend the standard industry charge.

Q - When we bill the refraction to Medicare, are we required to indicate the charge and the patient's payment?

A - Yes. The charge for the refraction and the amount paid by the patient should always be indicated.

Q - Since 92015 is a non-covered service, are we exempt from having the patient sign an advance notice of liability?

A - Yes. An advance notice/waiver of liability is not necessary because eye refraction is considered a Medicare program exclusion.

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99241-99275: Consultations

What Is a Consultation?

A consultation is advice or opinion requested from one physician to another and must include a written report. A consultation report must include the three key components of an evaluation and management service. These components are history, examination, and medical decision-making. When the attending physician requests a consultation, his or her intent should be to obtain an opinion, input, or advice on the best method of treatment for the patient's condition. The request for a consultation from the attending physician and the need for the consultation must be documented in the patient's medical records.

Example: Dr. Moore (Family Practice), is treating Mrs. Johnson, who has recurrent episodes of chest pain. Dr. Moore would like to obtain an opinion from a cardiologist on the best method of treatment for Mrs. Johnson. Dr. Moore requests a consultation from Dr. Barker, a cardiologist. Dr. Barker performs a radionuclide stress test and determines a left heart catheterization is needed. The patient returns to the attending physician and Dr. Barker provides Dr. Moore with a written report outlining her findings and the suggested plan of treatment.

Note: Dr. Barker's visit should be submitted to Medicare as a consultation. Dr. Barker must bill all subsequent visits as follow-up visits, not follow-up consultations.

Follow-Up Consultations

Follow-up consultations should only be billed if:

- A second visit is required to render an opinion and/or initiate treatment; or

- A request for another consultation to the same physician is required during the same hospitalization.

What Is a Referral?

A referral is the request from an attending physician to another physician to evaluate and treat a patient.

Example: Dr. Williams (Internal Medicine) is treating Mrs. Aldrich for diabetes and heart disease. During the course of Mrs. Aldrich's visit, Dr. Williams observed multiple lesions and refers Mrs. Aldrich to Dr. Barnes, a dermatologist.

Note: Dr. Barnes' visit should be submitted as an initial office visit. Since Dr. Barnes is treating Mrs. Aldrich, a consultation may not be billed, as there is no advice or opinion being requested.

Pre-Operative Consultations

Physicians may bill for pre-operative consultations performed for new or established patients if the criteria for consultation codes are met.

The request for a consultation for a hospital inpatient should be documented as part of a written plan in the surgeon's progress notes, an order in a hospital record, or a specific written request for the consultation by the surgeon. In an office or other outpatient setting, the request may be documented by a specific written request for the consultation from the surgeon, or the physician's records may show a specific reference to this request.

If any of these criteria are not met, the physician may not bill the encounter as a consultation. For example, if there is not a specific request from the surgeon for the consultation (i.e., the patient is given a form by the hospital or surgeon and told to have his physician complete it), or if there is not a report from the consulting physician provided to the surgeon for their use prior to surgery, the consultation codes cannot be used. Additionally, a referral from the surgeon to either the primary care or any other physician for surgical clearance does not meet the requirements for a pre-operative consultation.

Post-Operative Consultations

A physician who performs a post-operative evaluation of either a new or established patient at the surgeon's request may bill the appropriate consultation code if all of the criteria for the use of these codes are met and the same physician has not already performed a pre-operative consultation for the patient.

The requirements for the use of consultation codes mentioned for pre-operative encounters also apply to post-operative encounters

as well. For example, if the surgeon requests the opinion or advice of a physician regarding a specific problem that has arisen following the surgery and that physician also assumes responsibility for the management of the problem during the post-operative period, the initial encounter may be billed with the appropriate consultation code and any follow-up visits using the subsequent hospital care codes. However, if the surgeon does not request the physician's opinion or advice and simply refers the patient for post-operative management of a specific condition, the physician may not bill the encounter as a consultation. Instead, these services constitute concurrent care and should be billed using the appropriate level visit codes.

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LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

Table Of Contents

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

Effective Dates

The policies contained in this section are effective for claims processed April 20, 1998, and after, unless otherwise noted.

Sources of Information

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

Noncoverage Guideline Additions

The following two services/procedures are considered noncovered due to their being investigational/experimental:

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

55899* - T3 System

* Since procedure code 55899 is an unlisted procedure code, a concise description of the service must be indicated in Item 19 of the HCFA-1500 claim form or the equivalent EMC field.

Both these services have been added to the local noncoverage section of the guidelines.

Advance Notice Requirements

Due to the investigational/experimental status of the above mentioned procedures, an acceptable advance notice of Medicare's denial of payment must be given to the patient if the provider does not want to accept financial responsibility for the service. For additonal information on advance notice requirements, refer to page 4.

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J0585: Botulinum Toxin Type A (Botox)

Botulinum toxin is a complex protein produced by the anaerobic bacterium Clostridium botulinum. Botulinum Toxin Type A injections can be used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, etc.

Botulinum toxin type A blocks neuromuscular conduction by binding to receptor sites on motor nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. When injected intramuscularly or subcutaneously at therapeutic doses, botulinum toxin type A produces a localized chemical denervation muscle paralysis. The resulting chemical denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively. It has the advantage of being a potent neuromuscular blocking agent with good selectivity, duration of action, with the smallest antigenicity, and fewest side effects.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider Botulinum Toxin Type A (Botox) (J0585) to be medically reasonable and necessary for the treatment of blepharospasm, cranial nerve aberrant regeneration, strabismus, hemifacial spasm, facial spasm, achalasia, spasmodic dysphonia, spasmodic torticollis, laryngeal dystonia, and for other dystonias (e.g., writer's cramp, focal task-specific dystonias) and limb spasticity.

Botulinum Toxin Type A can be used to reduce spasticity or excessive muscular contractions to relieve pain; to assist in posturing and walking; to allow better range of motion; to permit better physical therapy; to reduce severe spasm in order to provide adequate perineal hygiene.

Botox can also be used in the treatment of achalasia. It should not be used for all patients with this disorder, but it can be considered individually in patients who have one or more of the following:

- have failed conventional therapy

- are at high risk of complications of pneumatic dilatation or surgical myotomy

- have failed a prior myotomy or dilation

- have had a previous dilation induced perforation

- have an epiphrenic diverticulum or hiatal hernia both of which increase the risk of dilation-induced perforation

Due to the uncommonness, one would not expect to see the diagnosis of organic writer's cramp (333.84) billed frequently.

There may be patients who require electromyography in order to determine the proper injection site(s). The electromyography procedure codes specified under the HCPCS section of this policy may be covered if the physician has difficulty in determining the proper injection site.

Medicare of Florida will allow payment for one injection per each functional muscle group (e.g., elbow flexors or elbow extensors) regardless of the number of injections made into each group or the muscles that compose it.

NOTE: It is expected that a patient will not receive continued injections of Botox if treatment failure occurs after two consecutive injections, using maximum dose for the size of the muscle.

HCPCS Codes

The following HCPCS codes are to be reported for the injection of Botulinum Toxin A:

J0585 - Botulinum Toxin Type A, per unit

The following procedure codes are to be reported with the respective listed covered ICD-9 diagnosis codes: (See Coding Guidelines for correct reporting of services)

31513 - Laryngoscopy, indirect (separate procedure); with vocal cord injection

31570 - Laryngoscopy, direct, with injection into vocal cord(s), therapeutic

31571 - with operating microscope

64612 - Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)

64613 - cervical spinal muscles (e.g., for spasmodic torticollis)

64640 - Destruction by neurolytic agent; other peripheral nerve or branch

67345 - Chemodenervation of extraocular muscle

92265 - Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report

95860 - Needle electromyography, one extremity and related paraspinal areas

95861 - Needle electromyography, two extremities and related paraspinal areas

95869 - Needle electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)

ICD-9 Codes That Support Medical Necessity (J0585 Only)

333.6
333.7
333.81-333.89
351.8
378.00-378.87
478.75
530.0
723.5
728.85

Reasons for Denial

Botulinum Toxin Type A used for the treatment of anal spasm, irritable colon, biliary dyskinesia or any other spastic conditions not listed as covered in this policy are considered investigational and therefore, noncovered by Medicare of Florida.

The procedure is considered osmetic for the removal of wrinkles.

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Noncovered ICD-9 Code(s)

Any ICD-9 code not listed in the Covered ICD-9 section of this policy.

Coding Guidelines

When billing for injections of Botulinum Toxin Type A for covered conditions/diagnoses, the following guidelines should be used. Failure to report this procedure according to these guidelines may result in a denial of a claim.

Correct procedure code: 31513 - laryngoscopy, indirect; diagnostic with vocal cord injection, 31570 - therapeutic laryngoscopy withvocal cord injection;31571 - with operation microscope
Correct ICD-9 code: 478.75 - spastic dysphonia

Correct procedure code: 64612 - destruction by neurolytic agent; muscles enervated by facial nerve
Correct ICD-9 code: 333.81 - blepharospasm, 333.82 - oral facial dyskinesia (oral mandibular dystonia), 351.8 - hemifacial spasm

Correct procedure code: 64613 - destruction by neurolytic agent; cervical spinal muscles
Correct ICD-9 code: 333.83 - spasmodic torticollis, 723.5 - torticollis, unspecified

Correct procedure code: 64640 - Destruction by neurolytic agent; other peripheral nerve or branch
Correct ICD-9 code: 333.6 - idiopathic torsion dystonia, 333.7 - symptomatic torsion dystonia, 333.84 - writer's cramp, 333.89 - other torsion dystonia, 530.0 - achalasia, 728.85 - spasm of muscle

Correct procedure code: 67345 - Chemodenervatin of extraocular muscle
Correct ICD-9 code: 378.00 -378.87 - strabismus

Botulinum Toxin A is supplied in vials and each contains 100 units. If less than 100 units is given during a single treatment session and the remainder is not used for another patient, bill 100 units in the days/units field, (Item 24G), of the 1500 claim form. If more than 100 units are billed during a single treatment session per patient, round up to the nearest 100 units serum only

if the remainder was not used. For EMC billing, document the units injected in the units of service field, FAO.18. In each case, Botulinum Toxin A is coded as J0585.

Due to the short life of the botulinum toxin, Medicare will reimburse the unused portion of this drug, only when the vial is not split between patients.

However, documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

Scheduling of more than one patient is encouraged to prevent wastage of Botulinum Toxin Type A. If a vial is split between two patients, the billing in these instances must be for the exact amount of Botulinum Toxin Type A used for each individual patient using J0585. If there is any toxin unused after injecting multiple patients, the remainder can be appropriately billed as wastage on the claim of the last patient injected. For EMC billings, document the units injected in the units service field, FAO.18. Medicare would not expect to see billing for the full fee amount for Botulinum Toxin Type A on each beneficiary when the vial is split between two or more patients.

Electromyography guidance (CPT codes 92265, 95860, 95861, 95869) may be covered if the physician has difficulty in determining the proper injection site(s). However, electromyography is not required for every patient.

Only one electromyography guidance procedure per injection site should be billed.

Needle electromyography (95869), limited study of a specific muscle group(must specify), should be used if only individual muscle groups are being tested.

Only one procedure will be allowed per claim for procedure code 64640 despite the number of muscle groups injected.

The physician should not be reimbursed for an office visit in conjunction with the procedure itself, unless there is a clear indication that the patient was seen for a different reason. The physician should use modifier 25 to indicate that the office visit was for an unrelated condition.

Documentation Requirements

Documentation (i.e., history and physical, office/progress notes) must be maintained on file and should include the following elements in the event of a postpayment review:

- support for the medical necessity of the Botulinum Toxin A injection

- a covered diagnosis

- a statement that traditional methods of treatment have been tried and proven unsuccessful

- dosage and frequency of the injections

- support for the medical necessity of electromyography procedures

- support of the clinical effectiveness of the injections

- specify the site(s) injected

Advance Notice Requirements

Applies to diagnosis requirements (see page 4).

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Anesthesia Services (Ocular Procedures)

A variety of types of anesthesia can be used during an ocular procedure. These types are:

Local Anesthesia: the administration, topical and/or injection, of an anesthetic agent at or around the site at which the procedure is to be performed to effect a regional loss of sensation.

General Anesthesia: the administration, inhalation and/or intravenous injection of an anesthetic agent that results in complete anesthesia, affecting the entire body with loss of consciousness.

Monitored Anesthesia Care (MAC): the intraoperative monitoring by a physician or other qualified anesthesia personnel of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.

Additionally, these services can be performed under a variety of anesthesia arrangements, such as:

- Personally performed by an anesthesiologist,

- Performed by a medically-directed CRNA,

- Performed by the surgeon performing the surgery.

The purpose of this policy is to define the medical necessity of the varying types of anesthesia used during various ocular procedures.

HCPCS Codes

00103 - Anesthesia for blepharoplasty

00140 - Anesthesia for procedures on eye, not otherwise specified

00142 - Anesthesia for lens procedure

00144 - Anesthesia for corneal transplant

00145 - Anesthesia for vitrectomy

00147 - Anesthesia for iridectomy

Indications and Limitations for Coverage and/or Medical Necessity

Anesthesia is covered only when it is determined to be medically necessary and reasonable and the procedure for which it is performed is a covered service, i.e. anesthesia for cosmetic procedures would be noncovered.

General anesthesia and Monitored Anesthesia Care can be covered if the anesthesiologist:

1) Performs a pre-anesthesia examination and evaluation which may include, but is not limited to, medical history of the patient, information related to present illness, social history, allergies, review of systems as applicable and a physical examination of a body area(s) as deemed appropriate by the physician;

2) Prescribes the anesthesia plan, such as Monitored Anesthesia Care, if determined to be necessary;

3) Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence, i.e., in general anesthesia when the patient is anesthetized and/or any emergency such as an arrhythmia, hypotension, hypertension, etc., which the patient may experience during the procedure or immediately following the procedure.

4) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist such as a medically-directed CRNA;

5) Monitors the course of anesthesia administration at intervals;

6) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

7) Provides indicated post-anesthesia care such as may be required when the patient's physiological vital signs were abnormal during the procedure. Also, if the patient was under general anesthesia and was intubated, the anesthesiologist may extubate the patient when stable.

While the following CPT codes represent services in which one would not expect to see general anesthesia given or generally would not require Monitored Anesthesia Care, there may be instances in which anesthesia or MAC would be appropriate:

65205 - Removal of foreign body, external eye; conjunctival superficial

65210 - conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating

65220 - corneal, without slit lamp

65222 - corneal, with slit lamp

65272 - Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization

65286 - application of tissue glue, wounds of cornea and/or sclera

65430 - Scraping of cornea, diagnostic, for smear and/or culture

65435 - Removal of cornea epithelium; with or without chemocauterization (abrasion, curettage)

65600 - Multiple punctures of anterior cornea (e.g., for corneal erosion, tattoo)

65860 - Severing adhesions of anterior segment, laser technique (separate procedure)

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66761 - Iridotomy/iridectomy by laser surgery (e.g., for glaucoma)(one or more sessions)

66762 - Iridoplasty by photocoagulation (one or more sessions) (e.g., for improvement of vision, for widening of anterior chamber angle)

66770 - Destruction of cyst or lesion iris or ciliary body (nonexcisional procedure)

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

67031 - Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)

67110 - Repair of retinal detachment; by injection of air or other gas (e.g., pneumatic retinopexy)

67141 - Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy

67145 - photocoagulation (laser or xenon arc)

67208 - Destruction of localized lesion of retina (e.g., maculopathy choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy

67210 - photocoagulation (laser or xenon arc)

67227 - Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), one or more sessions; cryotherapy, diathermy

67228 - photocoagulation (laser or xenon arc)

67500 - Retrobulbar injection; medication (separate procedure does not include supply of medication)

67515 - Injection of therapeutic agent into Tenon's capsule

67700 - Blepharotomy, drainage of abscess, eyelid

67710 - Severing of tarsorrohaphy

67115 - Canthotomy (separate procedure)

67800 - Excision of chalazion; single

67801 - multiple same lid

67805 - multiple, different lids

67810 - Biopsy of eyelid

67820 - Correction of trichiasis; epilation, by forceps only

67825 - epilation by other than forceps (e.g., by electrosurgery, cryotherapy, laser surgery)

67840 - Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure

67875 - Temporary closure of eyelids by suture (e.g., Frost suture)

68020 - Incision of conjunctiva, drainage of cyst

68040 - Expression of conjunctival follicles (e.g., for trachoma)

68200 - Subconjunctival injection

68760 - Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery

68761 - by plug, each

68801 - Dilation of lacrimal punctum, with or without irrigation

68810 - Probing of nasolacrimal duct, with or without irrigation

68840 - Probing of lacrimal canaliculi, with or without irrigation

There are rare circumstances in which anesthesia services may be rendered for the aforementioned HCPCS codes. These include, but are not limited to, the following:

- Description of severe patient anxiety,

- Description of a planned, complex procedure,

- Description of patient discomfort under local anesthesia, or

- Description of complications arising during the planned procedure.

Anesthesia performed by the operating surgeon is covered, however, reimbursement is included in the allowance of the surgical procedure.

Documentation Requirements

Hospital, outpatient or office records or the anesthesia record should clearly document the medical necessity for performing the general anesthesia or MAC. A copy of an appropriate history and physical documented by either the anesthesiologist or attending physician and the anesthesia record should be provided by the qualified anesthesia personnel who performed the anesthesia service if requested by Medicare of Florida.

An anesthesiologist may block more than one patient at a time as long as he/she has arranged for each patient to be monitored by another qualified anesthesia person. The same anesthesiologist can medically direct up to four CRNAs who are involved in concurrent procedures. The CRNA must provide continuous monitoring and other appropriate anesthesia services during the surgical procedure.

If anesthesia is performed for any of the procedure codes listed in the "Indications and Limitations" section of this policy, documentation should be maintained which clearly outlines why general anesthesia or MAC was performed.

HCFA's National Policy

Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically necessary.

Medicare Carrier Manual Sections: 2050.2, 2136, 4830, 15018, and 16003.1

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HCFA Publication 6, Coverage Issues Manual, Section: 35-44B

Reasons for Denial

General Anesthesia or MAC for ocular procedures will be denied if determined not to be medically necessary and reasonable.

Anesthesia services performed during noncovered surgical procedures, e.g., cosmetic surgery, are noncovered.

If the block is administered by the same qualified anesthesia personnel who provides MAC or general anesthesia, only the general anesthesia or MAC service will be allowed.

If qualified anesthesia personnel under the medical direction of the physician administers a block and monitors for immediate but not prolonged effects (e.g., not over 10-15 minutes) only the block, (CPT code 67500) and not general anesthesia or MAC can be billed.

Advance Notice Requirement

Applies to medical necessity guidelines (see page 4).

Sources of Information

- Model Local Medical Review Policy

- CMD Clinical Anesthesia Workgroup

Coding Guidelines

- When billing MAC procedures, modifier QS must be used.

- Consult the correct coding guidelines for applicable special code combinations and reduction in payment due to specific codes billed. An operating surgeon cannot be paid separately for an anesthesia service if he or she also provides the surgical service.

- Inpatient or outpatient consultations, (99241-99245, 99251-99255), for anesthesia services for ocular procedures, in lieu of MAC, related to providing pain management with a nerve block (67500), prior to the surgical procedure will be denied as medically unnecessary. Also, subsequent hospital visits for pain management (99231-99233) will be denied as medically unnecessary. This would clearly circumvent what is considered ocular anesthesia as defined in this policy (00140-00147).

- These services may be provided in a hospital, outpatient, ASC or in an office setting.

- Qualified anesthesia personnel who provide the complete ocular anesthesia service cannot bill separately for the block for the same ophthalmological procedure. If both procedures are billed, only the MAC service will be allowed.

- If anesthesia services are billed by a physician, the following modifiers must also be billed:

AA - Anesthesia services performed personally by the anesthesiologist,

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals,

AD - Medical direction by a physician; more than four concurrent procedures,

QS - Monitored Anesthesia Care (MAC) service.

In situations where the CRNA and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the following modifier may be used:

QY - Single medically directed service by anesthesiologist.

If anesthesia services are billed by a CRNA the following modifiers must also be billed:

QX - CRNA service with medical direction by a physician,

QS - Monitored Anesthesia Care (MAC) service (if MAC was performed).

In addition, the following modifiers may be used to describe the patient's status if general anesthesia or MAC is administered:

P1 - A normal healthy patient.

P2 - A patient with mild systemic disease.

P3 - A patient with severe systemic disease.

P4 - A patient with severe systemic disease that is a constant threat to life.

MAC will always have 2 different modifiers when billed. For example, if an anesthesia code is billed with a QS modifier indicating MAC, it should also be billed with a modifier AA if the anesthesia was performed personally by the anesthesiologist.

Other Comments

A CRNA can provide anesthesia service for ocular procedures under the medical direction of an anesthesiologist.

This policy does not express the sole opinion of the carrier. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from the Florida Society of Anesthesiology and the Florida Society of Ophthalmology.

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17304: MOHS' Micrographic Surgery (MMS)

MMS is the removal of the tumor followed by marking of margins, immediate frozen section histopathologic examination of margins with subsequent reexcission of tumor-positive areas, and final closure of the defect.

MMS is a precise tissue-sparing surgical technique used in the removal and treatment of selected malignant neoplasms of the skin. This surgery requires a single surgeon to act in two distinct roles: surgeon and pathologist.

HCPCS Codes

17304 - Chemosurgery (Mohs' micrographic technique), including removal of all gross tumor, surgical excision of tissue specimen, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation; first stage, fresh tissue technique, up to 5 specimens

17305 - second stage, fixed or fresh tissue, up to 5 specimens

17306 - third stage, fixed or fresh tissue, up to 5 specimens

17307 - additional stage(s), up to 5 specimens, each stage

17310 - more than 5 specimens, fixed or fresh tissue, any stage

HCFA'S National Policy

Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Indications And Limitations Of Coverage And/or Medical Necessity

Medicare will consider reimbursement for Mohs' Micrographic Surgery for accepted diagnoses and indications. The current accepted diagnoses and indications are listed in this policy. The physician performing the Mohs' Micrographic Surgery must be trained and highly skilled in MMS technique and pathology identification. The physician must document in the patient's medical record that the diagnosis is appropriate for MMS and that MMS is the most appropriate choice for the treatment of the particular lesion.

No payment will be allowed for the biopsy and pathology of a lesion which requires removal by the Mohs' technique if a biopsy of that lesion has been performed within 60 days prior to Mohs' surgery, unless, if a biopsy has been performed within that period, the clinical record clearly shows the results were unable to be obtained by the Mohs' surgeon using reasonable effort.

Current accepted diagnoses and indications for Mohs' Micrographic Surgery are:

- Basal Cell Carcinomas, Squamous Cell Carcinomas, or Basalosquamous Cell Carcinomas in anatomic locations where they are prone to recur:

    - Central facial areas, nose, and temple areas of the face (the so-called"mask area" of the face) which includes the

eyebrows, and periorbital areas, the superlateral temple areas, and the periauricular and postauricular areas

- Lips, cutaneous and vermillion
- Eyelids
- Auricular helix and canal
- The external ear and ear canal.

- Other skin lesions:

1. Angiosarcoma of the skin

2. Keratoacanthoma, recurrent

3. Dermatofibrosarcoma protuberans

4. Malignant fibrous histiocytoma

5. Sebaceous gland carcinoma

6. Microcystic adnexal carcinoma

7. Extramammary Paget's disease

8. Bowenoid papulosis

9. Merkel cell carcinoma

10. Bowen's Disease (squamous cell carcinoma in situ)

11. Adenoid type of squamous cell carcinoma

12. Rapid growth in a squamous cell carcinoma

13. Longstanding duration of a squamous cell carcinoma

14. Verrucous Carcinoma

15. Atypical Fibroxanthoma

16. Leiomyosarcoma or other spindle cell neoplasms of the skin

17. Adenocystic Carcinoma of the skin

18. Erythroplasia of Queryrat

19. Oral and Central facial, paranasal sinus neoplasm

20. Apocrine Carcinoma of the skin

21. Malignant melanoma (facial, auricular, genital, and digital) when anatomical or technical difficulties do not allow conventional excision with appropriate margins

22. Basal Cell Carcinomas, Squamous Cell Carcinomas, or Basalosquamous Carcinomas that have one or more of the following features:

- Recurrent
- Aggressive pathology in the hands or feet, genitalia, nail unit/periungual
- Large size (2.0 cm or greater)

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- Positive margins on recent excision

- Poorly defined borders
- In the very young (40 yr. age)
- Radiation-induced
- In patients with proven difficulty with skin cancers or who are immunocompromised
- Basal Cell Nevus Syndrome
- In an old scar (e.g. a Marjolin's ulcer)
- Associated with xeroderma pigmentosum
- Perineural invasion on biopsy, and/or
- Deeply infiltrating lesion or difficulty estimating depth of lesion
- Laryngeal Carcinoma

Medicare will closely monitor the appropriate billing of the MMS procedure codes through its normal medical review activities. Failure to properly document may result in the denial of claims(s).

ICD-9 Codes That Support Medical Necessity
160.0
160.2
160.4
161.0
161.1
161.2
161.3
161.8
161.9
173.0
173.1
173.2
173.3
*173.8

*If Mohs' Micrographic Surgery is being submitted for one of the skin diagnoses listed under "Other Skin Lesions", the claim must be submitted with diagnosis code 173.8 (malignant neoplasm, other specified site of skin).

Reasons For Denial

- Claims may be denied when the above "Indications and Limitation" criteria are not met.

- Claims will be denied when Medicare determines that the services were not medically reasonable and necessary, or that services were determined to fall under one of the Medicare "Exclusions", i.e. cosmetic surgery.

Noncovered ICD-9 Codes

Any other diagnosis code or condition that is not specified in the section "ICD-9 Codes That Support Medical Necessity" of this policy.

Coding Guidelines

If Mohs' Micrographic Surgery is being submitted for one of the skin diagnoses listed under "Other Skin Lesions," the claim must be submitted with diagnosis code 173.8 (malignant neoplasm, other specified site of skin). Documentation referencing the number of designation of the appropriate lesion in the "Other Skin Lesions" and supporting medical necessity of the procedure must be available if requested by Medicare.

Medicare is aware that a biopsy is necessary in order for the physician to determine the exact nature of the lesion(s) to be removed. Occasionally, that biopsy may need to be done on the same day that the Mohs' surgery is performed. In order to allow separate payment for a biopsy and pathology on the same day as MMS, the -59 modifier is appropriate. The -59 modifier is only to be used when there has not been a biopsy of the lesion for which Mohs' surgery is performed, within 60 days of the Mohs' surgery or when the Mohs' surgeon cannot obtain a pathology report, with reasonable effort, from the referring physician or when the biopsy is performed on a lesion that is not associated with the Mohs' surgery.

Report the -59 modifier on the same detail line as the biopsy procedure code and one of the pathology procedure codes: 88304, 88305, 88307, 88331, or 88332.

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

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

88307 - Level V - Surgical pathology, gross and microscopic examination

88331 - Pathology consultation during surgery; with frozen section(s), single specimen

88332 - Pathology consultation during surgery; each additional tissue block with frozen section(s)

Do not report the -59 modifier on the same detail line as the Mohs' surgical procedure.

Some tumors may require more than three Mohs' micrographic surgical stages for complete removal of tumor. The appropriate code to submit for each additional stage is 17307.

If more than 5 specimens are obtained during any stage, then procedure code 17310 should be billed for each additional specimen in addition to the appropriate stage code.

Diagnosis(es) must be present on any claim submitted, and must be coded to the highest level of specificity.

Documentation Requirements

The surgeon's documentation in the patient's medical record should be legible and support the medical necessity of this procedure. The operative notes and pathology documentation in the patient's medical record should clearly show that Mohs' micrographic surgery was performed using accepted Mohs' technique, in which the physician acts in two integrated and distinct capacities: surgeon and pathologist (i.e., the medical records should demonstrate that true Mohs' surgery was performed).

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If the -59 modifier was used with a skin biopsy/pathology code on the same day the Mohs' surgery was performed, the physician's documentation should clearly indicate:

- that the biopsy was performed on a lesion other than the lesion that the Mohs' surgery was performed upon; or

- that if the biopsy is of the same lesion that the Mohs' surgery was performed upon, a biopsy of that lesion had not been done within the previous 60 days; or

- if a recent (within 60 days) biopsy of the same lesion that Mohs' surgery was performed on had been done, the results of that biopsy were unobtainable by the Mohs' surgeon using reasonable effort.

If diagnosis code 173.8 is used, the specific type of lesion that was removed should be clearly documented in the progress notes.

Other Comments

This policy was developed to define Mohs' surgery and the indications for which Medicare will reimburse for this procedure. It also identifies, pathology codes which are generally billed with MMS.

Advance Notice Requirements

Applies to diagnosis requirements (see page 4).

This policy does not express the sole opinion of the Carrier Medical Director, the Carrier Advisory Committee or any individual providing input. The Carrier Medical Director has received extensive input from the staff, the Carrier Advisory committee and other medical authorities prior to approving this policy.

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61855: Coverage of Deep Brain Stimulation

Deep Brain Stimulation (DBS) is a neurological procedure where electrical stimulation of deep brain structures take place. Certain regions within the thalamus or the basal ganglia are the usual subcortical structures that are currently the therapeutic targets for DBS. Although DBS may be helpful in many clinical situations, this policy addresses DBS of the Ventral Intermediate Nucleus (VIM) of the thalamus for intractable tremors of Parkinson's Disease and Essential Tremor.

The Medtronic Activa Tremor Control System is a device that stimulates targeted cells in the brain's thalamus via electrodes that are surgically implanted in the brain and connected to a pulse generator implanted near the collarbone. This device uses mild electrical stimulation to block brain signals that cause tremor. The electrical stimulation can be non-invasively adjusted to meet each patient's need. In addition, the patient can turn the device on and off by placing a small magnet over the generator site. Prior to implantation of the device, a test simulation is performed. If the patient's tremor is suppressed during the test simulation, the Activa system is implanted.

The Activa System consists of three implantable components and two external components. The DBS lead electrode, Itrel II pulse generator (IPG), and the extension wire are the implanted components. The external components of the system include a console programmer and the patient's hand-held magnet.

On July 31, 1997, the Activa System (Medtronics) was FDA approved to provide unilateral thalamic stimulation for the following condition:

- suppression of tremor in the upper extremity in patients who are diagnosed with essential tremor or Parkinsonian tremor not adequately controlled by medications and where the tremor constitutes a significant functional disability.

Medicare will consider this service medically necessary if performed for the above indication. It is expected that the patients have been on an appropriate anti-Parkinson or anti-tremor medication regimen. In addition, a significant functional disability is defined as the patient's inability or severe difficulty in performing activities such as using utensils, feeding self, dressing, writing, and many other activities of daily living. The functional disability must have occurred as a direct result of the tremor.

The patient should not have other independent diagnoses that could explain the failure to respond to medical treatment.

In order to bill for this service, one or more of the following procedure codes should be billed:

61855 - Twist drill of burr hole(s) for implantation of neurostimulator electrodes; subcortical

61880 - Revision or removal of intracranial neurostimulator electrodes

61885 - Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling

61888 - Revision or removal of cranial neurostimulator pulse generator or receiver

63690 - Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); without reprogramming of pulse generator

63691 - Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); with reprogramming of pulse generator.

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64999 - Unlisted procedure, nervous system

When DBS is performed the diagnosis 332.0 - Paralysis agitans (Parkinsonian tremor) or 333.1- Essential and other specified forms of tremor (Essential tremor) should be billed.

Reasons for Denial

- Deep Brain Stimulation for tremors caused by conditions other than those associated with Parkinson's Disease or Essential Tremor. These include tremors due to: trauma, Multiple Sclerosis, degenerative disorders, metabolic, infectious diseases and drug induced movement disorders.

- The patient is suffering from advanced dementia.

- Upper extremity motor function is not sufficient prior to implant; therefore, no functional improvement postoperatively would be expected.

- The patient has had previous thalamotomy on the side of the proposed VIM DBS.

- The patient has in place other operating pacemakers.

- The implantation of simultaneous bilateral DBS of the VIM thalamus.

Coding Guidelines

The computer assisted stereotactic guidance that is performed as part of this procedure should be billed utilizing procedure code 64999. The applicable ICD-9 code (332.0 or 333.1) should be submitted with the unlisted code and any other CPT code performed.

If the procedure is unsuccessful, e.g., incomplete localization, failure to respond during test simulation, or termination for other reasons, only procedure code 61855 should be submitted.

It is expected that procedure code 63690 or 63691 would be submitted periodically to evaluate the status of the generator system.

Documentation Requirements

The medical records must include the following information:

- patient's history and a complete neurological examination to exclude CNS disorders other than Parkinsonian tremor and/or Essential Tremor;

- medications the patient is currently taking for the tremors;

- indication that the medication is not adequate in controlling the tremors;

- description of the functional limitation(s) that are directly related to the tremors;

- description of the surgical procedure.

This information is normally found in the office/progress notes, history and physical, and/or the operative note.

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86812-86822: Histocompatibility Testing

Histocompatibility testing involves the matching or typing of the human leucocyte antigen (HLA) and is a covered service of the Medicare program in specific instances.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider this test medically reasonable and necessary when performed on patients:

- in preparation of a kidney transplantation
- in preparation of a bone marrow transplantation
- in preparation of blood platelet transfusions (particularly where multiple infusions are involved).
- who are suspected of having ankylosing spondylitis

Ankylosing spondylitis is a chronic inflammatory disease of the joints of the axial skeleton, manifested clinically by pain and progressive stiffening of the spine. The age at onset is usually in the late teens or early 20s. The incidence is greater in males than in females, and symptoms are more prominent in men, with ascending involvement of the spine more likely to occur.

Before consideration of coverage can be made for the diagnosis of ankylosing spondylitis (ICD-9 code 720.0), documentation must verify and support that other diagnostic methods would not be appropriate or have yielded inconclusive results. Histocompatibility testing is not indicated as a screening or routine diagnostic test for this diagnosis because the HLA-B27 antigen occurs in the normal population as well in ankylosing spondylitis.

The patient's symptoms and the history and physical examination generally provide the most important clues for diagnosing ankylosing spondylitis. The diagnosis of ankylosing spondylitis is generally characterized by the following:

- Chronic low back pain that awakens the patient at night

- Other features such as pain lasting longer than 3 months, morning stiffness, improvement of pain with exercise, and pain radiating to the buttocks

- Progressive limitation of back motion and of chest expansion

- Positive Mennell's sign which detects pain in the sacroiliac joint with hyperextension

- Positive Shober test which detects limitation in flexion of the lumbar spine

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- Positive Occiput-to-Wall test which detects decreases in cervical extension

- Transient or permanent peripheral arthritis

- Uveitis in 20-25% of patients

- Diagnostic x-ray showing changes in sacroiliac (S-I) joints. Early in the course of the disease, the S-I joints may appear widened and irregular with adjacent increased density. Later, the S-I joints may be fused partially or completely.

- Additional x-ray findings may include periosteal new bone formation on the iliac crest, ischial tuberosities and calcanei, and alterations of the pubic symphysis and sternomanubrial joint.

- Accelerated erythrocyte sedimentation rate

- Negative serologic tests for rheumatoid factor

Reasons for Denial

Histocompatibility testing performed for conditions other than those listed as covered in this policy will be denied as not medically necessary.

Documentation Requirements

Medical record documentation (i.e., office/progress notes, history and physical, test results) maintained by the ordering/referring physician must clearly document the medical necessity of histocompatibility testing.

When submitting a claim with the diagnosis of ankylosing spondylitis (720.0), documentation is required from the physician that must verify and support that other methods of testing would not be appropriate to confirm this diagnosis or give the type of any prior testing and the results.

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94799: Pulmonary Rehabilitation Services

Pulmonary Rehabilitation is a designed program, incorporating various services delivered by a multidisciplinary team

specifically trained in pulmonary medicine and pulmonary rehabilitation techniques. The purpose of Pulmonary Rehabilitation is to:

1. Reduce and control the symptoms and pathophysiological complications experienced by patients with debilitating pulmonary disease, and

2. Teach the patient how to achieve optimal capability for carrying out his/her activities of daily living (ADLs).

The services provided under the program umbrella of Pulmonary Rehabilitation include:

Supervised/monitored therapeutic exercise - for the purpose of initiating an individualized exercise regime and training the patient in safe exercise techniques which will increase the patient's functional independence in his/her ADLs. These therapeutic exercises must require the presence of and skills of a qualified therapist.

The exercise sessions typically include a bicycle ergometer, treadmill, or upper body exercise and education regarding energy conservation techniques, compensatory techniques, etc. to be used during exercise.

While it is expected that the exercise sessions will be supervised and run by appropriately trained staff, physiological parameters such as respiratory rate, heart rate, blood pressure and pulse oximetry need only be monitored during the Pulmonary Rehabilitation exercise sessions when medically indicated.

Breathing retraining - for the purpose of teaching the patient methods of relieving and controlling dyspnea and improving ventilatory function at rest and during activity.

Patient education - for the purpose of providing the patient with knowledge of his/her pulmonary disease, so that he/she may actively participate in the disease management process. This education includes, but is not limited to, knowledge of the diagnosed pulmonary disease, individualized protocols for home care (e.g., medications, exercise, relaxation techniques, or use of oxygen) and indicators for the need to seek additional medical care.

Education may be rendered in a group setting, however the content of the education material must be individualized to the patient's specific needs, reasonable and necessary for the treatment and effective management of the patient's illness, and must not exceed the patient's needs.

The purpose of this policy is to define the services encompassed by the term "Pulmonary Rehabilitation" and to define when this service will be considered medically necessary and reasonable.

Indications and Limitations of Coverage and/or Medical Necessity

Therapeutic exercise, breathing retraining and patient education in and of themselves do not constitute "Pulmonary Rehabilitation services" for the purpose of reimbursement by BCBSF Medicare. All three of these service components must be rendered to the patient at some time during the course of treatment for their pulmonary condition for the services to be considered "Pulmonary Rehabilitation".

Pulmonary Rehabilitation, containing all 3 major service components (supervised/monitored therapeutic exercise, breathing retraining, and patient education), is covered when:

1. The patient meets the appropriate criteria, and

2. The services are generally rendered within medically accepted clinical guidelines.

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Patient Medical Necessity Criteria

Pulmonary Rehabilitation services will be considered medically reasonable and necessary when the patient:

- Is under the care of a physician;

- Has undergone pulmonary function testing (i.e., spirometry 94010 or 94060) within the past year, which documents moderate to moderately severe obstructive or restrictive pulmonary disease (FEV 1 and/or FVC 80% of predicted);

- Has undergone simple pulmonary stress testing (i.e., six minute walk test), prior to admission or during the admission evaluation, that identifies the potential for rehabilitation through assessment of oxygen status at rest and during exercise. It is realized that for some patients (i.e., paraplegics), this test is inappropriate. It is expected that an appropriate aerobic alternative be utilized in these situations;

- Displays significant respiratory symptoms (e.g., dyspnea at rest and/or while performing ADLs) and remains symptomatic despite optimal medical management;

- Is medically stable and not limited by another serious or unstable medical condition;

- Exhibits limited functional status (dependence versus independence) in relation to performance of ADLs;

- Demonstrates an appropriate level of cognition, since an integral part of the Pulmonary Rehabilitation services involves comprehension and retention of new learning;

- Demonstrates ability to perform lower or upper extremity exercise;

- Demonstrates a high level of motivation to participate in his/her plan of care.

Pulmonary rehabilitation programs being carried out in the physician's office, and billed to the Medicare Part B Program under the physician's provider number, must be either:

A) personally performed by the physician, or

B) performed by the physician's employees under the "incident to" provision.

Please refer to the March/April 1997 Medicare B Update! for the "incident to" guidelines.

Clinical Guidelines

It is expected that each patient will undergo an evaluation/assessment performed by the treating physician prior to referral and admission to the Pulmonary Rehabilitation program which establishes that the patient has a medical need for Pulmonary Rehabilitation services and rehabilitation potential.

Additionally, an evaluation/assessment must be performed by a physician and/or other qualified staff members upon admission to the Pulmonary Rehabilitation program to ensure that the patient meets medical necessity criteria and to establish the treatment plan. The evaluation/assessment must be reviewed and signed by a physician.

Pulmonary Rehabilitation services must be rendered under a written plan of care/treatment plan. This plan must:

- Be consistent with the nature and severity of the individual's symptoms and diagnosis and tailored to meet his/her specific needs;

- Be reasonable in terms of the modality, amount, frequency, and duration of the treatment;

Include services which are generally accepted by the professional community as safe and effective treatment for the purpose used;

- Be developed upon admission and establish specific individualized objective, measurable, functional goals and how the goals will be met; and

- Be signed by a physician.

Continuous patient observation by qualified staff during the Pulmonary Rehabilitation exercise sessions is expected, as well as periodic "spot checks" of physiological parameters such as respiratory rate, heart rate, blood pressure, and pulse oximetry.

Each Pulmonary Rehabilitation session is documented and reflects the treatment provided and the patient's progress toward his/her goals.

Periodic reevaluation by the physician directing the Pulmonary Rehabilitation program is carried out and documented to determine the patient's progress toward goals in relation to the start of care, any necessary revisions to the individualized treatment or goals as indicated by the patient's response, as well as any necessary revisions to the discharge plan.

It is not generally expected that Pulmonary Rehabilitation services will exceed 12 weeks. Individual cases of course may require a longer or shorter course of Pulmonary Rehabilitation. Services which exceed the frequency or duration indicated by the accepted standards of medical practice are not covered unless there are special circumstances which justify additional sessions. Please ensure that the medical documentation supports the need for services rendered in excess of these clinical guidelines.

Pulmonary Rehabilitation services are anticipated to generally occur once in a lifetime. It is recognized that some patients, because of an exacerbation or new complications (e.g., disease worsening, beginning use of supplemental oxygen, chronic hypercapnea, respiratory failure, use of oxygen at night or with non-invasive ventilation, etc.) could benefit from additional participation in Pulmonary Rehabilitation. A limited number of additional Pulmonary Rehabilitation sessions may be considered medically necessary following a re-assessment of the patient. Medical record documentation must support the need for the additional Pulmonary Rehabilitation sessions.

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HCPCS Codes

94799

ICD-9 Codes That Support Medical Necessity

135 277.0 491.0-491.9 492.0-492.8 493.0-493.9 494
495 496 500 501 502 503 504 505 506.4
508.1 508.8 508.9 515 516.0-516.9 517.8 518.2

518.3 518.6 518.81 518.89 519.0-519.9 714.81 737.30 737.34 V42.6

Reasons for Denial

A Pulmonary Rehabilitation service will be denied when the following circumstances occur:

- The service does not meet all of the conditions for coverage referred to in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

- The beneficiary has a severe psychiatric disturbance (i.e., dementia, organic brain syndrome) which would not allow him/her to comprehend and retain new learning.

- The beneficiary has an unstable medical condition.

- The documentation indicates that the patient is receiving "maintenance" care (e.g., the patient has not demonstrated progress toward achieving stated goals in a reasonable and predictable amount of time, the patient is at the same level week after week, the patient is making progress in a sawtooth pattern where gains are seen only while the patient is with the clinician but is unable to sustain these gains between sessions, or the patient is at a stable chronic baseline condition).

- The documentation indicates the patient has attained his/her pulmonary rehabilitation treatment goals and the skills of the therapist(s) are no longer required.

- The documentation indicates that the level of complexity and sophistication of the activity do not require the skills of a qualified clinician.

- The documentation indicates a duplication of services (e.g., an overlap of physical and occupational therapies).

- Pulmonary Rehabilitation services performed in conjunction with Lung Volume Reduction Surgery (LVRS) are noncovered under this policy. LVRS is currently considered investigational. It and the associated services are covered only under special study arrangements in approved centers.

Coding Guidelines

Pulmonary function testing (i.e., spirometry 94010 or 94060) and other diagnostic testing must be completed prior to admission and may not be billed as part of the Pulmonary Rehabilitation program, unless such testing becomes medically necessary during the course of the program. The medical need for such testing must be supported by the medical record documentation.

The periodic or continuous monitoring of the patient's physiological parameters during the exercise session is an

integral part of the exercise session and is not line item billable.

Documentation Requirements

The following documentation must be maintained in the patient's medical record:

- A physician order or referral for the Pulmonary Rehabilitation services written by the treating physician (who has evaluated the patient and determined that a medical need and rehabilitation potential exists).

- A copy of the evaluation /assessment performed by the treating physician which establishes that the patient has a medical need for Pulmonary Rehabilitation services and rehabilitation potential.

- An evaluation /assessment of the patient performed by a physician and/or other qualified staff members upon admission to ensure the patient meets medical necessity criteria and to set up a treatment plan signed by the physician. The assessment must include the treatment diagnosis with onset/exacerbation date, secondary diagnosis, past medical history, prior functional level (as it relates to performance of ADLs), psychosocial status, dietary status, rehabilitation potential, and current status (e.g., hard copy results of pulmonary function tests (i.e., spirometry 94010 or 94060) performed within the past year, hard copy results of six minute walk test (oximetry), medications, oxygen therapy, exercise endurance, functional level and assistance required, coughing/sputum production, breathing pattern, etc.).

- An individualized treatment plan which contains an individualized problem list, the specific procedure or activity to be done and the responsible discipline, the frequency and duration of the service (s), individualized treatment goals (which are objective, measurable, and functional) and a discharge plan. The treatment plan written by the therapist must be signed and dated by the referring or attending physician (only handwritten signatures are allowed-NO STAMPED SIGNATURES!!!). Any change to the plan of care must be signed by the physician.

- Daily documentation (progress note) which reflects the individualized activity, instruction given, the patient's response to the skilled service, and the patient's progress toward stated goals. The daily note must be signed and dated by the qualified Pulmonary Rehabilitation team member who rendered the service.

- Periodic physician notes that reflect the individual patient's goals and progress.

- Discharge summary indicating the changes since the start of care, goals accomplished, the reason why goals were not achieved (if applicable), and the discharge plan.

99183: Hyperbaric Oxygen Therapy

As part of the Carrier's process of reviewing current Local Medical Review Policies, HBO has been revised to further define Medicare's national coverage indications as listed in Coverage Issues Manual Section 35-10. This policy revision also communicates the required documentation needed in the event of a medical records request.

Hyperbaric Oxygen Therapy is a medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O2) at greater than one atmosphere (atm) pressure. Either a monoplace chamber pressurized with pure O2 or a larger multiplace chamber pressurized with compressed air where the patient receives pure O2 by mask, head tent, or endotracheal tube may be used.

The physician must be personally in attendance at the hyperbaric chamber when the patient is receiving hyperbaric oxygen therapy. This is a professional activity that cannot be delegated in that it requires independent medical judgement by the physician. The physician must be present, carefully monitoring the patient during the hyperbaric oxygen session and be immediately available should a complication occur.

HBO is covered by Medicare Part B for the following conditions:

1. Acute carbon monoxide intoxication induces hypoxic stress. The cardiac and central nervous systems are the most susceptible to injury from carbon monoxide. The administration of supplemental oxygen is essential treatment. Hyperbaric oxygen causes a higher rate of dissociation of carbon monoxide from hemoglobin than can occur breathing pure air at sea level pressure. The chamber compressions should be between 2.5 and 3.0 atm abs. It is not uncommon in patients with persistent neurological dysfunction to require subsequent treatments within six to eight hours, continuing once or twice daily until there is no further improvement in cognitive functioning.

2. Decompression illness arises from the formation of gas bubbles in tissue or blood in volumes sufficient enough to interfere with the function of an organ or to cause alteration in sensation. The cause of this enucleated gas is rapid decompression during ascent. The clinical manifestations range from skin eruptions to shock and death. The circulating gas emboli may be heard with a doppler device. Treatment of choice for decompression illness is HBO with mixed gases. The result is immediate reduction in the volume of bubbles. The treatment prescription is highly variable and case specific. The depths could range between 60 to 165 feet of sea water for durations of

1.5 to over 14 hours. The patient may or may not require repeat dives.

3. Gas embolism occurs when gases enter the venous or arterial vasculature embolizing in a large enough volume to compromise the function of an organ or body part. This occlusive process results in ischemia to the affected areas. Air emboli may occur as a result of surgical procedures (e. g., cardiovascular surgery, intra-aortic balloons, arthroplasties, or endoscopies), use of monitoring devices (e.g., Swan-Ganz introducer, infusion pumps), in nonsurgical patients (e.g., diving, ruptured lung in respirator-dependent patient, injection of fluids into tissue space), or traumatic injuries (e.g., gunshot wounds, penetrating chest injuries). Hyperbaric oxygen therapy is the treatment of choice. It is most effective when initiated early. Therapy is directed toward reducing the volume of gas bubbles and increasing the diffusion gradient of the embolized gas. Treatment modalities range from high pressure to low pressure mixed gas dives.

4. Gas gangrene is an infection caused by the clostridium bacillus, the most common being clostridium perfringens. Clostridial myositis and myonecrosis (gas gangrene) is an acute, rapidly growing invasive infection of the muscle. It is characterized by profound toxemia, extensive edema, massive death of tissue and variable degree of gas production. The most prevalent toxin is the alpha-toxin which in itself is hemolytic, tissue-necrotizing and lethal. The diagnosis of gas gangrene is based on clinical data supported by a positive gram-stained smear obtained from tissue fluids. X-ray radiographs, if obtained, can visualize tissue gas.

The onset of gangrene can occur one to six hours after injury and presents with severe and sudden pain at the infected area. The skin overlying the wound progresses from shiny and tense, to dusky, then bronze in color. The infection can progress as rapidly as six inches per hour. Hemorrhagic vesicles may be noted. A thin, sweet-odored exudate is present. Swelling and edema occur. The noncontractile muscles progress to dark red to black in color.

The acute problem in gas gangrene is to stop the rapidly advancing infection caused by alpha-toxin. Medical treatment is aimed at stopping the production of alpha-toxin and to continue treatment until the advancement of the disease process has been arrested. The goal of HBO therapy is to stop alpha-toxin production thereby inhibiting further bacterial growth at which point the body can use its own host defense mechanisms. HBO treatment starts as soon as the clinical picture presents and is supported by a positive gram-stained smear. A treatment approach utilizing HBO is adjunct to antibiotic therapy and surgery. Initial surgery may be limited to opening the wound. Debridement of necrotic tissue can be performed between HBO treatments when clear demarcation between dead and viable tissue is evident. The usual treatment consists of oxygen administered at 3.0 atm abs pressure for 90 minutes three times in the first 24 hours. Over

the next four to five days, treatment sessions twice a day are usual. The sooner HBO treatment is initiated, the better the outcome in terms of life, limb and tissue saving.

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5. Crush injuries and suturing of severed limbs, acute traumatic peripheral ischemia (ATI), and acute peripheral arterial insufficiency: Acute traumatic ischemia is the result of injury by external force or violence compromising circulation to an extremity. The extremity is then at risk for necrosis or amputation. Secondary complications are frequently seen: infection, non-healing wounds, and non-united fractures.

The goal of HBO therapy is to enhance oxygen at the tissue level to support viability. When tissue oxygen tensions fall below 30mmHg., the body's ability to respond to infection and wound repair is compromised. Using HBO at 2-2.4 atm, the tissue oxygen tension is raised to a level such that the body's responses can become functional again. The benefits of HBO for this indication are enhanced tissue oxygenation, edema reduction and increased oxygen delivery per unit of blood flow thereby reducing the complication rates for infection, nonunion and amputation.

The usual treatment schedule is three 1.5 hour treatment periods daily for the first 48 hours. Additionally, two 1.5 hour treatment sessions daily for the next 48 hours may be required. On the fifth and sixth days of treatment, one 1.5 hour session would typically be utilized. At this point in treatment, outcomes of restored perfusion, edema reduction and either demarcation or recovery would be sufficient to guide discontinuing further treatments.

For acute traumatic peripheral ischemic, crush injuries and suturing of severed limbs, Hyperbaric Oxygen Therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened. Arterial insufficiency ulcers may be treated by HBO therapy if they are persistent after reconstructive surgery has restored large vessel function.

6. The principal treatment for progressive necrotizing infections (necrotizing fasciitis, meleney ulcer) is surgical debridement and systemic antibiotics. HBO is recommended as an adjunct only in those settings where mortality and morbidity are expected to be high despite aggressive standard treatment. One of the necrotizing infections, Meleney's ulcer, is a polymicrobial (mixed aerobic-anaerobic organisms) ulcer which slowly progresses affecting the total thickness of the skin. Also called a bacterial synergistic gangrene, the Meleney ulcer is associated with the formation of burrowing cutaneous fissures and sinus tracts that emerge at distant skin sites. This ulcer presents as a wide area of pale red cellulitis that subsequently ulcerates and gradually enlarges to form a large ulcerative plaque,

typically with a central area of granulation tissue encircled by gangrenous or necrotic tissue.

Another type of progression necrotizing infection is necrotizing fasciitis. This condition is a relatively rare infection. It is usually a result of a group A streptococcal infection beginning with severe or extensive cellulitis that spreads to involve the superficial and deep fascia, producing thrombosis of the subcutaneous vessels and gangrene of the underlying tissues. A cutaneous lesion usually serves as a portal of entry for the infection, but sometimes no such lesion is found.

7. Preparation and preservation of compromised skin grafts utilizes HBO for graft or flap salvage in cases where hypoxia or decreased perfusion have compromised viability. HBO enhances flap survival. Treatments are given at a pressure of 2.0 to 2.5 atm abs lasting from 90-120 minutes. It is not unusual to receive treatments twice a day. When the graft or flap appears stable, treatments are reduced to daily. Should a graft or flap fail, HBO may be used to prepare the already compromised recipient site for a new graft or flap. It does not apply to the initial preparation of the body site for a graft. HBO therapy is not necessary for normal, uncompromised skin grafts or flaps.

8. Chronic refractory osteomyelitis persists or recurs following appropriate interventions. These interventions include the use of antibiotics, aspiration of the abcess, immobilization of the affected extremity, and surgery. The Undersea and Hyperbaric Medical Society have defined "chronic" as existing six months or more. HBO is an adjunctive therapy used with the appropriate antibiotics. Antibiotics are chosen on the basis of bone culture and sensitivity studies. HBO can elevate the oxygen tensions found in infected bone to normal or above normal levels. This mechanism enhances healing and the body's antimicrobial defenses. It is believed that HBO augments the efficacy of certain antibiotics (gentamicin, tobramycin, and amikacin). Finally, the body's osteoclast function of removing necrotic bone is dependent on a proper oxygen tension environment. HBO provides this environment. HBO treatments are delivered at a pressure of 2.0 to 2.5 atm abs for a duration of 90-120 minutes. It is not unusual to receive daily treatments following major debridement surgery. The number of treatments required vary on an individual basis. Medicare Part B can cover the use of HBO for chronic refractory osteomylitis that has been demonstrated to be unresponsive to conventional medical and surgical management.

9. HBO's use in the treatment of osteoradionecrosis and soft tissue radionecrosis is one part of an overall plan of care. Also included in this plan of care are debridement or resection of nonviable tissues in conjunction with antibiotic therapy. Soft tissue flap reconstruction and bone grafting may also be indicated. HBO treatment can be indicated both preoperatively and postoperatively.

The patients who suffer from soft tissue damage or bone necrosis present with disabling, progressive, painful tissue breakdown. They may present with wound dehiscence, infection, tissue loss and graft or flap loss. The goal of HBO treatment is to increase the oxygen tension in both hypoxic bone and tissue to stimulate growth in functioning capillaries, fibroblastic proliferation and collagen synthesis. The recommended daily treatments last 90-120 minutes at 2.0 to 2.5 atm abs. The duration of HBO therapy is highly individualized.

10. Cyanide poisoning carries a high risk of mortality. Victims of smoke inhalation frequently suffer from both carbon monoxide and cyanide poisoning. The traditional antidote for cyanide poisoning is the infusion of sodium nitrite. This treatment canpotentially impair the oxygen carrying capacity of hemoglobin. Using HBO as an adjunct therapy adds the benefit of increased plasma dissolved oxygen. HBO's benefit for the pulmonary injury related to smoke inhalation remains experimental. The HBO treatment protocol is to administer oxygen at 2.5 to 3.0 atm abs for up to 120 minutes during the initial treatment. Most patients with combination cyanide and carbon monoxide poisoning will receive only one treatment.

11. Actinomycosis is a bacterial infection caused by Actinomyces israelii. Its symptoms include slow growing granulomas that later breakdown, discharging viscid pus containing minute yellowish granules. The treatment includes prolonged administration of antibiotics (penicillin and tetracycline). Surgical incision and draining of accessible lesions is also helpful. Only after the disease process has shown refractory to antibiotics and surgery, could HBO be covered by Medicare Part B.

HBO therapy should not be a replacement for other standard successful therapeutic measures; however, it is the treatment of choice and standard of care for decompression sickness and arterial gas embolism. Traumatic or spontaneous pneumothorax constitute contraindications to adjunctive HBO therapy only if untreated. Pregnancy is considered a contraindication to HBO except in the case of carbon monoxide poisoning where it is specifically indicated.

Prior to the initiation of HBO therapy, it is expected in most cases that the diagnosis will be established by the referring or treating physician.

Indications of effective treatment outcomes for HBO:

- There is improvement or healing of wounds.

- There is improvement of tissue perfusion.

- There is new epithelial tissue growth and granulation.

- Tissue PO2 of at least 30 mmHg of oxygen is necessary for oxidative function to occur.

- The mechanical reduction in the bubble size of air emboli alleviates decompression sickness and gas/ air emboli.

- Tissue PO2 of 40 or greater defines resolved hypoxia. The body can now resume host functions of wound healing and anti-microbial defenses without the need of HBO.

ICD-9 Codes That Support Medical Necessity:

039.0-039.9
040.0
444.21-444.22
526.89
686.01
728.86
730.11-730.19
733.41-733.49
903.01
904.0
904.41
909.2
927.00-927.09
927.10-927.11
927.20-927.21
927.8
927.9
928.00-928.01
928.10-928.11
928.20-928.21
928.8-928.9
958.0
986
987.7
989.0
990
993.3
993.9
996.52
996.90-996.99
999.1

Reasons for Denial

Services not medically reasonable and necessary.

Topical application of oxygen (Topox) does not meet the definition of HBO therapy. Also, its clinical efficacy has not been established; therefore, no reimbursement may be made.

HBO's benefit for the pulmonary injury related to smoke inhalation remains experimental.

No program payment may be made for HBO in the treatment of the following conditions (Per CIM 35-10):

- Cutaneous, decubitus (707.0), and stasis ulcers (454.0, 454.2)

- Chronic peripheral vascular insufficiency (443.0-443.9)

- Anaerobic septicemia and infection other than clostridial

- Skin burns (thermal)

- Senility (797)

- Myocardial infarction (410.00-412)

- Cardiogenic shock (785.51)

- Sickle cell crisis (282.62)

- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency

- Acute or chronic cerebral vascular insufficiency

- Hepatic necrosis (570)

- Aerobic septicemia

- Nonvascular causes of chronic brain syndrome (Pick's disease [331.1], Alzheimer's disease [331.0], Korsakoff's disease [294.0])

- Tetanus (037)

- Systemic aerobic infection

- Organ transplantation (V42.0-V42.9)

- Organ storage

- Pulmonary emphysema (492.8)

- Exceptional blood loss anemia (280.0, 285.1)

- Multiple sclerosis (340)

- Arthritic diseases

- Acute cerebral edema (348.5)

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Coding Guidelines

Evaluation and management services and/or procedures (e.g., wound debridement, transcutaneous PO2 determinations) provided in a hyperbaric oxygen treatment facility in conjunction with a hyperbaric oxygen therapy session may be reported separately.

This code reflects a per session descriptor, therefore, regardless of the time HBO therapy is performed (i.e., 1 hour, 2 hours) during each session, each unit billed equals one session.

For each of the fourteen covered conditions, the following diagnosis should be utilized:

1. Acute carbon monoxide intoxication - Diagnosis 986

2. Decompression illness - Diagnosis 993.3

3. Gas embolism - Diagnosis 958.0, 993.9, or 999.1

4. Gas gangrene - Diagnosis 040.0

5. Acute traumatic peripheral ischemia - Diagnosis 903.01, 904.0 or 904.41

6. Crush injuries and suturing of severed limbs - Diagnosis 927.00-927.09, 927.10-927.11, 927.20-927.21, 927.8, 927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.8-928.9, or 996.90-996.99

7. Progressive necrotizing infections: Meleney ulcer-Diagnosis 686.01, necrotizing fasciitis- Diagnosis 728.86

8. Acute peripheral arterial insufficiency - Diagnosis 733.41-733.49, 444.21, or 444.22

9. Preparation and preservation of compromised skin grafts - Diagnosis 996.52

10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management - Diagnosis 730.11-730.19

11. Osteoradionecrosis as an adjunct to conventional treatment - Diagnosis 526.89 or 909.2

12. Soft tissue radionecrosis as an adjunct to conventional treatment - Diagnosis 990

13. Cyanide poisoning - Diagnosis 987.7 or 989.0

14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment. - Diagnosis 039.0-039.9

Documentation Requirements

There must be medical documentation to support the condition for which HBO therapy is being given. Documentation for all services should be maintained on file, (e.g., progress notes and treatment record) to substantiate medical necessity for HBO treatment. This medical documentation must include:

1. An initial assessment which will include a medical history detailing the condition requiring HBO. The medical history should list prior treatments and their results including antibiotic therapy and surgical interventions. This assessment should also contain information about adjunctive treatment currently being rendered.

2. Physician progress notes.

3. Any communication between physicians detailing past or future (proposed) treatments.

4. Positive gram-stain smear is required to support the diagnosis of gas gangrene.

5. Culture reports are required to confirm the diagnosis of Meleney's ulcer.

6. Definitive radiographic evidence and bone culture with sensitivity studies are required to confirm the diagnosis of osteomylitis.

7. HBO treatment records describing the physical findings, the treatment rendered and the effect of the treatment upon the established goals for therapy.

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

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EMC Vendor, Billing Service and Clearinghouse List

The Provider Electronic Services Marketing department has released this year's updated listing, effective January 1, 1998. For those considering submitting electronic media claims as well as those currently sending, this listing gives you service, support and feature information about vendors, billing services and clearinghouses that are approved to submit Medicare Part B electronic media claims. The list is available in two different

sorts: alphabetically by city or by company name. Any requests for the listing, or additions or changes to the listing can be made by calling the PES Marketing department at: 904/791-8767. A complete list is also available via the Medicare B-Line (BBS).

*This listing should not be construed as a recommendation or sponsorship by Blue Cross Blue Shield of Florida, Medicare Part B of Florida, or the Medicare administration, for any of the organizations that appear on this listing. Specific services and financial arrangements must be made between Vendor/Service Bureau and Provider/Supplier. Medicare Part B will not be a party to any such arrangement. This listing is being provided to you solely for your convenience. This information is subject to change after the date of publication.

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Mailbox Migration Deadline

Effective in 1998, Electronic Data Interchange (EDI) will no longer support some Non-Job Entry Sub-systems (Non-JES). If you are currently using a Non-JES system to transmit your claims electronically, you may be required to move to the Mailbox system in 1998. As of January 1, 1998, we are strongly encouraging new customers to begin their transmissions by using the Mailbox system. This will prevent the additional work involved with moving to the Mailbox system should the changes become mandatory.

The Mailbox system offers superior tracking ability. This will enable us to give you faster and more efficient service. Whether you are required to move to the Mailbox system in 1998, or choose to move in order to have the advantages offered by the Mailbox system, we will be working with you to make the transition as easy as possible.

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Attention, MEDFACS Users: Migration to PC-ACE is Underway!

The time has finally come for you to migrate from the old MEDFACS program to the new and improved PC-ACE software! This is a necessity now because the way that you currently communicate with us, using a remote number, is being eliminated.

Mailbox is the formal name of our communication system which will completely replace the existing system by June 1998. MEDFACS does not use Mailbox to transmit claims and will not be upgraded to support this function.

To obtain the PC-ACE software, you will need to complete the New Installation for PC-ACE Software form. If you have old versions of the PC-ACE software but have not installed it, please discard them since a new version was distributed in January 1998. If you have questions about the conversion from MEDFACS to PC-ACE, please contact the PC-ACE Support line at (904)-355-0313.

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IN-HOUSE TRAINING FOR PC-ACE USERS

We now offer in-house training to those senders willing to make a trip to Jacksonville. The training session is FREE and lasts approximately four hours. The next session will be in June. Not only will you receive an overview of the PC-ACE product, but we can also address any questions/concerns that you have experienced in your office. If you are interested in attending our training session in June or future sessions, please let us know. You can fax (904-791-6692) the form provided below to the attention of our PC-ACE Support Team advising us of your desire to attend.

IN-HOUSE TRAINING

NUMBER OF ATTENDEES: _____

NAME(S):
_____

MEDICARE PART B (HCFA 1500): _____

MEDICARE PART A (UB92): _____

LEVEL OF KNOWLEDGE:
BEGINNER _____ ADVANCED _____

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Electronic Eligibility File for Beneficiaries

Electronic Eligibility is an automated mechanism for the EMC sender submitting claims using the National Standard format (NSF) or the American National Standard Institute (ANSI X12 837) format to obtain beneficiary eligibility information. As mandated by the Health Care Financing Administration (HCFA), Medicare Part B of Florida will provide beneficiary eligibility and deductible status information to providers/suppliers, provided the following criteria are met:

- The provider/supplier must be participating in the Medicare Program.

- Their claims must be submitted electronically using either the NSF or ANSI X12 837 format.

This is the information which will be provided to you:

- Beneficiary entitlement date and termination date (if applicable)

- Current and prior year deductible met (yes or no)

- HMO enrollment and termination date (if applicable)

- HMO name

- HMO code (cost or risk)

- In addition, the provider/supplier will be able to receive updated patient HICN information.

For more information on obtaining eligibility status for your office contact your SOFTWARE VENDOR or call the EMC Marketing department at (904) 791-8767.

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Top 10 Errors That Cause Claims to Reject

The EMC Marketing Department is working hard to keep the EMC error rate for rejected claims at or below 1.9 percent before the claims enter the Medicare Part B processing system. If your claims have been rejected this means that your claims are not in the Medicare Part B processing system.

Listed below are the TOP 10 errors that cause claims to reject. These reject errors accounted for 114,786 rejected claims for the month of January 1998. With your help, by ensuring that your claims do not have these errors, we can reduce these errors to a more manageable level.

When you receive an EMC error report, remember that the entire claim rejected, so the entire claim needs to be resubmitted electronically after corrections have been made.

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Error Report Message: INV HDR DIAG
NSF Record & Field: EAO - 30
Explanation: Refer to one of the two situations below:(1) Either no diagnosis was submitted or one of the diagnosis codes submitted was not valid. Verify the Diagnosis codes submitted by checking a current ICD-9 book or contact the Customer Service area at 904/634-4994.(2) The first Header Diagnosis code field was left blank yet diagnosis code(s) were transmitted in the second, third, or fourth diagnosis code fields. These codes must be transmitted in sequential field order.

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Error Report Message: INV HIC
NSF Record & Field: DA0 - 18
Explanation: The patient's Medicare number was either not submitted on this claim or, if submitted, wasn't in the proper format. A valid Medicare number = the first 9 digits are numeric, the tenth digit is alpha, and the eleventh/twelfth positions are blank or alpha/numeric. NOTE - Railroad claims should be sent

directly to MetraHealth in Augusta Ga (See Important Addresses in the Medicare Part B Update)

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Error Report Message: INV MODIFIER
NSF Record & Field: FA0 - 10, FA0 - 11, FA0 - 12, FA0 - 36
Explanation: These fields are used to submit modifiers when appropriate. The data entered was in an invalid format (contained special characters- decimal point, $$ sign, etc). It must be left blank or contain a valid modifier.

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Error Report Message: INV PHYS/SUPF
NSF Record & Field: A0 - 23
Explanation: The performing provider number was left blank or was not in the correct format. . Valid formats are ANNNN or NNNNN (A=alpha, N=numeric). A sixth digit can be added to NNNNN, but it must be alpha (NNNNNA or ANNNNA).

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Error Report Message: INV PROC
NSF Record & Field: FA0 - 09
Explanation: This field must contain a valid procedure code (HCPCS or CPT-IV codes of 5 characters in length) but was left blank or contained an invalid format (special characters- decimal point, $$ sign, etc). NOTE: Ensure Procedure Codes are valid for the Date of Service (1997's for 1997 dates of service and 1998's for 1998 dates of service).

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Error Report Message: INV PROV NBR
NSF Record & Field: NSF 1.04 - BA0 02.0, NSF 2.00 - BA0 09.0
Explanation: The number you have entered for the billing provider is not valid on Medicare B provider files. Please correct the billing provider number and retransmit. If you have any questions, please call 904-791-6878.

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Error Report Message: INV REND PROV
NSF Record & Field: FA0 - 23
Explanation: You have entered a PA group number in the individual performing provider field. To bill correctly, replace this number with the appropriate performing provider number. If you believe the provider number you have submitted is correct, call 904-634-4994 for validation.

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Error Report Message: MISS FAC ID#

NSF Record & Field: EA1 - 04
Explanation: This claim contains physician services in a place of service other than office or home (POS 11 or 12) which require that either the facility identification number (EA1-4) or the complete name and address (address, city, state, zip) of the facility where the services were rendered be included on the claim. The Fac ID number was not given and one of the name/address fields was left blank or contained special characters.

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Error Report Message: PROV # INCONS
NSF Record & Field: NSF 1.04 - BA0 02.0, NSF 2.00 - BA0 09.0
Explanation: The billing provider number submitted does not have an electronic data interchange agreement on file under this sender number. Check the billing provider number and, if submitted incorrectly, retransmit your claims. If you believe the provider number to be correct and you have submitted an EDI agreement to have this provider added to this sender number, call 904-791-6379 for validation.

.....
.....
Error Report Message: PROV NOT IN GROUP
NSF Record & Field: FA0 - 23
Explanation: You have entered a performing provider number that is not a member of the PA group billing for the service. Correct the performing provider number (and suffix if applicable) and retransmit your claims. If you believe the provider number(s) entered are correct, call 904-634-4994 for validation.
.....
.....

Hints to Prevent Your Claims From Rejecting:

1. Never use special characters (dashes, $$, spaces, periods, &, # etc.)

2. Always use uppercase characters (A not a).

3. Ensure to use appropriate "O" (alpha) or "0" (numeric) characters in specific fields. The (0) numeric should have a slash (\) or a dot (ù) in the middle and should be slightly smaller than (O) alpha.

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Legislation Passed to Strengthen Anti-Fraud and Abuse Activities

Experts estimate that fraud, waste and abuse cost the Medicare program over $20 billion a year. This has caught the attention of the federal government, taxpayers, health care providers, beneficiaries, the media, and fortunately, the United States Congress.

Although laws have been passed over the years which helped detect, prevent and prosecute health care fraud and abuse, the recent rise in such activity has dictated more stringent safeguard initiatives. In response, Congress passed legislation in 1996 and 1997 which provides for a more expansive and concentrated program to combat health care fraud, waste and abuse at a national level. The following information highlights the anti-fraud and abuse provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA).

Health Insurance Portability and Accountability Act of 1996

Much of the attention drawn toward the Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as the Kennedy-Kassebaum Act, focuses on the "portability" provisions of this law; that is, accessibility to health care coverage. The other provisions of HIPAA, or the "accountability" portions, focus on fighting health care fraud and abuse. These provisions of HIPAA use a four-pronged approach to combat health care fraud, waste and abuse: education, extended coverage, enhanced enforcement and expanded penalties as discussed below.

Provisions to Improve Education

Advisory Opinions - The Office of the Inspector General (OIG) is authorized to issue advisory opinions to individuals or entities regarding the legality of specific activities and transactions under the Anti-Kickback Statute.

Safe Harbors and Fraud Alerts - The OIG is required to solicit for proposals from the public for modifying existing safe harbors, establishing new safe harbors, issuing special fraud alerts, and rendering advisory opinions. In addition, requests may be submitted to the OIG at any time for issuance of special fraud alerts regarding practices that the OIG considers suspect or of particular concern. The OIG is obligated to investigate the merits of such proposals and requests.

Beneficiary EOMBs - The Department of Health and Human Services (HHS) is required to issue Medicare beneficiaries "explanations of benefits" for each Medicare covered item or service. The theory seems to be that EOMBs, by informing beneficiaries of payments made, will assist with beneficiaries' questions; the beneficiaries will then report to Medicare apparently improper billing.

Incentives for Efficiency Suggestions - Individuals are permitted to submit suggestions to HHS on methods to improve efficiency in the Medicare program. Financial awards may be given to those whose suggestions are adopted and result in program savings.

National Data Bank - HHS must establish a national data bank to record information about providers and suppliers that have committed health care fraud or abuse. The data bank is open to

federal and state law enforcement, health care licensing and health plan administrative agencies, and to private health plans.

Provisions to Extend Coverage

Health Fraud Crimes - "Health care fraud" is now an independent federal crime that protects both public and private health plans. This federal crime outlaws knowing and willful schemes to defraud or obtain by false pretenses money or property of any health care benefit program, not just Medicare or Medicaid. "Health care benefit program" is defined as "any private or public plan or contract providing medical benefits, items, or services."

All Federal Health Programs - The criminal prohibition against illegal remuneration and false statements and claims of the Anti-Kickback Statute are extended beyond Medicare and Medicaid to all federal health care programs except the Federal Employee Health Benefit Program.

Waiver of Copayments and Deductibles - Waiver of any part of coinsurance or deductibles, or transfer of items or services for free or for less than fair market value is "remuneration" which exposes persons and organizations to civil monetary penalties and permissive program exclusion if the conduct is likely to influence beneficiaries to order an item or service paid by Medicare or Medicaid.

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Fraudulent Disposition of Assets - It is now a federal crime to knowingly and willfully dispose of assets, including by "transfer in trust," to become eligible for Medicaid.

Provisions to Enhance Enforcement

Medicare Integrity Program - HHS is authorized to contract with eligible private organizations, as well as Medicare contractors, to review and audit provider activities and otherwise assure the integrity of the Medicare program.

Public and Private Enforcement Coordination - To improve law enforcement, OIG and the Department of Justice are directed to implement programs that coordinate federal, state, local and private activities to combat health care fraud and abuse. The programs are supposed to facilitate investigations, audits and inspections of health care delivery and payments, and enforcement of criminal, civil and administrative fraud and abuse controls.

Assured Enforcement Funding - Funding for effective implementation of the government's expanded fraud and abuse control programs is assured by the creation of a "Health Care Fraud and Abuse Control Account" within the Federal Hospital Insurance Trust Fund.

Bounties - HHS is authorized to pay awards to individuals who report Medicare fraud and abuse activities which result in the collection of fines, penalties, or overpayments.

Investigative Subpoenas - The Department of Justice is authorized to issue investigative subpoenas in connection with investigations of health fraud crimes. These subpoenas can require the production of records and other documents and the testimony of their custodians.

Provisions to Expand Penalties

Mandatory Program Exclusions - Persons or organizations may be excluded from Medicare or Medicaid if they are convicted of felony fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care items or services or with respect to acts or omissions in any health care program operated or financed at least in part by any federal, state, or local government agency, as well as for felony conviction relating to controlled substances.

Permissive Program Exclusions - Persons or organizations may be excluded from Medicare or Medicaid if they are convicted of misdemeanor fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care items or services or with respect to acts or omissions in any program - health care or otherwise - operated or financed at least in part by any federal, state, or local government agency.

Owner, Manager and Provider Exclusion - Individuals who own or control sanctioned organizations and who know or should know of the sanctionable conduct are now subject to permissive program exclusion.

HMO Intermediate Sanctions - HMOs that fail to comply with their Medicare contracts are now subject to intermediate sanctions, such as fines and suspension, as an alternative to contract termination.

Civil Monetary Penalties - HHS' authority to impose civil monetary penalties is extended to fraud and abuse affecting not only Medicare and Medicaid, but every other federal health plan (except FEHBP). In addition, civil monetary penalties have been increased from $2000 to $10,000 and from double to triple the amount of improper or excess reimbursement claimed.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 was signed into law on August 5, 1997, by President Clinton. The law makes numerous changes to the various titles of the Social Security Act, and creates a new Title XXI, the State Children's Health Insurance Program. The Act

also includes the following anti-fraud and abuse provisions designed to help improve the integrity of the Medicare program:

Permanent Exclusion For Those Convicted Of Health Care-Related Crimes

This provision excludes from Medicare or any state health care program for at least 10 years, an individual who has been convicted on one previous occasion of one or more health related crimes for which a mandatory exclusion could be imposed, including Medicare and state health care program-related crimes, patient abuse, or felonies related to health care fraud or controlled substances. It also permanently excludes an individual who has been convicted on two or more previous occasions of such crimes.

Authority To Refuse To Enter Into Medicare Agreements With Individuals Or Entities Convicted Of Felons

This provision authorizes HHS to refuse to enter into, renew an agreement or terminate an agreement with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of the program or program beneficiaries.

Exclusion Of Entity Controlled By Family Member Of A Sanctioned Individual

This provision authorizes HHS to exclude from Medicare or any state health care program, those entities where a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following a conviction, assessment, or exclusion.

Imposition Of Civil Monetary Penalties

This provision provides that a civil monetary penalty of up to $10,000 could be levied when a person arranges or contracts with an individual or entity for the provision of items or services when it knows or should know that the individual or entity has been excluded from a federal health care program. The individual or entity would also be subject to an assessment of up to three times the amount claimed and exclusion from federal health care programs.

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A civil monetary penalty of up to $50,000 plus up to three times the amount of remuneration offered, paid, solicited or received could be levied for each violation of the anti-kickback provisions of title XI of the Social Security Act.

Anti-Fraud Messages In Medicare Handbook

This provision states that the Medicare Handbook must contain:

- a statement indicating that errors occur and Medicare fraud, waste and abuse is a significant problem and encouraging beneficiaries to review any EOMB or statement for accuracy and to report any errors or questionable charges;

- a description of a beneficiary's right to request an itemized statement from their provider for Medicare items and services;

- a description of the beneficiary incentive program established under HIPAA; and

- the HHS toll-free hotline number which receives complaints and information about waste, fraud and abuse.

Disclosure Of Information And Surety Bonds

This provision states that durable medical equipment (DME) suppliers, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs) and rehabilitation agencies would be required to provide a surety bond of at least $50,000.

DME suppliers would also be required to identify each person with an ownership or controlling interest in the supplier or any subcontractor in which the supplier has a direct or indirect ownership interest of five percent or more. HHS may waive the requirement if the DME supplier, HHA, CORF, or rehabilitation agency provides a comparable bond under state law.

HHS may elect to impose disclosure of information and surety bond requirements on Part A providers, suppliers, or other persons (other than physicians and other practitioners).

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Electronic/Paper Remittance Advice Revisions Delayed

Due to late notification of additional changes to the National Standard Format/Remittance Advice (NSF/RA), the effective date of the change has been extended from March 5, 1998, to July 1, 1998. The effective date for the changes to the paper remittance format has also been extended to July 1, 1998. Electronic claim filers will be notified of these changes through the normal sender/vendor educational process.

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Random Review of Services Begins January 31, 1998

Beginning January 31, 1998, Medicare Part B of Florida will conduct random prepayment reviews on providers' claims. This prepayment review is a distinct effort from the random review of evaluation and management services, which began in November 1997. The random prepayment review is not meant to be punitive to providers; it is designed to support efforts to make the provider

community aware that there must be proper, complete, and accurate documentation in their files to support claims sent to Medicare Part B for payment.

All services on a selected claim will be reviewed. When a claim has been selected for review, the provider will receive a letter requesting documentation for all services on that claim. The documentation received will be reviewed according to the carrier's current guidelines. If documentation requested is not received within the time frame specified in the letter, the claim will be denied payment. If the documentation received does not support the service billed, the service will be reduced or denied payment. Do not send documentation for claims unless it is requested!

All claims selected for prepayment review for this effort will be noted with new remark code M87 (Claim/Service(s) subjected to CFO - CAP prepayment review) on the Provider Remittance Notice (PRN).

Advance Notice Requirement

Applies to medical necessity (see page 4).

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Top Denial Codes Affecting Multiple Specialties for the First Quarter of Fiscal Year 1998

The following article outlines the top denials noted during the first quarter of fiscal year 1998 along with quick tips on how to avoid them for the following specialties: General Practice (01), Family Practice (08), Internal Medicine (11), Oral Surgery (19), Chiropractic Medicine (35), Pediatrics (37), Certified Nurse Midwife (42), Podiatry (48), Ambulatory Surgical Centers (49), Nurse Practitioners (50), Critical Care Medicine (81) Maxillofacial Surgery (85), and Emergency Medicine (93).

These denials result from simple claims processing/completion errors, however continue to plague providers. Please assure that you are aware of your own denial messages and the appropriate actions to be taken to correct them. The staff in this contractor's Provider Education Department is committed to providing this information in an effort to assist providers in avoiding or receiving claim denials which could be easily avoided.

Action Codes: DG
Action Code Descriptors: No indication that documentary x-rays are available for review
Tips to Avoid Denial: This requirement is specific to claims filed by Chiropractic physicians. Documentary X-Ray information is required by this specialty. This information should be placed in block 19 of the HCFA-1500 claim form.

Action Codes: HG
Action Code Descriptors: Required UPIN information invalid or omitted
Tips to Avoid Denial: A UPIN must be submitted when billing for the following services: 1) Consultations, 2) Pathology services, and 3) Diagnostic services (i.e., X-Rays, Nerve conduction tests). UPINs must be submitted using a valid format.

In block 17 of the HCFA 1500,enter the name of the referring or ordering physician. In block 17A include the actual UPIN number (e.g., D12345). UPIN information can be obtained by accessing the contractor Bulletin Board System via modem at (904) 791-6991 or by contacting the referring physician.

If you determined that the service was required and provided, your own information should be noted in blocks 17 & 17A.

Action Codes: JP
Action Code Descriptors: 1-Digit reference code not submitted for ICD-9CM diagnosis in block 21, i.e. incorrect completion of block 24e
Tips to Avoid Denial: Physicians must enter the one-digit diagnosis code reference number as identified in block 21 of the HCFA-1500 claim form in block 24E of the claim form. This indicates which diagnosis most closely indicates the medical need for the service performed and being billed.

Action Codes: P1
Action Code Descriptors: This procedure/item not payable for the diagnosis as reported
Tips to Avoid Denial: This indicates the service is subject to specific Medicare diagnosis code requirements. Procedure codes which have diagnosis-specific medical necessity requirements are found throughout Medicare Updates and are accessible via the contractor Bulletin Board System by modem at (904) 791-6991.

Action Codes: 6M
Action Code Descriptors: Diagnosis not coded to highest level of specificity
Tips to Avoid Denial: Many ICD-9-CM codes are to the third, fourth, or fifth level (if available). Medicare requires you to use the highest available level. Please refer to the most current version of the diagnosis coding book and choose the ICD-9 code which is to the highest level.

Action Codes: 24
Action Code Descriptors: Two-digit Place of Service codes must be submitted
Tips to Avoid Denial: Medicare requires the use of two-digit all numeric place of service codes for all detail lines submitted on a claim. A complete list of the place of service codes can be found in the September 1996 Medicare B Update! on pages 14 and 15.

Action Codes: 98
Action Code Descriptors: Allowance included in payment made for surgery -E/M service within post-op period

Tips to Avoid Denial: Medicare B will only pay for an E/M visit within the post-operative period of a surgery if the visit is for a significant, separately identifiable reason.

If the visit was significant and separately identifiable, you must use a 25 modifier on the E/M service if performed on the same day as a minor surgery; a 57 modifier on the E/M service if performed on or before a major surgery; and a 24 modifier on the E/M service if it is an unrelated E/M service during the global period of a surgery. A minor surgical procedure has a 10 day post operative period and a major surgical procedure has an associated 90 day post operative period.

Lists of procedure codes with post-operative periods were published in the December 1997 HCPCS/MPFSDB Medicare B Update! Special Issue

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UPIN Directory Available on CD-ROM

The CD-ROM version of the UPIN directory is available upon request. The directory is a complete national UPIN listing, current through August 1997. Updates will be issued at a later date. Since there is a limited amount, they will be sold on a first come first serve basis. The cost will be $18.00 plus a $5.00 shipping and handling fee.

System Requirements

The following configuration is needed to use this CD-ROM disc:

- An IBM PC/AT or PS/2 or compatible with 640 KB 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 your complete CD-ROM version, make checks payable to Blue Cross Blue Shield of Florida (Account #754-250) and mail to the following address:

Medicare Registration
532 Riverside Ave. - 14 Tower
Jacksonville, Florida 32207
Attn: Tawny Stewart, UPIN Coordinator

Starting March 6, 1998, the CD is available through the Government Printing Office (GPO) for $18.00 plus shipping and handling. The contact person for GPO sales is Esther Edmonds at

(202) 512-1530. Please refer to stock number 017-060-00601-3 when requesting your CD directory from GPO.

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When not to Show Patient Paid Amounts on Claims

Some providers who accept assignment have a concern that we have issued partial checks to beneficiaries. After researching these cases, we found that such checks were generally issued because of the patient paid amount noted in block 28 of the HCFA-1500 claim form. Here are a few notes about this situation:

There is no need to show a patient paid amount in block 28 (or with your EMC transmissions) when assignment is not accepted.

When assignment is accepted, Medicare Part B recommends:

- Since it is difficult to predict when deductible/coinsurance amounts will be applicable - and over-collection is considered program abuse - do not collect these amounts until you receive Medicare Part B payment.

- If you believe you can accurately predict the coinsurance amount and wish to collect it before Medicare Part B payment is received, note the amount collected for coinsurance on your claim form. (We do not recommend that you collect the deductible prior to receiving payment from Medicare Part B because, as noted above, over-collection is considered program abuse and can cause a portion of the provider's check to be issued to beneficiaries on assigned claims.)

- Do not show any amounts collected from patients if the service is never covered by Medicare Part B or you believe, in a particular case, the service will be denied payment. Where patient paid amounts are shown for services that are denied payment, a portion of the provider's check may go to the beneficiary.

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Claims Status Inquiries

Due to fiscal year budget reduction requirements, we recently required all providers calling to request the status of claims to use the Automated Response Unit (ARU) to obtain the information. Beginning March 1, 1998, we will no longer accept written inquiries regarding claim status. Any written inquiry received requesting status information will be returned to the provider. All status information must be obtained by calling the ARU at (904) 353-3205. The ARU is available from 7:30 a.m. to 5:30 p.m. Monday, and from 7:30 to 6:30 Tuesday through Friday.

If you need instructions on how to use the ARU, please refer to page 37 of the November/December 1997 Medicare B Update! or call the ARU and follow the instructions.

We would appreciate any suggestions for enhancements that you may have. Please send all suggestions to:

Rita Sheppard 16T
P.O. Box 2078
Jacksonville, Florida 32231

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Project Prevention: Pneumonia, the Flu, and Breast Cancer

Project Prevention is the Health Care Financing Administration's effort to educate providers and beneficiaries about some of the preventative services Medicare covers. Consider (and tell Medicare beneficiaries about) the following facts:

Prevent Pneumonia and Flu:

- Approximately 40,000 people die each year as a result of pneumococcal pneumonia. However, a one-time vaccination is available to protect patients from pneumococcal disease.

- Medicare Part B reimburses for both the pneumococcal pneumonia vaccine (procedure code 90732) and its administration (procedure code G0009) at 100 percent of the Medicare allowed amount to both participating and nonparticipating providers. Since deductible and co-insurance do not apply, there is no out of pocket expense incurred by the beneficiary.

- Medicare Part B covers one influenza vaccination (procedure code 90724) and its administration (procedure code G0008) per flu season for each beneficiary. As with the pneumococcal pneumonia vaccine, reimbursement is 100 percent of the Medicare allowed amount to all providers with no out of pocket expense to the beneficiary.

- Both the pneumococcal pneumonia and influenza vaccines can now be submitted to Medicare Part B using a simplified roster billing method.

Prevent Breast Cancer

Breast cancer is most common in women age 65 and over.

- According to the most current statistics available, women age 65 and older accounted for 50 percent of all new breast cancer cases and 56 percent of all breast cancer deaths.

- Medicare Part B covers the performance and interpretation of screening mammograms (procedure code 76092) every year for women over age 39.

- While diagnostic mammograms are covered whenever there is any sign or symptom of breast disease and a physician orders the

examination, only 45 percent of Florida's female beneficiaries take advantage of this important benefit.

- There is no Medicare deductible applied to screening mammographies.

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Keep a Copy of Patients' Medicare Cards

Medicare Part B consistently receives a high volume of claims with incomplete or invalid information for the following items: the beneficiary's name, health insurance claim number and/or address.

Submitting the beneficiary's legal name, correct health insurance claim number and complete address will reduce the claims processing time, eliminate requests for the missing/invalid information (development letters) and reduce the chances of a claim denial or rejection.

To avoid claim processing delays and/or possible denials, providers should obtain and keep on file a copy of the beneficiary's red, white and blue Medicare card as well as a copy of the beneficiary's picture identification. (Keeping a copy of the beneficiary's picture identification on file will help to prevent fraud.) When submitting claims to Medicare Part B, ensure the beneficiary's name and health insurance claim number is submitted exactly as it appears on the Medicare card (illustrated below). In addition, providers should ensure the beneficiary's complete address (i.e., street address, post office box, city, state and ZIP code) is provided.

For more information about completing the HCFA-1500 claim form, please refer to page 11 of the September/October 1997 Medicare B Update! Beneficiary eligibility information may also be obtained by calling the Provider Automated Response Unit (ARU) at (904) 353-3205.

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Medicare Registration Wants You to Know...

The Medicare Registration Department has implemented new procedures in which an entity may acquire a group provider number even if all providers working for an entity are not actual employees (W2 income tax withholding method). In fact, a group provider number should be assigned any time two or more providers are being reimbursed under the same employee identification number (EIN) and/or tax identification number (TIN). If you or any of your employees or contracted providers fall into this category, you may be assigned a group provider number in the future. When group provider numbers are assigned, a letter will be generated informing the group of the provider number and the appropriate way to bill for services.

Changing SSN AND/OR EIN

If a currently enrolled provider wishes to change his/her reimbursement from a social security number (SSN) to an employer identification number (EIN) or vice versa, completion of a HCFA 855 (General Enrollment Application) is required. Documentation (CP575, 8109 tax coupon, or W9) must be attached to the completed application. If the documentation shows that the EIN was assigned in a name which is different from the individual, section 18 of the HCFA 855 must be completed. For example, John Smith M.D. is changing from his SSN to his EIN. Documentation shows that the EIN was assigned in the name of John Smith M.D. P.A., completion of the HCFA 855 (including section 18) is required. Section 18 should show that John Smith M.D. is authorizing Medicare to pay in the name of John Smith MD PA. See pages 75 - 79 of the January/February Update! for specific information on completion of the HCFA 855.

Part A And Certified Part B Providers

Part A and certified Part B providers include but are not limited to: hospitals, skilled nursing facilities (SNF), end stage renal disease facilities (ESRD), rural health clinics (RHC), community mental health centers (CMHC), comprehensive outpatient rehabilitation facilities (CORF), registered physical therapists (RPT), portable x-ray suppliers, ambulatory surgical centers (ASC), etc. Any of these entities that wish to enroll as a Medicare Part A or certified Part B provider should contact the Agency For Health Care Administration (AHCA), 2727 Mahan Dr., Tallahassee, FL. 32308. The AHCA will mail an application package to the provider with any necessary documentation requirements. The application should be completed and returned to the ACHA with all required documentation. DO NOT forward the completed application(s) to Medicare Registration as the state agency should be the initial contact.

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Millennium Changes for HCFA-1491, 1490S, and 1490U Forms

There are currently three paper forms used to bill Medicare Part B that are not millennium compliant. These forms include the HCFA-1491 (Request for Medicare Payment - Ambulance: OMB Number 0938-0042), the HCFA-1490S (Patient's Request for Medicare Payment: OMB Number 0938-0008), and the HCFA-1490U (Request for Medicare Payment: OMB Number 0938-0008).

For your information, Form HCFA-1491 is a paper form used to bill ambulance services covered by Medicare Part B. Form HCFA-1491 has one date field: Item 7 (Date of Service). Form HCFA-1490S is a paper form used by beneficiaries to bill Medicare Part B. This form is used when the beneficiary can not get any assistance from their physician or supplier for completing a Medicare Part B claim. Form HCFA-1490S has one date field: Item 6b (Patient Signature Date). Form HCFA-1490U is a paper form used by employers, unions, employer-employee organizations to bill Medicare Part B for paid physician or supplier services to

employees, group practice prepayment plans, and health maintenance organizations. Form HCFA-1490U has three date fields: Item 6 (Organization Signature Date), Item 7 (Date of Each Service), and Item 13 (Physician or Supplier Signature Date).

Since these forms are not OCR (Optical Character Recognition) scannable, HCFA will not be revising these forms or their completion instructions to accommodate an eight-digit date (MMDDCCYY). Any individual who completes one of these forms for Medicare payment will not be required to enter an eight-digit date in the fields specified above.

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New Clean Claim Interest Rate

Effective January 1, 1998, clean paper and electronic claims that have not been paid by the thirtieth day after the date of receipt will accrue 6.25 percent interest.

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Overpayment Interest Rates

Medicare Part B assesses interest on overpaid amounts which were not refunded in a timely manner. The interest rate was implemented to help ensure the timely repayment of overpaid funds due to the Medicare program.

The interest rate is based on the higher of the following rates: the Private Consumer Rate (PCR) or the Current Value of Funds (CVF). The following table lists the current interest rates assessed:

Period: April 30, 1996 - July 18, 1996
Interest Rate: 13.625%

Period: July 19, 1996 - October 23, 1996
Interest Rate: 13.50%13.50%

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

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

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

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

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

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Attention Ambulance Suppliers and Beneficiaries: Forms HCFA-1491 and HCFA-1490S are now Available on the Internet

Forms HCFA-1491 and HCFA-1490S are now available electronically on the HCFA homepage. To access these forms from the Internet, enter the following: http://www.hcfa.gov/medicare/ edi/edi5.htm

Form HCFA-1491 (Request for Medicare Payment-Ambulance) is used to bill Medicare Part B covered ambulance services. Note that Medicare Part B covered ambulance services can be billed on Form HCFA-1500 too.

Form HCFA-1490S (Patient's Request for Medicare Payment) is used by Medicare beneficiaries for billing Medicare covered services. Note that providers and suppliers are required by law to submit Medicare claims on behalf of a beneficiary. If a beneficiary wishes to submit a claim, he or she must do so on Form HCFA-1490S. A beneficiary must also attach to Form HCFA-1490S any bill(s) he or she receives from providers/suppliers.

Feel free to download or copy these forms from the HCFA homepage.

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1998 Customer Service Hours of Operation

The normal hours of operation for the Medicare Part B of Florida Provider Telephone Customer Service area are from 9 a.m. until 4:30 p.m., Monday through Thursday, and from 8 a.m. until noon on Friday. The Automated Response Unit (ARU) system is available from 7:30 a.m. until 5:30 p.m. on Mondays and Fridays, and 7:30 a.m. until 6:30 p.m. Tuesday through Thursday. However, certain holidays observed throughout the year affect our normal hours of operation. The 1998 holidays and hours of business during these holidays are as follows:

Thursday, April 9, 1998.....Closed at 2 p.m.

Friday, April 10, 1998.....Good Friday Observed

Monday, May 25, 1998.....Memorial Day Observed

Thursday, July 2, 1998.....Closed at 2 p.m.

Friday, July 3, 1998.....Independence Day Observed

Monday, September 7, 1998.....Labor Day Observed

Thursday, November 26, 1998....,,.....Thanksgiving Day Observed

Friday, November 27, 1998.....Thanksgiving Observed

Thursday, December 24, 1998.....Christmas Eve Observed

Friday, December 25, 1998.....Christmas Day Observed

Thursday, December 31, 1998.....Closed at 2 p.m.

Friday, January 1, 1999.....New Year's Day Observed

The phone number for Provider Customer Service is (904) 634-4994, and the ARU can be reached by calling (904) 353-3205.

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Updates To The Medigap Insurer Listing

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

Medigap Insurer Address Changes:

Number: 27019
Insurer Name: INTEGRITY NATIONAL LIFEPO BOX 655433 DALLAS TX 75265-5433

Number: 59029
Insurer Name: NORTH AMERICAN INSURANCEPO BOX 46337 MADISON WI 53744

Number: 43002
Insurer Name: PENINSULAR LIFEPO BOX 130007 RALEIGH NC 27605

Number: 19020
Insurer Name: PENINSULAR LIFE2610 WYCLIFF ROAD RALEIGH NC 27607

Medigap Insurer Name/Address Change:

Number: 53055
Former Name: LIFE OF AMERICA
Changed To: CENTRAL UNITED LIFE PO BOX 2728 HOUSTON TX 77252

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: 19726
Insurer Name: NORTH AMERICA LIFE

Number: 20093
Insurer Name: WASHINGTON NATIONAL

Number: 53070
Insurer Name: WASHINGTON NATIONAL

Significant Changes to Medigap Insurers

HEALTHCARE USA
Medigap Insurer #18055

As advised by HealthCare USA, they closed the Florida plan membership effective, June 30, 1997. The closing was coordinated with the Florida Department of Insurance and the Agency for Health Care Administration. No previous members have eligibility beyond June 30, 1997 and no new member can be enrolled.

Based on this, claims for dates of service July 1, 1997, and afterward are not being honored. We were instructed by HealthCare USA to discontinue Medigap crossovers effective January 1, 1998. The assigned Medigap insurer number 18055 has been changed to an Exempt (non-active) status. Please change the N to a Y in your Update.

CUNA MUTUAL INSURANCE SOCIETY
Medigap Number 48399

Effective January 1, 1998, Providian will no longer be servicing the Medicare supplemental claims for CUNA Mutual Insurance Society. Providian will no longer receive CUNA Mutual's claims electronically.

Therefore, effective January 1, 1998 CUNA Mutual will receive paper Medigap claims at the following address.

CUNA MUTUAL INSURANCE SOCIETY
PO BOX 2995
MADISON WI 53701

All CUNA Mutual Insureds will be notified of the change from electronic to paper filing of claims. Please update your Medigap Update of this change.

AMERICAN LIFE ASSURANCE
Medigap Number 19991 and 11136

Effective January 1, 1998, American Pioneer will no longer administer plans for American Life Assurance. American Pioneer will no longer receive American Life Assurance's claims electronically.

New Era Life will assume the responsibility of handling American Life Assurance's plans. Therefore, effective January 1, 1998, New Era Life will receive the Medigap claims for American Life Assurance at the following address. Please update your Medigap Update of this change.

American Life Assurance
PO Box 4884
Houston TX 77210

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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 BClaims Review
P. O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests

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

Administrative Law Judge Hearing

Administrative Law Judge Hearing
P.O. Box 45001
Jacksonville, FL 32231-5001

Status/General Inquiries

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

Overpayments

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

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims

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

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:

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

Over 40 days of initial request:

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

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

MISCELLANEOUS

Fraud and Abuse

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

Medicare Claims for Railroad Retirees:

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

Provider Change of Address:

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

and

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

Provider Education:

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

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

For Seminar Registration:

Medicare Part B
Provider Education Department
P. O. Box 45157
Jacksonville, FL 32231

Limiting Charge Issues:

For Processing Errors:

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

For Refund Verification:

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

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

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

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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 provider's 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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Page 72

Medicare Part B Financial Services
Provider Service Request form
---unable to provide form in this format---

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Page 73

Instructions for Completing
Medicare Part B Financial Services
Provider Service Request form
---unable to provide form in this format---

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Page 74

Florida Medicare B-Line BBS

What is the B-LINE?

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

What's available on the B-LINE?

Once you've connected to the B-Line you can view and search through information while on line. You will also be able to copy

the same information to your own computer by downloading for future access. You'll find things like:

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

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

And much more will be available in the future.

To Access the B-Line

(904)791-6991 Initial Access - All first-time callers must use this number first.

(800)838-8859 Participating Providers can use the toll-free number after first/ initial access and registration on the above toll number.

Before using the 800# allow one business day for participation verification.

Technical Support:

(904)791-8384 Voice "Help Line"

What you need to access the B-LINE:

- Personal Computer (PC)

- Telephone Line

- Modem - internal or external

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

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

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

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

B-Line User-ID and Password

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

Welcome To The B-Line BBS !!!

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Windows 95 Access to the "B-Line BBS"

Using HyperTerminal

Windows 95 includes a communications program called HyperTerminal which will allow you to connect to the B-Line BBS without exiting to the DOS prompt. The program includes a simple setup wizard used to establish your connections.

Step 1:

To access HyperTerminal program; from the Start menu, click Programs, click Accessories, click HyperTerminal.

Step 2:

Look for the icon labeled "Hypertrm", or "HYPER.TRM". Double-click this icon to start the setup wizard.

Step 3:

The setup wizard will ask you to name the connection and select an icon. Name the connection B-Line BBS, select the icon you want to use by clicking on it, and click OK.

Step 4:

The setup wizard will ask you for the phone number to dial. First time users must enter area code 904 (if outside the 904 calling area) and phone number 791-6991. Users with existing accounts

should enter the area code and telephone number they are now using. Click OK.

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Step 5:

The setup wizard allows you to revise dialing properties in order to make your connection. Click on Dialing Properties. Revise settings appropriately under "How I dial from this location": how your location accesses an outside line (i.e., "9" for an outside line), long distance access (i.e., "1" for long distance), and disabling call waiting (click on selections available and choose appropriately: i.e., "*70"). When complete, click OK.

Step 6:

The setup wizard will ask you to make the connection (call). At this time choose Dial to call the B-Line BBS.

Signing On To The B-Line - If you are a new user to the B-Line, type "new" when the system asks for your User ID. You will then complete a brief questionnaire (registration) about your practice/office. Please be sure to indicate your provider number. Within 48 hours we will verify your participation status and allow you to access the B-Line via a toll-free number (see "Modifying HyperTerminal Dialing Number for Toll Free Access" below on how to change the dialing number).

That's it - when you sign off the B-Line and then exit HyperTerminal, be sure to save this new connection. The next time you open HyperTerminal, you will have an icon in this group titled "B-Line BBS". Simply double-click on this icon to connect in the future.

Modifying HyperTerminal Dialing Number for Toll Free Access

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

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

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

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

Need Help?

If you have any questions or problems with the B-Line BBS, contact our Voice Help Line at (904)791-8384. We will respond to you within 48 hours. In leaving your message, please speak slowly and clearly when leaving your company name, contact name and telephone number.

If you are unable to access HyperTerminal, contact us at the above help number and we will provide you with a free DOS based communication software program which will enable you to access the B-Line BBS.

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FREE
Medicare Fraud and Abuse Programs

Why is Medicare offering free seminars?

Estimated costs to the Medicare program due to fraud and abuse now exceed $20 billion each year! The Health Care Financing Administration (HCFA) is emphasizing the prevention and early detection of fraud and abuse. HCFA, in collaboration with Florida Medicare, is offering several fraud and abuse seminars at no cost to providers. This program is designed to inform both Part A and B providers about the delicate situations they may encounter concerning fraud and abuse within the Medicare program.

Seminar Objectives

Seminar participants will learn to:

ú accurately define fraud and abuse;
ú correctly identify and accurately report suspected fraud and abuse;
ú identify the penalties associated with Medicare fraud and abuse;
ú understand the provider s responsibilities and liabilities; and
ú learn preventative practices that can be implemented to help protect organizations.

Seminar Schedule

The seminars being offered throughout Florida are planned for April 1998. An up-to-date schedule
will be available at the following locations:

The Medicare Bulletin Board System (BBS);

The Florida Medical Association
(850) 224-6496 / Roberta Kelley

The Florida Hospital Association
(407) 841-6230 / Becky Dunne
or Ana Gonzalez

The information will also be posted to our website at the following address:

www.floridamedicare.com

IMPORTANT NOTE: All Florida sessions are currently being scheduled. Please wait until after March 16th to contact the above resources for the seminar information in your area! Seating will be limited to each facility s capacity and will be available on a first come first serve basis.

Computer Based Training

We also have a computer based training module on fraud and abuse! Please visit our BBS or website
to download your FREE copy.

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INTRODUCTION TO MEDICARE 101

A Medicare Seminar Designed For The New Provider Or New Billing Staff

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

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

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

- Roles of the Medicare staff (Who to call, where to write)

- Discussion of MUST-HAVE reference materials

- Claim filing rules, time limits, penalties

- What's covered, what's not, and how do I know the difference?

- Preventative medicine services (billable or not?)

- Using the appropriate modifier and discussion of their importance

- National Correct Coding Initiatives and how do I change those bundled code combinations?

- Medicare Provider and Beneficiary Remittance Notices

- Provider Enrollment Process

- Appeals Process

- Overpayment Recoveries

- Patient Waiver of Liability, when does the patient need to sign?

- Focused Medical Review Initiatives - Am I at risk of an audit?

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

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

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

Introduction To Medicare 101 Seminar Registration Form:

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

Registrant's Name: _____

Provider's Name: _____

Medicare billing provider number: _____

Address: _____

City, State, ZIP code:_____

Phone ( )_____ Fax ( )
_____

PLEASE BRING YOUR CONFIRMATION FORM TO THE SEMINAR.

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

_____ June 23 - Orlando

_____ July 21 - Fort Lauderdale

_____ August 20 - Miami

_____ September 17 - Tampa

Amount enclosed ($149 per person) $ _____

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1998 MEDPARD order form

--- form not available in this format ---

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ORDER FORM - 1998 PART B MATERIALS

--- form not available in this format ---

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Index to publications by topic

Not Available in this format
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IMPORTANT PHONE NUMBERS:

PROVIDERS

Express Line/ARU Status Inquiries:
904-353-3205

Specialty Customer Service Reps and EMC Billing Problems/Guidelines:
904-634-4994

B LINE BBS

Access:
1-800-838-8859
1-904-791-6991

Technical Problems:
1-904-791-8384

BENEFICIARY

Outside Duval County (in Florida): 1-800-333-7586

Duval County (or outside Florida): 904-355-3680

Hearing Impaired: 1-800-754-7820

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

EMC:

EMC Billing Problems/Guidelines: 904-354-5977

EMC Start-Up: 904-791-8767

EMC Front-End Edits/Rejects: 904-791-6878

PC-ACE Support: 904-355-0313

Testing: 904-354-5977

Help Desk (Confirmation/Transmission): 904-791-9880

OCR

Printer Specifications/Test Claims: 904-791-6911

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MEDICARE B FINANCIAL SERVICES DEPARTMENT
 -Special tear out insert between page 57 and 58 (page 1, page 2, page 3, page 4)

The Medicare Part B Financial Services department assists providers and beneficiaries with the following issues:

Overpayments: Manages the notification and collection of overpayments which are due to Medicare Part B.

Checks: Assists providers and beneficiaries with researching Medicare Part B checks which may have been lost, stolen or mutilated. This includes providing copies of endorsed checks and reissuing duplicate checks when necessary.

Forgeries: Researches cases where a Medicare Part B check may have been endorsed and cashed by an unauthorized party.

Garnishments/Tax Levies: Manages the recoupment of Medicare Part B payments which are the result of garnishments and/or tax levies.

Bankruptcies: Manages the coordination of Medicare Part B overpayments for parties who have filed a petition for bankruptcy.

Written Inquiries: Assists beneficiaries and providers with questions related to refund requests and various other functions of the Financial Services department through written responses.

Undeliverables: Researches provider and beneficiary addresses to ensure that all returned checks are successfully delivered to the appropriate recipient. Providers who relocate must notify the Medicare Registration department by using the HCFA 855C. The form should be mailed to:

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

For further information, providers can call the Provider Customer Service department at (904) 634-4994.

Medicare Part B Financial Services Provider Request Form

The Financial Services department has created a form which will ensure inquiries and refunds are handled appropriately. This form is located on page 72 of this Update! This form may be photocopied, or additional copies may be requested by calling our Provider Customer Service department.

The following pages provide in-depth information about the notification and collection of overpayments which are owed to Medicare Part B.

What is an Overpayment?

Overpayments are Medicare funds that a provider or a beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined that an overpayment has been made, the amount of the overpayment is a debt owed to the United States government. The following are some examples of overpayments:

- Payment based on a charge that exceeds the fee schedule or reasonable charge (e.g., services which are processed with an incorrect procedure code; thus, the Medicare approved amount is incorrect).

- Duplicate processing of the same charges/claims (e.g., duplicate billing).

- Payment made to incorrect payee.

- Payment for non-covered items/services or medically unnecessary services.

- Incorrect application of the deductible or co-insurance.

- Payment for items/services provided during a period of patient non-entitlement.

- Claims processed with Medicare Part B as the primary payer when Medicare Part B should have been the secondary payer.

Overpayments are referred to the Medicare Part B Financial Services department and are identified in many ways:

- Providers and beneficiaries determine overpayments are made. In these instances, they should notify Medicare Part B of the overpayments by writing to the Financial Services department.

- An overpayment can be identified through the review or hearing process.

- Overpayments can also be the result of an investigation of customer complaints or a random sample of a provider's billing practices.

- Federal agencies (e.g., Health Care Financing Administration, Office of Inspector General, etc.) conduct audits of providers' claims which may result in the identification of overpayments.

Regardless of how overpayments are detected, they are referred to the Financial Services department for collection. All overpayment refund requests are made by letter and clearly state how the overpayment occurred, who is liable and what is necessary to satisfy the obligation to repay the debt.

Overpayments Detected by Providers and Beneficiaries

Providers and beneficiaries occasionally determine overpayments exist before refunds are requested by Medicare Part B. In these instances, refunds may be made without written overpayment requests.

If a provider finds that an overpayment exists on all claims associated with their Medicare check, the original check and all Provider Remittance Notices associated with the check should be returned to the Financial Services department with an explanation for returning the check. If an overpayment exists on only one or some of the claims, the provider should cash the Medicare check and issue a separate check to Medicare for the overpaid amount. The refund should include an explanation of the overpaid amount and a copy of the Provider Remittance Notice or a detailed listing, to include the health insurance claim number, date of service and amount of refund, explaining the claims in which the overpayment applies.

Beneficiaries may follow these same instructions for their overpayments. However, it is unusual for overpayments to exist on multiple claims for beneficiaries. Therefore, the original Medicare check and a copy of the Medicare Summary Notice should be returned to the Financial Services department.

How to Refund Overpayments

Overpayments must be refunded to Medicare Part B within 30 days from the date of the overpayment refund request letter. If a refund is not made within 30 days, a second overpayment refund request letter will be sent and the balance due (either full or partial) will be satisfied by withholding future claim payments.

The second overpayment refund request letter does not imply that the debtor has another 30-day period to refund the amount due and it does not prevent the withholding of future claim payments after the 30-day period has elapsed. Additionally, overpayments due from providers are subject to the assessment of interest on the balance due after the 30-day period.

To ensure timely and accurate posting of overpayments, refunds should be made by check payable to Medicare Part B and should be

sent with a copy of the overpayment refund request letter. If a copy of the overpayment refund request letter cannot be included with the check, the following information should be given:

- Medicare provider number or patient's Medicare health insurance claim number (depending upon to whom the refund request was made.)

- Date of service(s) involved.

- A brief explanation of why a refund is being made.

- A copy of the Medicare Summary Notice or Provider Remittance Notice to which the overpayment applies.

All refunds should be sent to the Financial Services department.

Disagreements with Overpayment Requests

In some cases, a provider or beneficiary may disagree with the overpayment request (e.g., they do not believe an overpayment exists). In these instances, they should follow the steps for requesting an appeal as outlined in the overpayment refund request letter. Listed below are the general appeal rights:

If the amount of the refund request is $100 or more, you should request a hearing if you do not agree with the overpayment refund request letter.

The address for requesting a hearing is:

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

You can combine other refund requests you have received, or claims that have previously been reviewed to meet the $100 limit for requesting a hearing.

If the amount of the refund request is under $100, you should request a review if you do not agree with the overpayment refund request letter. The address for requesting a review is:

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

Review requests for overpayments resulting from claims paid in error as primary when Medicare should have been the secondary payer should be sent to the following address:

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

How to Track Offset Claims

Overpayment refund request letters contain an accounts receivable number known as a Financial Control Number (FCN). The FCN is used to account for and track monies refunded and/or offset (withheld) from paid claims. If refunds due are satisfied through the offset of paid claims, the FCN will appear on the Provider Remittance Notice or the Medicare Summary Notice on which the offset was applied. The FCN can then be used to cross-reference the offset claim to the overpayment refund request letter.

We are required to accrue interest on provider overpayments that are not refunded within 30 days from the date on the overpayment refund request letter. When money is offset (withheld)from your paid claims, it is applied to the accrued interest first and then to the principal.

Extended Repayment Schedules for Overpayments

The Health Care Financing Administration (HCFA) has established repayment options for providers who find it difficult to repay debts to the Medicare program. For debts in excess of $1000, Medicare Part B may approve repayment schedules up to a period of 12 months.

Requests for extended repayment schedules must be documented in writing to Medicare Part B. The documentation should include:

- A detailed explanation of the problems preventing a lump sum repayment.

- A statement of how much the provider can pay for each installment and the number of months.

- A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 must be completed or must indicate"N/A' (not applicable).

- A copy of the provider's most recent federal income tax return.

Requests for extended repayment schedules should be sent to the Financial Services department.

Within 10 to 15 days of the request, Medicare Part B will document to the provider an approval or renegotiate the payment amount. Once the extended repayment schedule is established,

Medicare Part B will provide an amortization schedule based on the approved amount (which will begin with the balance and any accrued interest). An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

Repayment Schedules for Longer Than 12 Months

Requests for extended repayment schedules for longer than 12 months are referred to HCFA for approval.

The requests must include extensive and specific financial documentation from the provider to support the request. HCFA will make a decision to grant, modify or reject the extended repayment schedule based on the financial documentation submitted with the request.

The documentation required to support a request for an extended repayment schedule for more than 12 months varies. This depends on the debtor's legal identity (as explained below) at the time the overpayment case was established. The forms for the documentation are provided upon request by the Financial Services department or the Provider Customer Service department.

Sole Proprietors: For sole proprietors (i.e., an individual physician who is not part of a group or individual owner), the following documentation must be completed and submitted to the Financial Services department:

- A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 must be completed or must indicate "N/A" (not applicable).

- A copy of the provider's most recent federal income tax return.

Entities: For entities (i.e., partnership, group or corporation), the following documentation must be completed and submitted to the Financial Services department:

- A copy of the federal income tax return for the most recent tax year for both the partnership, group or corporation and the individual debtor or principal owner of the group or corporation.

- A Financial Statement of Debtor form (HCFA-379).

- The most current balance sheet and the balance sheet for the last complete fiscal year.

- The most current income statement and the income statement for the last complete fiscal year.

- A statement of source and application of funds for the period covered by the submitted income statements.

- Cash flow statements for the periods covered by the submitted balance sheets. If the date of request for an extended repayment schedule is more than three months after the date of the most recent balance sheet, a cash flow statement for all months between that date and the date of the request is required.

- A projected cash flow statement covering the remainder of the fiscal year. If fewer than six months remain in the fiscal year, a projected cash flow statement for the following year is required.

- A list of restricted cash funds, by amount, as of the date of the request and the purpose of each.

- A list of investments, by type (stock, bond, etc.,), amount and current market value as of the date of the request.

- A list of notes and mortgages payable by amount as reflected in the balance sheet and their due dates.

- If requesting an extended repayment period of 12 months or more, the debtor must include at least two letters from separate financial institutions denying the debtor's loan request for the amount of the overpayment. A copy of the loan application(s) is also required.

The financial statements should be completed by the debtor's accountant. The balance sheets and income statements should include the following statements:

Misrepresentation or falsification of any information contained in this balance sheet or income statement may be punishable by fine and/or imprisonment under federal law.

Certification by Officer/Owner of Debtor(s):

I hereby certify that I have examined the balance sheet and income statement prepared by

and that to the best of my knowledge and belief, it is true, correct and the complete statement from the books and records of debtor.

Signed:

Officer or Owner of Debtor(s):

Title:

Date:

Once all documentation is submitted for requests for extended repayment schedules for longer than 12 months, Medicare Part B reviews the documentation and sends their recommendations to HCFA. The requested repayment schedule is either approved by HCFA or Medicare Part B is advised of the suggested repayment schedule. When the repayment schedule is established, Medicare Part B notifies the debtor of the results and sends an amortization schedule based on the approved amount. An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

End of insert - Medicare Part B Financial Services Department

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(END OF FILE)