Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

Features

Please share the *Medicare B Update!* with appropriate members of your organization.

Routing Suggestions:

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Y2K Officer
- Other _____

HCFA Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.
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The *Medicare B Update!* is published bimonthly by the Medicare Publications Department to provide timely and useful information to Medicare Part B providers in Florida. Questions concerning this publication or its contents may be directed in writing to:

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

A PHYSICIAN'S FOCUS

The 1999-2000 Flu and Pneumococcal Vaccination Campaign is Under Way! Mobilize to Immunize!

The Health Care Financing Administration is working with its national partners, the National Centers for Disease Control and Prevention (CDC), and the National Coalition for Adult Immunization (NCAI), to promote influenza and pneumococcal immunizations for 39 million Medicare beneficiaries.

You as a physician are an important partner in promoting the benefits of influenza and pneumonia vaccination. Research shows that their physician's recommendation is the most influential factor in patients' decisions to be immunized against flu and pneumonia. Advising beneficiaries to receive the once-in-a-lifetime pneumonia immunization and an annual flu shot is a vital part of effective preventive health care.

Influenza and pneumonia claim the lives of as many as fifty thousand Americans a year—more than all other vaccine-preventable diseases combined. ***More than ninety percent of these deaths occur in the Medicare population.***

The flu season is not far away. Tell your patients about the benefits of influenza and pneumonia vaccines now. Start your planning—seventy percent of flu shots are given during October, and seventy percent of pneumococcal vaccines are given during October, November, and December. Initiate *your* flu and pneumococcal 2000 campaign by considering and establishing some systematic procedures, such as:

- Tracking each patient's immunization status.
- Tracking the percentage of *all* immunized patients.
- Sending flu shot reminders to patients during the summer.
- Giving flu and pneumococcal shots at the time of other visits or hospitalizations.
- Putting standing orders in place to empower your office nurse to vaccinate.
- Displaying in your office posters showing the benefits of immunizations.

These are proven techniques to achieve your joint goals of promoting patient health care and building your practice.

Thank you for advocating this important preventive health care benefit to your Medicare patients. We thank you, and your patients will, too.

Sincerely

Sidney R. Sewell, M. D.
Medical Director

Advance Notice Requirement

The following information applies to all articles in this publication referencing services that must meet medical necessity requirements (e.g., services with specific diagnosis requirements). Refer to this information for articles that indicate advance notice applies.

Medicare Part B allows coverage for services and items deemed 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 list is not inclusive):

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

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment 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., the 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 payment is denied as being not medically reasonable and necessary for the reason(s) indicated on the advance notice. The signature of the provider of service is not required.

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

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

General Information About the *Medicare B Update!*

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

Distribution of the *Update!* is limited to individual providers and professional association (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 meeting this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit distributing a copy to all of a provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. For additional copies, providers may purchase a separate annual subscription for $75 (see order form on page 68), or download the text version from our online service, the Medicare Online BBS (see page 66 for information about the 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, providers must keep their mailing addresses current with the Medicare Registration Department.

About the Format

The *Update!* is divided into several sections, starting with an article by the carrier Medical Director. Following is administrative information, then "Claims," which provides claims submission requirements and tips. Correspondence (appeals and hearings) information is in this section. "Coverage" discusses CPT and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" presents coverage information of interest to psychiatrists, clinical psychologists and clinical social workers. "Reimbursement" presents changes to the Medicare Physician Fee Schedule (MPFS) and other pricing issues. "Focused and Local Medical Review Policies" follows, then "Electronic Media Claims (EMC)." Additional sections (not in every issue) include: "General Information," other information for Medicare Part B providers including Fraud and Abuse issues; and "Educational Materials" that includes Medifest schedules, information pertaining to the Medicare Online BBS (our online bulletin board service), and reproducible forms. Important addresses and phone numbers are on the back cover.❖

YEAR 2000

Y2K Readiness Survey Reveals Providers Have Some Work to Do...

In a recent survey conducted by First Coast Service Options, Inc. (FCSO), providers were asked about their "readiness" for Y2K. Here are some of the key results.

The good news is that 92 percent of the responding providers consider their practice (computer systems, telephone systems, etc.) Y2K compliant. Unfortunately, only 51 percent of the responding providers have a contingency plan in place, in the event one or more failures occur. In other words, only half the providers who responded to the survey have taken time to think through and develop a backup plan for potential Y2K related failures. Even if providers have a contingency plan, they should discuss the issue with whom they do business (e.g., computer vendor, billing service), to ensure those organizations have a backup plan, too. For example, what action will the billing service take if claims cannot be transmitted electronically? Of course, a contingency plan should include planning in the event utilities (such as electricity or telephone service) are interrupted or sporadic.

More than 87 percent of the responding providers said they have *no* special plan to reduce claim filing or review inventory before **January 1, 2000**. However, most providers reported that when filing claims they stay fairly current by filing within one to three days from the date of the service. Medicare is urging providers to keep claim and review filing inventories current. Claims should be filed within five days from the date of service.

Providers should file review requests as soon as they receive determinations they disagree with. Medicare is requesting that **all** inventories be depleted by no later than **October 1, 1999.** ❖

Y2K Compliance for Biomedical Equipment

The Department of Veterans Affairs (VA) and the Department of Health and Human Services (DHHS) have established an online database to provide timely information to health care providers and their patients regarding the potential impact of the Y2K date change on specific biomedical equipment.

The database presents information about medical devices that health care practitioners, medical treatment facilities, and consumers may use and/or manage, with an eye toward ensuring patient health and safety.

Under an interagency agreement, the VA and DHHS have designated the Federal Y2K Biomedical Clearinghouse as an online database on an Internet Web site operated and maintained by the Food and Drug Administration (FDA). The Web site address is:

http://www.fda.gov/cdrh/yr2000/year2000.html

Data in the clearinghouse is restricted to publicly releasable information provided directly by manufacturers to the members of the clearinghouse.

There are approximately 13,000 medical device manufacturers. The database identifies equipment unaffected by the date change and lists equipment with problems ranging from display of an incorrect date to expected device failure on January 1, 2000.

Third party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators. ❖

ELECTRONIC MEDIA CLAIMS

Y2K Future Date Testing Available

The Health Care Financing Administration (HCFA) has instructed contractors to make available to providers the ability to test electronic claim submissions in a future date environment. First Coast Service Options, Inc. (FCSO) is offering this Y2K testing utility to the healthcare community from September 1, 1999, through October 29, 1999. To participate in Y2K future date testing with FCSO, please call Mary Anne Zingaro of the Medicare EDI Department at (904) 791-8769 or submit a written request to the address below:

Medicare EDI Department - 7 Center
P. O. Box 44071
Jacksonville, FL 32231

These documents are Year 2000 disclosures made pursuant to the Year 2000 Information and Readiness Disclosure Act (S.2392). Your legal rights regarding the use of the statements made herein may be substantially limited as provided in the Act. ❖

CLAIMS

Promoting Influenza and Pneumococcal Vaccinations

The flu season is here! Please remember to promote influenza and pneumococcal vaccinations, both Medicare Part B covered preventive health care benefits. These vaccines greatly reduce hospital admissions for pneumonia and deaths due to complications from influenza. Research shows that a provider's recommendation is a strong motivator for a patient to get vaccinated.

Standing orders are one example of an effective strategy that a hospital, public health clinic, or nursing home can use to increase immunization rates. For example, a physician could write a standing order in the hospital inpatient setting requiring the assessment and vaccination of all Medicare patients. A missed opportunity in the inpatient hospital setting occurs when a beneficiary is discharged without being offered and receiving an influenza and/or pneumococcal vaccination. Missed opportunities can often result in a beneficiary being readmitted to a hospital for influenza and related illnesses, like pneumonia. Unfortunately, missed vaccination opportunities occur in all settings. Strategies aimed at modifying systems for delivering care, such as standing orders, are one way of reducing missed opportunities. Please note that a standing order is not required for Medicare coverage of influenza immunizations, but it is required for coverage of pneumococcal vaccinations.

Other strategies are also effective in reducing missed vaccination opportunities. Health care providers and their office personnel can promote influenza and pneumococcal vaccinations by hanging posters on the facility walls to function as reminders for both the provider and his/her patients, and by using wall charts to track immunizations. Most importantly, physicians can make influenza and pneumococcal vaccinations available in their office or refer patients to other health care providers for these vaccinations. Postcards and phone calls to patients to remind them to get vaccinated are also powerful incentives.

The most effective strategies for increasing influenza and pneumococcal immunizations involve the health care provider. Simply put, Medicare beneficiaries are most likely to get immunized when their health care provider *specifically recommends vaccination.* We ask that providers realize their significant roles and discuss and promote influenza and pneumococcal vaccinations with their patients.

Please remember that while influenza immunizations are seasonal and should be given every year in the fall, pneumococcal vaccinations can be given at any time of the year. Generally, one pneumococcal vaccination after the age of 65 is all a person needs to be protected for a lifetime. However, persons who are considered at highest risk, such as persons with chronic illnesses, like diabetes, and cardiovascular or pulmonary disease, and people with compromised immune systems, like chronic renal failure, should discuss the necessity of a booster pneumococcal vaccination with their doctor. If any person 65 and over is unsure of his/her pneumococcal vaccination status, revaccination is recommended and will be covered by Medicare Part B.

Your Medicare contractor can provide you with free brochures and posters to display in general areas, to promote both influenza and pneumococcal vaccinations. To request these materials or for instructions on how to bill Medicare for influenza and pneumococcal vaccinations, please call Medicare Part B Customer Service at (904) 634-4994. ❖

Roster Billing Guidelines for Influenza and Pneumococcal Pneumonia Vaccines

The following article is reprinted from the July/August 1998 *Medicare B Update!* The changes are highlighted in the "What's New for 1999" section below.

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

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

- Established the roster billing method for mass immunizers who agree to accept assignment,
- Expanded use of the roster billing method to all providers licensed to render the vaccines and/or their administrations,
- Allowed physicians who administer the vaccine in the office setting to use the roster billing method regardless of the number of beneficiaries immunized, provided no other services were rendered to these beneficiaries, and
- Accepted "signature on file" on the roster in lieu of the actual patient's signature where the provider has a signed authorization on file to bill Medicare for services rendered.

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

What's New for 1999

There are three new procedure codes for influenza vaccine and PPV. Influenza virus vaccine should be billed using codes 90657, 90658, or 90659. These codes are for the vaccines only and do not include administration. Administration of the influenza virus vaccine continues to be billed using HCPCS code G0008.

There is one new code for polyvalent pneumococcal conjugant vaccine (90669); however, it is currently not FDA-approved and is therefore noncovered under the Medicare program. PPV is billed using code 90732. This code also is for the vaccine only and does not include administration. Administration of PPV continues to be billed using HCPCS code G0009.

Pneumococcal Pneumonia Vaccine

PPV may be billed to Medicare Part B using the simplified roster billing method. Typically, the vaccine is administered once in a lifetime to persons at high risk of pneumococcal disease. Considered at risk are persons age 65 or older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks), and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Medicare requires for coverage purposes that the vaccine be ordered by a doctor of medicine or osteopathy. However, to meet the physician order requirement, a physician does not have to be present if a previously written physician order (standing order) is on hand specifying that for any person receiving the vaccine:

- The person's age, health, and vaccination status must be determined;
- A signed consent must be obtained;
- The vaccine may be administered only to persons at high risk of pneumococcal disease who have not been previously vaccinated; and
- A record of vaccination must be provided.

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

PPV Vaccine Codes

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

HCPCS Codes

90669* Pneumococcal conjugant vaccine, polyvalent, for intramuscular use

***Note: procedure code 90669 is non-covered**

90732 Pneumococcal polysaccharide vaccine, 23 valent, adult dosage, for subcutaneous or intramuscular use

G0009 Administration of pneumococcal vaccine

ICD-9 Diagnosis Code

PPV claims should be submitted using diagnosis code V03.82 (other specified vaccinations against single bacterial diseases, streptococcus pneumoniae [pneumococcus]).

Advance Notice Requirement for PPV

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

Influenza Virus Vaccine

The influenza virus vaccine and its administration are covered by Medicare Part B and may be billed to Medicare Part B using the simplified roster billing method.

Influenza Virus Vaccine Codes

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

HCPCS Codes

90657 Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use

90658 Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use

90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use

G0008 Immunization, active; influenza virus vaccine

ICD-9 Diagnosis Code

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

Advance Notice Requirement for Influenza Services

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

Benefits of Accepting Assignment

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

Reimbursement for Flu and PPV Claims

The fees for the influenza vaccine, PPV, and their administration are not based on the Physician Fee Schedule; therefore, the limiting charge rules do not apply. Part B reimburses for the influenza vaccine and its administration, and for PPV and its administration, at 100 percent of the Medicare allowed amount. Deductible and coinsurance do not apply, and reimbursement is the same for both participating and nonparticipating providers.

When the claim is **nonassigned**, the provider may collect payment for the full charges from the beneficiary on the spot. Though the provider cannot roster bill, he/she must complete and submit a claim to Medicare Part B on the patient's behalf.

The 1999 Medicare allowed amounts for the influenza vaccine and its administration, and PPV and its administration are outlined below:

Code	Loc 01	Loc 02	Loc 03	Loc 04
G0008	$4.08	$4.08	$4.54	$4.93
G0009	$4.08	$4.08	$4.54	$4.93
90657	$1.66	$1.66	$1.66	$1.66
90658	$3.32	$3.32	$3.32	$3.32
90659	$3.32	$3.32	$3.32	$3.32
90669*	N/C	N/C	N/C	N/C
90732	$10.83	$10.83	$10.83	$10.83

(*N/C denotes a noncovered service)

Both the administration of the vaccines and the vaccines themselves are covered separately when rendered with or without other covered physician services. If the sole purpose of the patient encounter is to provide the flu vaccine or PPV, only the administration and vaccine provided should be billed. If a patient receives other services constituting an office visit level of service, the physician may also bill for the visit. Medicare will pay for medically reasonable and necessary visits when rendered with the administration and vaccine.

When other services are rendered to the beneficiary on the same day, claims must be submitted using the standard HCFA-1500 and related filing requirements.

How To Roster Bill for Influenza and PPV Claims

The chart on the following page outlines the fields on the HCFA-1500 claim form that must be completed for the roster billing of flu and PPV claims. For roster billing of either or both services, use the preprinted HCFA-1500 forms on pages 11 and 13 as cover sheets to the preprinted rosters (pages 10 and 12). **Information in lightly shaded blocks must be added to the HCFA-1500 form by the provider.**

Note: the sample HCFA-1500 for flu on page 11 shows procedure code 90658; providers should use 90657, 90658 **or** 90659 **as appropriate**, based on the descriptor.

Separate claim forms and rosters must be submitted for each of the influenza vaccine codes, and for PPV claims.

All entities that use the simplified billing process should use place of service 60 (mass immunization center) on any roster claim submitted to Medicare Part B.

How to Complete the Roster

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

- Provider name and number
- Date of service
- Patient's health insurance claim number (copy directly from the patient's red, white, and blue Medicare card)
- Patient's name
- Patient's address
- Date of birth
- Sex
- Beneficiary's signature, or stamped "Signature on File"

Note the following warning that must be printed on the PPV roster bill form:

WARNING: Ask beneficiaries if they have been vaccinated with PPV.

Rely on patients' memory to determine prior vaccination status.

If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine.

If patients are certain that they have been vaccinated within the past 5 years, *do not revaccinate.*

This information must be printed clearly so these claims can be processed in a timely manner. No more than 50 claims (i.e., five rosters per claim form) should be submitted with each claim form.

Finally, if *only* the vaccine or its administration is being rendered, mark out on the HCFA-1500 claim form the service *not* being provided.

Submitting Claims to Medicare Part B of Florida

Roster billings of the PPV and flu vaccine must be mailed to the following address:

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

Be sure to include the appropriate HCFA-1500 claim form, front **and back** (see pages 11, 13 and **14**), and the appropriate vaccine roster (pages 10 and 12).

Filing Electronically

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

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

HCFA-1500 Block	Influenza Virus Vaccine Claims	PPV Claims
Block 1	Check "Medicare"	Check "Medicare"
Block 2	See attached roster	See attached roster
Block 11	None	None
Block 17	N/A	Name of ordering physician MUST be entered **(One name per claim form)**
Block 17a	N/A	UPIN of ordering physician MUST be entered **(One UPIN per claim form)**
Block 20	No	No
Block 21	V04.8	V03.82
Block 24B	60-Mass Immunization Center	60-Mass Immunization Center
Block 24D (line 1) (line 2)	 90657, 90658 *or* 90659 G0008	 90732 G0009
Block 24E (lines 1 AND 2)	1	1
Block 24F	Enter the charge for each listed service.	Enter the charge for each listed service.
Block 27	X in YES block	X in YES block
Block 29	0.00	0.00
Block 31	Entity's representative must sign	Entity's representative must sign
Block 32	N/A	N/A
Block 33	Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number	Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number

Influenza Virus Vaccine Roster

Provider Payee Name _____

Provider Number _____ Date of Service _____

Number	Insured's I.D. number	Patient's Name (Last, First, Middle Initial)	Patient's Address (Number, street, city, ZIP code)	Patient's date of birth	Patient's sex	Patient's signature, or "signature on file"
00						
01						
02						
03						
04						
05						
06						
07						
08						
09						

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

INFLUENZA VIRUS VACCINE CLAIMS ONLY

ROSTER BILLING ONLY

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare #) | MEDICAID [ ] (Medicaid #) | CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (VA File #) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
SEE ATTACHED ROSTER

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
N/A

17a. I.D. NUMBER OF REFERRING PHYSICIAN
N/A

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V048
2. ____
3. ____
4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1		60		90658		1						
2		60		G0008		1						
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
N/A

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Pneumococcal Pneumonia Virus Vaccine Roster

Provider Payee Name _____

Provider Number _____ Date of Service _____

Number	Insured's I.D. number	Patient's Name (Last, First, Middle Initial)	Patient's Address (Number, street, city, ZIP code)	Patient's date of birth	Patient's sex	Patient's signature, or "signature on file"
00						
01						
02						
03						
04						
05						
06						
07						
08						
09						

Warning! Ask beneficiaries if they have been vaccinated with PPV

- Rely on patient's memory to determine prior vaccination status
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine
- If patients are certain they have been vaccinated within the past 5 years, do not revaccinate

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PNEUMOCOCCAL PNEUMONIA VIRUS VACCINE CLAIMS ONLY

ROSTER BILLING ONLY

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
SEE ATTACHED ROSTER

3. PATIENT'S BIRTH DATE MM DD YY SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V0382
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1		60		90732		1						
2		60		G0009		1						
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
N/A

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Claims Involving Beneficiaries Who Have Elected Hospice Coverage

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of 6 months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare-certified hospice is covered under the hospice benefit provisions. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an "attending physician." For purposes of administering the hospice benefit provisions, an "attending physician" means a physician who:

- Is a doctor of medicine or osteopathy; and
- Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of his/her medical care.

Even though a beneficiary elects hospice coverage, he/she may designate and use an attending physician who is not employed by the hospice for professional services furnished, in addition to the services of hospice-employed physicians. The professional services of an attending physician that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered hospice services. Such services are billed to Medicare Part B, provided they are not furnished by the physician under a payment arrangement with the hospice. If a private attending physician furnishes services related to a hospice patient's terminal condition under a payment arrangement with the hospice, such services are considered hospice services and are billed by the hospice to its intermediary. Private physicians should enter the statement "Hospice patient. Dr._____is the attending physician and is not employed by the hospice." on the HCFA-1500 claim form in block 19. For the National Standard Format (NSF) for electronic claims, refer to record FA0 field 40.0. For the American National Standards Institute (ANSI) X12 837 3051 3B.0,1 refer to Table 2 - 370 SV111 or, for the 837 3032 2B.00, Table 2 - 290 SV117.

If the claim contains this statement and there is no indication the physician is an employee of the hospice, Part B will process the claim and reimburse the physician or beneficiary, as appropriate, 80 percent of the fee schedule for covered service(s) subject to any unmet Part B deductible (unless special payment provisions apply).

In addition, Part B will process covered services that hospice-employed physicians may furnish to patients after their hospice benefits are exhausted or revoked, even if the beneficiary continues to be treated by the hospice after the benefits are exhausted or revoked. Claims for such services should *not* include the above certification statement. ❖

Correct Coding Initiative

Version 5.2 of the Correct Coding Initiative (CCI), was loaded to the Florida Medicare Part B claims processing system and became effective July 1, 1999. Version 5.2 includes all previous versions and updates from January 1996 to the present.

The U.S. Department of Commerce, National Technical Information Service (NTIS), has developed a national correct coding policy manual to assist physicians in correctly coding services for reimbursement. Medicare carriers are prohibited from publishing specific correct coding edits (CCE). Concerns about correct coding edit pairs must be submitted in writing to:

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

- Information related to CCI may be obtained by ordering a national correct coding policy manual from NTIS.
- Single issues of the national correct coding policy manual may be requested by calling (703) 605-6000, or (800) 553-6847.
- Subscriptions to the national correct coding policy may be requested by calling (703) 605-6060 or (800) 363-2068.

Ordering and product information is also available via the World Wide Web at **www.ntis.gov/cci.**

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators. ❖

Proper Mailing of Paper Claims

An article was published on page 36 of the July/August 1999 *Medicare B Update!* extolling the advantages of Electronic Media Claims (EMC) submission. While providers are encouraged to increase their use of EMC submission, Medicare understands that paper claims are still being used.

Paper claims submitted to Medicare are processed by using optical character recognition (OCR) software. The OCR software reads the characters on the claims and enters the information in the processing system. The higher the quality of the print, the more likely the claim will be processed correctly. When poor print quality is received, the scanner cannot always distinguish between similar characters – an 8 may be read as a 3.

Paper claims must be submitted using high-quality ink and mailed in letter size (8½ x 11) envelopes, **with no folds or staples**.

If paper claims are submitted with poor-quality ink and/or folds, the scanner may not be able to read the information along the crease, or the paper claim may jam in the scanner, requiring manual intervention. When the automated process is altered, the chance of processing the claim incorrectly increases. ❖

Changes to Health Professional Shortage Area Designations

Effective **August 1, 1999**, the following Health Professional Shortage Area (HPSA) designation is being reinstated:

County	Parts
Madison	All

Additionally, an article was published in the January/February 1999 *Medicare B Update!* (page 75) indicating that Gadsden County was reinstated as a HPSA effective December 1, 1998. That date is incorrect; the correct date is ***January 1, 1998.*** ❖

UPIN and Date Last Seen Requirements for Physical Therapist Services

As a reminder, claims submitted by Physical Therapists must include in block 19 of Form HCFA-1500 the Unique Provider Identification Number (UPIN) and date last seen of the attending physician. If this information is provided in a different block on the 1500, a development letter will be generated requesting the information. This causes a delay in claims processing. In the event a response to the development letter is not received within the specified timeframe, the claim will be processed without the information, resulting in a denial.

This requirement is part of the HCFA -1500 completion mandate that became effective on March 1, 1996. A comprehensive article regarding HCFA-1500 requirements was published in the March/April 1996 *Medicare B Update!* (pages 46-56). Those who do not have this issue may obtain it electronically on the Medicare Online Bulletin Board System (BBS). For more information on the BBS, see page 66. ❖

COVERAGE/REIMBURSEMENT

AMBULANCE

Final Rule Revising and Updating Medicare Policies Concerning Ambulance Services

This is to provide notification of revisions to Medicare policies concerning ground ambulance transportation services published in the January 25, 1999, *Federal Register,* pages 3637-3650. The final rule provisions require:

- minimum vehicle and staff requirements to qualify as an ambulance;
- a national definition of the term "bed confined;"
- ambulance suppliers to obtain a physician's written order certifying the need for scheduled and unscheduled nonemergency ambulance service; and
- ambulance suppliers to use a standardized form to document compliance with state licensure and certification requirements.

The final rule clarifies the circumstances under which an ambulance service is paid under Medicare Part A as opposed to Medicare Part B and also allows for scheduled round-trip transportation of a beneficiary with end stage renal disease from home to the nearest appropriate dialysis facility, freestanding or hospital-based. The final rule also allows for direct Medicare payment for rural paramedic intercept services; however, this provision does not apply in Florida. For more information related to the paramedic intercept provision and reimbursement for ambulance services to nonhospital-based dialysis facilities, refer to the July/August 1999 *Medicare B Update!* (page 8).

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment, and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by state or local law. This should include, at a minimum, one two-way voice radio or wireless telephone.

Basic Life Support ambulances must be staffed by at least two people, one of whom must be certified as an emergency medical technician (EMT) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. Advanced Life Support (ALS) vehicles must be staffed by two people with one of the two staff members certified as a paramedic or an EMT who is trained and certified, by the state or local authority where the services are being furnished, to perform one or more ALS service.

The final rule revised the medical necessity requirements to include a national definition of the term "bed confined." The criteria outlined in the preamble of the final rule states that the beneficiary is:

> **Unable to get up from bed without assistance; unable to ambulate; and is unable to sit in a chair or wheelchair.**

As defined in the *Federal Register*, the term "bed confined" is not synonymous with "bed rest" or "non-ambulatory." In addition, "bed confined" is not meant to be the sole criterion to be used in determining medical necessity. It is one factor to be considered when making medical necessity determinations

For scheduled and unscheduled nonemergency ambulance transports, the rule requires ambulance service suppliers to obtain a physician's written order certifying the need for an ambulance (CMN, or certificate of medical necessity). In addition to the physician's signature, it is acceptable to obtain signed certification statements when professional services are furnished by physician assistants, nurse practitioners, or clinical nurse specialists (where all applicable state licensure or certification requirements are met).

The physician's certification must be dated no more than 60 days prior to the date that the service is provided. In cases where a beneficiary requires a nonemergency, unscheduled transport, the physician's certification may be obtained 48 hours after the ambulance transportation has been provided.

In addition to obtaining the certification, ambulance suppliers are required to retain the certificate on file and, upon request, present the requested certification. This requirement applies to both repetitive and one-time ambulance transports. However, there is one exception to the physician certification rule. A physician's certification is not required for nonemergency, unscheduled transportation of beneficiaries residing at home or in facilities where they are not under the direct care of a physician. These situations should be rare because most transports occur for beneficiaries receiving dialysis or diagnostic tests.

Currently the Health Care Financing Administration (HCFA) has not made revisions to the HCFA-1500 and HCFA-1491 claim forms. ***Although the claim forms have not been modified, ambulance suppliers must still comply with the requirement of the physician certification provision.***

Pending further notification from HCFA, implementation of the provision requiring ambulance suppliers to use a standardized form to document compliance with state or local licensure and certification requirements is delayed.

The final rule clarifies the circumstances under which an ambulance trip is paid as a patient transport under Medicare Part A as opposed to an ambulance service under Medicare Part B. The movement of a beneficiary from his or her home, an accident scene, or any other point of origin to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury is covered, assuming medical necessity and other coverage criteria are met, only under Part B as an ambulance service. Part A coverage is not available because, at the time the beneficiary is being transported, he or she is not an inpatient of any provider paid under Part A of the program. The transfer of a beneficiary from one provider to another is also not covered as a Part A provider service because, at the time that the beneficiary is in transit, he or she is not an inpatient of either provider. This service may be covered under Part B.

Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the patient to another hospital or other site for specialized care. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B.

Implementation of the provisions contained in the final rule that are addressed in this notice are effective for ambulance services furnished on or after October 1, 1999. ❖

CARDIOLOGY

M0302: Cardiac Output Monitoring by Electrical Bioimpedance

Cardiac monitoring using electrical bioimpedance, a form of plethysmography, is covered for the uses and conditions described below, effective for services furnished on or after July 1, 1999. Devices utilize electrical bioimpedance to noninvasively produce hemodynamic measurements of cardiac output; specifically, stroke volume, contractility, systemic vascular resistance, and thoracic fluid content. The devices are covered for the following uses:

- Noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease;
- Differentiation of cardiogenic from pulmonary causes of acute dyspnea;
- Optimization of atrioventricular interval for patient with A/V sequential cardiac pacemakers;
- Patients with need of determination for intravenous inotropic therapy;
- Post-heart transplant myocardial biopsy patients; and
- Patients with a need for fluid management.

Not covered at this time are the use of such devices for any monitoring of patients with proven or suspected disease involving severe regurgitation of the aorta, or for patients with minute ventilation (MV) sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker. Also, these devices do not render accurate measurements in cardiac bypass patients while on a cardiopulmonary bypass machine, but do provide accurate measurements prior to and post-bypass pump.

This technology is in the process of being proven for additional uses. Therefore, the above uses represent the current coverage situation. Local medical review policy (LMRP) may be developed that may cover additional uses when there is sufficient evidence of the medical effectiveness of such uses.

The following are the Medicare Fee Schedule amounts for M0302:

	Participating			Nonparticipating			Limiting Charge		
Code	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
M0302	$14.82	$15.95	$16.90	$14.08	$15.15	$16.06	$16.19	$17.43	$18.46
M0302-TC	$5.32	$5.88	$6.33	$5.05	$5.59	$6.01	$5.81	$6.42	$6.92
M0302-26	$9.50	$10.07	$10.57	$9.03	$9.57	$10.04	$10.38	$11.00	$11.55

93799: Enhanced External Counterpulsation (EECP) - Revised Procedure Code

Information concerning EECP was provided in the July/August *Medicare B Update!* (page 9). Physicians were instructed in that article to use procedure code 97016 to report EECP services rendered on or after July 1, 1999 (EECP services rendered prior to July 1, 1999 continue to be non-covered and should be billed using procedure code 92971).

Medicare has received additional information that instructs physicians to bill for EECP using CPT code **93799** (Unlisted cardiovascular service or procedure), until a specific code for EECP is developed.

Additionally, the codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761) and plethysmography (93922 or 93923) are not medically necessary with this service and should not be paid on the same day, unless they occur in a clinical setting not connected with the delivery of the EECP. Daily evaluation and management codes (99211-99215) cannot be billed with the EECP treatments. Any evaluation and management service must be justified with adequate documentation of the medical necessity of the visit.

EECP must be performed under direct supervision of a physician. The physician must be present in the office suite and immediately available to provide assistance and direction throughout the time personnel are performing services. ❖

DRUGS AND BIOLOGICALS

Additional Changes to Injectable Drugs Fees

The following are updates to certain injectable drugs prices. These amounts are effective for services processed on or after June 28, 1999.

CODE	NAME OF INJECTABLE DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J0850	Injection, cytomegalovirus immune globulin intravenous (human) per vial	$612.18	$581.57	$668.81
J1160	Injection, digoxin, up to 0.5 mg	$1.86	$1.77	$2.03
J1820	Injection, insulin, up to 100 units	$1.97	$1.87	2.15
J1990	Injection, chlordiazepoxide HCL, up to 100 mg	$16.34	$15.52	17.85
J3301	Injection, triamcinolone acetonide, per 10 mg	$1.48	$1.41	1.62
J3302	Injection, triamcinolone diacetate, per 5 mg	$0.81	$0.77	0.88
J9050	Carmustine, 100 mg	$98.36	$93.44	107.46
J9151	Daunorubicin Citrate, Liposomal formulation, 10 mg	$64.60	$61.37	70.58
J9214	Interferon alfa-2B, recombinant, 1 million units	$8.81	$8.37	9.62
J9293	Injection, mitoxantrone HCL, per 5 mg	$210.39	$199.87	229.85

Clarification: Non FDA-Approved Radiopharmaceuticals

An article was published in the July/August 1999 *Medicare B Update!* (page 9) explaining that Medicare does not pay for radiochemicals because they are not approved by the Food and Drug Administration (FDA). Medicare does pay for some *radiopharmaceuticals*, but only for those that are FDA-approved. Radiopharmaceuticals that are not approved by the FDA are noncovered.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

LABORATORY/PATHOLOGY

New CLIA Waived Tests

Listed below are the latest tests approved by the Center for Disease Control as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). The procedure codes for these new tests must be submitted with modifier QW to be recognized as a waived test.

- Roche/Boehringer Mannheim CoaguChek System for Professional Use
- Applied Biotech SureStep Mono Test (whole blood)
- Becton Dickinson Link 2 *H. pylori* Rapid Test (for whole blood)
- Bion Diagnostic Sciences BTA Stat Test (for home use)
- Diatech Diagnostics Uriscreen (for OTC use)
- Lifestream Technologies Cholesterol Monitor
- Abbott TestPack Plus H. pylori (for whole blood)
- Jant Accutest Infectious Mononucleosis Test (whole blood)

Two new waived CPT codes have been assigned:

- 83518QW for the Bion Diagnostics Sciences BTA Stat Test; and
- 81007QW for the Diatech Diagnostics Uriscreen Test.

The complete list of waived tests (prior to these additions) can be found on pages 20-24.

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Dipstick or tablet reagent urinalysis - non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Various	81002	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Fecal occult blood	Various	82270, G0107 (contact Medicare for payment instructions)	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
Ovulation tests by visual color comparison for human luteinizing hormone	Various	84830	Detection of ovulation (optimal for conception)
Urine pregnancy tests by visual color comparison	Various	81025	Diagnosis of pregnancy
Erythrocyte sedimentation rate - non-automated	Various	85651	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia
Hemoglobin by copper sulfate - non-automated	Various	83026	Monitors hemoglobin level in blood
Blood glucose by glucose monitoring devices cleared by the FDA for home use	Various	82962	Monitoring of blood glucose levels
Blood count; spun microhematocrit	Various	85013	Screen for anemia
Hemoglobin by single instrument with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout	HemoCue	85018QW (effective 10/1/96)	Monitors hemoglobin level in blood (HCPCS code Q0116 should be discontinued for this test 9/30/96)
HemoCue B-Glucose Photometer	HemoCue	82947QW, 82950QW, 82951QW, 82952QW (effective 10/1/96)	Diagnosis and monitoring of blood glucose levels (HCPCS codes G0055, G0056 and G0057 should be discontinued for this test 9/30/96)
ChemTrak AccuMeter	ChemTrak	82465QW	Cholesterol monitoring
Advanced Care	Johnson & Johnson	82465QW	Cholesterol monitoring
Boehringer Mannheim Chemstrip Micral	Boehringer Mannheim	82044QW	Monitors low concentrations of albumin in urine which is helpful for early detection in patients at risk for renal disease
Cholestech LDX	Cholestech	82465QW, 83718QW, 84478QW, 82947QW, 82950QW, 82951QW, 82952QW, 80061QW	Measures total cholesterol, HDL cholesterol, triglycerides and glucose levels in whole blood

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Serim Pyloritek Test Kit	Serim	87072QW	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers)
QuickVue In-Line One-Step Strep A Test	Quidel	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
Boehringer Mannheim Accu-Chek InstantPlus Cholesterol	Boehringer Mannheim	82465QW	Cholesterol monitoring
All qualitative color comparison pH testing - body fluids (other than blood)	Various	83986QW	pH detection (acid-base balance) in body fluids such as semen, amniotic fluid and gastric aspirates
SmithKline Gastroccult	SmithKline	82273QW	Rapid screening test to detect the presence of gastric occult blood
QuickVue One-Step H. Pylori Test for Whole Blood	Quidel	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood.
Binax NOW Strep A Test	Binax	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
Delta West CLOtest	Delta West Tri-Med Specialties	87072QW	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers)
Wampole STAT-CRIT Hct	Wampole Laboratories	85014QW	Screen for anemia
SmithKline Diagnostics FlexSure HP Test for IgG Antibodies to H. pylori in Whole Blood	SmithKline Diagnostics, Inc.	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Wyntek Diagnostics OSOM Strep A Test	Wyntek Diagnostics, Inc	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
GI Supply HP-FAST	Mycoscience Labs, Inc.	87072QW	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers)
Abbott FlexPak HP Test for whole blood	Abbott Laboratories	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Chemtrak AccuMeter H. pylori Test (for whole blood)	ChemTrak	Pending	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
BioStar Acceava Strep A Test (direct specimen only)	Wyntek Diagnostics, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
LXN Fructosamine Test System	LXN Corporation	82985QW	Used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period. Not a useful test for screening diabetes mellitus.
ITC Protime Microcoagulation System for Prothrombin Time	International Technidyne Corporation (ITC)	85610QW (contact Medicare for claims instructions)	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency.
CoaguChek PST for Prothrombin Time	Boehringer Mannheim Corporation	85610QW (contact Medicare for claims instructions)	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency.
SmithKline ICON Fx Strep A Test (from throat swab only)	Binax	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
Abbott Signify Strep A Test (from throat swab only)	Wyntek Diagnostics, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
Bayer Clinitek 50 Urine Chemistry Analyzer - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes - automated	Bayer	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Bayer DCA 2000 - glycosylated hemoglobin (Hgb A1c)	Bayer	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Wampole Mono-Plus WB	Wampole Laboratories	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
LXN Duet Glucose Control Monitoring System	LXN Corporation	82962, 82985QW	Monitoring of blood glucose levels and measures fructosamine which is used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period.
ENA.C.T Total Cholesterol Test	ActiMed Laboratories, Inc.	82465QW	Cholesterol monitoring
Genzyme Contrast Mono (for whole blood)	Genzyme Diagnostics	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Applied Biotech SureStep Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
STC Diagnostics Q.E.D. A150 Saliva Alcohol Test	STC Technologies Inc.	Pending	Qualitative determination of alcohol (ethanol) in saliva
STC Diagnostics Q.E.D. A350 Saliva Alcohol Test	STC Technologies Inc.	Pending	Qualitative determination of alcohol (ethanol) in saliva

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Micro Diagnostics Spuncrit Model DRC-40 Infrared Analyzer for hematocrit	Micro Diagnostics Corporation	Pending	Screen for anemia
Chemstrip Mini UA - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes - automated	Boehringer Mannheim Corporation	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Litmus Concepts FemExam TestCard (from vaginal swab)	Litmus Concepts, Inc.	84999QW	Qualitative test of a vaginal fluid sample for elevated pH (pH greater than or equal to 4.7) and the presence of volatile amines
Wyntek Diagnostics OSOM Mono Test (for whole blood)	Wyntek Diagnostics, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)	Applied Biotech, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
Seradyn Color Q Mono (whole blood)	Genzyme Diagnostics	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
BioStar Acceava Mono Test (whole blood)	Wyntek Diagnostics, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
LifeSign UniStep Mono Test (for whole blood)	Princeton BioMeditech Corp.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab)	Applied Biotech, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
DynaGen NicCheck I Test Strips	Dynagen, Inc.	80101QW (This test may not be covered in all instances. Contact Medicare.)	Detects nicotine and/or its metabolites in urine, which is used as an aid in indicating the smoking status of an individual and as an aid in the identification of a smoker as a low or high nicotine consumer
Mainline Confirms Strep A Dots Test (direct from throat swab)	Applied Biotech, Inc.	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
Quidel Cards O.S. Mono (for whole blood)	Quidel Corporation	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Bayer Clinitek 50 Urine Chemistry Analyzer - for HCG, urine	Bayer Corp	84703QW	Diagnosis of pregnancy

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Bayer Clinitek 50 Urine Chemistry Analyzer - for microalbumin, creatinine	Bayer Corp.	82044QW	Detection of patients at risk for developing kidney damage.
Bayer DCA 2000+ - glycosylated hemoglobin (Hgb A1c)	Bayer Corp.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
GDS Diagnostics HemoSite Meter - for hemoglobin	GDS Technology, Inc.	85018QW	Measures hemoglobin level in whole blood
ActiMed Laboratories ENA.C.T. Total Cholesterol Test (PDU)	ActiMed Laboratories, Inc.	82465QW (Contact Medicare for claims instructions)	Cholesterol monitoring
Genzyme Contrast Strep A (direct from throat swab)	Genzyme Diagnostics	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever
*Roche/Boehringer Mannheim CoaguChek System for Professional Use	Roche Diagnostics/ Boehringer Mannheim Corporation	85610QW (contact Medicare for claims instructions)	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency.
*Applied Biotech SureStep Mono Test (for whole blood)	Applied Biotech, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
*Becton Dickinson Link 2 *H. pylori* Rapid Test (for whole blood)	Becton Dickinson Microbiology Systems	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
*Bion Diagnostic Sciences BTA stat Test (for home use)	Bion Diagnostic Sciences, Inc.	83518QW	Immunoassay for the qualitative detection of bladder tumor associated antigen in urine of persons diagnosed with bladder cancer and used as an aid in the management of bladder cancer patients
*Diatech Diagnostics Uriscreen (for OTC use)	Savyon/USA	81007QW	Detects catalase in urine which is associated with urinary tract infections (UTIs). White blood cells and some bacteria associated with UTIs are positive for catalase.
*Lifestream Technologies Cholesterol Monitor	Lifestream Technologies	82465QW	Cholesterol monitoring
*Abbott TestPack Plus H. pylori (for whole blood)	Abbott Laboratories	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
*Jant Accutest Infectious Mononucleosis Test (for whole blood)	Jant Pharmacal Corporation	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis

* Newly-added waived test system

NON-PHYSICIAN PRACTITIONERS

Effective July 1, 1999, ARNP/PA/CNS Must Use PIN, Not Modifiers

This is a clarification to an article on the cover of the May/June 1999 *Medicare B Update!* that provided information regarding continued use of modifiers that were deleted effective January 1, 1999. Advanced Registered Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists were instructed to continue using the modifiers through June 30, 1999, even though they may have received their provider identification number (PIN) from Medicare. The deleted modifiers are:

AK - NP, rural, team member
AL - NP, non-rural, team member
AN - PA services for other than assistant-at-surgery, non-team member
AU - PA for other than assistant-at-surgery, team member
AV - NP, rural, non-team member
AW- CNS, non-team member
AY - CNS, team member

As a reminder, beginning July 1, 1999, *all* services billed by these practitioners *must* be submitted using their PIN. The modifiers shown above were **discontinued** on that date. ❖

RADIOLOGY

Modifier GH: Billing for Screening Mammography Converted to Diagnostic

Claims for mammographies that have been converted from screening to diagnostic for the same beneficiary, same day, and same visit *must* be reported with modifier GH.(Diagnostic mammogram converted from screening mammogram on the same day).

An ICD-9 "V-code" is required, or the claim will be returned as unprocessable.

For more information regarding mammographies converted from screening to diagnostic, refer to the following issues of the *Medicare B Update!*: March/April 1999 (page 31) and September/October 1998 (page 28). ❖

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

This section of the *Medicare B Update!* features new and revised medical policies developed as a result of either the Local Medical Review (LMR) or Focused Medical Review (FMR) initiatives. Both 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 January 1, 1999 and after, unless otherwise stated in the "Effective Date" section of the policy.

Sources of Information

The sources of information used in the development of these policies may be obtained by accessing the Medicare online Bulletin Board System (BBS).❖

Table of Contents — Medical Review Policies

Pain Rehabilitation

Chronic pain is difficult and frustrating to manage, and patients who experience it are often viewed as being undesirable to treat. Patients with chronic pain are often characterized by low levels of activities of daily living (ADLs), a high demand for medication accompanied by physical and psychological dependency, high verbalization of pain, and the inability to work. In many cases, patients with chronic pain are so entrenched in pain behavior that a behavior modification approach is essential.

Pain rehabilitation programs are an innovative approach to the treatment of intractable pain. The goal of such programs is to give patients the tools to manage and control his or her pain and thereby improve his or her ability to function independently.

Indications and Limitations of Coverage and/or Medical Necessity

Services furnished under outpatient hospital pain rehabilitation programs are considered medically necessary and appropriate if:

- The patient's pain is attributable to a physical cause;
- The usual methods of treatment have not been successful in alleviating pain; and
- A significant loss of ability by the patient to function independently has resulted from pain.

In addition, the following criteria must also be met:

- The patient must be under the care of a physician;
- The patient must have an evaluation that includes an evaluation of the physiological, psychological, and social aspects of pain;
- The patient must have an individualized treatment plan that is specific to his or her needs and functional limitations;
- The patient must exhibit limited functional status in relation to performance of ADLs;
- The patient must have the cognitive ability to understand and carry out instructions and must be compliant and cooperative; and
- The patient must demonstrate a high level of motivation to participate in his or her plan of care. The level of patient participation is usually measured by the team members and documented in the progress notes.

To enter the program, the patient must undergo an extensive evaluation. A problem-solving group attempts to identify the medical, behavioral, vocational, financial, social, and other significant problems of the patient. Coverage of services furnished under outpatient hospital pain rehabilitation programs, including services furnished in group settings under individualized plans of treatment, is available if the patient meets the criteria listed in this policy.

A pain rehabilitation program is one that employs a coordinated multidisciplinary team to deliver, in a controlled environment, a concentrated program designed to modify pain behavior through the treatment of physiological, psychological, and social aspects of pain. Such programs generally include diagnostic testing, skilled nursing, psychotherapy, structured progressive withdrawal from pain medication, physical therapy and occupational therapy to restore physical fitness (mobility and endurance) to a maximal level within the constraints of a physical disability, and the use

of mechanical devices and/or activities to relieve pain or modify a patient's reaction to it (e.g., nerve stimulator, hydrotherapy, massage, ice, systemic muscle relaxation training, and diversional activities). The activities of this program are under general supervision and, as needed, direct supervision of a physician.

The multidisciplinary pain approach begins with a complete clinical evaluation. Comprehensive medical and psychosocial evaluations with particular emphasis on functional capabilities and behavioral responses to pain are essential. Previous medical records should be obtained to avoid repeating appropriately performed studies and unsuccessful treatment approaches.

The multidisciplinary team functions at several levels within the treatment process. An attempt is made to identify and resolve documentable organic problems when present and to improve the patient's ability to cope with pain. In addition, considerable effort is devoted to improving the patient's functional outcome, as measured by increased activity time, improved activities of daily living, increased distance walked, and increased tolerance for specific homemaking or vocational activities.

Pain rehabilitation services must be rendered under a written plan of care/treatment. The plan must:

- Be consistent with the nature and severity of the individual's symptoms and diagnosis, and be tailored to meet his or her specific needs;
- Be reasonable in terms of the modality, amount, frequency, and duration of the treatment;
- Include services generally accepted by the professional community as safe and effective treatment for the purpose used;
- Be developed upon admission and establish specific individualized objectives, measurable, functional goals, and steps to achieve the goals; and
- Be signed by a physician.

Each pain rehabilitation session should be documented and should reflect the treatment provided and the patient's response toward his or her goals.

Diagnostic tests may be an appropriate part of pain rehabilitation programs. Such tests would be covered on an individual basis only when they can be reasonably related to the patient's illness, complaint, symptom, or injury, and when they do not represent an unnecessary duplication of tests previously performed.

The average program will usually last 4 weeks on an inpatient or outpatient basis or a combination thereof.

HCPCS Codes

Various diagnostic testing, therapeutic testing, services and procedures.

ICD-9 Codes That Support Medical Necessity

N/A

Reasons for Denial

Pain rehabilitation services will be denied for the following circumstances:

- When the services do not meet all the criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy;
- When a patient has a severe psychiatric disturbance that would not allow him/her to comprehend and retain new learning;
- When the documentation indicates that the patient is not demonstrating progress toward achieving stated goals within a reasonable period of time (the time frame is included in the plan of care);
- When the patient has attained his or her pain rehabilitation goals and does not require the skills of a qualified clinician;
- When the documentation indicates a duplication of services (e.g., an overlap of physical and occupational therapies);
- Some pain rehabilitation programs may utilize services and devices that are excluded from coverage, (e.g., acupuncture, vocational counseling).
    - Some of the services that may be utilized have limited coverage criteria, (e.g., biofeedback, dorsal column stimulator, family counseling services).
    - See Coverage Issues Manual (CIM) for coverage criteria.
- Pain rehabilitation will be considered noncovered when chronic pain has resulted from a mental condition, rather than from any physical cause.
- Chemical dependency should not be the primary diagnosis. The chemical dependency must be secondary to the pain syndrome.

Noncovered ICD-9 Code(s)

N/A

Coding Guidelines

This policy does not provide the medical necessity requirements for each modality rendered in the program. Some of the HCPCS codes listed in this policy are included in individual Local Medical Review Policies (LMRPs) that have specific coverage guidelines that must be met in order for the service to be covered by Medicare of Florida. Please see individual LMRPs for coverage criteria for each HCPCS code listed in this policy. Some examples of LMRPs that may effect coverage are 97003: Occupational Therapy Policy for Rehabilitation Services and 97010: Physical Medicine and Rehabilitation. These LMRPs contain multiple HCPCS codes. The provider of the service is responsible for ensuring the medical necessity of each service rendered.

Documentation Requirements

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

- A physician order or referral for the Pain Rehabilitation services written by the treating physician who 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 Pain Rehabilitation services and rehabilitation potential;
- An evaluation/assessment of the patient performed by a physician and/or qualified staff members upon admission to the Pain Rehabilitation program to ensure the patient meets medical necessity criteria for the program;
- An individual treatment plan containing an individualized problem list, the specific procedure or activity to be performed and the responsible disciplines, the frequency and duration of the service(s), individual treatment goals (that are objective, measurable, and functional), and a

discharge plan. The treatment plan(s) must be dated and signed by the physician;
- Daily documentation (progress notes) reflecting 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 by the qualified team member who rendered the service;
- Regular team conference notes that reflect the individual patient's goals and progress;
- Discharge summary indicating the changes since the start of care, goals accomplished, the reason for failure to achieve goals (if applicable), and the discharge plan.

Each progress note must be legible, dated, signed, and the credentials of the qualified person rendering the service must be present. In addition, if the HCPCS code billed is based on time, then the time spent by the provider in a face-to-face encounter with the patient should be documented.

Other Comments

Terms defined: Chronic pain—pain that lasts six months or more.

Effective Date

This policy is effective for services rendered on or after October 1, 1999.

Advance Notice Statement

Various procedure codes may be billed for pain rehabilitation. For advance notice requirements for a specific procedure code, refer to the Local Medical Review Policy (LMRP) for that code. LMRPs can be found in previous issues of the *Medicare B Update!*, or on Medicare's bulletin board system (BBS). For more information about the BBS, see page 66 of this issue. ❖

A9270: Additions to Noncoverage Policy

The following services have been added to the *local* noncoverage decisions, effective for services processed on or after October 18, 1999:

A9270* Abdominal Aorta Transplant from a Cadaver
A9270* Adoptive Immunotherapy
A9270* Neocontrol (Magnetic Incontinence Chair)
A9270* Percutaneous Polymethylmethacrylate (PMMA) Vertebroplasty
A9270* SPECT with Altropane for the early diagnosis of Parkinson's disease

The following service has been added to *national* noncoverage decisions, effective for services processed on or after October 18, 1999:

A9270* Rebetron

The following services have been deleted from both the *local* and **national** noncoverage decisions, effective for services processed on or after July 1, 1999:

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

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

Advance Notice Statement

An advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for a service that is considered investigational/experimental, or is not approved by the FDA, or because there is a lack of scientific and clinical evidence to support the procedure's safety and efficacy. Refer to page 4 for more information concerning advance beneficiary notice requirements. ❖

J1561-J1562: Intravenous Immune Globulin

Intravenous immune globulin is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Indications and Limitations of Coverage and/or Medical Necessity

The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide IgG antibodies to those who lack them. Medicare of Florida will provide coverage for intravenous immune globulin when it is used in treatment of the following conditions:

- Primary Humoral Immunodeficiency
  Congenital agammaglobulinemia
  Common variable immunodeficiency
  Wiskott-Aldrich syndrome
  X-linked agammaglobulinemia
  Severe combined immunodeficiency

  A serum trough IgG level should be measured every 3 months before the infusion, and the dose of intravenous immune globulin adjusted accordingly. Infusions are usually given every 4 weeks, but the interval should be adjusted, depending on the serum trough IgG concentrations and the patient's clinical condition. Serum trough levels should be maintained at 400-600mg/dl, a value close to the lower limit of normal. In a rare circumstance where a patient would need his/her serum trough level greater than 600/mg, documentation should support the rationale.

- Recurrent Severe Infection and documented severe deficiency or absence of IgG subclass

  For IgG subclass deficiency, a serum IgG subclass trough level should be monitored at least every three months prior to the dose of intravenous immune globulin, along with clinical progress of signs and symptoms for which intravenous immune globulin therapy is required.

- Clinically significant functional deficiency of humoral immunity as evidenced by documented failure to produce antibodies to specific antigens *and* a history of recurrent infections.

  For functional deficiency, the deficient antibody(ies) should be monitored at least every three months prior to the dose of intravenous immune globulin, along with clinical progress of signs and symptoms for which intravenous immune globulin therapy is required.

- Idiopathic Thrombocytopenic Purpura (ITP)

  Doses should be based on the patient's clinical appearance and platelet count. Infusions are usually administered when signs and symptoms of bleeding and/or a platelet count less than 30,000/mm3 are found.

- Chronic Lymphocytic Leukemia with associated hypogammaglobulinemia

  To initiate intravenous immunoglobulins for this disease, the IgG level should be less than 600 mg/dl or there should be evidence of specific antibody deficiency and the presence of repeated bacterial infections.

- Symptomatic Human Immunodeficiency Virus (HIV)—less than 13 years of age and CD4+ lymphocyte count 200/mm3 or greater

  Indications for intravenous immunoglobulin would include:
  Children less than 13 years of age
  Entry CD4+ lymphocyte counts greater than or equal to 200/mm3
  Clinically symptomatic or asymptomatic but immunologically abnormal

- Low-birth weight infants weighing between 500 and 1750 grams at birth

  Indications for intravenous immunoglobulin would include:
  Weight at birth between 500-1750 grams
  Expected to survive for more than 48 hours
  Stable cardiovascular function
  Intravenous access for medical therapy

- Bone marrow transplantation

  Indications for intravenous immunoglobulin would include:
  Patients 20 years of age or older
  Seropositive for cytomegalovirus (CMV) before transplantation
  Seronegative, had seronegative marrow donors, and undergoing allogeneic transplantation for hematologic neoplasms

- Kawasaki Disease (mucocutaneous Lymph Node Syndrome)

For diagnoses of Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, autoimmune hemolytic anemia, autoimmune neutropenia, acquired inhibitor of clotting factor VIII, immune thrombocytopenic purpura in pregnancy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. Intravenous immunoglobulin may be recommended when *other therapy has failed or is contraindicated, and for potentially severe or life-threatening manifestations of these diseases.*

- Acute Inflammatory Demyelinating Polyradiculoneuropathy, Guillain-Barre Syndrome, and Myasthenia Gravis:

  It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. The following situations would constitute appropriate indications:
  Other therapy has failed or is contraindicated
  Difficulty with venous access for plasmapheresis
  Recommended for rapidly progressive forms of these diseases

- Autoimmune Hemolytic Anemia

  It is noted that not all patients with this disease need treatment with intravenous immunoglobulin. Intravenous immunoglobulin should be used for patients whose condition is resistant to conventional forms of therapy and/or demonstrates severe or life-threatening manifestations of this disease.

- Autoimmune Neutropenia

  This disease is usually benign and self-limiting, and does not require treatment. Not all patients with this disease need treatment with intravenous immunoglobulin. Occasionally, however, it is marked by repeated infection. Intravenous immunoglobulin may be recommended for the treatment of patients with an absolute neutrophil count less than 800/mm3 with recurrent bacterial infections.

- Coagulopathy due to inhibitors or antihemophilic factor (Factor VIII)

  This is a relatively rare bleeding disorder caused by circulating autoantibodies against Factor VIII. Not all patients with this disease need treatment with intravenous immunoglobulin. Patients who develop serious hemorrhage may be administered intravenous immunoglobulin, in addition to other appropriate therapies.

- Immune Thrombocytopenic Purpura in Pregnancy

  Pregnant women with this disease are at risk for delivering thrombocytopenic infants. Protection of the fetus becomes an important consideration in the management of a pregnant woman with immune thrombocytopenic pupura. Intravenous immunoglobulin can be recommended in the following:
  Pregnant women who have previously delivered infants with autoimmune thrombocytopenia
  Pregnant women who have platelet count less than 75,000/mm3 during the current pregnancy
  Pregnant women with past history of splenectomy

- Inflammatory Myopathies: Refractory Polymyositis and Refractory Dermatomycoitis

  The criteria for the use of intravenous immune globulin in polymyositis or dermatomyositis is: patients who are *refractory* to standard therapy, including patients who are refractory to corticosteroids; patients who have been unable to successfully taper corticosteroids below moderately high doses; patients developing *severe* side effects due to steroid therapy; and patients who have also failed at least one immunosupressive agent (e.g., azathioprine, Methotrexate, cyclophosphamide, cyclosporine) .

HCPCS Codes

J1561 Injection, immune globulin, intravenous, 500 mg
J1562 Injection, immune globulin intravenous, 5 gms

ICD-9 Codes That Support Medical Necessity

042
204.10
204.11
279.03
279.04
279.06
279.09
279.12
279.2
283.0
286.0
287.3
288.0
357.0
357.8
358.0
446.1
710.3
710.4
765.02-765.07
996.85

Reasons for Denial

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

Noncovered ICD-9 Code(s)

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

Coding Guidelines

Evaluation and management services will be reimbursed in addition to payment for intravenous administration (CPT 90780-90781).

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly document the medical necessity to initiate intravenous immune globulin therapy and the continued need thereof. Required documentation of medical necessity should include:

history and physical
office/progress note(s), and
test results with written interpretation
an accurate weight in kilograms should be documented prior to the infusion, since the dosage is mg/kg-based.

Effective Date

This Local Medical Review Policy is effective for services processed on or after August 16, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

J9999: Antineoplastic Drugs – Additions to Policy

The policy for antineoplastic drugs was published in the March/April 1999 *Medicare B Update!*, pages 45-48. At the time of publication, the ICD-9 code range that supports the medical necessity for the antineoplastic drug **Doxorubicin (J9000)** was shown on page 26 as 202.00 - 202.***0***8. It has since been determined that the code range should, instead, be 202.00 - 202.***9***8.

Additionally, since the publication of that article, the following coverage criteria for the antineoplastic drugs Traztuzumab (Herceptin®) and Denileukin diftitox (Ontak®) have been added to the antineoplastic drugs policy:

Traztuzumab (Herceptin®)

Indications and Limitations of Coverage and/or Medical Necessity

Trastuzumab is a monoclonal antibody, one of a group of drugs designed to attack specific cancer cells. Trastuzumab's targets are cancer cells that produce a protein called HER2 or HER2/neu, which occurs in high numbers in about 25 to 30 percent of breast cancers.

Herceptin® is indicated for the treatment of patients with metastatic breast cancer whose tumors overexpress the HER2 protein and who have received one or more chemotherapy regimens for their metastatic disease.

Herceptin®, in combination with paclitaxel, is indicated for treatment of patients with metastatic breast cancer whose tumors overexpress the HER2 protein and who have not received chemotherapy for their metastatic disease.

Herceptin® is supplied as a 440 mg multi-dose vial. The reconstituted solution is intended for administration by intravenous infusion.

The recommended initial loading dose of Herceptin® is 4mg/kg administered as a 90-minute infusion. The recommended weekly maintenance dose for Herceptin® is 2mg/kg and can be administered as a 30-minute infusion if the initial loading dose was well tolerated.

HCPCS Codes

J9999 Not otherwise classified, antineoplastic drug

ICD-9 Codes That Support Medical Necessity

174.0-174.9
175.0-175.9
196.0-196.9
197.0-197.8
198.0
198.1
198.2
198.4
198.5
198.6
198.7
198.82

Note: The billing of Herceptin® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. The primary and secondary site of the malignancy must *both* be billed to indicate the breast malignancy is metastatic (e.g., ICD-9 codes 174.0 *and* 198.5).

Denileukin diftitox (Ontak®)

Indications and Limitations of Coverage and/or Medical Necessity

Denileukin diftitox is a fusion protein designed to direct the cytocidal action of diphtheria toxin to cells that express the IL-2 receptor.

Ontak® is indicated for the treatment of patients with persistent or recurrent cutaneous T-cell lymphoma (CTCL) whose malignant cells express the CD25 component of the IL-2 receptor.

The safety and efficacy of Ontak® in patients with CTCL whose malignant cells do not express the CD25 component of the IL-2 receptor have not been examined.

Ontak® is supplied in single use 2ml vials (300 mcg in 2ml) as a sterile, frozen solution intended for intravenous administration only. The recommended treatment regimen (one treatment cycle) is 9 or 18 mcg/kg/day administered intravenously for 5 consecutive days every 21 days. Ontak® should be infused over at least 15 minutes.

HCPCS Codes

J9999 Not otherwise classified, antineoplastic drug

ICD-9 Codes That Support Medical Necessity

202.10-202.18
202.20-202.28

Reasons for Denial

The use of Herceptin® or Ontak® for any clinical indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 Code(s)

Any ICD-9 diagnosis code not listed in each of the "ICD-9 Codes That Support Medical Necessity" sections of this policy.

Coding Guidelines/Documentation Requirements

When billing for Trastuzumab 440mg, use HCPCS code J9999 and include the name of the drug and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated. The primary and secondary site of the malignancy must *both* be billed to indicate the breast malignancy is metastatic (e.g., ICD-9 codes 174.0 *and* 198.5). Documentation demonstrating that the patient's tumor overexpresses the HER2 protein must also be submitted with the claim. The patient's weight must also be documented, as well as the dosage administered.

When billing for Denileukin diftitox, use HCPCS code J9999 and include the name of the drug and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated. Documentation demonstrating that the patient's malignant cells express CD25 must also be submitted with the claim.

Effective Date

The effective date for the change to the diagnosis range for Doxorubicin is April 19, 1999. The addition of Herceptin® and Ontak® is effective for services processed on or after October 18, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

70450: Computerized Tomography Scans

Tomography is the recording of internal body images at a pre-determined plane by X-ray. Computerized axial tomography, or CAT scans, involve the measurement of the emergent X-ray beam by a scintillation counter. The electronic pulses are recorded on a magnetic disk and then processed by a minicomputer for reconstruction display of the body in cross-section on a cathode ray tube.

Indications and Limitations of Coverage and/or Medical Necessity

Computerized Tomography Scans:

Medicare of Florida will only consider computerized tomography scans to be reasonable and necessary when performed for documented cases of illness or injury.

HCPCS Codes

70480 Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481 with contrast material(s)
70482 without contrast material, followed by contrast material(s) and further sections
70486 Computerized axial tomography, maxillofacial area; without contrast material
70487 with contrast material(s)
70488 without contrast material, followed by contrast material(s) and further sections
70490 Computerized axial tomography, soft tissue neck; without contrast material
70491 with contrast material(s)
70492 without contrast material, followed by contrast material(s) and further sections
71250 Computerized axial tomography, thorax; without contrast material
71260 with contrast material(s)
71270 without contrast material, followed by contrast material(s) and further sections
72125 Computerized axial tomography, cervical spine; without contrast material
72126 with contrast material
72127 without contrast material, followed by contrast material(s) and further sections
72128 Computerized axial tomography, thoracic spine; without contrast material
72129 with contrast material
72130 without contrast material, followed by contrast material(s) and further sections
72131 Computerized axial tomography, lumbar spine; without contrast material
72132 with contrast material

72133	without contrast material, followed by contrast material(s) and further sections
73200	Computerized axial tomography, upper extremity; without contrast material
73201	with contrast material(s)
73202	without contrast material, followed by contrast material(s) and further sections
73700	Computerized axial tomography, lower extremity; without contrast material
73701	with contrast material(s)
73702	without contrast material, followed by contrast material(s) and further sections
74150	Computerized axial tomography, abdomen; without contrast material
74160	with contrast material(s)
74170	without contrast material, followed by contrast material(s) and further sections

ICD-9 Codes That Support Medical Necessity

N/A

Computerized Tomography Scans — Head:

Medicare of Florida will consider computerized tomography scan of the head to be medically reasonable and necessary when performed to establish a diagnosis or to monitor treatment for the following conditions:

Intracranial neoplasms, cerebral infarctions, ventricular displacement or enlargement, cortical atrophy, cerebral aneurysms, intracranial hemorrhage and hematoma, infection, edema, degenerative processes, cyst formation, multiple sclerosis, seizure disorders, head trauma, congenital abnormalities, presence of foreign body, and radiation treatment planning.

Coverage for headache should only be for the following situation:

1. Patient suffering from headaches after a head injury. Head CAT scan is performed to rule out the possibility of a bleed.
2. Patient suffering from headaches unusual in duration and not responding to medical therapy. Head CAT scan is performed to rule out the possibility of a tumor.
3. Patient suffering from headaches characterized by sudden onset and severity. Head CAT scan is performed to rule out possibility of aneurysm and/or arteriovendes malformation.

HCPCS Codes

70450	Computerized axial tomography, head or brain; without contrast material
70460	with contrast material(s)
70470	without contrast material, followed by contrast material(s) and further sections

ICD-9 Codes That Support Medical Necessity

006.5	055.0	115.91
013.00-013.36	056.01	130.0
013.60-013.96	062.0-062.9	162.0-162.9
036.0-036.2	063.0-063.9	170.0
042	064	191.0-191.9
046.0-046.9	072.1-072.2	192.0.192.1
047.0-047.9	090.40-090.49	194.3-194.4
049.0-049.9	094.0-094.9	195.0
052.0	112.83	196.0
053.0	114.2	198.3-198.5
054.3	115.01	199.0-199.1
054.72	115.11	200.11
200.21	351.0-351.9	768.9
201.11	352.0-352.9	770.8
201.21	368.11	772.1-772.2
201.41	368.12	779.0-779.2
201.51	368.2	780.01-780.09
201.61	368.40	780.1
201.71	368.8	780.2
201.91	368.9	780.31-780.39
213.0	374.31	780.4
225.0-225.2	377.00-377.01	780.6
225.8	377.51-377.52	780.9
227.3-227.4	377.61	781.0-781.9
237.0-237.1	377.71	784.2
237.5-237.9	378.51-378.56	784.3
239.6-239.7	386.2	784.5
250.20-250.23	388.2	784.60-784.69
250.30-250.33	388.5	793.0
253.0-253.9	430-438.9	794.00-794.09
255.0-255.9	572.2	800.00-804.99
290.0-290.9	674.00-674.04	850.0-854.19
293.0-293.83	738.10-738.19	873.0-873.1
294.0-294.9	740.0-740.2	873.9
298.9	742.0-742.4	950.0-950.9
310.0-310.9	742.8	951.0-951.9
320.0-326	742.9	959.01
330.0-334.9	747.81	996.2
341.0-341.9	756.0	997.00-997.09
342.00-342.92	759.2-759.9	V10.85
343.0-343.9	765.0-765.1	V10.86
344.00-344.9	767.0	V10.88
345.00-345.91	767.1	V45.2
348.0-348.9	767.3	V67.1
349.1-349.9	768.5	V67.2
350.1-350.9	768.6	

Reasons for Denial

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

Noncovered ICD-9 Code(s)

Any diagnosis codes not listed under the "ICD-9 Codes That Support Medical Necessity" section of this policy for HCPCS Codes 70450-70470.

Coding Guidelines

Documentation of medical necessity should be maintained on file in the event of postpayment audit for CAT scans performed on the same anatomical site as an MRI scan, on the same day, by the same physician.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test and the test results. This information is usually found in the history and physical, office/progress notes, or test results.

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

Effective Date

This policy is effective for services processed on or after July 19, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

70541: Magnetic Resonance Angiography (MRA)

The complete local medical review policy (LMRP) for MRA was published in the July/August 1999 *Medicare B Update!* to reflect national coverage changes for services performed on or after July 1, 1999. Since that time, the following additional ICD-9 diagnosis codes have been added to the LMRP for procedure code 70541 [Magnetic resonance angiography, head and/or neck, with or without contrast material(s)]:

094.89	431
191.0-191.9	432.1
192.1	432.9
194.5	442.81
227.5	446.5
228.02	900.00-900.9
430	

Effective Date

The additional ICD-9 codes also have an effective date of July 1, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

76075: Bone Mineral Density Studies—Additional Covered Diagnosis

On pages 35-37 of the September/October 1998 *Medicare B Update!*, the Bone Mineral Density Studies (76075) policy was published. Since that publication, ICD-9 code 627.2 (Menopausal or female climacteric states) has been added to the policy.

Effective Date

This addition is effective for claims processed on or after July 19, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

Coverage for Iron (83540), Iron-binding capacity (83550) and Transferrin (84466)

Coverage for these tests was published in the July/August 1996 *Medicare B Update!* Analysis of 1998 Medicare Part B claims data shows that Florida continues to pay for these services at a rate three-and-a-half times higher per 1,000 Medicare enrollees than is paid nationally, with significant findings in the specialties of internal medicine and clinical laboratory providers. Therefore, the local medical review policy (LMRP) is being republished below to remind providers of coverage requirements.

In order for iron, iron-binding capacity, or transferrin to be covered, the medical record documentation must indicate one of the following conditions:

- Diagnosis of hemochromatosis
- Distinguish between iron deficiency anemia and anemia of chronic disease
- Evaluation of thalassemia
- To determine response to iron therapy

Once an initial diagnosis of iron deficiency is determined, testing should only be performed to monitor iron replacement therapy. In addition, a ferritin level is normally performed in conjunction with iron to determine iron storage status.

Iron testing will not be covered if performed on a routine or screening basis in the absence of abnormal signs or symptoms.

If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies.

ICD-9 Codes That Support Medical Necessity

275.0	585
280-289.9	790.4
571.5	790.5
572.8	

Effective Date

This local medical review policy is effective for services processed on or after August 19, 1996.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

85044, 85045: Reticulocyte Count

Reticulocytes are nonnucleated, immature red blood cells (RBCs) that remain in the peripheral blood for 24 to 48 hours while maturing. In this test, reticulocytes in a whole blood sample are counted and expressed as a percentage of the total red cell count. When bone marrow activity and hemoglobin levels are normal, the reticulocyte count is between 0.5% to 1.5%.

The reticulocyte count is part of the initial evaluation of anemia and is an index of effective erythropoiesis and bone marrow response to anemia. It is useful, along with the complete blood count (CBC), serum iron, total iron-binding capacity, and serum ferritin, in classifying the anemia according to the functional defect in erythropoiesis—whether there is a failure in red blood cell production, an abnormality in precursor maturation, or an increase in red blood cell destruction.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider a reticulocyte count (procedure codes 85044 and 85045) medically reasonable and necessary in the following circumstances:

- To initially evaluate a patient with unexplained anemia, and/or
- To evaluate the response to the therapeutic intervention(s) for the diagnosed anemia. Generally, it is expected that a followup reticulocyte count will be performed when the test results will be used in the management of the patient's anemia. Usually other laboratory tests, such as a hemoglobin, better reflect the effects of treatment on the patient's laboratory values.

To ensure that Medicare only pays for services that are medically reasonable and necessary, a reticulocyte count is covered only when it is performed for the diagnosis of anemia (ICD-9 diagnoses 280.0-285.9).

Reasons for Denial

A reticulocyte count performed routinely with a CBC without evidence of an anemic condition is considered screening and is not covered by Medicare.

Documentation Requirements

Medical record documentation maintained by the ordering physician must clearly indicate the medical necessity of the services being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or test results.

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

Effective Date

This policy is effective for services processed on or after October 18, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

86781: Fluorescent Treponemal Antibody Absorption (FTA-abs)

This policy was originally published in the July/August 1997 Medicare B *Update!* (page 36). Since that time, the policy has been revised to expand ICD-9 coverage and to reflect current medical policy format. Therefore, it is being published in its entirety.

The fluorescent treponemal antibody absorption (FTA-abs) test is the most widely employed treponemal test. It is a specific test for the diagnosis of syphilis. The FTA-abs test includes a serum specimen that is absorbed and then tested with immunofluorescence for the antibody to Treponema pallidum, the causative agent of syphilis.

FTA-abs is the most sensitive test in all stages of syphilis. The FTA-abs test is of value principally in determining whether a positive nontreponemal antigen test **(**e.g., Rapid Plasma Reagin [RPR] or Venereal Disease Research Laboratory [VDRL]) is "false positive" or is indicative of syphilis. Because of its great sensitivity, particularly in the late stages of the disease, the FTA-abs test is also of value when there is clinical evidence of syphilis but the nontreponemal serologic test for syphilis is negative. The test is positive in most patients with primary syphilis and in virtually all with secondary syphilis.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider FTA-abs (CPT code 86781) to be medically reasonable and necessary for the following indications:

- Confirmation of a positive RPR or VDRL test
- A patient with suspected primary syphilis who has a negative RPR or VDRL
- A patient with suspected latent syphilis or neurosyphilis who has a negative RPR or VDRL

ICD-9 Codes That Support Medical Necessity

090.0-090.9	093.0 -093.9	097.0-097.9
091.0-091.9	094.0-094.9	386.10-386.19
092.0	095.0-095.9	386.2
092.9	096	386.9

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test. This information is usually found in the history and physical, office/progress notes, or lab reports.

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

Effective Date

This policy is effective for services processed on or after July 16, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

93000: Electrocardiograpy

The Local Medical Review Policy (LMRP) for electrocardiography has been reevaluated. The following is the newly revised LMRP.

Electrocardiography (ECG, EKG) is the graphic tracing of the variations in electrical potential caused by the excitation of the heart muscle as detected at the body surface by electrodes placed on the patient's limbs and chest. The monitoring electrodes detect the electrical activity of the heart from a variety of spatial perspectives. The EKG lead system is composed of several electrodes, that are placed on each of the four extremities and at varying sites on the chest. It provides information regarding rate, rhythm, myocardial injury, and conduction system.

The normal EKG pattern is composed of waves arbitrarily designated by the letters P, Q, R, S, and T. Through the analysis of these wave forms and time intervals, valuable information about the heart may be obtained. The EKG is used primarily to identify abnormal heart rhythms (arrhythmias or dysrhythmias) and to diagnose acute myocardial defects, ventricular hypertrophy, and/or strain.

Indications and Limitations of Coverage and/or Medical Necessity

Electrocardiograms are indicated for diagnosis and patient management purposes involving symptoms of the heart, pericardium, thoracic cavity, and systemic diseases which produce cardiac abnormalities.

Medicare of Florida will consider an EKG medically necessary in any of the following circumstances:

1. Initial diagnostic workup for a patient who presents with complaints of symptoms such as chest pain, palpitations, dyspnea, dizziness, syncope, etc. which may suggest a cardiac origin.
2. Evaluation of a patient on a cardiac medication for a cardiac arrhythmia or other cardiac condition which affects the electrical conduction system of the heart (e.g., inotropics such as digoxin; antiarrhythmics such as Tambocor, Procainamide, or Quinidine; and antianginals such as Cardizem, Isordil, Corgard, Procardia, Inderal, and Verapamil). The EKG is necessary to evaluate the effect of the cardiac medication on the patient's cardiac rhythm and/or conduction system.
3. Evaluation of a patient with a pacemaker with or without clinical findings (history or physical examination) that suggest possible pacemaker malfunction.
4. Evaluation of a patient who has a significant cardiac arrhythmia or conduction disorder in which an ekg is necessary as part of the evaluation and management of the patient. These disorders may include, but are not limited to, the following: Complete heart block, second degree av block, left bundle branch block, right bundle branch block, paroxysmal vt, atrial fib/flutter, ventricular fib/flutter, cardiac arrest, frequent pvcs, frequent pacs, wandering atrial pacemaker, and any other unspecified cardiac arrhythmia.
5. Evaluation of a patient with known coronary artery disease (CAD) and/or heart muscle disease that presents with symptoms such as increasing shortness of breath (SOB), palpitations, angina, etc.
6. Evaluation of a patient's response to a newly established therapy for angina, palpitations, arrhythmias, SOB or other cardiopulmonary disease process.
7. Evaluation of patients after coronary artery revascularization by coronary artery bypass grafting (CABGs), percutaneous transluminal coronary angiography (PTCA), thrombolytic therapy (e.g., TPA, streptokinase, urokinase), and/or stent placement.
8. Evaluation of patients presenting with symptoms of a myocardial infarction (MI).
9. Evaluation of other symptomatology that may indicate a cardiac origin especially in those patients who have a history of an MI, CABG surgery or PTCA *or* patients who are being treated medically after a positive stress test or cardiac catherization.
10. Pre-operative Evaluation of the patient when:
    - undergoing cardiac surgery, such as CABGs, automatic implantable cardiac defibrillator, or pacemaker, or
    - the patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial ischemia such as Dressler's Syndrome, history of MI, angina pectoris, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, valvular disease or cardiomyopathy to name a few.

HCPCS Codes

93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	tracing only, without interpretation and report
93010	interpretation and report only

ICD-9 Codes That Support Medical Necessity

079.0-079.99	780.02	789.06
240.0-246.9	780.2	794.30-794.39
250.10-250.13	780.31-780.39	799.0
250.20-250.23	780.4	799.1
250.30-250.33	780.79	860.0-860.5
250.70-250.73	782.0	861.00-861.32
276.0-276.9	782.61-782.62	959.1
277.00-277.01	785.0	972.0-972.9
277.3	785.1	980.0-989.9
337.0	785.2	995.0-995.89
337.9	785.3	996.00-996.09
390-429.9	785.50-785.59	996.80-996.89
435.9	786.00	997.1
436	786.01	997.2
440.0-448.9	786.02	997.3
668.10-668.14	786.03-786.09	V45.01-V45.09
710.0-710.9	786.50-786.59	V45.81-V45.82
714.0-714.9	786.6	V72.81
745.0-745.9	789.01	
746.00-747.9	789.02	

Reasons for Denial

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

Noncovered ICD-9 Code(s)

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

Coding Guidelines

When using diagnosis code V72.81, it is expected that the medical record would contain information supporting the two pre-operative evaluation indications listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, the EKG strip and a copy of the test results should be maintained in the medical record.

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

Effective Date

This policy is effective for services processed on or after October 18, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

93619-93642, 93737, 93738: Intracardiac Electrophysiological Evaluation

An intracardiac electrophysiological evaluation is a study of the electrical processes involved with the heart action.

Electrophysiological studies routinely require vascular access, injections/infusions, and continuous monitoring. In the course of an electrophysiological study, an advanced pacing device is routinely used to stimulate and record intracardiac activities. In order to ensure that services are medically reasonable and necessary, procedure codes 93619-93631 are covered when performed for the following diagnoses:

426.0	426.9	427.69
426.10-426.13	427.0	427.81
426.2	427.1	427.89
426.3	427.2	427.9
426.4	427.31-427.32	746.9
426.50-426.54	427.41-427.42	780.2
426.6	427.5	
426.7	427.61	

Electrophysiological Evaluation of Cardioverter-Defibrillator:

Effective for services performed on or after January 24, 1986, through July 1, 1991, electrophysiologic evaluation of cardioverter-defibrillator and/or leads (93640, 93641, 93642) and electronic analysis of cardioverter/defibrillator only (93737, 93738) is covered only when the automatic defibrillator was implanted into a patient who had one of the following indications:

- A documented episode of life-threatening ventricular tachyarrhythmia; or
- Cardiac arrest not associated with myocardial infarction.

These patients must have been found, by electrophysiologic testing, to have an inducible tachyarrhythmia that proves unresponsive to medication or surgical therapy (or be considered unsuitable candidates for surgical therapy).

Effective for services performed on or after July 1, 1991, electrophysiologic evaluation of cardioverter-defibrillator and electronic analysis of cardioverter/defibrillator is a covered service if the automatic defibrillator was implanted into a patient who had a documented episode of life-threatening ventricular tachyarrhythmia or cardiac arrest not associated with myocardial infarction.

Effective for services performed on or after July 1, 1999, electrophysiologic evaluation of cardioverter-defibrillator and electronic analysis of cardioverter/defibrillator is a covered service if the automatic defibrillator was implanted into a patient who had any of the following conditions:

1. A documented episode of cardiac arrest due to ventricular fibrillation not due to a transient or reversible cause;
2. Ventricular tachyarrhythmia, either spontaneous or induced, not due to a transient or reversible cause; or,
3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias such as long QT syndrome or hypertrophic cardiomyopathy.

In addition to the above coverage indications, procedure codes 93642, 93737, and 93738 are covered to periodically follow up or evaluate a patient's cardioverter/defibrillator status.

To ensure that Medicare covers services that are medically reasonable and necessary, procedure codes 93640-93642 and 93737-93738 are covered when performed for the following diagnoses:

425.1	
425.4	
427.1	
427.5	
794.31	
996.04	(procedure codes 93642, 93737, and 93738 only)
V45.02	(procedure codes 93642, 93737, and 93738 only)

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the services being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or procedural report.

Effective Date

This policy is effective for services processed on or after August 16, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

93875-93882: Coverage for Noninvasive Extracranial Arterial Studies

Procedure codes 93875 and 93880 were selected as Focused Medical Review aberrancies based on January through June 1997 Medicare claims data. Based on the data analysis and medical review findings, a recommendation was made to update the current Local Medical Review Policy (LMRP). Therefore, as a result of this recommendation, the current policy has been revised and is detailed below in its entirety.

Noninvasive extracranial arterial studies involve the use of direct and occasionally indirect methods of ultrasound to evaluate and monitor the blood vessels that supply the brain. The direct methods of assessment are Doppler and duplex ultrasound, whereas the indirect methods include techniques such as oculoplethysmography.

Doppler ultrasonography is used to evaluate hemodynamic parameters, specifically the velocity of blood flow and the pattern or characteristics of flow. The Doppler ultrasound involves the evaluation of the supraorbital, common carotid, external carotid, internal carotid, and the vertebral arteries in the extracranial cerebrovascular assessment.

The second key component of vascular diagnostic ultrasound is the B-mode, or brightness-mode image. This real time imaging technique provides a two-dimensional gray-scale image of the soft tissues and vessels based on the acoustic properties of the tissues.

Duplex ultrasonography combines the direct visualization capabilities of B-mode ultrasonography and the blood-flow velocity measurements of Doppler ultrasonography.

In addition to the direct methods of Doppler and duplex ultrasonography to evaluate the cerebrovascular arterial system, indirect methods such as supraorbital Doppler ultrasonography and oculoplethysmography are used as an adjunct to assess the carotid artery. Supraorbital Doppler ultrasonography indirectly assesses blood flow from collateral branches of the internal carotid artery through the supraorbital vessels. This test is done by placing a directional Doppler probe over a supraorbital artery and observing the flow with and without compression of neighboring arteries. Oculoplethysmography indirectly measures blood flow in the ophthalmic artery by graphically recording ocular pulses obtained from corneal cups held in place by mild suction. Because the ophthalmic artery is the first major branch of the internal carotid artery, its blood flow accurately reflects carotid blood flow and ultimately that of cerebral circulation.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider non-invasive extracranial arterial studies (procedure codes 93875-93882) medically reasonable and necessary under the following circumstances:

- To evaluate a patient with suspected occlusive cerebrovascular disease as demonstrated by the presence of transient ischemic attacks (TIA's), possible carotid bruit(s), diminished or absent pulses in the neck or arms, and/or a blood pressure difference in 2 arms of greater than 10mmHg.
- To evaluate a patient with signs/symptoms of subclavian steal syndrome. The symptoms usually associated with subclavian steal syndrome are a bruit in the supraclavicular fossa, unequal radial pulses, arm claudication following minimal exercise, and a difference of 20mmHg or more between the systolic blood pressures in the arms.
- To monitor a patient with known carotid stenosis. Patients demonstrating a diameter reduction of 30-50% are normally followed on an annual basis, whereas patients with a diameter reduction of greater than 50% are normally followed every six months. It is not necessary to monitor patients with a diameter reduction of less than 30%.
- To evaluate a patient with transient monocular blindness (amaurosis fugax). Normally a patient with this symptom is evaluated with an ocular pneumoplethysmography.
- To monitor patients who are post-carotid endarterectomy. These patients are normally followed with duplex ultrasonography on the affected side at 6 weeks, 6 months, 1 year, and annually thereafter.
- To initially evaluate a patient presenting with an asymptomatic carotid bruit identified on physical examination. Routine monitoring of a patient with an asymptomatic carotid bruit without evidence of carotid stenosis is considered screening, and therefore, noncovered.
- To initially evaluate a patient who has had a recent stroke (recent is defined as less than six months) to determine the cause of the stroke.
- To evaluate a patient presenting with an injury to the carotid artery.
- To evaluate a patient with a suspected aneurysm of the carotid artery. This is suspected in patients with swelling of the neck, particularly if occurring post-carotid endarterectomy.
- To preoperatively validate the degree of carotid stenosis of a patient whose previous duplex scan revealed a greater than 70% diameter reduction. The duplex is only covered when the surgeon questions the validity of the previous study and the repeat test is being performed in lieu of a carotid arteriogram.

Note: The current medical literature contains inconclusive information regarding the evaluation and monitoring of patients with asymptomatic carotid bruits. Even though the presence of bruit increases the likelihood of finding disease of extracranial carotid arteries, it does not necessarily indicate severe stenosis. Also, the predictive value of a bruit is questioned when severe disease is found in patients without a bruit.

In addition, the literature supports that the test of choice for all the above indications is the duplex scan, which is represented by procedure code 93880 and 93882.

Since the standard for the above indications is a color-duplex scan, portable equipment must be able to produce combined anatomic and spectral flow measurements.

To ensure that Medicare pays for services that are medically reasonable and necessary, non-invasive extracranial arterial studies are covered for the following diagnoses:

362.34	435.2	785.9
433.10	435.3	900.00
433.11	435.8	900.01
434.00-434.91	435.9	900.02
435.0	436	900.03
435.1	442.81	V67.0

Coding Guidelines

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided.

The use of a single hand-held or other Doppler device that does not produce hard copy output, or produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reimbursed under procedure codes 93875, 93880, or 93882.

Since a duplex scan of the extracranial arteries includes the combined capabilities of the B-mode and Doppler ultrasonography, it is not expected that procedure code 93875 will be billed in addition to a duplex scan (93880 or 93882)

Documentation Requirements

Medical record documentation maintained by the ordering physician must clearly indicate the medical necessity of the services being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or test results.

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

Effective Date

This policy is effective for services processed on or after October 18, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

95027: Skin End Point Titration—Proper Billing

It has been noted that some providers are billing improperly for procedure code 95027 (skin end point titration). Procedure code 95027 should be reported once for each allergen, rather than reporting the total number derived by multiplying the number of antigens by the number of dilutions utilized. For example, if skin end point titration is performed on two allergens with nine dilutions of each allergen, it should be reported two times, not eighteen times. ❖

95930: Visual Evoked Potential Testing

Visual evoked potential (VEP) studies, also known as visual evoked response (VER) tests, evaluate the integrity of visual nerve pathways (retina and optic nerve) by measuring the brain's response to repetitive visual stimuli. The rapidly reversing checkerboard stimuli is the most common form of this test. The patient is seated comfortably three feet from the pattern-shift stimulator. Electrodes are attached to the scalp at the occiput and parietal locations. A reference electrode is placed on the ear. One eye is occluded and the patient is instructed to fix his/her gaze on a dot in the center of the screen. A checkerboard pattern is projected and then rapidly reversed 100 times at a rate of once or twice per second. The procedure is then repeated for the other eye.

In children, the checkerboard pattern testing can be difficult. A flash technique may be used instead. In this situation, light-emitting diodes or a strobe are placed into goggles. The goggles are strapped to the patient's face.

Visual neural impulses derived from either method are recorded as they travel from the eye to the occipital cortex. A computer amplifies and averages the brain's response to each stimulus and the results are plotted in a waveform. The most significant wave on the waveform is the P100.

The two most clinically significant measurements are the time between the stimulus and peaking of the P100 wave (known as the absolute P100 latency), and the difference between the P100 latencies of both eyes. Normal P100 latencies occur approximately 100 msec after the application of the visual stimulus (normal range is 90-110 msec). Interocular latency is the difference in P100 latency between the right and left eye (normally the latency difference is less than 8-10 msec). Prolonged P100 latency is an abnormal finding indicating a lesion along the visual pathway.

VER is performed in a specially equipped electrodiagnostic procedure room. Test results vary greatly among laboratories.

Indications and Limitations of Coverage and/or Medical Necessity

Information from evoked potential studies is insufficient to confirm a specific diagnosis. Test data must be interpreted in light of clinical information. Therefore, Medicare of Florida will consider visual evoked potential studies medically reasonable and necessary in any of the following circumstances:

- To confirm the diagnosis of multiple sclerosis that is suspected on clinical grounds. several common early signs/symptoms are diplopia, nystagmus, optic neuritis and occasionally papillitis. The diagnosis of "clinically definite" multiple sclerosis can be made when the following criteria are met:
    1. past history of two or more episodes of a neurological deficit; and
    2. an isolated white matter lesion demonstrated on clinical exam (this is usually an MRI study); and
    3. a second, independent lesion on laboratory testing or clinical exam; this last criterion may be fulfilled by documenting an abnormal VER (which would be suggestive of optic neuritis).

- To assess the visual function in an infant or child under the age of one. These infants or children are premature or developmentally delayed and often have no fixational ability until six or twelve months of age. The primary caregiver will describe a lack of visual attentiveness. Once the diagnosis of delayed visual-system maturation is confirmed, repeat testing is not indicated. Spontaneous recovery is the typical outcome (ICD-9 code 369.20).
- To objectively rule out hysterical blindness and suspected malingerers. An abnormal VER would indicate poor central visual acuity. A normal VER would support the presence of normal visual nerve pathway.
- To evaluate the patient who presents with blindness due to optic trauma. The VEP will provide information to the treating physician regarding the viability of the optic nerve.

Note: In the severely myopic patient, one whose corrected visual acuity is less than 20/200, the checkerboard pattern cannot be seen. VERs performed for severely myopic patients will not be reimbursed. In addition, the patient must be cooperative and attentive enough to watch the reversing checkerboard pattern for several minutes.

HCPCS Codes

95930 Visual evoked potential (VEP) testing central nervous system, checkerboard or flash

ICD-9 Codes That Support Medical Necessity

300.11
368.2
369.20
377.30
377.31
377.32
377.39
379.57

Reasons for Denial

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

Noncovered ICD-9 Code(s)

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

Coding Guidelines

ICD-9 code 369.20 indicates the beneficiary is an infant or child under the age of one. ICD-9 code 300.11 indicates the beneficiary has been diagnosed with hysterical blindness. ICD-9 code 377.39 indicates the beneficiary presents with blindness due to optic trauma.

Documentation Requirements

Medical record documentation maintained by the ordering/ referring physician must clearly indicate the medical necessity of the test. The information must include a brief clinical history, pertinent neurological findings, and overall impression. This information is normally found in the office/progress notes, hospital notes, and /or test results.

If the provider of service is other than the ordering/ referring physician, the provider must maintain hard copy documentation of the test results and interpretation, along with copies of the ordering/ referring physician's order for the test. It is expected the referral will also contain a brief clinical history, pertinent neurological findings, and referring physician's overall impression.

Effective Date

This policy is effective for services processed on or after October 18, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

99183: Hyperbaric Oxygen Therapy

An article concerning the national coverage policy for Hyperbaric Oxygen Therapy (HBO) was published in the May/June 1999 *Medicare B Update!* (page 28). In addition to a list of covered diagnoses, the article indicated that the Health Care Financing Administration (HCFA) would issue instructions to Medicare contractors that require physicians performing HBO to be credentialed as a condition for payment. Implementation of this requirement has been delayed until April 1, 2000.

It is expected that final instructions will be released to Medicare carriers in January 2000. Provider notification, including the credentialing requirements and revised local medical review policy (LMRP), is tentatively scheduled for the March/April 2000 issue of the *Medicare B Update!*

Until that time, the LMRP that follows has been revised to include the list of covered diagnoses. The remainder of the policy is unchanged from the last time it was published (The *Medicare B Update!* May/June 1998 , page 51).

Hyperbaric Oxygen Therapy is a medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O_2) at greater than one atmosphere (atm) pressure. Either a monoplace chamber pressurized with pure O_2 or a larger multiplace chamber pressurized with compressed air where the patient receives pure O_2 by mask, head tent, or endotracheal tube may be used.

The physician must be personally in constant attendance in the hyperbaric department (unit) when the patient is receiving hyperbaric oxygen therapy. This is a professional activity that may not 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 must be immediately available should a complication occur.

Indications and Limitations of Coverage and/ or Medical Necessity

HBO therapy is covered by Medicare 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.

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, nonhealing 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 therapy 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, HBO 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 therapy 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 that 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 therapy for graft or flap salvage in cases where hypoxia or decreased perfusion have compromised viability. HBO therapy 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 therapy 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 abscess, immobilization of the affected extremity, and surgery. The Undersea and Hyperbaric Medical Society has defined "chronic" as existing six months or more. HBO therapy is an adjunctive therapy used with the appropriate antibiotics. Antibiotics are chosen on the basis of bone culture and sensitivity studies. HBO therapy 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 therapy 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 therapy 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 can cover the use of HBO therapy for chronic refractory osteomyelitis 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 can potentially impair the oxygen carrying capacity of hemoglobin. Using HBO therapy 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 therapy be covered by Medicare.

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 include:

Improvement or healing of wounds.
Improvement of tissue perfusion.
New epithelial tissue growth and granulation.
Tissue PO_2 of at least 30 mmHg of oxygen is necessary for oxidative function to occur.
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 therapy.

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 therapy except in the case of carbon monoxide poisoning where it is specifically indicated.

HCPCS Codes

99183 Physician attendance and supervision of hyperbaric oxygen therapy, per session

ICD-9 Codes That Support Medical Necessity

039.0-039.9
040.0
444.21-444.22
444.81
526.89
686.01
686.09
728.86
730.10-730.19
733.41-733.49
902.53
903.01
903.1
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
928.3
928.8-928.9
929.0-929.9
958.0
986
987.7
989.0
990
993.2
993.3
993.9
996.52
996.90-996.99
999.1

Reasons for Denial

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

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:

- 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)

Noncovered ICD-9 Code(s)

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

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 (e.g., 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 993.2, or 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 902.53, 903.01, 903.1, 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, 928.3, 928.8-928.9, 929.0-929.9, or 996.90-996.99
7. Progressive necrotizing infections: Meleney's ulcer-Diagnoses 686.01 or 686.09, (necrotizing fasciitis) - Diagnosis 728.86
8. Acute peripheral arterial insufficiency - Diagnosis 444.21, 444.22, 444.81, or 733.41-733.49
9. Preparation and preservation of compromised skin grafts - Diagnosis 996.52
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management - Diagnosis 730.10-730.19
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 that will include a medical history detailing the condition requiring HBO therapy. 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 osteomyelitis.
7. HBO treatment records describing the physical findings, the treatment rendered and the effect of the treatment upon the established goals for therapy.

Effective Date

This policy is effective for services processed on or after May 1, 1999.

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

FRAUD AND ABUSE

DHHS Announces Expanded "Senior Patrol" Grants to Help Spot Waste, Fraud, and Abuse in Medicare and Medicaid

The following information was excerpted from a U.S. Department of Health and Human Services (DHHS) press release.

DHHS Secretary Donna E. Shalala, joined by U.S. Senator Tom Harkin (D-Iowa), announced 41 grants totaling $7 million, to expand a program that recruits and trains retired professionals to identify waste, fraud, and abuse in the Medicare and Medicaid programs.

The Senior Medicare Patrol Project grants, including 29 new and 12 renewed grants, will be distributed among 38 states, plus Washington, D.C. and Puerto Rico. They are administered by the DHHS Administration on Aging to teach volunteer retired professionals such as doctors, nurses, accountants, investigators, law enforcement personnel, attorneys, teachers, and others how to work with Medicare and Medicaid beneficiaries. Volunteers work in their own communities and in local senior centers to help identify deceptive health care practices, such as overbilling, overcharging, or providing unnecessary or inappropriate services.

"We are committed to a strong, long-term effort to protect the integrity of the Medicare Trust Fund and prevent waste, fraud, and abuse in federal health programs," Secretary Shalala said. "We have undertaken a wide range of actions within [D]HHS. We are working with the millions of honest health care providers. And equally important, we want to help enable older Americans themselves to work closely with their family members, friends, and neighbors to recognize problems and to report them. That is why today we are expanding the Senior Patrol project nationwide."

The Senior Medicare Patrol Project grants, originally named the Health Care Anti-Fraud Waste and Abuse Community Volunteers Demonstration Projects, were authored in 1997 by Senator Harkin. The current projects have tested different models and in the past 18 months have trained more than 6,000 retired volunteers to serve as resources and educators for older persons in their communities. The trainees, in turn, have trained more than 70,000 Medicare beneficiaries to spot problems. Projects announced today will result in training 15,000 more volunteers, who will in turn help educate 250,000 additional beneficiaries. The projects teach not only what fraud and abuse are, but also what they aren't. Senior volunteers undergo several days of training reviewing health care benefit statements and outlining the steps seniors can take to protect themselves.

"We know that by expanding this program, even more volunteers and honest health care providers will join together to prevent older persons from being victimized," said DHHS Assistant Secretary for Aging, Jeanette C. Takamura, "The success of this program underscores the contributions our national aging network continues to make to our country as it works closely with older Americans, their family members and peers to prevent and halt this drain on our health care system."

The Senior Patrol project is part of the Clinton administration's broad initiative to combat waste, fraud and abuse in Medicare and Medicaid, including extensive efforts by the Health Care Financing Administration, which administers the programs, the DHHS Office of Inspector General (OIG), and the Department of Justice. Savings for this effort, including program and payment integrity improvements, total more than $38 billion since 1993. In addition, convictions and other successful legal actions stemming from anti-fraud and abuse efforts have increased more than 240 percent during this period.

To help beneficiaries and others report possible problems, the DHHS OIG maintains a toll-free hotline, 1-800-HHS-TIPS (1-800-447-8477). To date, the hotline has received over 50,000 tips warranting followup. In addition, DHHS and the American Association of Retired Persons (AARP), have recently joined forces in an outreach effort to AARP members, to help identify possible waste, fraud, and abuse by examining Medicare statements. ❖

Sanctioned Provider Information Available on the Internet

The Office of the Inspector General (OIG) keeps public records of individuals/entities that are excluded from reimbursement under Medicare (Title XVIII of the Social Security Act). This information is available on the Internet.

Providers may access **www.arnet.gov/epls** for the list of debarred, excluded, and suspended providers and entities. This Web site is updated daily. ❖

GENERAL INFORMATION

DMERC Physician Information Sheet for Osteogenesis Stimulator and Lymphedema Pump Devices

Medicare coverage of durable medical equipment is administered through the Durable Medical Equipment Regional Carriers (DMERCs). Dr. Paul D. Metzger, Medical Director for the Region C DMERC, has developed the following physician information sheets (PHYISs) for osteogenesis stimulator and lymphedema pump devices:

Dear Physician:
The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC's) regional medical review policy (RMRP) upon which Medicare bases reimbursement decisions for some of the equipment physicians might order for patients. It describes the equipment, its usual clinical indications, Medicare's coverage criteria for reimbursement, and the adjudication criteria for claims.

The DMERC strongly believes that the physician is still the "Captain of the Ship." Palmetto Government Benefits Administrators (Palmetto GBA) requires a physician's order before reimbursing any item. Sometimes Palmetto GBA requires a certificate of medical necessity (CMN) and extra documentation.

While this may inconvenience physicians with additional paperwork, it is only through physician cooperation that Medicare can provide beneficiaries with the appropriate equipment and supplies they need. Physicians are also helping to protect the Medicare Trust Fund from abusive and fraudulent claims for items that are not medically necessary or physician-ordered. Funds lost to unnecessary utilization of and fraudulent claims for DME come from the same Part B Medicare Fund from which physicians are reimbursed for their own services.

The following physician information sheets (PHYISs) are only a summary of the RMRP published in the DMERC Region C DMEPOS Supplier Manual. The definitive and binding coverage policy will always be the RMRP itself, which reflects national Medicare policy, and upon which actual claims adjudication is based. The physician information sheet is intended only as an effort to educate the physician community on conditions of coverage for items of durable medical equipment, prostheses, orthoses, and supplies when ordered for the care of Medicare beneficiaries.

If more detailed information is desired, the physician is encouraged to obtain a copy of the RMRP from the supplier servicing your patient, or directly from the Region C DMERC office of Professional Relations at (803) 735-1034, ext. 35707 or 35745.

Paul D. Metzger, M.D.
Medical Director
Region C DMERC
Palmetto Government Benefits Administrators
Columbia, SC

DMERC Region C Physician Information Sheet: Osteogenesis Stimulator Devices

Osteogenesis stimulators (OS) are devices used to augment bone repair associated with either a healing fracture or bone fusion. OS may be either electrical or ultrasonic. The ultrasonic type is not reimbursed by Medicare at this time. Electrical OS may be applied to the spine (spinal electrical OS), or other long bones (non-spinal electrical OS). They may be invasive or non-invasive. The non-invasive type (not implanted) has electrodes placed on the skin or on a cast or brace over the fracture or fusion site. Only claims for the non-invasive types are submitted to the Durable Medical Equipment Regional Carrier (DMERC) for processing.

Non-spinal Non-invasive Electrical OS (HCPCS Code E0747)

Non-spinal non-invasive electrical OS are reimbursed by Medicare DMERC for the following conditions:

- Long bone fracture which has failed to heal: the period of time after which failure is considered to have occurred is six months.
- Long bone fusions which have failed: the period of time after which failure is considered to have occurred is nine months.
- In the treatment of congenital pseudoarthroses (no minimal time requirement after the diagnosis).

Spinal Non-Invasive Electrical OS (HCPCS Code E0748)

Spinal non-invasive electrical OS are reimbursed by Medicare DMERC for the following conditions:

- Failed spinal fusion where a minimum of nine months has elapsed since that fusion surgery; or
- Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site (that is, more than nine months have passed since attempted fusion surgery at the same level which is being fused again). Here, so long as nine months passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device; or
- Following a multilevel spinal fusion (that is, involving three or more contiguous vertebrae, such as L3-L5 or L4-S1). Here there is no minimum time requirement for application after surgery.

CMN for OS

Physicians who order an OS must complete or review the questions concerning their patient's condition in Section B of the DMERC CMN for Osteogenesis Stimulators (DMERC 04). The newest version of this CMN (04.03) divides its questions between a non-spinal and spinal OS, depending on which type is being ordered.

The supplier should **not** have furnished the answers to these questions for the physician. The supplier should furnish a narrative description, what is being charged to Medicare, and how much Medicare should allow in Section C of the CMN, that the physician may review before he or she signs the CMN.

DMERC Region C Physician Information Sheet (Phyis): Lymphedema Pump Devices

These are also known as pneumatic compression devices. They should be used as a **treatment of last resort** for truly refractory lymphedema, associated with congenital and acquired conditions resulting in lymphatic blockage. Examples of such conditions would be Milroy's Disease, Lymphedema praecox and tarda, malignancies that involve axillary or pelvic lymph nodes, or surgery and/or radiation that have the same resultant effect. Lymphedema pump devices **are only covered as a treatment of last resort,** i.e., other less intensive treatments must have been tried first and found inadequate. Such conservative treatments that should first be tried include:

- limb elevation;
- properly applied compression dressings (as with elastic bandage wrapping);
- the use of *custom-fabricated* gradient-pressure compression dressings. Such products are individually fitted items, that require special order and fitting according to each patient's affected limb measurements.

Each of the above measures requires significant compliance by the patient and close management and follow-up by the physician. They must have been tried for a minimum of 6 months before the patient would qualify for Medicare coverage of a lymphedema pump. The lack of adequate documentation that each of the above measures had been tried would result in denial of coverage.

National Medicare policy also allows for coverage of lymphedema pumps in the treatment of chronic venous insufficiency (CVI) which has resulted in venous stasis ulcers on the affected limb(s). These ulcers must have persisted despite a minimum of 6 months of a treatment regimen including each of the above conservative components listed, in addition to the usual drug regimens used to address the underlying conditions which result in CVI. The same degree of patient compliance and close physician oversight is expected during such conservative treatment measures.

Pneumatic compression devices may be covered by Medicare only when prescribed by a physician and when they are used with appropriate physician oversight, i.e., physician evaluation of the patient's condition to determine medical necessity of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

Types of Lymphedema Pumps

The DMERC RMRP classifies lymphedema pumps into three basic categories. Those represented by the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS) code E0650, have compressors which have only a single outflow port, producing one pressure, that is then transmitted by connected tubing to a sleeve ("appliance") which wraps around the affected limb, and thereby exerts this single pressure over the entire limb, effecting lymphatic or third space fluid drainage back into the central circulation. There are available some sleeves which attach to this single port, but which supply a pre-set differential of pressure to distally segmented compartments. Such systems are still considered as single-ported, non-segmented E0650 pumps.

Models of pumps designated by code E0651 are truly segmented pumps, which have multiple ports on the pump delivering either different levels of pressure from each, or the same level of pressure, but at sequentially different times. Each port is connected to a separate segment of limb sleeve by its own tube. Therefore, either by sequentially timed inflation (from most distal to most proximal segment), or by differential pressures (highest most distally to lowest most proximally), a "milking" of fluid toward the central circulation is theoretically effected. E0651 pumps have preset pressures which do not allow for individual calibration of pressure at each port. Thus, once the most distal pressure is determined, all the other more proximal segments are predetermined by that setting.

An E0652 device also has a segmented, multi-ported pump which allows **for individual pressure calibration** at each port. The purpose for such a device would be to decrease the pressure over a discrete area of the limb (such as a painful lesion) and yet still maintain a distal-to-proximal decreasing pressure gradient along the entire limb. An E0652 must allow for manual calibration of pressure at individual ports on a minimum of three of the pump's outflow ports. Again, merely fitting an E0650 pump with tubing or sleeves that divide the generated single pressure into some gradient of pressure at the limb does not convert the device into an E0652.

The Following Devices Are Reimbursed By Medicare These Approximate Amounts

E0650: $600.00
E0651: $800.00
E0652: $4,000.00 - $6,000.00

When a pneumatic compression device is covered, a non-segmented device (E0650) or segmented device without manual control of the pressure in each chamber (E0651) is generally sufficient to meet the clinical needs of the patient. When a segmented device with manual control of the pressure in each chamber (E0652) is ordered and provided, payment will be based on the allowance for the least costly medically appropriate alternative, E0651, unless there is clear documentation of medical necessity in the individual case. Full payment for code E0652 will be made only when there is a painful focal lesion (e.g. significant sensitive skin scar or contracture) of the extremity which requires a reduction in pressure over the affected segment that can only be provided by an E0652 device. There must be documen-

tation that an E0651 device or its equivalent had been tried and had caused significant symptoms that were improved with this use of an E0652 device.

As you are aware, any compression treatment for edema resulting from CVI or lymphedema unavoidably causes some degree of pain. Therefore, careful consideration should be given to the significance of pain being produced by any lesion thought to require an E0652.

Documentation

As with all items for which the DMERC must determine whether Medicare may reimburse, our primary contact with the physician ordering these items is the documentation sent in with the claims for the items, or which is supposed to be available in the supplier's files or the patient's medical record for subsequent review by the DMERC.

- The physician is expected to complete a DMERC CMN for lymphedema pumps.

The CMN is supposed to show the physician the cost of the items being ordered. The physician question section (Section B) of the CMN is not to have been completed by the supplier. It must be completed, or at least reviewed, signed and dated by the ordering physician.

- In addition to completing the few questions listed on the CMN, it is necessary to further document the **etiology of the condition leading to lymphedema or CVI** with venous stasis ulcers.
- There should be documentation of the **conservative measures** used to treat the condition prior to ordering the lymphedema pump.
- If being ordered for CVI, the number, location, size and history of the venous ulcers must be indicated.
- If an E0652 pump is being ordered, the following **additional physician information** must be submitted on a signed and dated statement, submitted with the claim:
  - whether the patient has been treated with **custom fabricated** gradient pressure stockings/sleeves, approximately when, and the results.
  - the treatment plan, including the pressure in each chamber, and the frequency and duration of each treatment episode.
  - the location, size and etiology of the painful focal lesion which necessitates the use of this pump.
  - whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a segmented sleeve had been tried and the results.
  - why the features of the system that was provided are needed for this patient.
  - the name, model number, and manufacturer of the device.

Completing all of the above information will assist the DMERC Medical Review Unit in properly determining whether a claim for this costly equipment is medically necessary, **according to Medicare coverage criteria**. Since these devices may currently be sold outright (not necessarily rented), your ordering a lymphedema pump is not an insignificant decision. If you encounter difficulty determining answers to the above questions, you may need to consider if all the mentioned criteria have indeed been fulfilled.

Thank you for your cooperation in our effort to preserve the viability of the Medicare Trust Fund, the same one from which your professional services are also reimbursed.

Paul D. Metzger, M.D.
Medical Director
Region C DMERC
Palmetto Government Benefits Administrators
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Medicare HMO Information

The article below is reprinted from the May/June 1995 Medicare B Update! *Additional information concerning a beneficiary's liability when he/she chooses to see a physician who is not in his/her plan's network, or receives noncovered services, may be found in the section entitled "Beneficiary Liability and Provider Responsibility."*

A Medicare beneficiary may choose to have covered items and services furnished to him/her through a health maintenance organization (HMO). The HMO must have a contract with the Secretary of Health and Human Services (HHS) to participate in the Medicare program. A "Medicare" HMO must provide the same services that a beneficiary would be eligible to receive from Medicare if he/she were not an HMO enrollee. In other words, the beneficiary is still technically "on Medicare." He/she has simply selected a different carrier and is required to receive services according to that carrier's arrangements. The beneficiary's entitlement to Medicare is based on the same criteria, whether his/her health care expenses are payable by an HMO or by traditional Medicare carriers and intermediaries.

Two methods are available for a provider to determine if a patient may be enrolled in an HMO:

- First, during the initial interview with the patient, the patient should be asked if he/she is enrolled in an HMO, or if Medicare Part B is his primary insurance carrier.
- Second, there may be a sticker attached to the Medicare identification card indicating that the beneficiary has health insurance benefits through an HMO. Some HMOs give their members HMO identification stickers to apply to the Medicare card, but the beneficiary may or may not have one attached. The HMO is not required to issue a special membership card. Remember, the patient is still a Medicare beneficiary, and the standard Medicare card is all that the Health Care Financing Administration (HCFA) issues.

Beneficiaries may enroll or disenroll in an HMO as often as they wish, or change from one HMO to another. How-

ever, once the choice is made, enrollment in an HMO is effective for at least one full month. That is, effective dates are the first day of the month through and including the last day of the month of enrollment.

Types of HMOs

There are two types of HMOs: cost basis and risk basis. The cost basis type allows the beneficiary to have services provided by someone other than an HMO-affiliated physician or supplier. If a provider treats members of this type of HMO, claims may be processed by a traditional Medicare carrier, although it is preferred that the patient receive services through the HMO.

If the patient is a member of a risk-based HMO, Medicare Part B cannot process his/her claims. Additionally, the HMO is not considered responsible for paying claims for its members unless the service(s) provided can be considered emergency or urgent care services, or other covered services not made reasonably available by the HMO, or unless the provider is affiliated with the HMO.

When a claim is submitted for a beneficiary enrolled in this type of HMO, Medicare Part B denies payment for the service(s) (except dialysis and related services provided in a dialysis facility), but automatically transfers the claim to the appropriate HMO. The following message is printed on the Provider Claims Summary (PCS): THIS CLAIM HAS BEEN TRANSFERRED TO THE PATIENT'S HMO.

If the claim was filed electronically, the patient should be contacted to determine the name and address of the HMO. The claim should then be filed to that HMO. If the patient cannot provide the information, Medicare Part B Provider Customer Service, (904) 634-4994, should be contacted, regarding the specific claim.

Beneficiary Liability and Provider Responsibility

If the beneficiary is enrolled in a risk-based HMO and goes out of the plan to receive a service the HMO does not cover, because the physician is not in the plan's network, the service is not covered by Medicare; the physician may charge the beneficiary without regard to the limiting charge rule or the mandatory claims submission rule and does not have to privately contract with the beneficiary or opt out of Medicare.

Note: A private contract and associated opt-out of Medicare are necessary only for services that are covered by Medicare when the physician does not wish to comply with the limiting charge or the mandatory claims submission rules. Because out-of-plan services are not Medicare-covered, opt-out does not apply. For more information concerning the opt-out provision of section 1802(b) of the Social Security Act, refer to page 48 of this issue.

If the beneficiary is enrolled in a cost-based HMO and goes out of the plan to receive a service, the service remains covered under Medicare, and the physician must submit the claim to Medicare and abide by the limiting charge (or accept assignment for the service), since the benficiary is not locked into a cost-based HMO. Services a beneficiary receives outside the network of a cost-based HMO are processed by Medicare as if the beneficiary were not enrolled in the cost-based HMO. If a physician does not want to abide by the limiting charge or the mandatory claims submission rules, he/she may do so only by privately contracting with the beneficiary and opting-out of Medicare.

Any inquiries (claims status, review requests, etc.) related to HMO-denied claims must be sent to the appropriate HMO. Questions regarding enrollment or disenrollment should also be addressed to the HMO as it is responsible for notifying HCFA of such activity by its members. HCFA in turn advises the traditional Medicare carrier, on a per-claim basis, if a beneficiary is enrolled in an HMO. The traditional carrier has no control over HMO enrollment/disenrollment, payment policy, etc.

If an HMO patient chooses to see a non-HMO provider as a provider of health care services, he/she should have a clear understanding of the out-of-pocket expenses he/she may be incurring. Therefore, if a provider is not an HMO provider, patient liability should be discussed with HMO patients.

Providers who sign contracts with HMOs **are not allowed to require** beneficiaries to sign up with the HMO as a condition of continued treatment.

Appeal Rights for HMOs: Whom to Contact and When

The provider has appeal rights with the HMO if the patient feels that he/she was incorrectly enrolled in the HMO. In this situation, the provider must contact the HMO and request a review. The beneficiary should notify the HMO that he/she would like to be disenrolled from the HMO and added back to Medicare Part B, retroactive to the date that he/she joined the HMO. In this situation, the Social Security Administration will update the beneficiary's Medicare eligibility, and the claim will be paid by Medicare Part B. If the beneficiary is correctly enrolled in an HMO but does not understand the requirements of the primary care physician rule, the physician may request a review from the HMO, and the HMO should overturn the original denial.

Quality of Care Issues Involving HMOs

The Florida Medicare Peer Review Organization (PRO) is the same for all Medicare beneficiaries, regardless of who processes and pays the claim. For quality of care issues, contact:

Florida Medical Quality Assurance, Inc. (FMQAI)
1211 North Westshore Blvd., Suite 700
Tampa, FL 33607-4603
(813) 281-9024 (providers)
(813) 844-0795 (beneficiaries)

Fraud and Abuse in HMOs

For issues involving fraud and abuse in HMOs, all complaints, concerns, or allegations should be made to one of the following entities:

- Health Care Financing Administration
- Office of the Inspector General or
- Department of Insurance, Fraud Division

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Private Contracts Between Beneficiaries and Physicians or Practitioners

Section 1802 of the Social Security Act, as amended by section 4507 of the Balanced Budget Act (BBA) of 1997, permits a physician or practitioner to opt-out of Medicare and enter into private contracts with Medicare beneficiaries, if specific requirements of these instructions are met.

Information regarding private contracts between beneficiaries and physicians or practitioners was published in the January/February, March/April, and September/October 1998 issues of the *Medicare B Update!*, and in the December 1998 *Special HCPCS Issue Update!*. Medicare recently received comprehensive instructions regarding the rules and regulations for private contracts. The following instructions supersede those previously published.

Effect Of Beneficiary Agreements Not To Use Medicare Coverage

Physicians and practitioners, as defined below, may be released from the obligations of the Act, with regard to submission of claims and limits on charges for Medicare covered services, only if they opt-out of Medicare in accordance with the following sections. Physicians and practitioners who do not meet the definition of these terms for the purposes of opting out of Medicare, and other suppliers of services covered by Medicare, are required to submit claims "on behalf of" beneficiaries for all items and services for which Medicare payment may be made on a reasonable charge or fee schedule basis and to abide by the limits on charges to beneficiaries that apply to the item or service being furnished.

- The *only* situation in which non-opt-out physicians or practitioners, or other suppliers, are not required to submit claims to Medicare for covered services is where a beneficiary or his/her legal representative refuses, of his/her own free will, to authorize the submission of a bill to Medicare. In this situation, the bill would not be submitted "on behalf of" the beneficiary. However, the limits on what the physician, practitioner or other supplier may collect from the beneficiary continue to apply to charges for the covered service, notwithstanding the absence of a claim to Medicare.
- If an item or service is one that Medicare may cover in some circumstances but not in others, a non-opt-out physician or practitioner, or other supplier, must still submit a claim to Medicare. However, he/she may choose to provide the beneficiary, prior to the rendering of the item or service, an Advance Beneficiary Notice (ABN). An ABN notifies the beneficiary that Medicare is likely to deny the claim and that if Medicare does deny the claim, the beneficiary will be liable for the full cost of the services. Where a valid ABN is given, subsequent denial of the claim *does* in fact relieve the non-opt-out physician or practitioner, or other supplier, of the limitations on charges that would apply if the services were covered.

NOTE: Opt-out physicians and practitioners should not use ABNs, because they should use private contracts for any item or service that is, or may be, covered by Medicare, except for emergency or urgent care services (see below).

Where a physician or practitioner, or other supplier, fails to submit a claim to Medicare "on behalf of" a beneficiary for a covered Part B service within one year of providing the service, or knowingly and willfully charges a beneficiary more than the applicable charge limits on a repeated basis, he/she may be subject to civil monetary penalties. Congress enacted these requirements for the protection of all Part B beneficiaries. Their application cannot be negotiated between a physician or practitioner, or other supplier, and the beneficiary unless the physician or practitioner is eligible to opt-out of Medicare and the remaining requirements described herein are met. Agreements with Medicare beneficiaries that are not authorized as described and that purport to waive the claims filing or charge limitation requirements, or other Medicare requirements, have no legal force and effect. For example, an agreement between a physician or practitioner, or other supplier, and a beneficiary to exclude services from Medicare coverage, or to excuse mandatory assignment requirements applicable to certain practitioners, is ineffective.

General Rules of Private Contracts

The following rules apply to physicians or practitioners who opt-out of Medicare:

- A physician or practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare.
- A physician or practitioner who enters into at least one private contract with a Medicare beneficiary and who submits one or more affidavits, opts out of Medicare for a two-year period unless the opt-out is terminated early or unless the physician or practitioner fails to maintain opt-out. The physician's or practitioner's opt-out may be renewed for subsequent two-year periods.
- Both the private contracts described in the first paragraph of this section and the physician's or practitioner's opt-out described in the second paragraph of this section are null and void if the physician or practitioner fails to properly opt-out in accordance with the conditions of these instructions.
- Both the private contracts described in the first paragraph of this section and the physician's or practitioner's opt-out described in the second paragraph of this section are null and void for the remainder of the opt-out period if the physician or practitioner fails to remain in compliance with the conditions of these instructions during the opt-out period.
- Services furnished under private contracts meeting the requirements of these instructions are not covered services under Medicare, and no Medicare payment will be made for such services either directly or indirectly.

Effective Date of the Opt-Out Provision

A physician or practitioner may enter into a private contract with a beneficiary for services furnished no earlier than January 1, 1998.

Definition of Physician or Practitioner

For purposes of this provision, the term "physician" is limited to doctors of medicine and doctors of osteopathy who are legally authorized to practice medicine and surgery by the state in which such function or action is performed; no other physicians may opt-out. Also, for purposes

of this provision, the term "practitioner" means any of the following to the extent that they are legally authorized to practice by the state and otherwise meet Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker.

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. 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."

When a Physician or Practitioner Opts Out of Medicare

When a physician or practitioner opts of out of Medicare, no services provided by that individual are covered by Medicare and no Medicare payment may be made to that physician or practitioner directly or on a capitated basis. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician or practitioner who has opted out of the program.

> **EXCEPTION:** In an emergency or urgent care situation, a physician or practitioner who opts out may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician or practitioner may not charge the beneficiary more than what a non-participating physician or practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician or practitioner.

Under the statute, the physician or practitioner cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others, or for some services but not others. The physician or practitioner who chooses to opt-out of Medicare may provide covered care to Medicare beneficiaries only through private agreements.

Medicare will make payment for covered, medically necessary services that are ordered by a physician or practitioner who has opted out of Medicare if the ordering physician or practitioner has acquired a unique provider identification number (UPIN) from Medicare, provided that the services are not furnished by another physician or practitioner who has also opted out. For example, if an opt-out physician or practitioner admits a beneficiary to a hospital, Medicare will reimburse the hospital for medically necessary care.

When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician or practitioner

Payment may be made to a beneficiary for services of an opt-out in two cases:

- If the services are emergency or urgent care services furnished by an opt-out physician or practitioner to a beneficiary with whom he/she does not have a previously existing private contract, or
- If the opt-out physician or practitioner failed to privately contract with the beneficiary for services that he/she provided that were not emergency or urgent care services.

Definition of a Private Contract

A "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for 2 years for *all* covered items and services he/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. Pursuant to the statute, once a physician or practitioner files an affidavit notifying the Medicare carrier that he/she has opted out of Medicare, he/she is out of Medicare for 2 years from the date the affidavit is signed, unless the opt-out is terminated early, or unless the physician or practitioner fails to maintain opt-out. After those 2 years are over, a physician or practitioner could elect to return to Medicare or to opt-out again. Note that a beneficiary who signs a private contract with a physician or practitioner is not precluded from receiving services from other physicians and practitioners who have not opted out of Medicare.

Physicians or practitioners 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 section 1802 of the Social Security Act.

Requirements of a Private Contract

A private contract under this section must:

- Be in writing and in print sufficiently large to ensure that the beneficiary is able to read the contract.
- Clearly state whether the physician or practitioner is excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act.
- State that the beneficiary or his/her legal representative accepts full responsibility for payment of the physician's or practitioner's charge for all services furnished by the physician or practitioner.
- State that the beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician or practitioner may charge for items or services furnished by the physician or practitioner.
- State that the beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician or practitioner to submit a claim to Medicare.
- State that the beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician or practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
- State that the beneficiary or his/her legal representative enters into the contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

- State the expected or known effective date and expected or known expiration date of the opt-out period.
- State that the beneficiary or his/her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- Be signed by the beneficiary or his/her legal representative and by the physician or practitioner.
- Not be entered into by the beneficiary or by the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services. (However, a physician or practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with this provision.)
- Be provided (a photocopy is permissible) to the beneficiary or to his/her legal representative before items or services are furnished to the beneficiary under the terms of the contract.
- Be retained (original signatures of both parties required) by the physician or practitioner for the duration of the opt-out period.
- Be made available to HCFA upon request.
- Be entered into for each opt-out period.

In order for a private contract with a beneficiary to be effective, the physician or practitioner must file an affidavit with all Medicare carriers to which he/she would submit claims, advising that he/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/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), except for a Medicare beneficiary needing emergency or urgent care.

If a physician or practitioner has opted out of Medicare, he/she must use a private contract for items and services that are, or may be, covered by Medicare (except for emergency or urgent care services). An opt-out physician or practitioner is not required to use a private contract for an item or service that is definitely excluded from coverage by Medicare.

A non-opt-out physician or practitioner, or other supplier, is required to submit a claim for any item or service that is, or may be, covered by Medicare. Where an item or service may be covered in some circumstances, but not in others, the physician or practitioner, or other supplier, may provide an Advance Beneficiary Notice to the beneficiary, which informs the beneficiary that Medicare may not pay for the item or service, and that if Medicare does not do so, the beneficiary is liable for the full charge.

Requirements of the Opt-Out Affidavit

Under section 1802 (3)(B) of the Social Security Act, a valid affidavit must:

- Be in writing and be signed by the physician or practitioner.
- Contain the physician's or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number (if one has been assigned), uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI nor a UPIN has been assigned, the physician's or practitioner's tax identification number (TIN).
- State that, except for emergency or urgent care services, during the opt-out period the physician or practitioner will provide services to Medicare beneficiaries only through private contracts that meet the criteria for services that, but for their provision under a private contract, would have been Medicare-covered services.
- State that the physician or practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the physician or practitioner permit any entity acting on his/her behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except for emergency or urgent care services.
- State that, during the opt-out period, the physician or practitioner understands that he/she may receive no direct or indirect Medicare payment for services that he/she furnishes to Medicare beneficiaries with whom he/she has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.
- State that a physician or practitioner who opts out of Medicare acknowledges that, during the opt-out period, his/her services are not covered under Medicare and that no Medicare payment may be made to any entity for his/her services, directly or on a capitated basis.
- State on acknowledgment by the physician or practitioner to the effect that, during the opt-out period, the physician or practitioner agrees to be bound by the terms of both the affidavit and the private contracts that he/she has entered into.
- Acknowledge that the physician or practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician or practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom he/she has not previously privately contracted) without regard to any payment arrangements the physician or practitioner may make.
- With respect to a physician or practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit.
- Acknowledge that the physician or practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules specified below under "Emergency or Urgent Care Services" apply if the physician or practitioner furnishes such services.
- Identify the physician or practitioner sufficiently so 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 or practitioner 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.

In addition, it is expected that the affidavit will include an effective (signature) date.

Failure to Properly Opt-Out

A. A physician or practitioner fails to properly opt-out for any of the following reasons:
   - Any private contract between the physician or practitioner and a Medicare beneficiary, that was entered into before the affidavit was filed does not meet the requirements of a private contract under these rules or
   - He/she fails to submit the affidavit(s) in accordance with these requirements.

B. If a physician or practitioner fails to properly opt-out in accordance with the above paragraphs of this section, the following will result:
   - The physician's or practitioner's attempt to opt-out of Medicare is nullified, and all of the private contracts between the physician or practitioner and Medicare beneficiaries for the two-year period covered by the attempted opt-out are deemed null and void.
   - The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries, including the items and services furnished under the nullified contracts. A non-participating physician or practitioner is subject to the limiting charge provision. For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the approved amount for non-participating physicians or practitioners. A participating physician or practitioner is subject to the limitations on charges of the participation agreement he/she signed.
   - The practitioner may not reassign any claim except as provided in section 3060 of the Medicare Carrier's Manual.
   - The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts, or for noncovered services.
   - The physician or practitioner may make another attempt to properly opt-out at any time.

Failure to Maintain Opt-Out

A. A physician or practitioner fails to maintain opt-out under this section if during the opt-out period one of the following occurs:
   - He/she has filed an affidavit and has signed private contracts in accordance with these requirements but,
   - He/she knowingly and willfully submits a claim for Medicare payment (except emergency or urgent care services for non-contracted beneficiaries—see "Emergency or Urgent Care Services" section); or
   - He/she receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except emergency or urgent care services for non-contracted beneficiaries—see "Emergency or Urgent Care Services" section).
   - He/she fails to enter into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, or enters into private contracts that fail to meet the specifications of a private contract; or
   - He/she fails to comply with the provisions of these requirements regarding billing for emergency care services or urgent care services; or
   - He/she fails to retain a copy of each private contract that he/she has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit HCFA to inspect them upon request.

B. If a physician or practitioner fails to maintain opt-out in accordance with the above paragraphs of this section, and fails to demonstrate within 45 days of a notice from the carrier of a violation of the first paragraph of this section, that he/she has taken good faith efforts to maintain opt-out (including by refunding amounts in excess of the charge limits to the beneficiaries with whom he/she did not sign a private contract), the following will result effective 46 days after the date of the notice, **but only for the remainder of the opt-out period** (However, if the physician or practitioner did not privately contract and refunds coverage, he/she may still maintain the opt-out):
   - All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.
   - The physician's or practitioner's opt-out of Medicare is nullified.
   - The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries for the duration of the opt-out period.
   - The physician or practitioner or beneficiary will not receive Medicare payment on Medicare claims for the remainder of the opt-out period, except as stated above.
   - The physician or practitioner is subject to the limiting charge provisions as stated above.
   - The practitioner may not reassign any claim except as provided in section 3060 of the Medicare Carrier's Manual.
   - The practitioner may neither bill nor collect any amount from the beneficiary except for applicable deductible and coinsurance amounts, or for noncovered services.
   - The physician or practitioner may not attempt to once more meet the criteria for properly opting out until the two-year opt-out period expires.

Actions to be Taken in Cases of Failure to Maintain Opt-Out

If Medicare becomes aware that a physician or practitioner has failed to maintain opt-out, he/she will be advised that a claim has been received and that he/she may have inadvertently failed to maintain opt-out. An explanation must be provided within 45 days of being contacted by Medicare of what happened and how the physician or practitioner will resolve it.

If a claim is received from an opt-out physician or practitioner, Medicare will ask if the received claim was:

a) an emergency or urgent situation, with missing documentation (modifier GJ - see below); or
b) filed in error.

When the reason for the letter is that the physician or practitioner filed a claim that he/she did not identify as an emergency or urgent care service, he/she should submit the following information in response:

- Emergency or urgent care documentation, if the claim was for a service furnished in an emergency or urgent situation but included no documentation to that effect; and/or
- If the claim was filed in error, explain whether the filing was an isolated incident or a systematic problem affecting a number of claims.

If the violation was due to a systems problem, he/she should respond with an explanation of the actions being taken to correct the problem and when he/she expects the systems error is expected to be fixed

If no response is received by the specified date Medicare will assume that there has been no correction of the failure to maintain opt-out and that this could result in a determination that he/she is once again subject to Medicare rules.

In the case of a wrongly filed claim, Medicare will hold the claim in suspense until the requested information is provided or the response date lapses. In this case, if the physician or practitioner responds that the claim was filed in error, Medicare will deny the claim and send the physician or practitioner the appropriate Remittance Advice. The beneficiary will be sent a Medicare Summary Notice (MSN) explaining that the claim was submitted erroneously and he/she is responsible for the physician's or practitioner's charge. In other words, the limiting charge provision does not apply and the beneficiary is responsible for all charges. This process will apply to all claims until the physician or practitioner is able to get his or her problem fixed.

If Medicare does not receive a response from the physician or practitioner by the due date, or if it is determined that the opt-out physician or practitioner knowingly and willfully failed to maintain opt-out, the physician or practitioner will be notified of the effects specified in the "Failure to Maintain Opt-out" section above apply. Upon formal notification of this determination, standard Medicare rules again apply (e.g., mandatory submission of claims, limiting charge, etc.)

The act of claims submission by the beneficiary for an item or service provided by a physician or practitioner who has opted out *is not* a violation by the physician or practitioner and does not nullify the contract with the beneficiary. However, if Medicare receives a substantial number of claims submissions by beneficiaries for items or services by an opt-out physician or practitioner, an investigation will be conducted to ensure that contracts between the physician or practitioner and the beneficiaries exist and that the terms of the contracts meet the Medicare statutory requirements outlined in this instruction.

Physician or Practitioner Who Has Never Enrolled in Medicare

A physician or practitioner who has never enrolled in the Medicare program and wishes to opt-out of Medicare must be provided with a Unique Physician Identification Number (UPIN). In order to refer or order services for a Medicare patient, the physician or practitioner must have a UPIN.

If an opt-out physician or practitioner provides emergency or urgent care service to a beneficiary who has not signed a private contact with the physician or practitioner and the physician or practitioner submits an assigned claim, the physician or practitioner must complete Form HCFA-855 and enroll in the Medicare program before receiving reimbursement.

Non-Participating Physicians or Practitioners Who Opt-Out of Medicare

A nonparticipating physician or practitioner may opt-out of Medicare at any time in accordance with the following:

- The two-year opt-out period begins the date the affidavit meeting the requirements is signed, provided the affidavit is filed within 10 days after he/she signs his/her first private contract with a Medicare beneficiary.
- If the physician or practitioner does not timely file any required affidavit, the two-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit and the furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

Excluded Physicians and Practitioners

An excluded physician or practitioner may opt-out of Medicare by submitting the required documentation. When determining effective dates of the exclusion versus the opt-out, the date of exclusion takes precedence over the date the physician or practitioner opts out of Medicare. A physician or practitioner who has been excluded must comply with section 1001.1901, title 42 of the Code of Federal Regulations (CFR), "Scope and Effect of Exclusion."

If an excluded or opt-out physician or practitioner submits a claim to Medicare, payment will not be made for services furnished, ordered or prescribed on or after the effective date of the exclusion.

The Relationship Between This Provision and Medicare Participation Agreements

Participating physicians and practitioners may opt-out by filing an affidavit that meets the above-described 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).* The participation agreements will terminate at that time. Services may not be provided under private contracts with beneficiaries earlier than the effective date of the affidavit. Non-participating physicians and practitioners may opt-out at any time.

Because the participation agreement is terminated, services for emergency or urgent care services for beneficiaries with whom the opt-out provider has no contract will be paid at the nonparticipating rate.

Participating Physicians and Practitioners

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.

Participating physicians or practitioners are paid at the full fee schedule for the services they furnish to Medicare beneficiaries. However, the law sets the payment amount for nonparticipating physicians or practitioners at 95 percent of the payment amount for participating physicians or practitioners. Therefore, it is necessary to treat nonparticipating physicians or practitioners differently from participating physicians or practitioners in order to assure that participating physicians or practitioners are paid properly for the services they furnish *before* the effective date of the affidavit. Participating physicians or practitioners must provide Medicare with 30 days notice that they intend to opt-out at the beginning of the next calendar quarter. Participating physicians or practitioners may sign private contracts only after the effective date of affidavits filed.

Physicians or Practitioners who Choose to Opt-Out of Medicare

If a physician or practitioner chooses to opt-out of Medicare, it means that he/she opts out for all covered items and services he/she furnishes. Physicians and practitioners may not 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/her professional services and chooses to opt-out of Medicare, then he/she has opted out of Medicare for payment of laboratory services and durable medical equipment, prosthetics or orthotics (DMEPOS), as well as for professional services. If a physician or practitioner who has opted out refers a beneficiary to a non-opt-out physician or practitioner for medically necessary services, such as laboratory, DMEPOS, or inpatient hospitalization, those services would be covered by Medicare. In addition, because suppliers of DMEPOS, independent diagnostic testing facilities, clinical laboratories, etc., may not opt-out, the physician or practitioner owner of such suppliers may not opt-out as such a supplier. Therefore, the participating physician or practitioner becomes a nonparticipating physician or practitioner for purposes of Medicare payment for emergency and urgent care services on the effective date of the opt-out.

Relationship to Non-Covered Services

Because Medicare's rules do not apply to items or services that are categorically not covered by Medicare, a private contract is not needed to furnish such items or services to Medicare beneficiaries, and Medicare's claims filing rules and limits on charges do not apply to such items or services. For example, because Medicare does not cover hearing aids, a physician or practitioner, or other supplier, may furnish a hearing aid to a Medicare beneficiary and would not be required to file a claim with Medicare; further, the physician, practitioner, or other supplier would not be subject to any Medicare limit on the amount he/she could collect for the hearing aid.

If the item or service is one that is not categorically excluded from coverage by Medicare, but may be noncovered in a given case (for example, it is covered only where certain clinical criteria are met and there is a question as to whether the criteria are met), a non-opt-out physician or practitioner, or other supplier is *not* relieved of his/her obligation to file a claim with Medicare. If the physician or practitioner, or other supplier, has given a proper Advance Beneficiary Notice (ABN) he/she may collect from the beneficiary the full charge if Medicare does deny the claim.

Where a physician or practitioner has opted out of Medicare, he/she must provide covered services only through private contracts that meet the criteria specified (including items and services that are not categorically excluded from coverage but may be excluded in a given case). An opt-out physician or practitioner is prohibited from submitting claims to Medicare (except for emergency or urgent care services furnished to a beneficiary with whom the physician or practitioner did not have a private contract).

Organizations That Furnish Physician or Practitioner Services

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.

Where a physician or practitioner opts out and is a member of a group practice or otherwise reassigns his/her rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for services that the physician or practitioner furnishes to Medicare beneficiaries. However, if the physician or practitioner continues to grant the organization the right to bill and be paid for the services he/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.

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 because they are neither physicians nor practitioners. However, if *every* physician and practitioner within a corporation, partnership, or other organization opts out, then such corporation, partnership, or other organization would have in effect, opted out.

The Difference Between Advance Beneficiary Notices (ABN) and Private Contracts

An Advance Beneficiary Notice (ABN) allows a beneficiary to make an informed consumer decision by knowing in advance that he/she may have to pay out-of-pocket. An ABN is not needed where the item or service is categorically excluded from Medicare coverage or outside the scope of the benefit.

An ABN is used when the physician or practitioner believes that Medicare will not make payment, while pri-

vate contracts are used for services that are covered by Medicare and for which payment might be made *if the physician or practitioner had not opted out* and a claim were to be submitted.

Private Contracting Rules When Medicare is the Secondary Payer

The opt-out physician or practitioner must have a private contract with a Medicare beneficiary for all Medicare-covered services, notwithstanding that Medicare would be the secondary payer in a given situation. No Medicare primary *or* secondary payments will be made for items and services furnished by a physician or practitioner under the private contract.

Emergency and Urgent Care Situations

Payment may be made for services furnished by an opt-out physician or practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to, or ordered or prescribed for, such beneficiary on or after the date the physician opted out.

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.

In other words, where the physician or practitioner provides emergency or urgent services to the beneficiary, he/she must submit a claim to Medicare, may collect no more than the Medicare limiting charge in the case of a physician or the deductible and coinsurance in the case of a practitioner. This implements section 1802(b)(2)(A)(iii) of the Social Security Act, which specifies that the contract may not be entered into when the beneficiary is in need of emergency or urgent care. Because the services are excluded from coverage under section 1862(a)(19) of the Act *only* if they are furnished under private contract, HCFA concludes that they are not excluded in this case where there is no private contract, notwithstanding that they were furnished by an opt-out physician or practitioner. Hence, they are covered services furnished by a nonparticipating physician or practitioner, and the rules in effect absent the opt-out would apply in these cases. Specifically, a physician may choose to take assignment (thereby agreeing to collect no more than the Medicare deductible and coinsurance based on the allowed amount from the beneficiary) or not to take assignment (and to collect no more than the Medicare limiting charge), but a practitioner must take assignment under section 1842(b)(18) of the Act.

Therefore, in this circumstance the physician or practitioner must submit a completed Medicare claim on behalf of the beneficiary with the appropriate procedure code and modifier (GJ) that indicates the services furnished to the Medicare beneficiary were emergency or urgent, and the beneficiary does not have a private agreement with him/her.

> **Definition of modifier GJ: Opt-out Physician or practitioner EMERGENCY OR URGENT SERVICES**

The use of this modifier indicates that the service was furnished by an opt-out physician or practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to, or ordered or prescribed for, such beneficiary on or after the date the physician or practitioner opted out.

Payment for emergency or urgent care items and services to both an opt-out physician or practitioner and the beneficiary will be denied if these parties have previously entered into a private contract (i.e., prior to the furnishing of the emergency or urgent care items or services but within the physician's or practitioner's opt-out period).

Under the emergency and urgent care situation where an opt-out physician or practitioner renders emergency or urgent service to a Medicare beneficiary (e.g., a fractured leg) who has not entered into a private agreement with him/her, as stated above the physician or practitioner is required to submit a claim to Medicare with the appropriate modifier (GJ and 54 as discussed below) and is subject to all the rules and regulations of Medicare including limiting charge. However, if the opt-out physician or practitioner asks the beneficiary, with whom he/she has no private contract, to return for a followup visit (e.g, return within 5 to 6 weeks to remove the cast and examine the leg) the physician or practitioner shall ask the beneficiary to sign a private contract. In other words, once a beneficiary no longer needs emergency or urgent care (i.e., nonurgent followup care), Medicare cannot pay for the followup care and the physician or practitioner can and must, under the opt-out affidavit agreement, ask the beneficiary to sign a private agreement as a condition of further treatment.

The way this would work in the fractured leg example, is that the physician or practitioner would bill Medicare for the setting of the fractured leg with the emergency opt-out HCFA modifier **(GJ)** and the surgical care only modifier (54) to ensure that HCFA does not pay the Evaluation and Management (E&M) that is in the global fee for the procedure. The physician or practitioner would then either have the beneficiary sign the private contract or refer the beneficiary to a Medicare physician or practitioner who has not opted out, who would bill Medicare using the post-operative-only modifier to be paid for the post operative care in the global period.

It would be different if the beneficiary continues to be in a condition that requires emergency or urgent care (e.g., unconscious or unstable after surgery for an aneurysm). In such a case, the followup care would continue to be paid under emergency or urgent care until such time as the beneficiary no longer needed such care.

Definition of Emergency and Urgent Care Situations

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

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

- Placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
    - That there is inadequate time to effect a safe transfer to another provider before delivery; or
    - That transfer may pose a threat to the health or safety of the woman or unborn child.

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

Denial of Payment to Employers of Opt-Out Physicians and Practitioners

If an opt-out physician or practitioner is employed in a hospital setting and submits bills for which payment is prohibited under the opt-out provision, Medicare will contact the hospital or clinic or group practice and inform it that payment will be reduced by the amount of Medicare money involved in paying the opt-out physician or practitioner.

Denial of Payment to Beneficiaries and Others

If a beneficiary submits a claim that includes items or services furnished by an opt-out physician or practitioner on dates on or after the effective date of opt-out by such physician or practitioner, Medicare will deny such items or services.

Payment for Medically Necessary Services Ordered or Prescribed By An Opt-out Physician or Practitioner

If claims are submitted for any items or services ordered or prescribed by an opt-out physician or practitioner under section 1802 of the Social Security Act, Medicare may pay for medically necessary services of the furnishing entity, provided the furnishing entity is not also a physician or practitioner that has opted out of the Medicare program.

Mandatory Claims Submission

Social Security Act section 1848(g)(4), Physician or Practitioner Submission of Claims, regarding mandatory claims submission, does not apply once a physician or practitioner signs and submits an affidavit to the Medicare carrier opting out of the Medicare program, for the duration of his/her opt-out period, unless he/she knowingly and willfully violates a term of the affidavit.

Renewal of Opt-Out

A physician or practitioner may renew an opt-out without interruption by filing an affidavit with each carrier to which an affidavit was submitted for the first opt-out period, and to each carrier to which a claim was submitted during the previous opt-out period, provided the affidavits are filed within 30 days after the current opt-out period expires.

Early Termination of Opt-Out

If a physician or practitioner changes his/her mind once the affidavit has been approved by the carrier, the opt-out may be terminated within 90 days of the effective date of the affidavit. To properly terminate an opt-out a physician or practitioner must:

- Not have previously opted out of Medicare.
- Notify all Medicare carriers, with which he/she filed an affidavit, of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.
- Refund to each beneficiary with whom he/she has privately contracted all payment collected in excess of:
- The Medicare limiting charge (in the case of physicians or practitioners); or
- The deductible and coinsurance (in the case of practitioners).
- Notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period. In the event such claims are filed and have already been paid by the beneficiaries, the paid amount *must* be indicated on the claim.

When the physician or practitioner properly terminates opt-out in accordance with the second bullet above, he/she will be reinstated in Medicare as if there had been no opt-out. Requests for early termination of opt-out must be submitted in writing to:

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

Reader Survey Results

The staff of the Medicare Publications department would like to thank the readers of the May/June 1999 *Medicare B Update!* who participated in the reader survey. Readers provided us with a large number of suggestions and comments. In this article, we have outlined and discussed some of the most frequent comments we received.

Specialty

Several requests were received to sort or subdivide the *Update!* by specialty. The *Update!* is a general interest publication for *all* Part B providers and is arranged for the convenience of the majority of readers. However, reader consensus on this issue is reflected in the July/August issue, in which the "Coverage" section is divided by specialty *categories* (not specialties). For example, articles under "Mental Health" may interest psychiatrists, clinical psychologists, and clinical social workers. Articles under "Cardiology" may interest various specialties dealing with the cardiovascular *system* (EKGs, for example).

Index

A number of suggestions were made concerning the index. The "Index to Publications" section in the back of the *Update!* reflects up to a year's worth of articles published in previous issues. A complete index for calendar year 1998 is in the January/February 1999 issue. It includes all articles published in 1998, plus the 1998 HCPCS Special Issue *Update!* (December 1997). The index in the current issue (beginning on page 71) includes articles from the January/February, March/April, May/June, and July/August 1999 issues, plus the 1999 HCPCS Special Issue *Update!* published in December 1998. Past issues of the *Medicare B Update!* (back to 1992) can be found on the Medicare Online Bulletin Board System (BBS). See page 66 for more information about the BBS.

Diagnosis, Procedure Codes, and Modifiers

We received several comments about descriptors for diagnosis and procedure codes and modifiers. Additional information about modifier 25 is in the July/August issue of the *Update!* (page 12); look for other articles about modifiers in the future. Descriptors for CPT and HCPCS procedure codes are usually shown. Descriptors for ICD-9-CM diagnosis codes are usually not. There are exceptions to both. A few comments suggested the *Update!* is too lengthy. One way to reduce the size of the publication, without compromising accuracy, is by eliminating descriptors, especially in large local medical review policies (LMRPs).We will, however, continue to provide descriptors for newly assigned codes.

Timeliness

A few readers had concerns about timely receipt of the *Update!*, due to scheduling, mail delivery systems, or address problems. *Update!* publication is generally timed to make issues available close to the first of the month, although delays occasionally occur that the publications staff cannot control. Regarding reader questions about issues being mailed to various addresses within a provider's practice, please refer to our mailing policy, which is explained in the "General Information" section on page 4.

Visibility of New Information

Some readers asked us to provide a quick and visible way to find changes in articles. The publications staff plans to look at possible solutions to this issue.

Claims Denials

A few comments regarding claims denials were received. Some of these were very specific requests. A list of the most frequent claims denial reasons is located in the July/August *Update!* (page 6). Specific reader comments with return addresses will be individually researched by the appropriate subject areas. Please be assured that all information published in the *Update!* is verified by claims processing personnel.

Questions and Answers

Questions and answers provide effective communication in the *Update!* and will continue as needed. "Because You Asked...," once a regular feature of the *Update!*, was dropped because questions, rather than being of general interest, were usually situation-specific that were more appropriately handled via one-on-one education. However, a revival of "Because You Asked..." as an occasional feature is being considered.

Medigap

A few readers noted that the *Update!* has not published a complete Medigap listing since April 1996. Changes, additions and deletions to the list have been published on a regular basis. The entire listing has grown too large to incorporate into the *Update!* However, the complete Medigap listing is available via the Medicare Online BBS.

Examples

Another reader asked for samples of filled-out form 1500s. Examples of correctly filled-out claim forms are currently provided for roster billing of influenza virus and PPV vaccines (see pages 6-14); the publications staff will look into possibly expanding this feature in future issues.

Article Requests

Some requests for articles on specific topics (e.g., critical care) were also received; these have been forwarded to the appropriate areas for future articles.

Finally

Although the *Update!* staff received some very nice compliments (to which we can only say "aw, shucks" and "thanks"), other comments serve as a reminder that there's always room for improvement:

There are a number of specialists who do not wish to receive the entire *Update!* as a great deal of the information is "not relevant" to their practices. These and others believe that the *Update!* is too large, and a waste of paper and resources. Some suggested that the *Update!* is boring, difficult to understand, or "too geared for physicians." Another asked to have the *Update!* reviewed by a doctor before it is published.

In response: A number of medical personnel *do* review the *Update!*, including the carrier medical director. Medicare carriers, including this one, are required by HCFA to disseminate information to their providers. Every effort is made to minimize the expenses associated with producing a bimonthly publication. Single specialty issues are simply not cost-effective. There are instances where, in order to distribute specialty information timely, a *Specialty Update!* has been produced. Due to the cost, this process is only done when absolutely necessary. Generally speaking, specialty information will continue to be included in the complete *Medicare B Update!* This means specialists will receive more information than they truly need; the primary audience for Part B publications *is* mostly physicians. With regard to dull reading material, the publications staff tries to provide interesting articles; however, the mission of the *Update!* is after all, to inform health care providers of serious topics.

Once again, the publications staff greatly appreciates the thoughtful comments and welcomes the opportunity to publish a quality *Update!* for all readers. ❖

Overpayment Interest Rate

Medicare assesses interest on overpaid amounts that are not refunded in a timely manner. Interest will be assessed if the overpaid amount is not refunded within 30 days from the date of theoverpayment demand letter. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate.

Effective August 4, 1999, the interest rate applied to Medicare overpayments is **13.25** percent based on the new revised PCR rate. The table to the right lists previous interest rates. ❖

Period	Interest Rate
May 4, 1999 - August 3, 1999	13.375%
February 1, 1999 - May 4, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00%
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%

New Form to Report Unsolicited/Voluntary Refund Checks

Medicare sometimes receives voluntary refunds from providers or suppliers, including physicians and other practitioners, before refunds are requested. Often these are received with insufficient or missing information, causing delays and incorrect posting of the funds.

Medicare's Financial Services department has developed the "Physician/Supplier Service Request" form (see sample on the following page) to assist providers/suppliers with the return of voluntary refunds. If this form is properly filled out and submitted with a voluntary refund check, the payment will be credited timely and accurately.

The Office of the Inspector General (OIG), working with the Department of Justice and the Health Care Financing Administration (HCFA), has developed two initiatives to combat health care fraud and abuse by encouraging health care providers to comply with the federal health care rules and regulations.

- Compliance Program Guidance–a **voluntary** initiative providing guidance, recommendations, and suggestions to health care providers, to establish an internal self-monitoring process that will aid them in detecting potentially fraudulent and/or abusive practices resulting in overpayments due to the Medicare program.
- Corporate Integrity Agreements (CIA)–a **mandatory** initiative entered into between a health care provider and OIG. In a CIA, the provider is required to undertake specific compliance obligations, such as designating a compliance officer, undergoing training, and being audited. The provider must report compliance activities on an annual basis to OIG.

Both initiatives are designed to assist providers to properly refund inappropriately received Medicare trust funds.

Providers who are subject to a CIA initiative need to report this on the Overpayment Refund form when sending a refund to credit the global settlement to be reported to OIG. ❖

MEDICARE PART B FINANCIAL SERVICES
PHYSICIAN/SUPPLIER SERVICE REQUEST FORM
P.O. BOX 44141
JACKSONVILLE, FLORIDA 32231

See reverse for instructions on completing this form and documentation requirements

1. PHYSICIAN/SUPPLIER NAME _____ **PHYSICIAN/SUPPLIER #:** _____

ADDRESS: _____ **PHONE #** _____

_____

_____

CONTACT PERSON: _____

2. OVERPAYMENT REFUNDS:

Use this section to document the reason for the refund being returned to Medicare. If you do not know the exact amount of the overpayment simply indicate the reason for the refund below and you will be contacted by the Financial Services Department concerning the overpayment amount and how to make a refund.

This form, or a similar document containing the following information, should accompany every voluntary refund so the receipt of check is properly recorded and applied.

Check $ _____ **Check Date** _____ **Check #** _____

For each claim, provide the following:

Patient Name _____HIC #_____Claim Number _____ Amount Refunded $_____ Reason Code:_____ (Select reason code from list below. Use one reason per claim)

Please list all claim numbers involved. Attach separate sheet, if necessary

Reason codes for overpayment (choose one):

Billing/Clerical Error
01 - Corrected Date of Service
02 - Duplicate
03 - Corrected CPT Code
04 - Not Our Patient(s)
05 - Modifier Added/Removed
06 - Billed in Error
07 - Corrected CPT Code

MSP/Other Payer Involvement
08 - MSP Group Health Plan Insurance
09 - MSP No Fault Insurance
10 - MSP Liability Insurance
11 - MSP, Workers Comp.(Including Black Lung)
12 - Veterans Administration

Miscellaneous
13- Insufficient Documentation
14 - Patient Enrolled in an HMO
15 - Services Not Rendered
16 - Medical Necessity
17 - Other (Please Specify)
_____

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine the amount and reason for overpayment.

3. OTHER

☐ Overpayment Review Request (You must attach the overpayment letter along with a detailed explanation of why you believe the refund was requested in error)

☐ Forgery Allegation: Check # _____ Check Date _____ Check $ _____

☐ Request for an Extended Repayment Schedule (Please attached a copy of the refund request letter)

4. OIG REPORTING REQUIREMENTS:

Do you have a Corporate Integrity Agreement with OIG? _____ Yes _____No

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____ Contractor Deposit Control # _____ Date of Deposit: _____

Contractor Contact Name: _____ Phone #: _____ Fax #: _____

Contractor Address:

INSTRUCTIONS FOR COMPLETING THIS FORM

Quick Status Information: (904) 353-3205 9:00 A.M. - 4:25 P.M.

You may contact the Quick Status Department to obtain general information such as status of checks, reviews and inquiries.

Full Service Information: (904) 634-4994 9:00 A.M. - 4:25 P.M.

You may contact the Full Service Department to obtain the information about overpayment account balances and questions regarding the Financial Services Area.

SECTION 1: This section must be completed for all referrals to the Financial Services Department. Please complete all blocks of information listed.

SECTION 2: Complete this section if you are sending a refund check to Medicare Part B with this form or if you are reporting a Medicare Part B overpayment but are unsure of the amount due Medicare.

WE ENCOURAGE YOU TO MAKE A VOLUNTARY REFUND IF YOU KNOW THE AMOUNT OF THE REFUND DUE MEDICARE. SENDING A VOLUNTARY REFUND WILL HELP YOU AVOID ANY CHANCE OF BEING CHARGED INTEREST AS REQUIRED BY THE HEALTH CARE FINANCING ADMINISTRATION IF A REFUND IS NOT RECEIVED WITHIN 30 DAYS FROM THE DATE OF THE OVERPAYMENT LETTER.

PROPER DOCUMENTATION INDICATING THE SPECIFIC CLAIM BEING REFUNDED AND THE REASON FOR THE REFUND IS REQUIRED IN ORDER TO PROPERLY APPLY YOUR REFUND. IF THIS INFORMATION IS NOT RECEIVED, THE REFUND COULD BE APPLIED TO THE WRONG ACCOUNT. IF YOU ARE SENDING A REFUND FOR MORE THAN ONE CLAIM, COMPLETE THE FINANCIAL SERVICES PHYSICIAN/SUPPLIER SERVICE REQUEST FORM AND SEND A COMPLETE EXPLANATION OF THE REASON FOR THE OVERPAID AMOUNT AND A COPY OF THE PROVIDER REMITTANCE NOTICE (PRN) OR A DETAILED LISTING, THAT INCLUDES THE HEALTH INSURANCE CLAIM NUMBER, DATE OF SERVICE AND AMOUNT OF REFUND, EXPLAINING THE CLAIMS IN WHICH THE OVERPAYMENT APPLIES.

IF YOU HAVE RECEIVED A REQUEST FROM OUR OFFICE FOR A REFUND, YOU SHOULD INCLUDE A COPY OF THE REFUND REQUEST LETTER WITH YOUR REFUND PAYMENT.

SECTION 3: Complete this section if you have received an overpayment letter and disagree with the information in the letter, if you suspect a Medicare B check has been forged or if you believe you qualify to refund your overpayment in installments.

SECTION 4: Complete this section if you have a Corporate Integrity Agreement with the Office of Inspector General (OIG).

Free Services Available to Help Educate Your Patients About Medicare

All providers want to maintain good patient relationships; having answers to patients' Medicare questions—or knowing where to refer patients to get answers—can be crucial to those relationships. First Coast Service Options, Inc. (FCSO), Florida's HCFA-contracted carrier, has good news for providers! FCSO's **Medicare Education and Outreach (MEO)** team is dedicated to providing Medicare education to beneficiaries and to those who work with beneficiaries, such as office staff. To this end, MEO makes a number of services available to providers and beneficiaries FREE or at a small cost.

MEO's mission is to help Florida beneficiaries obtain clear and useful health care information, enabling them to access affordable and quality health care services, while protecting their benefits. MEO designs, develops, and delivers educational programs tailored to the informational needs of Florida Medicare beneficiaries, and the providers and other health and social service organizations who furnish services to beneficiaries. Working directly with beneficiaries, often in one-on-one situations, providers are uniquely able to provide needed information to Medicare patients, in a familiar and trusted environment. By maintaining strong partnerships with MEO, providers can reach and educate more than 2.8 million beneficiaries in Florida.

One interactive service MEO provides is a series of free seminars. MEO's regional staff will present, at a provider's facility, half- or full-hour talks (in English or in Spanish) on any of the Medicare topics listed on the following chart. The talks can be targeted to the specific needs of a group of Medicare patients and/or staff members. MEO's primary requirement is that at least 50 beneficiaries or 25 health or social service professionals be present for each seminar.

"Seniorfest" is another popular interactive approach to beneficiary education and outreach. This is a one-day, "one-stop shopping" event, offering information to seniors about their health care benefits, through exhibits, workshops, and educational materials. Free to the public, Seniorfest is presented by MEO and local, state, and federal government agencies serving Medicare and Medicaid beneficiaries. Seniorfest usually takes place in the fall, close to the start of the influenza and pneumococcal virus vaccination campaign and the October mammography campaign. These activities encourage beneficiaries to use their preventive benefits. In fact, many of these benefits are available at Seniorfest. Sponsoring Seniorfest is a great way to bring health information to patients, plus the extra bonus of positive public relations for participating provider organizations.

MEO can also provide providers with Medicare literature to display in the office or give to patients. In addition to the *1999 Medicare and You Handbook*, brochures are available on:

- Preventive benefits, such as mammography, flu, and PPV vaccines
- Medicare + Choice
- Fraud and Abuse
- Durable Medical Goods and more!

Copies may be ordered individually or in quantity.

Medicare video tapes are also available, for the cost of shipping and handling. Topics currently available include:

- Medicare, the Flu and You
- How to Talk to Your Doctor
- Medicare, Home Health, and Hospice
- Medicare Fraud and Abuse (English and Spanish)
- Medicare Services Available in Your Community

The advantage of patient education through video is that patients may check tapes out and view them at their leisure. Providers may also want to have copies available for patients who may be homebound or live in rural areas with poor transportation, or perhaps for training new staff.

More information about MEO services is available on Medicare's Web site: **www.medicarefla.com**.

To schedule a speaker, order materials or video tapes, or find out more about sponsoring or participating in Seniorfest, call Medicare Education and Outreach at **1-904-634-4994**. ❖

Module Name	Topics	Intended Audience
Medicare Overview	Complete overview of program includes eligibility, Parts A/B, Medicare + Choice and covered benefits	All audiences new to Medicare
Medicare Update	Most current policies/ benefits, changes, preventive care, hot issues, Medicare Education and Outreach services	Audiences familiar with Medicare
Managed Care Made Easy/ Medicare + Choice	Original fee for service vs. Managed Care, How to evaluate/ select/ enroll/ disenroll from a Medicare + Choice program	All audiences
Medicare Fraud and Abuse	Definition and examples of Fraud and Abuse, Operation Restore Trust, how to report Fraud and Abuse	All audiences
Medicare Preventive Care Benefits	Promote healthy living, preventive coverage: Mammography, Flu, PPV, Colorectal cancer screening, PAP smears, hepatitis B, and others	Beneficiaries, Caregivers
How to Help your Patients Understand Medicare	Communicating with your patient, understanding Medicare basics, Medicare Education and Outreach services, assistance and referral, frequently asked questions and hot topics	Healthcare providers (non-physician), office managers, social workers

Health Care-Related Web Sites

The following list of Web sites is published solely as a helpful tool for finding information related to the Medicare program, health care and health care quality issues.

Medicare Program

Medicare Computer Based Training (CBT)
www.medicaretraining.com

Health Care Financing Administration (HCFA) Home Page, National Provider System
www.hcfa.gov

Medicare Coverage Issues
www.medicare.gov
www.hcfa.gov

HCFA National Education Program
www.nmed.org

HCFA Transmittals
www.hcfa.gov/pubforms/transmit

HCFA 1500, UB-92 (1450) Claim Forms, Electronic Data Interchange (EDI) Formats
www.hcfa.gov/medicare/edi/edi.htm

Electronic Claim Format, Year 2000 (Y2K) Claim Specifications
www.hcfa.gov/medicare/edi3.htm

Paper Claims, 1491-1490 Ambulance Claim Forms, Year 2000 (Y2K) Claim Specifications
www.hcfa.gov/medicare/edi5.htm

Evaluation & Management (E&M) Documentation Information
www.hcfa.gov/medicare/mcarpti.htm

Clinical Laboratory Fee Schedules
www.hcfa.gov/stats/pufiles.htm

SNF/PPS Consolidated Billing
www.hcfa.gov/medicare/cbqa.htm and
www.hcfa.gov/medicare/ppsqa.htm

Correct Coding Initiative (CCI) Information & Ordering
www.ntis.gov/cci

Medicare Program Safeguards

DHHS, Office of the Inspector General (OIG) Fraud Alert
www.dhhs.gov/proorg/oig/frdalrt/index.htm

Compliance Program/Workplan
www.dhhs.gov/proorg/oig

Goverment Services Administration (GSA) Debarment, Exclusion, and Suspension List
www.arnet.gov/epls/

Department of Health and Human Services Database for all Sanctioned Providers
www.hhs.gov

Government-Related

American Compliance Institute, Alexandria, VA
www.compliance.com

Consumer Information Health and Health Care Quality
www.consumer.gov

Center for Healthcare Information Management
www.chim.org

Coalition Against Insurance Fraud, Washington, DC
www.insurancefraud.org

Code of Federal Regulations
www.access.gpo.gov/nara/cfr/index.html

Congressional Record
www.access.gpo.gov/su-docs/aces/aces150.html

False Claims Act Legal Center, Taxpayers Against Fraud
www.access.taf.org

Federal Register
www.access.gpo.gov/su_docs/

Department of Justice
www.usdoj.gov

General Accounting Office
www.gao.gov

National Health Care Anti-Fraud Association
www.nhcaa.org

Supreme Court Decisions
www.law.cornell.edu

U.S. House of Representatives
www.house.gov

U.S. Senate
www.senate.gov

U.S. Sentencing Commission
www.ussc.gov

Agency for Health Care Administration (AHCA)
www.fdhc.state.fl.us/medicaid/index.html

Medical Associations

American Medical Association
www.ama-assn.org

Florida Medical Association
www.fmaonline.org

Florida Hospital Association
www.fha.org

For Year 2000 (Y2K) issues refer to the *Medicare B Update!* January/February 1999 (page 71).

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators. ❖

Medicare Offers FREE National Education Programs

The Health Care Financing Administration (HCFA) has partnered with First Coast Service Options, Inc. (FCSO), the Florida contracted carrier and intermediary, to launch a series of FREE education and training programs designed to give healthcare providers the opportunity to study various topics about Medicare benefits, coverage and billing rules. Leveraging internet-based training and satellite technology to make Medicare education more readily available to healthcare providers throughout the nation saves on travel, challenging schedules and missed office hours. "This approach also helps Medicare providers and beneficiaries avoid potential problems before they occur further reducing waste, fraud and abuse," explains Diane Kelley, director of Medicare Program Relations at FCSO.

Medicare Computer Based Training

Computer Based Training Courses via the Internet

Healthcare providers can download FREE Medicare computer based training (CBT) courses that will help them strengthen their understanding of a variety of topics related to Medicare. The current Medicare library has several self-paced courses that are available 24 hours a day, seven days a week. These courses include:

- ICD-9-CM Coding
- Front Office Management
- HCFA-1500 Claims Filing
- HCFA-1450 (UB92) Claims Filing
- Medicare Fraud & Abuse
- Medicare Home Health Benefit
- Medicare Secondary Payer
- Introduction to the World of Medicare

Here's How it Works:

Users visit the Medicare On-line Training Web Site at **www.medicaretraining.com** and click on "Computer Based Training'' to download the course(s) of their choice. Once a course is downloaded and set up on their PC, users are then able to take the courses at their leisure. The site provides complete step-by-step instructions on how to download and set up the courses.

CBT System Requirements:

- Windows 95, 98 or NT
- mouse
- VGA color monitor

CBT offers users the flexibility to have control over their learning environment. In every course, users are given the opportunity to practice what they've learned through quizzes and tests. After each test is taken, users are given full access to their results, instantly. Users can take as long as they want to complete each lesson and they can take them as often as they like.

The Medicare Online Training Web Site gives Medicare contractors yet another channel to reach new audiences, build new partnerships, and deliver up-to-date materials and services. To date, the site has recorded more than 20,000 course downloads. HCFA and FCSO welcome your participation in this overwhelmingly successful program. Please visit the Medicare Online Training Web Site at **www.medicaretraining.com**.

Medicare Satellite broadcasts

Courses via Satellite Broadcast

When everyone better understands Medicare guidelines, appropriate services are rendered, claims are filed correctly, providers are paid timely (and accurately) and beneficiaries obtain the care and good service they are entitled to receive. The use of satellite technology gives healthcare providers the opportunity to share a nationwide "virtual" classroom and participate in "live" presentations. Participants retain the interactivity offered in a live seminar, as most programs offer a toll-free hotline for participants to call or to fax questions during the broadcast. The following broadcasts are currently scheduled:

Steps to Promoting Wellness: Adult Immunizations
Available on Videotape from the June 1999 National Satellite Broadcast

Medicare Fraud and Abuse: Proactive Measures to Avoid Becoming a Victim
Available on Videotape from the July 1999 National Satellite Broadcast

Steps to Promoting Wellness: Women's Health
Available on Videotape from the August 1999 National Satellite Broadcast

The Medicare Resident Training Program
Live via Satellite - September 16, 1999 - 2 p.m. ET

"Time and distance have very little meaning in computer-based training and satellite broadcasting education," adds Joe Montano, manager of the national program at FCSO. Additional computer-based training courses and satellite broadcasts are currently being planned. To access the computer-based training courses, a complete list of satellite-based courses, host sites, dates, times, and video availability, please visit the Medicare Online Training Web Site at **www.medicaretraining.com** or the "Learning Resources" section of HCFA's web site at **www.hcfa.gov**.

Third party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators. ❖

MEDIFEST

Medicare Part A and B Symposiums for Physicians, Hospitals, Facilities, Suppliers, Office Manager, Non-Physician Practitioners, and Billing Staff

Medifest is a symposium of seminars that offer the latest and most accurate information regarding Medicare guidelines.

1999 Medifest Date and Location

LOCATION	ADDRESS
MIAMI *Medifest* *Sept 21-22* *Specialty Seminars* *Sept 23*	Radisson Mart Centre 711 NW 72nd Ave Miami, FL 33126 (305) 261-3800 Hotel: Radisson Mart Plaza Hotel ask for the Medicare/Medifest hotel rate of $109.00

IMPORTANT REGISTRATION INFORMATION

- *Pre-registration and pre-payment are required. See registration form inside for more information. Note: Bring your confirmation number to the seminar.*
- *Since seating is limited please register as soon as possible. All registrations may be faxed to Medicare Seminar Registration at (904)791-6035.*
- *Some courses require additional materials (e.g., ICD-9-CM book, CPT book, etc.). Please see course description on the Medicare bulletin board system (BBS) for more information.*
- *Only register for one course per time slot.*

5 Good Reasons

why you can't afford to miss these symposiums!

1. *You'll gain strategies for implementing processes to improve reimbursement efficiency.*
2. *You'll find out proven ways to resolve Medicare denials.*
3. *You'll discover new Medicare technologies and different avenues of education.*
4. *Your questions will be answered directly by Medicare experts.*
5. *You'll get the rare opportunity to make contacts and network with other providers who face the same challenges you do.*

Continuing Education Units Available

You can obtain continuing Education Units (CEUs) for most Medifest courses. Details regarding CEUs may be obtained from your Medifest Course Instructor or the Medifest Training Coordinator when you register.

Medifest/Specialty Seminar Registration Form September 1999

Anyone interested in learning about Medicare billing may attend. Photocopies of these forms are acceptable. Be sure to make a copy of all forms for your records. Please print your name on all pages before you fax your registration to us.

Complete the Registration Form (one form per person)

Registration

- **Pre-registration is required. Registration will not be accepted at the door.**

Payment

- **Prepayment is required. Your method of payment may be in the form of checks or money orders (only).**

Cancellations and Refunds

- **All cancellation requests must be received 7 days prior to the seminar to receive a refund.**
- **All refunds are subject to a $20 per person cancellation fee. NO refunds or rainchecks will be issued for cancellations received less than 7 days prior to the event. (Also see substitution policy)**

Substitution

- **If you cannot attend, your company may send one substitute to take your place for the entire seminar. (Registration must be informed of any changes)**
- **Once you have signed in at the seminar, substitutions will not be permitted for the remainder of the seminar.**

Confirmation Number

- **Your confirmation number will be issued by fax from Seminar Registration.**
- **It is very important that you have a confirmation number. YOU MUST BRING THIS NUMBER WITH YOU.**
- **If you do not receive a confirmation number, please call (904) 791-8299.**

FOUR IMPORTANT STEPS

Please follow all four

STEP 1 FAX both registration form and class schedule to (904)791-6035.

STEP 2 Make checks payable to First Coast Service Options(FCSO) Account #756240.

STEP 3 (After you have faxed your form) Mail the form and payment to:

Medifest Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4 YOU MUST BRING YOUR CONFIRMATION NUMBER WITH YOU.

Please Print

Registrant's Name _____

Provider's Name _____

Medicare billing provider # _____(leave blank if you do not have one)

Address _____

City, State, ZIP code _____

Phone ( ) _____ Fax ( ) _____

Does your office bill electronically? Yes _____ No _____

How did you learn about Medifest? Medicare B Update!_____ Part A Bulletin _____

BBS _____ Co-worker _____ Other _____ Attended Previously _____ - ____times

Medifest/Specialty Seminar Package Deals are only valid for the same location/week

Medifest Only ***(please fill out one form per person)***

☐ *One day Medifest $149 - per person*
☐ *Two day Medifest $199 - per person*

Specialty Seminar Only

☐ *One Specialty Seminar $99 - per person*

Medifest/Specialty Seminar Package Deals

☐ *One day at Medifest and one Specialty Seminar $199 - per person*
☐ *Two days at Medifest and one Specialty Seminar $249 - per person*

This is the final Medifest this millenium!

Miami Medifest - September 21 & 22

_____ Medifest - September 21 & 22, 1999
(payment and registration must be received by September 13, 1999)

_____ Specialty Seminars - September 23, 1999
(payment and registration must be received by September 13, 1999)

Medifest Class Schedule

September 1999

Registrant's Name: _____

Please register for only one class per time slot.

Day 1 — *September 21*

8:30 - 10:00

54 ☐ Program Changes (A/B)
08 ☐ Medicaid (A/B)
57 ☐ PC-ACE for UB92 Claims Filing (A)
25 ☐ Direct Data Entry (A)
09 ☐ Bulletin Board System (BBS) (A/B)

8:30 - 12:00*

check this section only if you have **not checked a class from 8:30-10:00 or 10:30 12:00*

55 ☐ E/M Documentation & Coding (B)
05 ☐ Partial Hospitalization Program (A)
56 ☐ Medicare Part B Claims Filing (B)

10:30 - 12:00

76 ☐ Reimbursement Efficiency for Part A (A)
13 ☐ Global Surgery (B)
15 ☐ Electronic Media Claims (B)
19 ☐ Primary Care (B)
58 ☐ PC-ACE for HCFA-1500 Claims Filing (B)

1:30 - 3:00

59 ☐ Medical Review (A/B)
24 ☐ Bulletin Board System(BBS) (A/B)
60 ☐ Reimbursement Efficiency for Part B (B)
61 ☐ Direct Data Entry (A)
23 ☐ Medicaid (A/B)
62 ☐ How to Help Your Patients Understand Medicare (A/B)

1:30 - 5:00*

check this section only if you have **not checked a class from 1:30-3:00 or 3:30 5:00*

63 ☐ E/M Documentation & Coding (B)
44 ☐ ICD-9-CM for Beginners (B)

3:30 - 5:00

14 ☐ Fraud & Abuse (A/B)
06 ☐ Inquiries and Appeals (B)
66 ☐ Advanced Registered Nurse Practitioner/ Physician Assistant (B)
28 ☐ Electronic Media Claims (B)

Day 2 — *September 22*

8:30 - 10:00

67 ☐ How to Help Your Patients Understand Medicare (A/B)
36 ☐ Electronic Media Claims (B)
70 ☐ Advanced Registered Nurse Practitioner/ Physician Assistant (B)
47 ☐ Inquiries and Appeals (B)

8:30 - 12:00*

check this section only if you have **not checked a class from 8:30-10:00 or 10:30 12:00*

03 ☐ ICD-9-CM for Beginners (B)
71 ☐ UB-92 Claims Filing (A)

10:30 - 12:00

48 ☐ Global Surgery (B)
42 ☐ Bulletin Board System(BBS) (A/B)
43 ☐ Medicaid (A/B)
81 ☐ Reimbursement Efficiency for Part B (B)

1:30 - 3:00

72 ☐ Program Change (A/B)
73 ☐ How to Help Your Patients Understand Medicare (A/B)
52 ☐ Primary Care (B)
41 ☐ Medicaid (A/B)
50 ☐ Electronic Media Claims (B)
69 ☐ Reimbursement Efficiency for Part A (A)

1:30 - 5:00*

check this section only if you have **not checked a class from 1:30-3:00 or 3:30 5:00*

74 ☐ Medicare Part B Claims Filing (B)
17 ☐ CPT for Beginners (B)
75 ☐ E/M Documentation & Coding (B)

3:30 - 5:00

77 ☐ Medical Review (A/B)
53 ☐ Bulletin Board System(BBS) A/B)
01 ☐ Skilled Nursing Facilities/Consolidated Billing (A/B)
27 ☐ Fraud & Abuse (A/B)

Specialty Seminar Class Schedule (Only $99)

(Package deals are only valid for same location and week)

Registrant's Name _____ ***Miami - September 23, 1999***

A.M. 8:30 - 12:00

306 ☐ Radiology (B)
308 ☐ End Stage Renal Disease (ESRD) Facility (A)
309 ☐ Mental Health (B)
316 ☐ Orthopaedics (B)
318 ☐ CORF/ORF (A)
319 ☐ Dermatology (B)

*Your registration form **must** accompany your class schedules*

Medicare Online

Electronic Bulletin Board System(BBS)

Florida Electronic Bulletin Board System (BBS)

WHAT IS THE BBS?

The BBS is a Bulletin Board System maintained in a computer similar to your own. It is located at Medicare of Florida and enables you to access vast amounts of important Medicare (Part A and B) claims processing information. This system is available 24 hours a day, 7 days a week, to ***anyone*** (with no restrictions), from anywhere, even outside Florida). Access can be obtained by using your office ***or*** home computer, via a **TOLLFREE** telephone line.

WHAT'S AVAILABLE?

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

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

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

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

(CBT is also available online www.medicaretraining.com)

WHAT YOU WILL NEED:

To access the BBS, you will need:

A Personal Computer

A telephone line with long-distance access—a dedicated line is suggested but not required

A modem—internal or external

The communication software - There are dozens of programs available such as HyperTerminal, PCAnywhere, Procomm, etc.

Most computers purchased within the last five years that have modems, include communication software. Follow your communication software instructions to set up access to the BBS using the Medicare Online BBS phone numbers.

The following two items are examples of some of the communication software options available:

Windows95/98/NT - comes with a built in program called HyperTerminal and can be accessed by: selecting Start, then Programs, then Accessories, and then HyperTerminal. Follow the setup instructions onscreen to access the BBS.

Free Windows-based communication software is available for your use. If you are unable to use your existing software, Medicare has a Windows-based communication program available. To obtain it, send a fax request on your office letterhead (with your office name, address and contact name) to (904)791-6035.

TOLL FREE ACCESS:

Users - outside Jacksonville FL area:
(800)838-8859
Users - within Jacksonville FL area:
(904)791-6991

USER ID AND PASSWORD:

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

BBS HELP LINE:

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

Welcome To Medicare Online !

Using Windows 95/NT/98 To Access "Medicare Online BBS"

What is Medicare Online BBS?

Medicare Online BBS is an electronic Bulletin Board System (BBS) maintained at Medicare of Florida. It enables you to access vast amounts of important Medicare A and B claims processing information. This BBS is available to anyone (with no restrictions), from anywhere even outside Florida, and is available 24 hours a day, 7 days a week. Access can be obtained by using your office and/or home computer, via a TOLL FREE telephone number. All you need is a computer, telephone line, modem and communications software. The following are instructions for using a communications program included within Windows 95/NT/98 operating systems.

Using HyperTerminal

Windows 95/NT/98 includes a communications program called HyperTerminal that will allow you to connect to the Medicare Online BBS. The program includes a simple setup "wizard" used to establish your connection.

Step 1: Accessing HyperTerminal

To access the HyperTerminal program: from the Start menu, click Programs, then Accessories, then HyperTerminal.

Step 2: Setup Wizard

Look for the icon labeled "HyperTerminal", "Hypertrm", "HyperTrm.exe" or "HYPER.TRM". Double-click this icon to start the setup wizard.

Step 3: Connection Description

The setup wizard will ask you to name the connection and select an icon. Name the connection Medicare Online BBS (or any name you like), select the icon you want to use by clicking on it, and click OK. It doesn't matter which icon you use; you can change it later if you like.

Step 4: Phone Number

The setup wizard will ask you for the phone number to dial. Enter the appropriate phone number and then click OK.

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

Users within Jacksonville, FL area
791-6991

Step 5: Dialing Properties

The setup wizard allows you to revise dialing properties 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 (e.g., "9" for an outside line), long distance access (e.g., "1" for long distance), and disabling call waiting (click on selections available and choose appropriately: e.g., "*70"). When complete, click OK.

Step 6: Connect

The setup wizard will ask you to make the connection (call). At this time choose Dial to call the Medicare Online BBS.

Step 7: Signing On To Medicare Online BBS

If you are a new user to the Medicare Online BBS, type *NEW* when the system asks for your User ID. You will then complete a brief questionnaire (registration) about your practice/office, along with allowing you to assign your own User ID and password. It's very important that you write your User ID and password down exactly as you entered it (including any special characters), as you will need it for future access to the BBS.

That's it! - When you sign off the Medicare Online BBS and then exit HyperTerminal, be sure to save this new connection when prompted. The next time you open HyperTerminal, you will have an icon in this group titled "Medicare Online BBS." Simply double-click on this icon to connect in the future.

Need Help? - If you have any questions or need assistance with the Medicare Online BBS, contact our BBS Help Line at (904)791-8384. When leaving your message, please speak slowly and clearly when leaving your company name, contact name, telephone number and detailed description of your inquiry. Existing users should also leave their User ID. Please do not leave your password.

FREE Windows-Based Communications Software

We suggest you try this program; it's much more user friendly than the terminal access (which HyperTerminal uses) and makes downloading a lot easier. Once you access the BBS, you can download this program by selecting (M) at the Main Menu. If you are unable to use your existing communication software to access the BBS to download this program, it can be mailed to you. Fax your request to (904)791-6035, or contact the BBS Help Line at (904)791-8384. ❖

ORDER FORM - 1999 PART B MATERIALS

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Update!* Subscription** - For non-provider entities or providers who need additional copies at other office locations, an annual subscription is available. This subscription includes all issues published during calendar year 1999 (back issues sent upon receipt of order).	756245	$75.00
_____	**1999 Fee Schedule** - Available in booklet or diskette format. These items include the payment rates for injections, but do not include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* The diskette contains a fixed length ASCII text files of the 1999 physician fee schedule. File layout specifications are included on the disks, and these files can be imported into standard spreadsheet or database programs.	756250	**Booklet** $20.00 **Diskette** $20.00
_____	**Procedure/Diagnosis Relationship File** - This is a printout of the most current file used during claims processing to determine coverage for procedures subject to specific diagnosis criteria. This document is designed to assist providers by outlining coverage criteria in order to limit their financial liability for these procedures.	756245	$15.00
_____	**Medicare Online Bulletin Board Software (BBS)** - We can provide DOS or Windows based communications software that allows you to dial into our Medicare Online BBS to obtain various information (i.e., UPIN and Medigap insurer listings, text of Part B medical policy, text files of past publications, etc.). Note: If you have a modem, you probably already have communications software that can be used (such as HyperTerminal in Windows95). In this case, you do not need to use our communications software. For more information, see the BBS pages in the *Update!*	N/A	**FREE**

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

ORDER FORM - 1999 MEDIFEST AND SPECIALTY SEMINAR BOOKS

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	**1999 Medifest Book** - This is the same manual provided to Medifest attendees and includes information on claim form completion instructions, local medical review policies, home health services and more.	756245	$85.00
_____	**1999 Specialty Seminar Books** - This is the same manual provided to specialty seminar attendees and includes information on coding, coverage and medical policy, basic CPT, ICD-9-CM, primary care, evaluation and management documentation guidelines and more. _____ ASC _____ Ambulance _____ Anesthesia _____ Cardiology _____ Dermatology _____ Home Health _____ IDTF _____ Mental Health _____ Nurse Practitioner/CNS/Physician Assistant _____ Oncology (Medical and Radiation) _____ Orthopaedics _____ Pathology _____ Podiatry _____ Radiology _____ Urology	756245	$25.00 **per book**

NOTE: Please indicate (X) the books you would like to purchase.

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Year 2000 Medicare Part B of Florida
Physician and Non-Physician Practitioner Fee Schedule of Allowances

The Year 2000 Medicare Part B fee schedule will be available in late November, in either booklet or diskette format. The booklets and disks contain Year 2000 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2000. While these fees are subject to change during the course of a year, neither the booklet nor the diskettes are updated as these changes occur. Revisions to the fee schedule will be published in future *Medicare B Updates!*

Please note that the booklet and diskette include the payment rates for injectable drugs but *do not include* Year 2000 payment rates for clinical laboratory services, mammography screening and DMEPOS items. These fees will be published in future *Medicare B Updates!* **.**

The Year 2000 Medicare Part B fee schedule is also available **free of charge** through the Medicare Online BBS (electronic bulletin board system). Refer to page 66 for information on how to access the BBS.

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To order the Year 2000 Medicare Fee Schedule Booklet or Disk, please complete this form and return with payment to:

Medicare Education and Outreach
Medicare Part B
PO Box 2078
Jacksonville FL 32231-0048

Please make check/money order payable to:

BCBSFL- FCSO Account #756-250
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

Check format requested: Quantity

Booklet $20.00 $_____ _____

Diskette $20.00 $_____ _____

Sales Tax $1.30 (6.5%)+_____

TOTAL $21.30 $_____

Practice/Company Name _____

Addressee _____
Last First MI

Address _____

City _____

State _____ Zip_____

Phone Number _____

ALL ORDERS MUST BE PREPAID -

DO NOT FAX - PLEASE PRINT
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A

B

C

D

E

F

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

H

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M

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P

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

R

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T

U

Y

MODIFIERS

Index by Procedure Code

HCPCS Codes

A0000-Z9999

Anesthesia/Surgery

00100-69979

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

Diagnostic Tests

70010-89399

Medicine

90281-99199

Evaluation and Management

99201-99499

Special *Updates!*

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

Administrative Law Judge Hearings
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

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Education and Outreach
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
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

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

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

PHONE NUMBERS

BENEFICIARY

Outside Duval County (in Florida):
(800) 333-7586
Duval County (or outside Florida):
(904) 355-3680
Hearing Impaired:
(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.

PROVIDERS

Express Line/ARU Status Inquiries:
(904) 353-3205
Specialty Customer Service Reps:
(904) 634-4994

EMC

Format Issues & Testing:
(904) 354-5977
Start-Up & Front-End Edits/Rejects:
(904) 791-8767
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Help Desk
(Confirmation/Transmission):
(904) 791-9880

OCR

Printer Specifications/Test Claims:
(904) 791-8132

MEDICARE ONLINE BBS

Access:
(800) 838-8859
(904) 791-6991
Technical Problems:
(904)791-8384

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