Medicare BUpdate!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

Changes to the *Medicare B Update!*

Based on reader input, some changes to the layout of the Update! *have been made. See "General Information About the* Medicare B Update!*"* ..... *page 4*

The Most Frequently Seen Claim Denial Reasons and How to Avoid Them

"Top Denials and Tips" ..... *page 6*

Important Information About Using Modifier 25

"Pre-Payment Medical Review of Claims Containing Modifier 25" ..... *page 12*

Dade County Medical Association Fraud and Abuse Initiative

"Patient Safety in Clinics" ..... *page 37*

Durable Medical Equipment Regional Carrier Information

"DMERC Physician Information Sheet for Parenteral Nutrition and Hospital Beds" ..... *page 39*

Features

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

Routing Suggestions:

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

Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.
A HCFA Contracted Carrier & Intermediary

TABLE OF CONTENTS

Medicare B Update!

Vol. 12 No. 4
July/August 1999

Publications Staff:
Alan Tolleson

Bill Angel
Carol McCrossin
Cynthia Moore
Millie C. Pérez

The *Medicare B Update!* is published bimonthly by the Medicare Education and Outreach 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
Medicare Education and Outreach - Publications
P.O. Box 2078
Jacksonville, FL
32231-0048

A PHYSICIAN'S FOCUS

INTO THE FUTURE

Medicare continues to take an active approach to education and coverage of new services for beneficiaries.

Recognizing the power of multimedia communication, Medicare has recently launched a new Web site for the National Medicare Education Program (NMEP), in collaboration with private organizations and senior alliances. The NMEP creates a coordinated Medicare educational network extending from the national level down to the community level. This new Web site is intended to educate and empower Medicare beneficiaries to make informed choices as wise consumers in a dynamic health care system.

The Secretary of the Department of Health and Human Services (DHHS), Donna Shalala, in her opening statement of the NMEP, acknowledged that informing present and future beneficiaries about the changing Medicare system is a large undertaking, but is one that cannot be ignored. The challenge, according to Secretary Shalala, is to help beneficiaries understand that, although new plan options and services are available, traditional fee-for-service Medicare remains an acceptable choice. More details on the NMEP and ongoing information updates can be found by accessing the Web site: **www.nmep.org.**

Medicare coverage processes are also being redesigned to be more open and accessible via the Internet, to inform the public of the progress and determination of issues under coverage review, and to provide email contact so interested parties can send comments and feedback. The Web site is **www.hcfa.gov/quality.**

Continuing with this approach, Medicare has been evaluating new, innovative techniques and treatments which were traditionally not covered by Medicare. This has resulted in a number of new national coverage policies. Among these are cryosurgery of the prostate gland, which uses extremely cold temperatures to treat patients with prostate cancer. (It is important to note that cryosurgery of the prostrate for advanced cancer remains a noncovered service under Medicare). Another example is the new national policy for coverage of pancreas transplantation. An overview of this and other new policies is included in the Focused Medical Review section of this publication. We expect Medicare to be on the cutting edge by creating policies for coverage of new technology as we move into the next millennium.

Sincerely,

Sidney R. Sewell, M.D.
Medicare Medical Director

Advance Notice Requirement

The following information applies to all articles in this publication referencing services which must meet medical necessity requirements (e.g., services with specific diagnosis requirements). 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 54), or download the text version from our online service, the Medicare Online BBS (see page 43 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 New Format

The new *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.❖

Y2K

Are You Ready for the Year 2000?

The Non-Negotiable Deadline

What Can You Do To Prepare for Y2K?

Listed below are a few key tips:

1. Become aware of potential impacts
2. Assess your readiness
3. Test existing and newly purchased systems and software
4. Develop contingency plans for continuity of business

Please take a moment to complete the sample readiness list. Additionally, please indicate any questions and/or comments you have regarding Y2K in the spaces provided below.

Provider Type/Specialty (i.e., Cardiology): _____
Your Occupation:_____
Questions?

Checklist Items	Y2K Ready	Percent of Compliance	Contingency Plan in Place? (yes/no)	Unable to determine if preparation has occured
1. Medical Equipment				
2. Computer Hardware				
3. Computer Software				
4. Physician Referral Forms				
5. Claim Forms				
6. Billing Requirements				
7. Diagnostic Equipment				
8. Custom Applications				
9. Personnel Training Completed				
10. Telephone Systems				

Your thoughts regarding Y2K.....

Additional Information on Y2K may be obtained from the following Web sites.
1) www.y2k.gov 2) www.fcc.gov/year2000 3) www.itpolicy.gsa.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.*

Please fax this form to the Medicare Education and Outreach Department at (904) 791 - 8378.❖

Disclaimer

This document is a Year 2000 disclosure made pursuant to the Year 2000 Information and Readiness Disclosure Act (S.2392). Your legal rights regarding use of the statements made herein may be substantially limited as provided in the Act.

CLAIMS

Top Denials and Tips

During the second quarter of fiscal year 1999, Florida Medicare conducted an analysis of the top reasons for claims denials. This analysis revealed that most denials are due to simple claim completion errors. This article is intended to assist providers with ways to avoid these denials in the future. Providers should review their ANSI messages and pay close attention to the tips outlined below for the appropriate actions to avoid these denials.

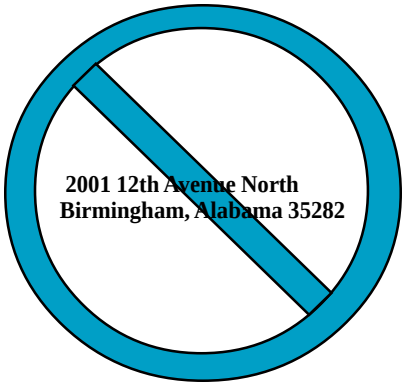
ANSI Message	Tips to Avoid Denial
The referring/prescribing provider is not eligible to refer/prescribe/order the service billed	When this occurs, it may mean that a procedure code was billed that is not allowed by the provider's specialty. Providers should review their code selection process to ensure that the procedure codes used are within the scope of their specialty. For more information on procedure codes and specialty relationships, please call customer service at (904) 634-4994.
Claim/service lacks information which is needed for adjudication.	All clams billed to Medicare for services that are the result of an order or referral by a physician (or physician assistant, nurse practitioner clinical nurse specialist) must be filed with the Unique Provider Identification Number (UPIN) referring/ordering provider. For more specific information, please refer to the March/April 1999 *Medicare B Update!* (page 17).
The diagnosis is inconsistent with the procedure.	This denial occurs when the ICD-9-CM diagnosis code billed is not considered "covered" for the procedure rendered. This means Medicare will only allow the service for certain ICD-9-CM diagnosis codes, based on the medical necessity of the beneficiary. While some of these denials are appropriate, many can be avoided by referencing the *Medicare B Update!*; accessing the Bulletin Board System (BBS); purchasing a *Procedure to Diagnosis Relationship* report booklet (see page 54 to order).
Claim/service lacks information which is needed for adjudication.	The claim is being denied or returned for improper completion. All claims submitted to Medicare must be completed according to the HCFA 1500 completion requirements. For more information please refer to the following issues of the *Update!*: Jan/Feb. 1998, Sept./Oct. 1997, June 1996 Special Issue, May/June 1996 (pages 10-14, 51-53); March/April 1996 (pages 46-58, 67); January/February 1996 (pages-68-74), and the September 1995 Special Issue.
Claim/service denied/reduced due to a submission/billing error.	The diagnosis was not coded to highest level of specificity. Many ICD-9-CM diagnosis codes list to the third, fourth, or fifth level. Medicare requires coding to the highest available level. Please refer to the most current version of the ICD-9-CM diagnosis coding book for the most specific code.
Claim/service denied/reduced because this service/procedure is not paid separately.	This denial may indicate that payment is included in another service furnished on the same day. Certain procedure codes are bundled together and allowed as one service. To order information about these code combinations, call (800) 553-6847 or write to: The Correct Coding Initiative AdminaStar Federal P.O. Box 50469 Indianapolis, IN 46250-0469 This denial may also indicate that a visit(s) or procedure(s) was performed during the pre - and/or post-operative period. For information on global surgery, please refer to the December 1998 Special Issue *Medicare B Update!*

❖

Correct Addresses for Filing Paper Claims

If Medicare claims are sent to the wrong address, payments will be delayed.

The Social Security Administration used to put the address of its payment center on the back of Social Security cards. Although this practice has been discontinued, each month hundreds of Medicare claims are sent to that address in error. No Medicare, Medicaid, supplemental, CHAMPUS, or Workers' Compensation claims should ever be sent to the following address:



Sending claims to the above address delays their processing. Send Part B Medicare claims to the Medicare carrier for the state in which the service was rendered. For Florida, the correct addresses are:

Participating Providers

Medicare Part B
P.O. Box 44117
Jacksonville, FL 32231-4117

Non-participating Providers

Medicare Part B
P.O. Box 2525
Jacksonville, FL 32231-0019

When filing a Medicare supplemental claim, send the claim to the address on the beneficiary's supplemental insurance card. If you are filing a Medicaid claim, contact your state Medicaid agency. When filing a Workers' Compensation claim, contact the patient or the patient's employer to obtain the correct billing address. ❖

Do Not Delay Filing of Review Requests

The Year 2000 is fast approaching and, while Medicare has taken extreme care to update systems to be able to process review requests beginning January 1, 2000, no one can predict the future. Although providers have six months to submit a review request (from the date the service(s) initially processed), Medicare strongly encourages providers to submit *all* of their review requests before October 1, 1999. This will allow our review staff time to process the greatest number of requests prior to January 1, 2000.

Remember, submit only one review request per review form. A copy of the Medicare Part B claim review form can be found in the September/October 1998 *Medicare B Update!* (pages 59-61). ❖

Inventory Depletion of Claims, Appeals and Review Requests

As part of Year 2000 readiness, Medicare strongly encourages providers to maintain a current status of their claim submission and review request inventories. Claims should be submitted to Medicare within a week from the day the services are provided. Backlogged inventories for appeals and review request should be submitted by October 1, 1999.❖

This document is a Year 2000 disclosure 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.

Changes to Health Professional Shortage Area Designations

Medicare has received Health Professional Shortage Area (HPSA) designation changes to specific census tracts in Dade county. These designations are effective July 1, 1999.

Added
Dade County
South Beach
C.T. 42
C.T. 43
C.T. 44
C.T. 45
C.T. 45.99
South Dade (Homestead)
C.T. 107.02

Withdrawn
South Dade (Homestead)
C.T. 103 ❖

COVERAGE

AMBULANCE

Paramedic "Intercept" Provision

The Balanced Budget Act (BBA) of 1997 includes a provision that allows Medicare carriers in certain situations to cover services provided by paramedics operating separately from ambulance suppliers. This provision, however, does not apply in the state of Florida.

Paramedic "intercept" services in rural areas, where volunteer ambulance squads providing only basic life support services are prohibited by state law from charging for services, are typically provided by a paramedic operating separately from an ambulance supplier and providing advanced life support services to a beneficiary. Under previous Medicare policy, there was no provision to pay for these "intercept" services separately from the ambulance service.

The Health Care Financing Administration (HCFA) has established a new procedure code for this service: Q0186 (Paramedic intercept, rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.).

Florida has no law that prohibits volunteer ambulance suppliers from billing for their services. Therefore, Medicare of Florida will deny claims for procedure code Q0186. The reimbursement for this procedure is included in the allowance for advanced life support services. ❖

Reimbursement for Ambulance Services to Nonhospital-Based Dialysis Facilities

For beneficiaries with end-stage renal disease, Medicare now allows scheduled round-trip ambulance service (if medically necessary) from home to the nearest appropriate freestanding or hospital-based dialysis facility. This change is effective for services rendered on or after February 24, 1999, processed on or after July 1, 1999. Previously, ambulance service for these beneficiaries was limited to hospital-based dialysis facilities.

Ambulance suppliers were notified in a *Medicare B Special Issue Update!* dated April 5, 1999, that this change was forthcoming. Information that outlines this and other changes to the way ambulance services are processed was published in the *Federal Register* on January 25, 1999 (64 FR 3637). At that time, HCFA had not advised Medicare contractors to implement any of the changes. Claims for this new benefit should be submitted with the origin and destination modifier "J." ❖

CARDIOLOGY

33999: Transmyocardial Revascularization (TMR) for Treatment of Severe Angina

Transmyocardial revascularization (TMR) is a surgical technique that uses a laser to bore holes through the myocardium of the heart, in an attempt to restore perfusion to areas of the heart not being reached by diseased or clogged arteries. This technique is used as a late or last resort for relief of symptoms of severe angina in patients with ischemic heart disease not amenable to direct coronary revascularization interventions, such as angioplasty, stenting or open coronary bypass.

The precise workings of this technique are not certain. The original theory upon which the technique was based, that the open channels would result in increased perfusion of the myocardium, does not appear to be the major or only action at work. Several theories have been proposed, including partial denervation of the myocardium, or the triggering of the cascade of biological reactions that encourage increased development of blood vessels.

However, research at several facilities indicates that, despite this uncertainty, the technique does offer relief of angina symptoms for a period of time in patients for whom no other medical treatment offering relief is available. Studies indicate that both reduction in pain and reduction in hospitalizations are significant for most patients treated. Consequently, Medicare has concluded that, for patients with severe angina (Class III or IV, Canadian Cardiovascular Society, or similar classification system) for whom all other medical therapies have been tried or evaluated and found insufficient, such therapy offers sufficient evidence of its medical effectiveness to treat the symptomatology. It is important to note that this technique does not provide for increased life expectancy, nor is it proven to affect the underlying cause of the angina. However, it appears effective in treating the symptoms of angina, and reducing hospitalizations and allowing patients to resume some of their normal activities of daily living.

TMR is therefore covered effective for services performed on or after July 1, 1999, as a late or last resort for patients with severe (Canadian Cardiovascular Society classification Classes III or IV) angina (stable or unstable), which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass. Coverage is further limited to those uses of the laser used in performing the procedure that have been approved by the Food and Drug Administration for the purpose for which they are being used.

TMR services rendered prior to July 1, 1999 continue to be noncovered.

Patients must meet the following additional selection guidelines:

- Have an ejection fraction of 25% or greater;
- Have areas of viable ischemic myocardium (as demonstrated by diagnostic study) that are not capable of being revascularized by direct coronary intervention; and,
- Have been stabilized, or have had maximal efforts to stabilize acute conditions such as severe ventricular arrhythmias, decompensated congestive heart failure or acute myocardial infarction.

Coverage is limited to physicians who have been properly trained in the procedure. Providers of this service must also document that all ancillary personnel, including physicians, nurses, operating room personnel and technicians, are trained in the procedure and the proper use of the equipment involved. Coverage is further limited to providers with dedicated cardiac care units, including the diagnostic and support services necessary for care of patients undergoing this therapy. In addition, these providers must conform to the standards for laser safety set by the American National Standards Institute, ANSIZ1363.

Because there is no CPT procedure code for TMR, this service should be billed using the unlisted code 33999 until a CPT code is established. All claims for TMR must therefore be filed on the paper HCFA 1500 claim form, and must include the supporting documentation described above. ❖

Enhanced External Counterpulsation (EECP)

ECP is a non-invasive outpatient treatment for coronary artery disease refractory to medical and/or surgical therapy. Although these and similar devices are cleared by the Food and Drug Administration (FDA) for use in treating a variety of conditions, including stable or unstable angina pectoris, acute myocardial infarction, and cardiogenic shock, effective for services performed on or after July 1, 1999, Medicare coverage is limited to its use in patients with stable angina pectoris, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Other uses of this device and similar devices remain noncovered. In addition, the noncoverage of hydraulic versions of these types of devices remains in force.

Coverage is further limited to EECP systems that have sufficiently demonstrated their medical effectiveness in treating patients with severe angina in well-designed clinical trials. Note that a 510(k) clearance by the Food and Drug Administration does not, by itself, satisfy this requirement.

Coverage is provided for the use of EECP for patients who have been diagnosed with disabling angina (Class III or Class IV, Canadian Cardiovascular Society Classification or equivalent classification) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention, such as PTCA or cardiac bypass because: (1) their condition is inoperable, or at high risk of operative complications or post-operative failure; (2) their coronary anatomy is not readily amenable to such procedures; or (3) they have co-morbid states that create excessive risk.

A full course of therapy usually consists of 35 one-hour treatments, which may be offered once or twice daily (usually 5 days per week). The patient is placed on a treatment table where his/her lower extremities are wrapped in a series of three compressive air cuffs that inflate and deflate in synchronization with the patient's cardiac cycle. During diastole the three sets of air cuffs are inflated sequentially (distal to proximal) compressing the vascular beds within the muscles of the calves, lower thighs and upper thighs. This action results in an increase in diastolic pressure, generation of retrograde arterial blood flow and an increase in venous return. The cuffs are deflated simultaneously just prior to systole, which produces a rapid drop in vascular impedance, a decrease in ventricular workload and an increase in cardiac output.

The augmented diastolic pressure and retrograde aortic flow appear to improve myocardial perfusion, while systolic unloading appears to reduce cardiac workload and oxygen requirements. The increased venous return coupled with enhanced systolic flow appears to increase cardiac output. As a result of this treatment, most patients experience increased time until onset of ischemia, increased exercise tolerance, and a reduction in the number and severity of anginal episodes. Evidence was presented that this effect lasted well beyond the immediate post-treatment phase, with patients symptom-free for several months to two years.

EECP services rendered prior to July 1, 1999, continue to be noncovered and should be billed using procedure code 92971. Services rendered on or after July 1, 1999, should be billed using procedure code 97016 (Application of a modality to one or more areas; vasopneumatic devices) until a specific code for EECP is established. Documentation that clearly establishes the criteria for coverage listed above *must* accompany the claim. Because of these requirements, claims for EECP may not be submitted electronically. ❖

DRUGS AND BIOLOGICALS

Billing for Radiochemicals

Radiochemicals are not approved by the Food and Drug Administration and, therefore, are not reimbursable under the Medicare program. Radiochemical drugs or biologicals should be billed with procedure code A9270 (Noncovered item or service). An acceptable advance notice statement must be provided to the beneficiary (see page 4). ❖

Q0159: Correction to Descriptor

The descriptor published in the July/August 1998 *Medicare B Update!* for procedure code Q0159 was incorrect. The correct descriptor is " Injection, Adenosine, 90mg (not to be used to report adenosine phosphate compounds, instead use A9270)".❖

Q0163-Q0181: Oral Anti-Emetic Drugs — Diagnosis Correction

Oral anti-emetics must be billed with a diagnosis of cancer. The diagnosis requirements for oral anti-emetic drugs was provided in the May/June 1998 *Medicare B Update!* (pages 34-35). The article reported the applicable ICD-9-CM diagnosis codes as 140 - 239.9, or V58.0. The initial code in this range is incorrect; the correct range is *140.0* - 239.9, or V58.0. Diagnosis 140 (no decimal) is not a valid ICD-9-CM code. Advance notice requirements apply to medical necessity for services with specific diagnosis criteria (see page 4). ❖

W4158 - Revision to Descriptor

On page 28 of the March/April 1999 *Medicare B Update!*, the descriptor for procedure code W4158 was printed incorrectly. The correct descriptor is:

W4158 Tc-99m Technetium, Exametazime, up to 30mCi (CERETEC, HMPAO). ❖

FOOT CARE

Treatment Of Ingrown Toenails - Clarification

The purpose of this article is to clarify the coding methodology when filing claims to Medicare for the treatment of ingrown toenails.

Procedure code **11750** (Excision of nail and nail matrix partial or complete, (e.g., ingrown or deformed nail) for permanent removal) is **used for permanent removal**.

Procedure codes **11730** (Avulsion of nail plate, partial or complete, simple: single) and **11765** (Wedge resection of skin of nail fold (e.g., ingrown toenail)) are used when the service is ***not* for permanent removal**. ❖

G0127: Effective Date

The effective date to begin using procedure code G0127 (trimming of dystrophic nails, any number) was originally communicated to providers as April 1, 1998. Medicare has received clarification from the Health Care Financing Administration (HCFA) that the correct effective date was January 1, 1998. ❖

LABORATORY/PATHOLOGY

Expanded Coverage for Pap Smears

Diagnostic and screening pap smears can be performed with several different techniques. Medicare of Florida has already established coverage for the traditional and thin prep methods. Effective for services performed on or after May 21, 1999, coverage began for diagnostic and screening pap smears performed with an automated system. The following procedure codes are now potentially covered for dates of service on or after January 1, 1999: 88147, 88148, G0141, G0147, and G0148. For information regarding the indications and limitation of coverage and/or medical necessity for these services, refer to the January/February 1999 *Medicare B Update!* (page 42). ❖

REIMBURSEMENT

Revised Fees for Pap Smears

Effective for services rendered on or after January 1, 1999, processed on or after May 24, 1999, the fee for the following ThinPrep Pap Smear procedure codes has been revised to $17.00:

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

G0143 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision

G0144 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision

G0145 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

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

88143 Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision

88144 Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and computer-assisted rescreening under physician supervision

88145 Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

Effective for services rendered on or after January 1, 1999, processed on or after May 24, 1999, the fee for the following Automated Pap Smear procedure codes is $10.42:

G0147 Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision

G0148 Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening

88147 Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision

88148 Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening ❖

Fees for Molecular Cytogenetics

The following fees have been established for procedure codes 88271-88275, effective for services rendered on or after January 1, 1999, processed on or after May 24, 1999.

88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)	$20.00
88272	chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivatives and markers)	$35.00
88273	chromosomal in situ hybridization, analyze 10-30 cells (e.g., for micro-deletions)	$45.00
88274	interphase in situ hybridization, analyze 25-99 cells	$65.00
88275	interphase in situ hybridization, analyze 100-300 cells	$75.00

For the covered indications and covered ICD-9 codes for procedure codes 88271-88275, please refer to the Cytogenetic Studies article in the January/February 1999 *Medicare B Update!* (pages 44-45). ❖

1999 Gap-Filled Clinical Laboratory Procedure Fees

The complete list of 1999 fees for gap-filled clinical laboratory procedures follows:

Code	Fee
87536	$97.25
88142	$17.00
88143	$17.00
88144	$17.00
88145	$17.00
88147	$10.42
88148	$10.42
88271	$20.00
88272	$35.00
88273	$45.00
88274	$65.00
88275	$75.00
G0123	$17.00
G0143	$17.00
G0144	$17.00
G0145	$17.00
G0147	$10.42
G0148	$10.42

❖

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 policy.

Sources of Information

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

Table of Contents

Pre-Payment Medical Review of Claims Containing Modifier 25

At the request of the Health Care Financing Administration (HCFA), a medical record review of Evaluation and Management (E/M) services billed with CPT modifier 25 was conducted by Medicare of Florida. During the analysis, it was noted that a majority of the associated E/M services were not warranted and should not have been reimbursed. In addressing this abnormal usage, it has been decided that pre-payment medical review is warranted.

Filing E/M services with CPT modifier 25 implies that the requirements as listed in the 1999 edition of CPT, shown below, have been met:

> Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure: The physician may need to indicate that on the day a procedure or service (identified by a CPT code) was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service. *Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery (see modifier -57).*

For Medicare purposes, this modifier is not required when billing an E/M service on the same day as most laboratory or diagnostic services (CPT procedure codes 70010 through 89399).

To avoid unnecessary claim denials and/or requests for additional information, providers should review their modifier selection process, to ensure that modifier 25 is being billed correctly. In the event of a review request, appropriate documentation that supports the use of modifier 25 *must* be provided. For more information, please consult the following:

AMA Current Procedural Terminology (CPT) manual
Medicare B HCPCS Update! Special Issue, December 1998 ❖

Focused Medical Review/Data Analysis Coding Issues

Over the past year, a number of issues related to incorrect/inappropriate coding have surfaced during analysis of procedure codes for the Focused Medical Review process. The following is a summary of the most common coding errors that have been uncovered.

00140, 00142: Anesthesia for the Eye

During analysis of issues related to cataract surgery, it was noted that a number of physicians are billing for anesthesia services used for cataract/lens procedures with procedure code 00140 (Anesthesia for procedures on eye; not otherwise specified). Providers should be aware that this is not the appropriate code when billed for procedures or diagnoses related to the lens or cataracts. The correct procedure code is 00142 (Anesthesia for procedures on eye; lens surgery).

94664, 94665: Aerosol Treatments

Procedure codes 94664 and 94665 are to be used when aerosol treatments are specifically administered for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes. If the physician is supplying an aerosol treatment in an acute situation with a plan for diagnostic testing, these codes are appropriate. However, during analysis of these two procedure codes, records reviewed rarely indicated this was the case; rather, patients required acute intervention for airway stabilization.

It was noted that some physicians are billing for in-office aerosol treatments in acute and chronic lung disease situations (e.g., acute bronchitis, asthma) using these codes. The most appropriate procedure codes for in-office aerosol treatments, in acute lung disorders, are either 94640 or 94642.

80100 - 80102: Drug Screening

Analysis of these procedure codes indicated that many labs are not billing these codes appropriately; they are billing the number of drug classes (e.g., amphetamines, barbiturates, alcohol) as the number of services billed. Procedure code 80100 should be used to report a qualitative drug screen that is performed to detect the presence of multiple drug classes. It should be reported as one unit for each specimen analyzed, regardless of the method or the number of drugs screened for simultaneously. Procedure code 80101 should be used to report a qualitative drug screen thatis performed to detect the presence of a single drug class. It is expected that procedure code 80101 will, on rare occasion, be reported. If the presence of more than one drug class is suspected, use procedure code 80100.

Procedure code 80102 should be used for each procedure necessary for confirmation. For example, if confirmation of three drugs by chromatography requires three stationary or mobile phases, 80102 should be billed with a number of services of three. However, if multiple drugs can be confirmed using a single analysis, 80102 should only be billed once.

For *quantitation* of drugs screened, the appropriate code(s) are: 82000-84999 or 80150-80299.

For more information on drug screening procedures, refer to the local medical review policy (LMRP), found on page 31 of this issue.

Providers should ensure that they are in compliance with the above guidelines for coding of these services. When Focused Medical Review/Data Analysis finds that Medicare dollars have been inappropriately paid, steps to recover this money will be undertaken.❖

Independent Diagnostic Testing Facility

In the March/April 1999 *Medicare B Update!* (page 48), the first phase of the credentialing requirements for nonphysician personnel for services performed in an Independent Diagnostic Testing Facility (IDTF) was published. The following article includes a complete list of credentialing requirements identified to this date.

A new regulation (CFR 410.33) entitled, "Independent Diagnostic Testing Facility (IDTF)," was published in the Federal Register on October 31, 1997. This regulation established that payment for diagnostic procedures would be made only where the service is provided by a physician, a group of physicians, an approved portable X-ray supplier, or an IDTF — except in the case of certain specified exceptions. An IDTF is defined as a fixed location, a mobile entity, or an individual nonphysician practitioner. This new entity, which replaces the Independent Physiological Laboratory (IPL), is independent of a hospital or physician's office. The diagnostic tests in an IDTF must be performed by licensed, certified nonphysician personnel under appropriate physician supervision.

This policy addresses the credentialing requirements for certain diagnostic tests when performed by nonphysician personnel in an IDTF. This policy will be updated as further credentialing requirements are identified and evaluated for other diagnostic tests.

Medicare of Florida will cover diagnostic tests performed by an IDTF when the medical necessity set forth in the individual Local Medical Review Policies are met **and** when furnished in accordance with the criteria listed below:

- **Supervising physician**

  An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of nonphysician personnel who use the equipment. This level of supervision is the requirement for general supervision.

  The supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. When a procedure requires the direct or personal supervision of a physician, the IDTF's supervising physician must personally furnish this level of supervision whether the procedure is performed in the IDTF or, in the case of mobile services, at the remote location.

- **Nonphysician personnel**

  Any nonphysician personnel used by the IDTF to perform tests must demonstrate the basic qualifications to perform the tests in question and have training and proficiency by licensure or certification by the appropriate state health or education department. In the absence of a state licensing board, the technician must be certified by an appropriate national credentialing body.

- **Ordering of tests**
  All procedures performed by the IDTF must be specifically ordered in writing by the physician treating the beneficiary, that is, the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. The order must specify the diagnosis or other basis for the testing. The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF's supervising physician is in fact the beneficiary's treating physician. The IDTF may not add any procedures based on internal protocols without a written order from the treating physician.

- **Multi-state entities**
  An IDTF that operates across State boundaries must maintain documentation that its supervising physicians and technicians are licensed and certified in each of the States in which it is furnishing services.

- **Applicability of state law**
  An IDTF must comply with applicable laws of any state in which it operates.

The nonphysician personnel credentialing requirements listed below cover the following sections:
Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology, Nuclear Medicine, Special Ophthalmological Services, Otorhinolaryngologic Services, Cardiology, Echocardiography, Cardiac Catheterization/Electrophysiological Procedures/Other Vascular Studies, Non-invasive Vascular Diagnostic Studies, Pulmonary, Allergy and Clinical Immunology and Neurology and Neuromuscular.

It is required that the nonphysician personnel performing the diagnostic tests be credentialed as evidenced by state licensure and/or national board certification. The carrier realizes that all IDTF applicants may not currently meet the credentialing criteria as outlined in this policy. Therefore, the carrier will allow up to one year from the date the applicant enrolled as an IDTF for the applicable certification/licensure to be obtained. It is expected that, once licensure and/or credentialing is obtained, documentation will be submitted verifying that credentialing requirements have been met.

In addition, the credentialed and/or licensed nonphysician personnel must maintain an active licensure and/or credential status in order for the diagnostic tests to be covered.

Note: For all credentialed technologists, licensed personnel and personnel in which no credentialing or licensing board is available, it is a requirement that the individual demonstrate proficiency in the service being performed. This must be documented and verified by the supervising physician.

The personnel performing the tests identified under the HCPCS Codes section must have the applicable certification/licensing as listed below:

- The American Registry of Radiologic Technologists (ARRT) provides credentialing for 3 primary radiologic sciences: radiography, nuclear medicine technology, and radiation therapy technology. Once credentialing is obtained, then a General license is obtained from the Florida State Board. A person holding a license may have one or more of the following certifications:

  General Radiographer: Certified Radiologic Technologist-Radiographer (CRT-R);
  Basic Machine Operator (BMO): Certified Radiologic Technologist-Radiographer (CRT-R)
  Radiation Therapy Technologist: Certified Radiologic Technologist-Radiation Therapy (CRT-T);
  Nuclear Medicine Technologist: Certified Radiologic Technologist-Nuclear Medicine (CRT-N).

In addition to the primary credentialing sciences mentioned above, there are five advanced examinations a technologist may take for credentialing. These are: cardiovascular interventional technology, mammography, computerized tomography, magnetic resonance imaging, and quality management.

- The American Registry of Diagnostic Medical Sonographers (ARDMS) offers the following credentials:
  Registered Diagnostic Medical Sonographer (RDMS);
  Registered Diagnostic Cardiac Sonographer (RDCS);
  Registered Vascular Technologist (RVT);
  Registered Ophthalmic Ultrasound Biometrist (ROUB).

The RDMS credential is obtained by a combination of physical principles/instrumentation in one or more of the following specialty examinations: Abdomen (AB), Neurosonology (NE), Obstetrics/Gynecology (OB/GYN), and Ophthalmology (OP).

- The Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) offers the following credentials:
  Certified Ophthalmic Assistant (COA);
  Certified Ophthalmic Technician (COT);
  Certified Ophthalmic Medical Technologist (COMT).

- The Medical Dosimetrist Certification Board provides credentialing for radiation oncologist (MDC).
- The Nuclear Medicine Technology Certification Board (NMTCB) offers the following credential:
  Certified Nuclear Medicine Technologist (CNMT).

- The Board of Certification of the Ophthalmic Photographers' Society offers the following credential:
  Certified Retinal Angiographer (CRA)

- Cardiovascular Credentialing International (CCI) offers the following credentials:
  Certified Cardiographic Technician (CCT);
  Registered Cardiac Sonographer (RCS);
  Registered Cardiovascular Invasive Specialist (RCIS);
  Registered Vascular Specialist (RVS).

- The State of Florida offers the following certification:
  Emergency Medical Technician (EMT); Paramedic.

- The National Board for Respiratory Care (NBRC) offers the following credentials:
  Certified Pulmonary Function Technologist (CPFT);
  Registered Pulmonary Function Technologist (RPFT);
  Certified Respiratory Therapist (CRT);
  Registered Respiratory Therapist (RRT);
  Perinatal/Pediatric Care Specialist.

When credentialing is obtained, then a state license is obtained from the Florida state board. A person holding a license may have one or more certifications.

Registered Nurse (RN) with active state licensure and proficiency demonstration.

The American Association of Electrodiagnostic Technologists (AAET) offers the following credentials:
Registered Electrodiagnostic Technologist (R. EDT.)

The American Board of Registration of Electro-encephalographic and Evoked Potential Technologists, Inc. (ABRET) offers the following credentials:
Registered Electroencephalographic Technologist (R. EEG T.);
Registered Evoked Potential Technologist (R. EP T.);
Certified Neurophysiologic Interoperative Monitoring Technologist (CNIM).

The Board of Registered Polysomnographic Technologists (BRPT) offers the following credentials:
Registered Polysomnographic Technologist (RPSGT)

CPT- 4 CODE(S)	CERTIFICATION
54240	ARDMS: RVT,CCI: RVS
70030-70160	State license: CRT-R (General Radiographer) Medical Physicist
70190-70330	State license: CRT-R (General Radiographer) Medical Physicist
70336	Demonstrates proficiency
70350-70355	State license: CRT-R (General Radiographer)
70360-70370	State license: CRT-R (General Radiographer) Medical Physicist
70371	State license: CRT-R (General Radiographer)
70380	State license: CRT-R (General Radiographer) Medical Physicist
70450-70488	State license: CRT-R (General Radiographer) Medical Physicist
70490-70492	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
70540-70553	Demonstrates proficiency
71100-71130	State license: CRT-R (General Radiographer)
71250-71270	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
71550-71555	Demonstrates proficiency
72010-72120	State license: CRT-R (General Radiographer) Medical Physicist
72125-72133	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
72141-72159	Demonstrates proficiency
72170-72190	State license: CRT-R (General Radiographer) Medical Physicist
72192-72194	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
72196-72198	Demonstrates proficiency
72200-72220	State license: CRT-R (General Radiographer) Medical Physicist
73000-73030	State license: CRT-R (General Radiographer) Medical Physicist
73050-73080	State license: CRT-R (General Radiographer) Medical Physicist
73120-73140	State license: CRT-R (General Radiographer) Medical Physicist
73200-73202	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
73220-73225	Demonstrates proficiency
73500-73520	State license: CRT-R (General Radiographer) Medical Physicist
73540-73565	State license: CRT-R (General Radiographer) Medical Physicist
73590-73610	State license: CRT-R (General Radiographer) Medical Physicist
73620-73660	State license: CRT-R (General Radiographer) Medical Physicist
73700-73702	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
73720-73725	Demonstrates proficiency
74000-74022	State license: CRT-R (General Radiographer) Medical Physicist
74150-74170	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
74181-74185	Demonstrates proficiency
74210-74249	State license: CRT-R (General Radiographer)
74250-74251	General license with training in gastrointestinal radiography
74260-74291	State license: CRT-R (General Radiographer)
74400-74420	State license: CRT-R (General Radiographer)
74710	State license: CRT-R (General Radiographer) Medical Physicist
74775	State license: CRT-R (General Radiographer)
75552-75556	Demonstrates proficiency

CPT- 4 CODE(S)	CERTIFICATION
76003	State license: CRT-R (General Radiographer)
76010-76066	State license: CRT-R (General Radiographer) Medical Physicist
76070-76076	State license: CRT-R (BMO)
76078	State license: CRT-R (General Radiographer)
76090-76092	ARRT: CRT-R with advanced credentialing in mammography
76093-76094	Demonstrates proficiency
76098	State license: CRT-R (General Radiographer)
76100-76350	State license: CRT-R (General Radiographer)
76355	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
76375-76380	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
76390-76400	Demonstrates proficiency
76499	Dependent on diagnostic procedure performed
76506	ARDMS: RDMS-Neurosonology
76511-76529	ROUB JCAHPO: COA, COT, COMT
76536	ARDMS: RDMS-Abdomen
76604-76778	ARDMS: RDMS-Abdomen
76800	ARDMS: RDMS-Neurosonology
76805-76818	ARDMS: RDMS-Obstetrics & Gynecology
76825-76828	ARDMS: RDMS-Obstetrics & Gynecology ARDMS: RDCS
76830-76831	ARDMS: RDMS-Obstetrics & Gynecology
76856-76857	ARDMS: RDMS-Obstetrics & Gynecology
76870	ARDMS: RDMS-Abdomen
76872	ARDMS: RDMS-Abdomen
76880	ARDMS: RDMS-Abdomen
76885-76886	ARDMS: RDMS
76977	Demonstrates proficiency
76999	ARDMS: RDMS-Appropriate credentialing based on body area examining
77417	State license MDC
78000-78099	State license: CRT-N, CNMT
78102-78199	State license: CRT-N, CNMT
78201-78299	State license: CRT-N, CNMT
78300-78350	State license: CRT-N, CNMT
78399	State license: CRT-N, CNMT
78414-78458	State license: CRT-N, CNMT
78460-78483	State license: CRT-N, CNMT
78494-78499	State license: CRT-N, CNMT
78580-78599	State license: CRT-N, CNMT
78600-78607	State license: CRT-N, CNMT
78610-78699	State license: CRT-N, CNMT
78700-78799	State license: CRT-N, CNMT
78800-78807	State license: CRT-N, CNMT
78999	State license: CRT-N, CNMT
92081-92083	JCAHPO: COT, COMT
92100-92130	JCAHPO: COA
92235-92240	JCAHPO: COT, COMT Registered Nurse CRA
92250	JCAHPO: COT, COMT CRA
92265-92275	JCAHPO: COT, COMT Registered Nurse
92283-92284	JCAHPO: COA, COT, COMT
92285	JCAHPO: COT, COMT, CRA
92286-92287	JCAHPO: COT, COMT Registered Nurse CRA
92516	Certified Audiologist
92520-92525	Speech Pathologist
92541-92548	Certified Audiologist
92552-92557	Licensed Audiologist
92561-92584	Licensed Audiologist
92585	ABRET: R. EP T., R. EEG T. Audiologist
92587-92589	Licensed Audiologist
93000-93278	CCI: CCT Registered Nurse (RN) Paramedic
93303-93308	ARDMS: RDCS CCI: RCS
93312	ARDMS: RDCS CCI: RCS
93315	ARDMS: RDCS CCI: RCS
93320-93325	ARDMS: RDCS CCI: RCS
93350	ARDMS: RDCS CCI: RCS, CCT for stress portion Registered Nurse Paramedic
93501	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93505	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93510-93533	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93555-93572	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93600-93642	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse
93660	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse
93724	CCI: CCT Registered Nurse Paramedic
93733-93738	CCI: CCT Registered Nurse Paramedic
93770	CCI: CCT Registered Nurse Paramedic

CPT- 4 CODE(S)	CERTIFICATION
93799	CCI: CCT Registered Nurse Paramedic
93875-93990	ARDMS: RVT CCI: RVS
94010, 94060-94070	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)
94200-94450	State license: RPFT, RRT, CPFT, CRT
94620-94621	State license: RPFT, RRT Registered Nurse (RN)
94664-94665	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)
94680-94750	State license: RPFT, RRT
94760-94762	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN) Paramedic
94770	State license: RPFT, RRT
94799	State license: Appropriate credentialing based on service performing
95004	RN with active state license
95024-95056	RN with active state license
95805, 95807-95811	ABRET: R. EEG T. BRPT: RPSGT State license: CPFT, RPFT, CRTT, RRT
95812-95822, 95827	ABRET: R. EEG T.
95900-95904	AAET: R. EDT. ABRET: R. EP T. Qualified Physical Therapist who is permitted to perform service under state law
95921-95923	AAET: R. EDT.
95925-95930	ABRET: R. EP T., R. EEG T.
95933-95937	AAET: R. EDT. Qualified Physical Therapist who is permitted to perform service under state law
95950-95953	ABRET: R. EEG T.
95954	ABRET: R. EEG T.
95956-95957	ABRET: R. EEG T.
95958	ABRET: R. EEG T.
95999	Appropriate credentialing based on service performing
G0004-G0015	CCI: CCT Registered Nurse (RN) Paramedic
G0050	ARDMS: RDMS-Abdomen
Q0035	CCI: CCT Registered Nurse (RN) Paramedic

Documentation Requirements

Medical record documentation maintained by the Independent Diagnostic Testing Facility must include the information listed below:

- hard copy documentation of the test results and interpretation; and
- the medical necessity (reason) for performing the diagnostic test(s).

In addition, documentation must be available upon request verifying that the technician performing the service meets the credentialing requirements as outlined in this policy. In the case where the technologist is obtaining the clinical experience required by the credentialing board prior to taking the examination, the documentation must support this rationale, including when the expected training will be completed.

Also, the IDTF must maintain documentation of sufficient physician resources during all hours of operations to assure that the required physician supervision is furnished.

Documentation must be maintained in the IDTF that the personnel performing the diagnostic test(s) have been adequately trained and demonstrate proficiency in the performance of the service(s). This documentation must contain verification by the supervising physician(s).

Effective Date

The effective date for the additional credentialing requirements specified in this policy is August 16, 1999.

Advance Notice Statement

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 of Florida's bulletin board system (BBS). For information about the BBS, see page 43 of this issue. ❖

A9270: Changes to Noncoverage Guidelines

In the March/April 1999 *Medicare B Update!* (page 34), the noncoverage guidelines were published in their entirety. Since that time, numerous additions and deletions have been made to this policy. Listed below are the additions and deletions to this policy and their implementation dates.

Local Noncoverage Additions

A9270***** (effective 8/16/99) - Blood Brain Barrier Disruption
64999***†** (effective 8/16/99) - Bretylium Bier Block
84134 (effective 8/16/99) - Prealbumin
90669 (effective 4/5/99) - Pneumococcal conjugate vaccine, polyvalent, for intramuscular use (not FDA approved)
92971***** (effective 7/1/99) - Cardioassist-method of circulatory assist; external

Local Noncoverage Deletions

G0141, G0147, G0148 (effective 1/1/99) - Screening cytopathology smears, cervical or vaginal
88147-88148 (effective 1/1/99) - Cytopathology smears, cervical or vaginal
88271-88275 (effective 1/1/99) - Molecular cytogenetics
97799 (effective 8/16/99) - Low vision rehabilitation

* Services which are noncovered due to their being investigational/experimental.
† Claims for these services will always be reviewed, as they must currently be billed with an unlisted procedure code.

National Noncoverage Additions

98943 (effective 1/1/97) - Chiropractic manipulative treatment (CMT); extraspinal, one or more regions

National Noncoverage Deletions

A9270 (effective 7/1/99) - Cardiac output monitoring by electrical bioimpedance
A9270 (effective 7/1/99) - Cryosurgery of the prostate
A9270 (effective 7/1/99) - Transmyocardial Revascularization (TMR)
J7140-J7180 (no longer valid codes) - Oral medication
A9270 (effective immediately) - Osteopathic cranial manipulation
A9270 (effective immediately) - Osteopathic pulmonary manipulation
48160 (effective 7/1/99) - Pancreatectomy, total, with transplantation
48550 (effective 7/1/99) - Donor pancreatectomy
48554 (effective 7/1/99) - Transplantation of pancreatic allograft
92971 - Enhanced External Counterpulsation (EECP)

Effective Date

Refer to the effective dates listed above for a specific procedure code.

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, is not approved by the FDA, or lacks scientific and clinical evidence to support the procedure's safety and efficacy. ❖

G0030-G0047, G0125, G0126, and G0163-G0165: Positron Emission Tomography (PET) Scans

Positron emission tomography (PET) also known as positron emission transverse tomography (PETT), or positron emission coincident imaging (PECI), is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images by detecting radioactivity from a radioactive tracer substance (radiopharmaceutical) that is injected into the patient.

Indications and Limitations of Coverage and/or Medical Necessity

Conditions Applicable to All Covered Uses of PET Scans

All Medicare-covered uses of PET scans, regardless of any other terms or conditions, must meet the following conditions:

- Such scans must be performed using a camera that has either been approved or cleared for marketing by the Food and Drug Administration (FDA) to image radionuclides in the body.
- Submission of claims for payment must include any information Medicare requires to assure that the PET scans performed: (a) were medically necessary; (b) did not unnecessarily duplicate other covered diagnostic tests; and (c) did not involve investigational drugs or procedures using investigational drugs, as determined by the FDA.
- The PET scan entity submitting claims for payment must keep on file such patient records as Medicare requires for each patient for whom a PET scan claim is made.

Coverage of PET Scans for Noninvasive Imaging of the Perfusion of the Heart - Effective For Services Performed on or after March 14, 1995:

PET scans done at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb82) are covered, provided such scans meet either of the following two conditions:

- The PET scan, whether rest alone or rest with stress, is used in place of, but not in addition to, a single photon emission computed tomography (SPECT); or
- The PET scan, whether rest alone or rest with stress, is used following a SPECT that was found inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data.)

HCPCS Codes

G0030 PET myocardial perfusion imaging, (following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic)
G0031 PET myocardial perfusion imaging, (following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic)
G0032 PET myocardial perfusion imaging, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)
G0033 PET myocardial perfusion imaging, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic)
G0034 PET myocardial perfusion imaging, (following stress SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic)
G0035 PET myocardial perfusion imaging, (following stress SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic)
G0036 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic)

G0037 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)
G0038 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460); single study, rest or stress (exercise and/or pharmacologic)
G0039 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460); multiple studies, rest or stress (exercise and/or pharmacologic)
G0040 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic)
G0041 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic)
G0042 PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)
G0043 PET myocardial perfusion imaging, (following stress nuclear ventriculogram 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)
G0044 PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)
G0045 PET myocardial perfusion imaging, (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic)
G0046 PET myocardial perfusion imaging, (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic)
G0047 PET myocardial perfusion imaging, (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)

ICD-9 Codes That Support Medical Necessity

411.81
414.00-414.03
414.11
414.8

Coverage of PET scans using the Glucose Analog 2-[fluorine-18]-fluoro-2-deoxy-D-glucose (FDG) in Characterization of Solitary Pulmonary Nodules (SPNs)-Effective for Services Performed on or after January 1, 1998:

PET scans using FDG are covered when used for the characterization of suspected SPNs. The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient.

The procedure consists of the FDG being injected into the patient intravenously, with image acquisition usually beginning 30-60 minutes later, and continuing for a period of 10-20 minutes. The FDG is metabolized by both normal and cancerous tissue in proportion to the rate of glycolysis. Since tumor cells have shown an increased utilization of glucose, those regions observed to have an increased FDG uptake relative to background indicate areas of cancerous tissue.

Characterizing Solitary Pulmonary Nodules (SPNs) with PET using FDG must meet the following conditions:

- Evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other detection method, indicating an indeterminate or possibly malignant lesion, not exceeding four centimeters (cm.) in diameter.
- Evidence of a concurrent thoracic CT, which is necessary for anatomic information, to ensure that the PET scan is properly coordinated with other diagnostic modalities.

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

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

HCPCS Codes

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

ICD-9 Codes That Support Medical Necessity

N/A

Coverage of PET Scans Using FDG for Initial Staging of Non-Small Cell Lung Carcinoma (NSCLC)-Effective for Services Performed on or after January 1, 1998:

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

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

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

- Evidence that a primary cancerous lung tumor has been confirmed. This should include, but is not limited to, a surgical pathology report that documents the presence of an NSCLC.
- Evidence of both (1) performance of a concurrent thoracic CT, which is necessary for anatomic information, and (2) performance of any lymph node biopsy to finalize whether the patient will be a surgical candidate.

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

HCPCS Codes

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

ICD-9 Codes That Support Medical Necessity

N/A

Coverage of PET Scans Using FDG to Determine the Location of Recurrent Colorectal Tumors - Effective for Services Performed on or after July 1, 1999:

PET scans using FDG are covered when used to determine the location of recurrent colorectal tumors when such tumors are indicated by rising levels of carcinoembryonic antigen (CEA). The primary purpose for determining the location of such tumors is to make a decision as to whether surgical intervention is warranted.

Determination of recurrent colorectal tumors with PET scan using FDG must meet the following conditions:

- Evidence of previous disease - this service is covered only in cases in which there has been a recurrence of colorectal tumor.
- Results of a concurrent CT and/or other diagnostic modalities, which are necessary for additional anatomic information, to ensure that the PET scan is properly coordinated with other diagnostic modalities.

Note: Gallium studies, including immunoscintigraphy such as an Oncoscint scan, will not be covered in the case of a PET scan done for locating recurrent colorectal cancer, when performed by the same facility within 50 days of each other.

Whole body PET scans will not be reimbursed more frequently than once every 12 months, unless medical necessity documentation supports a separate re-elevation of CEA within this period.

HCPCS Codes

G0163 Positron Emission Tomography (PET), whole body, for recurrence of colorectal or colorectal metastatic cancer

ICD-9 Codes That Support Medical Necessity

N/A

Coverage of PET Scans Using FDG to Stage and Re-stage Lymphomas as an Alternative to a Gallium Scan - Effective for Services Performed on or after July 1, 1999:

PET scans using FDG are covered when used for staging lymphomas (both Hodgkins and non-Hodgkins) as an alternative to a gallium scan. The primary purpose of such staging should be to determine the progress and extent of the disease, as well as the probable rate of its progression, in order to plan future management for the patient.

Staging and re-staging of lymphoma with PET scan using FDG as an alternative to a gallium scan must meet the following conditions:

- Evidence of disease - this service is covered only for staging or follow-up re-staging of lymphoma.
- Results of a concurrent CT and/or other diagnostic modalities, which are necessary for additional anatomic information, to ensure that the PET scan is properly coordinated with other diagnostic modalities.

Note: No PET scan may be covered in cases where it is done within 50 days of a gallium scan done by the same PET facility, where the patient has remained under the care of the same facility during the 50-day period. A PET scan will be allowed for re-staging no sooner than 50 days following the last staging PET scan or gallium scan, unless the medical necessity documentation supports that the re-staging at an earlier date is medically necessary.

HCPCS Codes

G0164 Positron Emission Tomography (PET), whole body, for staging and characterization of lymphoma

ICD-9 Codes That Support Medical Necessity

N/A

Coverage of PET Scans Using FDG for the Evaluation of Recurrent Melanoma Prior to Surgery - Effective for Services Performed on or after July 1, 1999:

PET scans using FDG are covered when used to evaluate recurrent melanoma prior to scheduling surgical intervention. The primary purpose of evaluating the recurrent melanoma is to determine whether surgical intervention would be medically effective in treating the patient.

Evaluation of recurrent melanoma with PET scan using FDG must meet the following conditions:

- Evidence of disease - this service is covered only for recurrent melanoma.
- Results of a concurrent CT and/or other diagnostic imaging modalities, which are necessary for additional anatomic information, to ensure that the PET scan is properly coordinated with other diagnostic modalities.

Note: No PET scan may be covered in cases where it is done within 50 days of a gallium scan done by the same PET facility, where the patient has remained under the care of the same facility during the 50-day period. Whole body PET scans will not be reimbursed when performed more frequently than once every 12 months, unless medical necessity documentation supports the specific need for anatomic localization of possible recurrent tumor within this period.

HCPCS Codes

G0165 Positron Emission Tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer

ICD-9 Codes That Support Medical Necessity

N/A

Reasons for Denial

- The service does not meet all of the conditions for coverage referred to in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.
- PET scans for routine screening of an asymptomatic patient, regardless of the number and severity of risk factors applicable to the patient.
- Procedure code 78810 (tumor imaging, positron emission tomography (PET), metabolic evaluation) is a noncovered service.
- Serial evaluation of SPNs using both CT and regional PET chest scanning that is repeated within 90 days following a negative PET scan.

Noncovered ICD-9 Code(s)

Any diagnosis codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy (for PET myocardial perfusion imaging).

Coding Guidelines

The following codes are not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services:

78459	myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
78492	myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest or stress

HCPCS Codes G0030 through G0047, G0125, G0126, and G0163 through G0165 represent the global service, so providers performing just the technical or professional component of the test should use modifier TC or 26, respectively.

In addition to the standard modifiers, a two-digit modifier is used for codes G0030 through G0047, G0125 and G0126 to indicate the results of the PET scan and the previous test. (The modifier is not required for technical component-only billings.) The first alpha character should indicate the result of the PET scan; the second alpha character should indicate the results of the prior test. The test result modifiers and their descriptions are listed below:

Modifier	Description
N	Negative
E	Equivocal
P	Positive, but not suggestive of extensive ischemia or not suggestive of malignant single pulmonary nodule
S	Positive and suggestive of extensive ischemia (>20% of the left ventricle) or malignant single pulmonary nodule

These modifiers may be used in any combination.

Claims submitted for codes G0030 through G0047, G0125 and G0126 without the two-digit modifier indicating the results of the PET scan and previous test will be returned as unprocessable.

The payment for the radiotracer or radiopharmaceutical is included in the technical components of PET scans. Therefore, no separate payment will be made for these agents for PET scans.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of the PET scan, along with the scan results. If the provider of the PET scan is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the study. The reason for the PET scan must be included in the ordering/referring physician's order for the procedure.

Claims for codes G0163 through G0165 must be submitted with supporting documentation.

- G0163 requires a statement or evidence of a previous colorectal tumor and the results of a concurrent CT and/or other diagnostic modalities.
- G0164 requires a statement or evidence of previous lymphoma tumor and the results of a concurrent CT and/or other diagnostic modalities.
- G0165 requires a statement or evidence of previous melanoma and the results of a concurrent CT and/or other diagnostic modalities.

Electronic billers should provide this documentation in the narrative section of the HA0 record.

Other Comments

Prior to ordering PET scans, a physician should discuss with his or her patients the implications of the decision to perform a TSP in the case of a negative PET for characterization of SPNs (G0125), or a lymph node biopsy in the case of a negative CT and negative PET for initial staging of NSCLC (G0126), with respect to the patient's responsibility for payment for such a biopsy if one is desired, as well as the physician's confidence in the results of such PET scans.

This physician-patient decision should occur with a clear discussion and understanding of the sensitivity and specificity trade-offs between CT and PET scans.

It is the responsibility of the physician ordering the TSP or lymph node biopsy to provide sufficient documentation of the medical necessity for these procedures. Such documentation should include, but is not necessarily limited to, a description of the features of the PET scan that call into question whether it is an accurate representation of the patient's condition, the existence of other factors in the patient's condition that call into question the accuracy of the PET scan, etc.

Effective Date

There are several effective dates specified in this policy. Refer to specific procedure code(s) for the appropriate effective date.

Advance Notice Requirement

Applies to medical necessity (see page 4). ❖

Coverage for Cryosurgery of the Prostate

Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CSAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland.

CSAP can be carried out under general or spinal anesthesia and lasts approximately 2-3 hours. Five to six cryoprobes are placed transperinally under transrectal ultrasound (TRUS). Once the probes are in place, freezing is carried out while observing under TRUS the increasing echoes as the block of frozen prostate tissue approaches the rectal mucosa. Such monitoring minimizes the risk of rectal freezing. The possibility of injury to the urethra is decreased by the use of a warming device which is inserted into the urethra.

Indications and Limitations of Coverage and/or Medical Necessity

Effective for services performed on or after July 1, 1999, Medicare will consider cryosurgery of the prostate medically reasonable and necessary under the following circumstance:

> For primary treatment of patients with clinically localized, stages T1-T3, prostate cancer.

The evidence is not yet sufficient to demonstrate the effectiveness of this procedure as salvage therapy for local failures after radical prostatectomy, external beam irradiation, and brachytherapy. Therefore, cyrosurgery of the prostate as salvage therapy is not covered under Medicare.

HCPCS Codes

G0160	Cryosurgical ablation of localized prostate cancer, primary treatment only (postoperative irrigations and aspiration of sloughing tissue included)
G0161	Ultrasonic guidance for interstitial cryosurgical probe placement

ICD-9 Codes That Support Medical Necessity

185

Coding Guidelines

Procedure code G0161 is reimbursable only when the patient has clinically localized prostate cancer, stages T1-T3 and when a claim for G0160 on the same date of service and for the same beneficiary has been approved for payment.

Documentation Requirements

Medical record documentation maintained in the patient's file must demonstrate that the service was performed as a primary treatment for clinically localized stage T1-T3 prostate cancer. 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 operative report.

Effective Date

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

Advance Notice Statement

Advance notice applies (see page 4). ❖

J0205, J1785: Ceredase/Cerezyme

Ceredase (alglucerase) and Cerezyme (imiglucerase) are analogues of the human enzyme B-glucocerebrosidase, produced by recombinant DNA technology. Ceredase and Cerezyme each catalyze the hydrolysis of glucocerebroside to glucose and ceramide. Clinical trials indicate that Ceredase/Cerezyme improve anemia and thrombocytopenia, reduce spleen and liver size, and improve mineralization of bone in patients with Type I Gaucher's disease.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider Ceredase and Cerezyme to be medically reasonable and necessary for use as long-term enzyme replacement therapy for patients with a confirmed diagnosis of Type I Gaucher's disease who, upon initiation of treatment, exhibit signs and symptoms that are severe enough to result in one or more of the following conditions:

- Moderate to severe anemia (Hgb < 10 g/dL for females; Hgb < 12 g/dL for males)
- Thrombocytopenia with bleeding tendency (platelets < 50,000/uL)
- Bone disease (x-ray indicates multiple bony lesions and/or skeletal complications including osteonecrosis and osteopenia with secondary pathological fractures)
- Significant hepatomegaly or splenomegaly (spleen with cephalocaudal diameter > 13 cm.)

Dosage and Administration

Ceredase/Cerezyme are administered by intravenous infusion over one to two hours. Dosage should be individualized to each patient. Initial dosage may be as little as 2.5 units/kg of body weight three times a week, up to as much as 60 U/kg administered as frequently as once a week or as infrequently as every four weeks. Disease severity may dictate that treatment be initiated at a relatively high dose or relatively frequent administration.

After patient response is well established, a reduction in dosage may be attempted for maintenance therapy. Maintenance therapy should be directed at achieving sustained benefit with the lowest possible dose. Progressive reductions can be made at intervals of three to six months while carefully monitoring response parameters.

HCPCS Codes

J0205	Injection, alglucerase, per 10 units (Ceredase)
J1785	Injection, imiglucerase, per unit (Cerezyme)

ICD-9 Codes That Support Medical Necessity

272.7

Reasons for Denial

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

When administered as part of a "study protocol".

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

Ceredase (J0205) will be reimbursed in increments of 10 units. Cerezyme (J1785) will be reimbursed per unit.

Documentation Requirements

Medical record documentation (e.g., office/progress notes, laboratory reports, X-ray reports, history and physi-

cal) maintained by the ordering/referring physician must demonstrate, upon initiation of treatment with Ceredase/ Cerezyme, that the patient has a confirmed diagnosis of Type I Gaucher's disease and exhibits one or more of the following: moderate to severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly and/or splenomegaly.

Effective Date

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

Advance Notice Statement

Applies to medical necessity (see page 4). ❖

J0850: Cytomegalovirus Immune Globulin (Human), Intravenous CMV-IGIV

CMV-IGIV (CytoGam®) is an intravenous immunoglobulin (Ig) that provides passive immunity by supplying a relatively high concentration of Ig-G antibodies against CMV.

CMV infection continues to be the most important disease encountered in organ transplantation. Patients who are at the greatest risk for morbidity are those who experience primary disease (i.e., those individuals who have never been exposed to the virus (CMV seronegative)), and receive an organ transplant from a CMV seropositive donor).

Indications and Limitations of Coverage and/ or Medical Necessity

Medicare of Florida will consider the use of CMV-IGIV (CytoGam®) medically reasonable and necessary for the following indications:

- Prophylaxis against CMV disease associated with transplantation of lung, liver, pancreas, and heart. In transplants of these organs, prophylactic CMV-IGIV should be considered in combination with ganciclovir.
- To attenuate primary CMV disease in seronegative kidney transplant recipients who receive a kidney from a CMV seropositive donor.

CMV seropositive recipients who receive organs (lung, liver, pancreas, heart, or kidney) from seropositive donors may experience reactivation or reinfection, but the clinical manifestations are often milder than primary disease. Therefore, CytoGam® is not considered medically reasonable and necessary when the recipient and the donor are CMV seropositive.

CytoGam® is supplied as an injectable drug (2.5g/50ml vial). Its intravenous administration is prescribed in accordance with the post transplant period.

The maximum recommended total dosage per infusion is 150 mg/kg, administered according to the following schedule:

	Type of Transplant	
	Kidney	**Lung, Liver, Pancreas, Heart**
Within 72 hours:	150 mg/kg	150 mg/kg
2 weeks after:	100 mg/kg	150 mg/kg
4 weeks after:	100 mg/kg	150 mg/kg
6 weeks after:	100 mg/kg	150 mg/kg
8 weeks after:	100 mg/kg	150 mg/kg
12 weeks after:	50 mg/kg	100 mg/kg
16 weeks after:	50 mg/kg	100 mg/kg

CytoGam® is not considered to be reasonable and necessary when given in excess of this administration/dosage schedule.

CytoGam® may not be used as a substitute for intravenous immunoglobulin (IVIG).

HCPCS Codes

J0850 Injection, cytomegalovirus immune globulin intravenous (human), per vial

ICD-9 Codes That Support Medical Necessity

V07.2
V42.0
V42.1
V42.6
V42.7
V42.83

Note: The billing of CytoGam® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9 codes V07.2 ***and*** the appropriate "V" diagnosis (V42.0, V42.1, V42.6, V42.7, or V42.83) to report the approved indication for J0850. (V07.2 represents prophylactic immunotherapy against CMV for coverage purposes in this policy.)

Reasons for Denial

Administration of CytoGam® for any indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Administration of CytoGam® in excess of the administration/dosage schedule in 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

The billing of CytoGam® requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted.

Providers must use ICD-9 codes V07.2 ***and*** the appropriate "V" diagnosis (V42.0, V42.1, V42.6, V42.7, or V42.83) to report the approved indication for J0850. (V07.2 represents prophylactic immunotherapy against CMV for coverage purposes in this policy.)

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate:

- The patient was CMV seronegative prior to the lung, liver, pancreas, heart, or kidney transplant and has received an organ from a CMV seropositive donor;
- The date of the organ transplantation;
- The patient's weight; and
- The administration and dosage of the CytoGam®.

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

Effective Date

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

Advance Notice Requirement

Applies to medical necessity (see page 4). ❖

Q9920 - Q9940: Chronic Renal Failure Erythropoietin (Epogen)

Erythropoietin (Epogen) is a glycoprotein that stimulates red blood cell production. It is produced in the kidney and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

Endogenous production of erythropoietin is normally regulated by the level of tissue oxygenation. Hypoxia and anemia generally increase the production of erythropoietin, which in turn stimulates erythropoiesis. In normal subjects, plasma erythropoietin levels range from 0.01 to 0.03 units/ml, and increase up to 100 to 1,000-fold during hypoxia or anemia. In contrast, in patients with chronic renal failure (CRF), production of erythropoietin is impaired, and this erythropoietin deficiency is the primary cause of their anemia.

This policy addresses Epogen given to chronic renal failure patients who are predialysis and patients who are on dialysis.

Indications and Limitations of Coverage and/or Medical Necessity

Epogen (procedure codes Q9920 - Q9940) is considered medically reasonable and necessary for the treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis. Epogen is indicated to elevate or maintain the red blood cell level (as manifested by the hematocrit or hemoglobin determinations) and to decrease the need for transfusions in these patients. It is not intended for patients who require immediate correction of severe anemia.

Prior to and during Epogen therapy, the patient's iron stores, including transferrin saturation and serum ferritin, must be evaluated. Transferrin saturation should be at least 20 percent and ferritin at least 100ng/mL. Virtually all patients will eventually require supplemental iron, to increase or maintain transferrin saturation to levels that will adequately support erythropoiesis stimulated by Epogen. In addition, blood pressure should be adequately controlled prior to initiation of Epogen therapy, and must be closely monitored and controlled during therapy.

To initiate Epogen therapy, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 30 percent or a hemoglobin (HGB) < 10g/dl and a creatinine level of 3 mg/dl or higher, unless there is medical documentation showing the need for EPO despite a HCT >29.9 percent or a HGB >9.9g/dl or a creatinine level < 3 mg/dl.

It may be medically necessary for a patient to initiate Epogen therapy when the hematocrit or hemoglobin is greater than 29.9 percent or 9.9g/dl and the patient exhibits severe signs and symptoms such as: extreme weakness and fatigue, cold intolerance, tachycardia, severe pulmonary distress, severe hypotension, angina, congestive heart failure, etc., caused by the anemic condition. In addition, it may be medically necessary to initiate Epogen therapy when the creatinine level is < 3mg/dl if one of the following is present: evidence of any type clearance test demonstrating a result of less than 30cc/min (e.g., creatinine clearance) or the patient's physical examination revealed muscle wasting or low muscle mass.

The initial dose of Epogen, whether given intravenously or subcutaneously, is between 50 and 100 units per kilogram (kg) of body weight. Subsequent injections are usually given at a frequency of three times per week. The dosage may be increased if, after eight weeks of therapy, the hematocrit has not increased by five to six points and is still below the suggested hematocrit target range of 30 to 36 percent. Adjustments in dosages are generally made in increments of 25 units/kg of body weight. The dose of Epogen should be reduced as the hematocrit approaches 36 percent or increases by more than four points in any two-week period. Epogen should be temporarily withheld if the reduced dose does not stop the rise in the hematocrit and the hematocrit exceeds 36 percent. When the hematocrit has returned to the desired range, therapy may be resumed using a dose that is 25 units/kg of body weight lower than the previous dose.

Note: The time required to elicit a clinically significant change in hematocrit (increase or decrease) following any dose adjustment may be two to six weeks. Dose adjustment should not be made more frequently than once a month, unless clinically indicated. After any dose adjustment, the hematocrit should be determined twice weekly (BIW) for at least two to six weeks.

Epogen is covered when furnished incident to a physician's service except when administered in a renal dialysis facility. Epogen is covered for patients with CRF who are on dialysis when:

- It is administered in the renal dialysis facility; or
- It is self-administered in the home by any dialysis patient (or patient caregiver) who is determined competent to use the drug and meets the other conditions listed below.

Requirements For Self Administration Of Epogen

Self administration of Epogen and related items related to its administration are covered for dialysis patients who use Epogen in the home when the following conditions are met:

1. Patient Care Plan - a dialysis patient who uses EPO in the home must have a care plan for monitoring home use of EPO which includes the following:
   a. Review of diet and fluid intake for aberrations as indicated by hyperkalemia and elevated blood pressure secondary to volume overload;
   b. Review of medications to ensure adequate provision of supplemental iron;
   c. Ongoing evaluations of hematocrit and iron stores;
   d. Re-evaluation of the dialysis prescription taking into account the patient's increased appetite and red blood cell volume;
   e. Method for physician follow up on blood tests and a mechanism (such as a patient log) for keeping the physician informed of the results;
   f. Training of the patient to identify the signs and symptoms of hypotension and hypertension; and
   g. The decrease or discontinuance of EPO if hypertension is uncontrollable.

2. Patient selection - the dialysis facility, or the physician responsible for all dialysis-related services furnished to the patient, must make a comprehensive assessment that includes the following:
   a. Pre-selection monitoring - the patient's hematocrit (or hemoglobin), serum iron, transferrin saturation, serum ferritin, and blood pressure must be measured.
   b. Conditions the patient must meet. The assessment must find that the patient meets the following conditions:
      1. Is a dialysis patient;
      2. Has a hematocrit (or comparable hemoglobin level) that is as follows:
         a. For a patient who is initiating EPO treatment, no higher than 30 percent unless there is medical documentation showing the need for EPO despite a hematocrit (or comparable hemoglobin level) higher than 30 percent. Patients with severe angina, severe pulmonary distress, or severe hypotension may require EPO to prevent adverse symptoms even if they have higher hematocrit or hemoglobin levels.
         b. For a patient who has been receiving EPO from the facility or the physician, between 30 and 36 percent; and
      3. Is under the care of:
         a. A physician who is responsible for all dialysis - related services and who prescribes the EPO and follows the drug labeling instructions when monitoring the EPO home therapy; and
         b. A renal dialysis facility that establishes the plan of care and monitors the progress of the home EPO therapy.
         c. The assessment must find that the patient or a caregiver meets the following conditions:
            1. Is trained by the facility to inject EPO and is capable of carrying out the procedure;
            2. Is capable of reading and understanding the drug labeling; and
            3. Is trained in, and capable of observing,aseptic techniques.
         d. Care and storage of the drug - the assessment must find that EPO can be stored in the patient's residence under refrigeration and that the patient is aware of the potential hazard of a child's having access to the drug and syringes.
3. Responsibilities of physician or dialysis facility - the patient's physician or dialysis facility must:
   a. Develop a protocol that follows the drug label instructions;
   b. Make the protocol available to the patient to ensure safe and effective home use of EPO;
   c. Through the amounts prescribed, ensure that the drug on hand at any time does not exceed a 2-month supply;
   d. Maintain adequate records to allow quality assurance for review by the network and State survey agencies. For Method II patients, current records must be provided to and maintained by the desig nated back-up facility.

ICD-9 Codes That Support Medical Necessity

285.8*
285.9*
585

*Patients with anemia associated with chronic renal failure must submit one of the anemia diagnoses and chronic renal failure.

Coding Guidelines

Epogen administration costs are included in the monthly capitation payment (MCP) for the ESRD facility or provider setting. If a physician other than the MCP physician provides the Epogen injection, then that physician must obtain payment from the MCP physician.

Documentation Requirements

The initial claim for Epogen must be submitted either on paper or through EMC with attached documentation that includes the following information:

- ICD-9 diagnosis for both chronic renal failure and anemia;
- The most recent hematocrit and serum creatinine level (within the past month) performed prior to the initiation of Epogen therapy;
- The beneficiary's current weight in kilograms; and
- The Epogen dose in units per kilogram.

Note: This information may be found on the certificate of medical necessity (CMN) or office/progress notes.

The documentation must indicate the patient has a hematocrit of <30 percent and a creatinine level >3mg/dl prior to initiation of Epogen therapy. If the patient's hematocrit is greater than or equal to 30 percent or the creatinine level is less than 3mg/dl, additional documentation must support the medical necessity for initiation of Epogen therapy despite the increased hematocrit and decreased creatinine levels.

Subsequent claims for Epogen may be submitted on either paper or EMC and must include the following information:

- ICD-9 diagnosis for both chronic renal failure and anemia;
- The Epogen dose in units per kilogram;
- The hemoglobin/hematocrit level as indicated by procedure code(s) Q9920-Q9940; and
- Modifier EJ indicating the service(s) as a subsequent service.

Documentation maintained in the patient's file must support the medical necessity for continuation of Epogen therapy despite a hematocrit level greater than 36 percent or dosages exceeding 18,000 units during a seven day period. The medical record should describe the ongoing assessment of therapy (e.g., symptoms, dosage changes, lab work) over time.

Effective Date

This policy is effective for services processed on or after March 22, 1999.

Advance Notice Statement

Applies to medical necessity (see page 4). ❖

33223, 33240-33249: Implantation of Automatic Defibrillators

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating.

Indications and Limitation of Coverage and/or Medical Necessity

Effective for services performed on or after January 24, 1986 through July 1, 1991, the implantation of an automatic defibrillator is a covered service only when used as a treatment of last resort for patients who have had a documented episode of life-threatening ventricular tachyarrhythmia or cardiac arrest not associated with myocardial infarction. Patients must also be 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). It must be emphasized that unless all of the above described conditions and stipulations are met in a particular case, including the inducibility of tachyarrhythmia, etc., implantation of an automatic defibrillator may not be covered.

Effective for services performed on or after July 1, 1991, the implantation of an automatic defibrillator is a covered service for patients who have 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, the implantation of an automatic defibrillator is also a covered service for patients with the following conditions:

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

HCPCS CODES

33223	Revision or relocation of skin pocket for implantable cardioverter-defibrillator
33240	Insertion or replacement of implantable cardioverter-defibrillator pulse generator only
33241	Removal of implantable cardioverter-defibrillator pulse generator only
33242	Repair of implantable cardioverter-defibrillator pulse generator and/or leads
33243	Removal of implantable cardioverter-defibrillator pulse generator and/or lead system; by thoracotomy
33244	by other than thoracotomy
33245	Implantation or replacement of implantable cardioverter-defibrillator pads by thoracotomy, with or without sensing electrodes
33246	with insertion of implantable cardioverter-defibrillator pulse generator
33247	Insertion or replacement of implantable cardioverter-defibrillator lead(s), by other than thoracotomy
33249	with insertion of cardio-defibrillator pulse generator

ICD-9 Codes That Support Medical Necessity

425.1 425.4 427.1 427.5 794.31

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 operative report.

Effective Date

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

Advance Notice Statement

Applies to medical necessity (see page 4). ❖

48554: Pancreas Transplantation

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Indications and Limitations of Coverage and/or Medical Necessity

Effective July 1, 1999, Medicare will consider performance of a whole organ pancreas transplantation medically reasonable and necessary under the following circumstances:

- When it is performed simultaneously with or after a Medicare covered kidney transplantation (HCPCS code 50360 or 50365).

If the pancreas transplant occurs after the kidney transplant, the 36-month period of entitlement to immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

Pancreas transplantation for diabetic patients who have not experienced end stage renal failure secondary to diabetes continues to be excluded from Medicare coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells.

HCPCS Codes

48554 Transplantation of pancreatic allograft

ICD-9 Codes That Support Medical Necessity

250.00-250.93
585
V42.0
V43.89

Note: The billing of pancreas transplantation requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9 codes 250.00-250.93 and 585, V42.0, or V43.89 to report the approved indication for 48554.

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

Providers must use ICD-9 codes 250.00-250.93 ***and*** 585, V42.0, or V43.89 to report the approved indication for 48554.

Documentation Requirements

Medical record documentation (e.g., history and physical, office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing a pancreatic transplant. Additionally, a copy of the operative report should be maintained in the medical records.

Effective Date

This policy is effective for services performed on or after July 1, 1999.

Advance Notice Requirement

Applies to medical necessity (see page 4) ❖

64553-64565, 64573, 64580: Coverage for Electrical Nerve Stimulation

Electrical nerve stimulation is a diagnostic procedure involving stimulation of peripheral nerves by a needle electrode inserted through the skin. The nerve stimulation does not prevent pain but only alleviates pain as it occurs. The procedure is used to treat chronic, intractable pain.

Insertion of Percutaneous Nerve Stimulator Electrodes (procedure codes 64553-64565)

Electrical nerve stimulation is an accepted modality for assessing a patient's suitability for ongoing treatment with an implanted nerve stimulator. The physician should be able to determine whether the patient is likely to derive a significant therapeutic benefit from continuing use of an implanted nerve stimulator within a trial period of one month. In a few cases, this determination may take longer to make. The medical necessity for such diagnostic services that are furnished beyond the first month must be documented in the patient records. This diagnostic procedure involving stimulation of peripheral nerves by a needle electrode inserted through the skin is covered only when performed by a physician or incident to a physician's service. If pain is effectively controlled by percutaneous stimulation, implantation of electrodes is warranted.

To ensure that payment is made only for medically necessary service, insertion of percutaneous nerve stimulator electrodes is covered only for the following diagnoses/conditions:

337.9	355.0-355.6	355.71-355.79
355.8	355.9	724.00-724.09
724.1	724.2	724.3
724.4	724.5	724.6
724.70-724.79	724.8	724.9

Incision for Implantation of Neurostimulator Electrodes (procedure codes 64573 and 64580)

Payment may be made under the prosthetic device benefit for implanted peripheral nerve stimulators. Use of this stimulator involves implantation of electrodes around a selected peripheral nerve. The stimulating electrode is connected by an insulated lead to a receiver unit implanted under the skin at a depth not greater than ½ inch. Stimulation is induced by a generator connected to an antenna unit which is attached to the skin surface over the receiver unit. Implantation of electrodes requires surgery and usually necessitates an operating room.

To ensure that payment is made only for medically necessary service, insertion of percutaneous nerve stimulator electrodes are covered only for the following diagnoses/conditions:

337.9
345.11
345.41 (allowed only with procedure code 64573)
345.51 (allowed only with procedure code 64573)
355.0-355.6
355.71-355.79
355.8
355.9
724.00-724.09
724.1
724.2
724.3
724.4
724.5
724.6
724.70-724.79
724.8
724.9

Reasons for Denial

While electric nerve stimulation has been employed to control chronic intractable pain for some time, its use in treatment of motor function disorders, such as multiple sclerosis, is a recent innovation, and the medical effectiveness of such therapy has not been verified by scientifically controlled studies. Therefore, where electric nerve stimulation is employed to treat motor function disorders, no reimbursement may be made for the stimulator or for the services related to its implantation, since this treatment cannot be considered reasonable and necessary.

The use of spinal cord electrical stimulators, rectal electrical stimulators and bladder wall stimulators to induce emptying of the urinary bladder cannot be considered reasonable and necessary. Therefore, no program payment may be made for these devices or their implantation.

Coding Guidelines

Diagnosis codes 345.41 and 345.51 should only be used when performing an incision for implantation of a neurostimulator electrode into the cranial nerve. This service is performed for Vagus Nerve Stimulation.

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 procedure report.

Effective Date

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

Advance Notice Statement

Applies to medical necessity (see page 4). ❖

61885, 64573, 64585-64595, 95970-95975: Vagus Nerve Stimulation

Vagus nerve stimulation has been shown to be an effective adjunctive therapy for persons with medically refractory partial seizures. The precise antiseizure mechanism of vagal nerve stimulation (VNS) is not clearly understood. A few theories have emerged. One theory is that general afferent projections of the vagus nerve into the limbic system produce desynchronization of brain waves, making seizures less likely to occur. Another theory is derived from the concept that chronic stimulation of the vagus nerve increases the amount of inhibitory neurotransmitters and decreases that amount of excitatory neurotransmitters.

Vagus nerve stimulation is accomplished by inserting a pulse generator into the subcutaneous pocket of the patient's chest wall, similar to a cardiac pacemaker. Another incision is made in the neck for placement of the bipolar lead. The bipolar lead has electrodes (platinum wires) that are attached around the left vagus nerve in the neck area inside the carotid sheath. The lead is then tunneled under the skin and connected to the pulse generator. The stimulating electrodes conduct signals from the generator to the vagus nerve. The implantation of the system usually takes one to three hours and is generally done under general anesthesia.

Once implanted, the generator may be programmed externally with a programming wand attached to a standard personal computer. The generator is programmed to deliver electrical current to the vagus nerve. The generator delivers intermittent stimulations, 24 hours a day, in accordance with its programming. In addition, the patient may use an external magnet to activate the generator and deliver additional stimulations.

After battery depletion, the pulse generator must be replaced. The projected battery life is approximately 3-5 years at the recommended stimulation parameters. Replacement surgery of the pulse generator usually takes about one hour and is typically done with local anesthesia. Pulse generator replacement does not of itself require lead replacement unless a lead fracture is suspected.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider vagus nerve stimulation to be medically necessary and reasonable for the following condition:

> For patients with medically refractory partial onset seizures, for whom surgery is not recommended or for whom surgery has failed.

A partial onset seizure has a focal onset in one area of the brain and may or may not involve a loss of motor control or alteration of consciousness. Partial onset seizures may be simple, complex, or complex partial seizures, secondarily generalized. Patients with medically refractory partial onset seizures have failed multiple drug therapies, which include both conventional (e.g., Phenytoin, Carbamazepine, Primidone, Valproate) and new anticonvulsant drugs (e.g., Felbamate, Lamotrigine, Gabapentine, Vigabatrine, Topiramate, Tiagabine) in controlling seizures and do not qualify for surgery.

HCPCS Codes

61885	Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling
64573	Incision for implantation of neurostimulator electrodes; cranial nerve
64585	Revision or removal of peripheral neurostimulator electrodes
64590	Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral neurostimulator pulse generator or receiver
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g.: rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex neurostimulator pulse generator, without reprogramming
95971	simple neurostimulator pulse generator, with intraoperative or subsequent programming
95974	complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
95975	complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

ICD-9 Codes That Support Medical Necessity

345.41 345.51

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.

Vagus nerve stimulation is not covered for patients with other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed.

Noncovered ICD-9 Code(s)

When CPT codes 61885, 64573, 64585, 64590, 64595, 95970, 95971, 95974, and 95975 are performed for vagus nerve stimulation, any diagnosis codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy will be considered noncovered.

Coding Guidelines

A physician, usually a neurologist, typically tests the device and leads and sets the initial programming parameters, both in the operating room and in the office setting during the days/weeks following the implant. The services are coded with the following procedure codes: 95970, 95971, 95974, and/or 95975. These analysis and programming codes may be billed periodically to test and reprogram the device.

When CPT codes 61885, 64573, 64585, 64590, 64595, 95970, 95971, 95974, and 95975 are performed for vagus

nerve stimulation, the appropriate diagnosis code that supports medical necessity should be submitted.

Documentation Requirements

Documentation maintained in the patient's file should include:

History and physical (including a neurologic history, examination, and documentation of neurologic symptomatology);

A history of medically refractory partial onset seizures;

Documentation of medical regimes, which should include all conventional and newer anticonvulsant medications that failed;

Current medication regimes; and

A description of the surgical procedure.

This information can generally be found in the office/ progress notes, history and physical, and/or operative note.

Effective Date

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

Advance Notice Statement

Applies to medical necessity (see page 4). ❖

70541, 71555, 73725, 74185: Magnetic Resonance Angiography (MRA)

National policy recently expanded coverage for procedure code 70541 (MRA, head and/or neck) and also added new coverage for procedure code 74185 (MRA, abdomen) and procedure code 71555 (MRA, chest). This expanded coverage has an effective date of July 1, 1999. Therefore, the policy has been revised to reflect these national coverage changes for services performed on or after July 1, 1999.

Magnetic Resonance Angiography (MRA) is an application of magnetic resonance imaging that provides visualization of blood flow, as well as images of normal and diseased blood vessels. MRA techniques are typically noninvasive because they do not require the use of contrast media. While contrast media may sometimes be used to enhance the images obtained in MRA, the use of these agents is not necessary. As a result, MRA is an imaging alternative for patients who cannot tolerate contrast media.

Indications and Limitations of Coverage and/or Medical Necessity

Although MRA appears to be a rapidly developing technology, the clinical safety and effectiveness of this procedure for all anatomical regions has not been proven. As a result Medicare will provide coverage on a limited basis. Below are the indications for which Medicare coverage is allowed for MRA. All other uses of MRA will not be covered.

70541: Head and/or Neck (for services performed before 7/1/99)

Medicare will provide coverage for the evaluation of the carotid vessels in the head and neck when all of the following conditions are met:

- For a patient who has a positive ultrasonography; and
- When performed on patients with symptoms associated with carotid stenosis for which surgery may be found to be appropriate based on the results of these tests.

It should be noted that physicians may choose either contrast angiography (CA) or MRA as diagnostic tests after a positive ultrasound for their patients. MRA is not performed routinely as an adjunct to CA. CA furnished in addition to MRA might be appropriate only when the results from the MRA and the ultrasound are incongruent or inconclusive.

70541: Head and/or Neck (for services performed on or after 7/1/99)

Medicare will provide coverage for the evaluation of the vessels in the head and neck when all of the following conditions are met:

- To evaluate the carotid arteries, the circle of Willis, the anterior, middle or posterior cerebral arteries, the vertebral or basilar arteries, or the venous sinuses; and
- Be performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion or thrombosis.

MRA and contrast angiography (CA) are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests.

ICD-9 Codes That Support Medical Necessity

Services performed before 7/1/99

433.10 433.11 435.0-435.9 436

Services performed on or after 7/1/99

239.6 433.00-433.91
434.00-434.91 435.0-435.9
436 437.3
747.81

73725: Peripheral Arteries of Lower Extremities

Studies have proven that MRA of peripheral arteries is useful in determining the presence and extent of peripheral vascular disease in lower extremities. Effective May 1, 1997, Medicare will consider MRA of the arteries of the lower extremities to be a covered service only when the following criteria have been met:

- Either MRA or CA can be performed to evaluate peripheral arteries of the lower extremities. However, both MRA and CA may be useful in some cases, such as:
  - A patient has had CA and this test was unable to identify a viable run-off for bypass. When exploratory surgery is not believed to be a reasonable medical course of action for this patient, MRA may be performed to identify the viable runoff vessel.
  - A patient has had MRA, but the results are inconclusive.

74185: Abdomen

Studies have proven that MRA is considered a reliable diagnostic tool for the preoperative evaluation of patients who will undergo elective abdominal aortic aneurysm (AAA) repair. In addition, scientific data has revealed that MRA is considered comparable to contrast angiography (CA) in determining the extent of AAA, as well as evaluation of aortoilliac occlusion disease and renal artery pathology that may be necessary in the surgical planning for AAA repair. These studies also reveal that MRA could provide a net benefit to the patient. If preoperative angiography is not necessary, patients are not exposed to the risks associated with invasive procedures, contrast media, end-organ damage or arterial injury. As with coverage

of MRA for other anatomical sites, Medicare will provide coverage for either MRA or CA but not both tests on a routine basis.

The physician may choose between CA or MRA for preoperative imaging, after other tests such as computed tomography (CT) or ultrasound have been used to diagnose AAA and evaluate aneurysm size over time. However, both MRA and CA may be used when the physician can demonstrate the medical need for both tests to be performed, such as when a follow up CA is necessary to clarify renal artery pathology, which might not be diagnosed definitively by an initial MRA.

71555: Chest

Medicare will cover MRA of the chest for the following indications:

For the Diagnosis of Pulmonary Embolism

Medicare will consider MRA of the chest for diagnosing a suspected pulmonary embolism to be a covered service when the following criteria have been met:

- A patient is suspected of having a pulmonary embolism, and it is contraindicated for the patient to receive intravascular iodinated contrast material.
- A patient is allergic to iodinated contrast material and would face a high risk of developing complications if he/she undergoes pulmonary angiography or computed tomography angiography.

For Pre-operative or Post-operative Evaluation of Thoracic Aortic Dissection and Aneurysm

Medicare will consider MRA of the chest for the evaluation of thoracic aortic dissection and aneurysm to be a covered service when the following criteria are met:

- Depending on the clinical presentation, MRA may be used as an alternative to other non-invasive imaging technologies, such as transesophageal echocardiography and CT.
- Either MRA or CA may be used as a diagnostic test for thoracic aortic dissection and aneurysm, but not both tests on a routine basis.
- If both MRA and CA of the chest are used to diagnose thoracic aortic dissection and aneurysm, the physician must demonstrate the medical need for performing both tests.

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.

HCFA considers the following codes to be noncovered by Medicare:

72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)

Documentation Requirements

Documentation maintained in the patient's file must indicate the medical necessity of this procedure. All coverage criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section must be documented in the patient's medical record, as well as a hard copy of the procedure results, and made available to Medicare upon request. This information can generally be found in the office/progress notes, history and physical, and/or operative notes.

If the provider of the magnetic resonance angiography study is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the reason for the MRA in his order for the test.

Effective Date

This policy is effective for services processed on or after July 1, 1999, except where otherwise noted.

Advance Notice Statement

Applies to medical necessity (see page 4).❖

72192, 72193, and 72194 Computed Tomography of the Pelvis

Computed Tomography of the Pelvis (CT Scan of the Pelvis) is a noninvasive yet accurate X-ray procedure which results in images from passing X-rays through an organ at many angles. The variation and density of each tissue allows for variable penetration of the X-rays. Each density is computed by utilizing a coefficient (or numeric value) that is digitally computed into shades of gray. These shades of gray are then displayed on a monitor as thousands of dots in various shades.

The pelvis is a basin-like structure that supports the spinal column and rests on the lower limbs. The true pelvis is defined as that portion of the pelvis situated below and behind the pelvic brim.

The CT scan of the pelvic area includes the bladder, prostate, ovaries, uterus, lower retroperitoneum and iliac lymph node chains. CT scans are generally performed to study the pelvic viscera. In males, this includes the bladder and prostate and, in females, the bladder, uterus and adnexa. The CT scan of the pelvis is useful in evaluating cysts, tumors, masses, metastasis to one or more of these organs, and iliac lymph nodes. Intravenous contrast material may be administered when enhanced views are needed.

Medicare of Florida will consider a CT scan of the pelvis medically necessary and reasonable under the following conditions:

- To evaluate cysts, tumors, or masses of the pelvic structure (i.e., that which lies at or below the pelvic brim, or true pelvis);
- To evaluate metastasis of primary cancers to this region;
- To evaluate inflammatory processes of this region;
- To evaluate abnormalities of pelvic vascular structures;
- To evaluate lymphadenopathies of this region;
- To evaluate lower abdominal, generalized abdominal or pelvic pain;
- To evaluate other genitourinary disorders in which the physician can not make a diagnosis on physical examination and/or by ultrasound;
- To evaluate trauma to the pelvic structure/organs; and/or
- To evaluate the effectiveness of a radiation treatment plan.

To ensure the services are medically necessary, CT of the pelvis is covered only for the following diagnoses:

015.00-015.06	236.0-236.2	639.0
016.10-016.96	236.5	639.1
153.0-153.9	236.7	665.10
154.0-154.8	236.90	665.40
171.6	239.4-239.5	665.50
179	256.4	670.00-670.04
180.0-180.9	441.3	682.2
182.0-182.8	441.4	682.5
183.0-183.9	442.2	682.9
184.0	444.0	719.45
184.8	457.1	751.0
184.9	540.0	751.2
185	540.1	752.0
186.0-186.9	543.9	752.10-752.19
187.8	552.21	752.3
187.9	553.8	752.40
188.0-188.9	553.9	752.51-752.52
189.2	555.0	752.8
189.3	555.1	753.0-753.9
189.8	555.2	780.6
189.9	555.9	785.6
195.3	557.0-557.9	789.03
196.2	560.0	789.04
196.5	560.81	789.05
196.6	560.9	789.07
197.6	562.10	789.09
198.1	562.11	789.33-789.35
198.5	566	789.5
198.6	567.2	789.63-789.65
200.00	567.9	789.67
200.05	568.0	789.9
200.06	568.81	793.5
200.08	568.82	793.6
200.10	568.89	793.9
200.15	569.41-569.5	863.89
200.16	569.60-569.69	876.0-876.1
200.18	569.83	877.0-877.1
200.20	569.89	879.2
200.25	578.1	879.3
200.26	591	879.4
200.28	593.3	879.5
201.00-201.98	593.4	879.6
202.80	593.5	879.7
202.85	593.82	958.4
202.86	593.89	958.5
202.88	596.0	959.1
211.3	596.6	995.54
211.4	596.8	995.81
211.8	599.1	996.1
215.6	599.7	996.30-996.39
218.0-218.9	614.0-614.9	996.81
219.0-219.9	615.0-615.9	996.89
220	617.0-617.9	997.5
221.0	619.0-619.9	998.2
228.04	620.0-620.9	998.4
228.1	621.4	998.51-998.59
230.4	621.8	V42.0
233.1-233.9	625.8	V44.3
235.2	626.6	V44.50-V44.59
235.4		

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

If the procedure is performed using contrast only, procedure code 72193 should be billed. If the procedure is performed initially without contrast, followed by contrast, procedure code 72194 should be billed. Procedure codes 72192, 72193 and/or 72194 should not be billed on the same day for the same patient.

Documentation Requirements

The reason for the procedure should be documented in the physician's progress note. Also, test results should be included in the documentation. In addition, if the CT scan is the primary diagnostic tool and physical examination, and/or another test, such as echography, could have been performed to determine the patient s diagnosis or status, the reason for utilizing the CT scan should also be documented. This information can usually be found in the office notes, facility progress notes, history and physical and or test results.

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/her order for the test.

Effective Date

This policy is effective for services processed on or after May 3, 1999.

Advanced Notice Statement

Applies to medical necessity (see page 4).❖

80100: Qualitative Drug Screen

A qualitative drug screen is used to detect the presence of a drug in the body. A blood or urine sample may be used. However, urine is the best specimen for broad qualitative screening, as blood is relatively insensitive for many common drugs, including psychotropic agents, opioids, and stimulants.

Current methods of drug analysis include chromatography, immunoassay, chemical ("spot") tests, and spectrometry. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound (a laboratory must possess a valid reference agent for every substance that it identifies). Drugs or classes of drugs are commonly assayed by qualitative screen, followed by confirmation with a second method.

Examples of drugs or classes of drugs that are commonly assayed by qualitative screen, followed by confirmation with a second method, are: Alcohols, Amphetamines, Barbiturates, Benzodiazepines, Cocaine and Metabolites, Methadones, Methaqualones, Opiates, Phencyclidines, Phenothiazines, Propoxyphenes, Tetrahydrocannabinoids, and Tricyclic Antidepressants.

A qualitative drug screen may be indicated when the history is unreliable, with a multiple-drug ingestion, with a patient in delirium or coma, for the identification of specific drugs, and to indicate when antagonists may be used.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider performance of a qualitative drug screen medically reasonable and necessary when a patient presents with suspected

drug overdose and one or more of the following conditions:

- Unexplained coma;
- Unexplained altered mental status;
- Severe or unexplained cardiovascular instability (cardiotoxicity);
- Unexplained metabolic or respiratory acidosis;
- Unexplained head trauma with neurological signs and symptoms;
- Suspected history of substance abuse; and/or
- Seizures with an undetermined history.

Additionally, a qualitative drug screen (80100) will be considered medically reasonable and necessary for patients receiving active treatment for substance abuse when the patient presents with clinical signs and/or symptoms of noncompliance (e.g., feelings of euphoria, panic, mood swings). Providers must report ICD-9 code 304.90 for this coverage indication.

A qualitative drug screen is not medically reasonable or necessary under the following circumstances:

- In known overdose cases when the patient is asymptomatic (responsive to verbal stimuli, and has no seizures, hypoventilation, or cardiac abnormalities other than sinus tachycardia after several hours of observation);
- When the clinical picture is consistent with the reported history;
- To screen for the same drug with both a blood and a urine specimen simultaneously;
- To routinely monitor substance abuse compliance (i.e., the patient does not present with clinical signs and/or symptoms indicative of noncompliance);
- For medicolegal purposes (i.e., court-ordered drug screening); or
- For employment purposes (i.e., as a prerequisite for employment or as a means for continuation of employment).

HCPCS Codes

80100	Drug, screen; multiple drug classes, each procedure
80101	single drug class, each drug class
80102	Drug, confirmation, each procedure

ICD-9 Codes That Support Medical Necessity

276.2
304.90
345.9
780.01
780.09
977.9

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

Qualitative screening tests are coded by procedure, not method or analyte.

Procedure code 80100 should be used to report a qualitative drug screen which is performed to detect the presence of multiple drug classes. Procedure code 80100 should be reported as one unit for each specimen analyzed, regardless of the method or the number of drugs screened for simultaneously.

Procedure code 80101 should be used to report a qualitative drug screen that is performed to detect the presence of a single drug class. It is expected that procedure code 80101 will, on rare occasion, be reported. If the presence of more than one drug class is suspected, use procedure code 80100.

Use procedure code 80102 for each procedure necessary for confirmation. For example, if confirmation of three drugs by chromatography requires three stationary or mobile phases, bill 80102 three times. However, if multiple drugs can be confirmed using a single analysis, bill 80102 only once.

For quantitation of drugs screened, use the appropriate code (82000-84999 or 80150-80299).

Documentation Requirements

Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing a qualitative drug screen. Additionally, a copy of the lab results should be maintained in the medical records.

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

Effective Date

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

Advance Notice Requirement

Applies to medical necessity (see page 4). ❖

82947: Glucose, Quantitative - Proper Billing

It has been noted that procedure code 82947 (Glucose, quantitative) is being billed with inappropriate place of service codes. The glucose quantitative method is a more complex assay performed after the blood has clotted and separated to assay the serum or plasma in a laboratory device generally designed for multiple sequential assays. Many times, the glucose quantitation is performed as part of a serum microanalysis of several serum chemistries and is not coded separately. The result provided by this method represents a serum or plasma value of glucose.

Because this code represents a complex assay method using a laboratory device, it is not appropriate to bill 82947 for the following places of service:

home,
custodial care facility,
ambulance - land ,
ambulance - air or water,
community mental health center,
comprehensive outpatient rehabilitation facility, and
other unlisted facility. ❖

84154: Coverage for Free Prostate Specific Antigen

Prostate-specific antigen (PSA) is a serum glycoprotein tumor marker used in the early detection of prostate cancer. The PSA exists in multiple forms in serum and is predominantly complexed to protease inhibitors; however, one form of PSA, free PSA, is not bound to these proteins. The measurement of PSA forms in serum helps discriminate between prostate cancer and benign prostatic disease. For unknown reasons, the percentage of free PSA (fPSA) is lower in serum samples from patients with prostate cancer than in serum samples from patients with a normal prostate or benign disease.

Medicare of Florida will consider a free PSA (procedure code 84154) medically reasonable and necessary in the following circumstances:

To evaluate the patient whose total PSA is between 4.0-10.0 ng/mL and has a palpable benign prostate gland; and
To eliminate the need for unnecessary biopsies.

A free PSA is not indicated for patients that demonstrate a palpable abnormal gland that is suspicious for carcinoma. In addition, since this test is used to eliminate unnecessary biopsies, usually when the free PSA to total PSA is at least 25 percent, it is not expected that a biopsy would be performed on patients with documentation suggestive of benign prostatic disease.

Note: Free PSA is not medically necessary to monitor for the recurrence of disease or to monitor the response to therapy.

To ensure that payment is made only for medically necessary service, a free PSA is covered only for the following diagnosis:

790.93

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 August 16, 1999.

Advance Notice Statement

Applies to medical necessity (see page 4). ❖

86235: Extractable Nuclear Antigen

An extractable nuclear antigen (anti-ENA Ab) is an antibody directed against other nuclear and cytoplasmic components in serum. The antibody against these extractable nuclear antigens is identified via specific nuclear testing methodology.

Detecting specific autoantibodies via extractable nuclear antigen (ENA) testing is useful to determine the exact classification of an autoimmune disorder when a patient has a positive antinuclear antibody (ANA) result and presents with overlapping features of various autoimmune disorders.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the performance of an extractable nuclear antigen test for a specific autoantibody medically reasonable and necessary under the following circumstances:

The patient has a positive ANA result; and
It has been demonstrated that, upon clinical examination of the patient, the physician is unable to distinguish between various autoimmune disorders and the ENA test for a specific autoantibody is performed to help provide a differential diagnosis for one of the following disorders:

Systemic lupus erythematosus (SLE)
Subacute cutaneous lupus
Inflammatory polyarthritis
Scleroderma
CREST syndrome (calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, and telangiectasia)
Sjogren's syndrome
Sicca syndrome
Mixed connective tissue disease (MCTD)
Polymyositis

Note: A patient may, on rare occasion, have a negative ANA and a positive SS-A result when Sjogren's syndrome, SLE, or subacute cutaneous lupus is suspected. Therefore, an ENA test for the SS-A antibody may be considered medically reasonable and necessary in the absence of a positive ANA when Sjogren's syndrome, SLE, or subacute cutaneous lupus is suspected.

An ENA test for a specific autoantibody generally is not performed more than once, since it is used to provide a differential diagnosis and not to assist in the management of the identified autoimmune disorder.

However, an ENA test for a specific autoantibody may, on rare occasion, be repeated once for the following circumstances:

- For confirmational purposes due to inconclusive test results (for purposes of this requirement, an inconclusive test result is a result that is technically uninterpretable or discordant with a patient's other clinical data); or
- When an ENA test result for a specific autoantibody was negative and the patient now presents with a significant change in signs and symptoms indicative of an evolving autoimmune disorder.

HCPCS Codes

86235 Extractable nuclear antigen, antibody to, any method (eg, nRNP, SS-A,SS-B, Sm, RNP, Scl70, J01), each antibody

ICD-9 Codes That Support Medical Necessity

279.4 695.4 701.0 710.0 710.1 710.2
710.3 710.4 710.8 710.9

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.

Documentation Requirements

Medical record documentation (e.g., history and physical, office/progress notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing an ENA test. Additionally, a copy of the lab results should be maintained in the medical records, as well as evidence of a positive ANA result obtained prior to the performance of the ENA test.

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

Effective Date

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

Advance Notice Requirement

Applies to medical necessity (see page 4). ❖

90846, 90847, 90849: Family Psychotherapy

Family participation in the treatment process of a psychiatric patient is sometimes necessary. Family psychotherapy sessions may occur with or without the patient present. The process of family psychotherapy helps reveal a family's repetitious and ultimately predictable communication patterns, that are sustaining and reflecting the identified patient's behavior. For the purposes of this policy, a family member is any individual who spends a significant amount of the time with the patient and provides psychological support to the patient (e.g., caregiver, significant other). Group psychotherapy sessions for multiple families are utilized when similar dynamics are occurring due to the commonality of problems in the family members under treatment.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider family psychotherapy medically reasonable and necessary only when the primary purpose of such psychotherapy is the treatment/management of the patient's condition. Examples are as follows:

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members; and/or
- Where there is a need to assess the conflicts or impediments within the family, and assist through psychotherapeutic techniques, the family members in the management of the patient.

Family psychotherapy must be ordered by a provider as an integral part of an active treatment plan directly related to the patient's identified condition/diagnosis.

Family psychotherapy must be administered by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by Florida state law and considered eligible for Medicare B reimbursement.

Family psychotherapy is considered to be medically reasonable and necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

A family psychotherapy session generally lasts for at least 45-50 minutes.

HCPCS Codes

90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy

ICD-9 Codes That Support Medical Necessity

290.0-318.1

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.

Family psychotherapy is not considered medically reasonable and necessary when it is primarily concerned with the effects of the patient's condition on the family members and treatment of family problems, rather than primarily related to the treatment/management of the patient's problems.

Family psychotherapy is not considered medically reasonable and necessary when it includes socialization, music therapy, recreational activities/recreational therapy, art classes/art therapy, excursions or eating together, sensory stimulation, cognitive stimulation, or motion therapy.

Group psychotherapy sessions for multiple families (HCPCS code 90849) has restrictive coverage by Medicare and is generally noncovered. Such group therapy is directed to the effects of the patient's condition on the family and does not meet the Medicare standards of being part of the physician's personal services to the patient.

Family psychotherapy for the patient with profound mental retardation is not considered medically reasonable and necessary.

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

HCPCS codes 90846 and 90847 represent psychotherapy services for treatment of mental disorders. These codes should not be used when obtaining a family history or providing evaluation and management (E/M) counseling services.

HCPCS code 90849 is intended for group psychotherapy sessions for multiple families, when similar dynamics are occurring due to the commonality of problems in the family members under treatment.

Documentation Requirements

Medical record documentation maintained by the provider must indicate the medical necessity of the family psychotherapy and include the following:

- The presence of a psychiatric illness and/or demonstration of emotional or behavioral symptoms of the patient sufficient to significantly alter baseline functioning;
- The patient's ability to actively participate in and benefit from family psychotherapy (active participation is not applicable for 90846); and
- The estimated duration of treatment in terms of the number of sessions required; the target symptoms, the goals of family psychotherapy and method of monitoring outcome, and why family psychotherapy is the appropriate adjunct treatment modality.

This information is usually found in the initial psychiatric evaluation and/or ongoing plan of treatment.

A separate progress note must be written for each HCPCS code billed. The progress note must be legible, dated, signed, and not only include the credentials of the rendering provider, but also the length of time that the provider spent in the face to face encounter.

The family psychotherapy progress note must be written by the person rendering the service and must include the following:

- The problem/functional deficit to be addressed during the session and how it relates to the patient's current condition and diagnosis;
- The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal;
- The patient's status (behavior, verbalizations, mental status) during the session (this is not applicable for 90846); and
- The patient's/family's response to the therapeutic intervention including the benefit from the session and how it relates to the short/long term goals in measurable and functional terms.

Effective Date

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

Advance Notice Requirement

Applies to medical necessity (see page 4). ❖

GENERAL EMC INFORMATION

Why Use Electronic Media Claims?

Electronic Media Claims (EMC) filing enables providers' and suppliers' claims to be received at Medicare the same day of transmission. Due to increasing volume of claims being filed to Medicare Part B, this is an ongoing effort to expedite payments and to maintain cost effectiveness to both Medicare carriers and Medicare providers. EMC is rapidly changing to improve services and enhance features to better serve all Medicare customers.

There are several ways to submit claims electronically:

System to System - Most providers already have a computer currently in their offices that can be used for this purpose. A communications software package and a modem (if necessary) is all it takes.

Service Bureaus, Billing Services, and Clearinghouses - These are companies that specialize in sending claims electronically to Medicare.

Claims may be sent to Medicare seven days a week, 24 hours a day. The only cost is for long-distance telephone charges that may apply.

In the past, only a few types of claims could be submitted electronically, but in the last several years Medicare has expanded the claims to include:

- All physicians' claims
- Ambulance
- Ambulatory Surgical Centers
- Anesthesia
- Chiropractic
- Dialysis
- Extended Care Facility/Skilled Nursing Facility
- Hospital (Inpatient & Outpatient)
- Independent Laboratory
- Medicare Secondary Payer claims
- Nursing Home
- Ophthalmologists
- Optometrists
- Physical Therapy
- Podiatry
- Portable X-ray
- Psychiatric
- Radiology

Most surgical claims may be sent electronically. Call the Provider Customer Service department at (904) 634-4994 to find out if a specific claim can be submitted electronically.

Advantages to EMC Claims

- Lower administrative cost, estimated to be about $.50 per claim
- 14-day processing time for clean claims
- Fewer additional development letters
- Electronic posting of accounts receivable (ERN), saving office time and money
- Confirmation report stating receipt of claims
- Eliminates possible keying errors - "You key the claims, you're in control."
- Phone lines available 24 hours a day, seven days a week
- Electronic Eligibility information
- Electronic Rejects
- Electronic Claims Status
- Certificate of Medical Necessity for Ambulance, Chiropractor and Podiatrists

Disadvantages to Paper Claims

- Higher administrative costs (e.g., stamps, envelopes, claim forms), estimated to be about $1.50 per claim
- 27-day processing time for clean claims
- Additional development letters
- Manual posting of accounts receivable
- No acknowledgment of receipt of claims
- Additional staff. ❖

EDI/EMC Vendor, Billing Service, and Clearinghouse List

For those considering submitting electronic media claims as well as those currently sending, this listing provides service, support and feature information about vendors, billing services, and clearinghouses. The companies listed have software available that's been approved to submit electronic claims to Medicare Part A and Medicare Part B of Florida.

This list is available electronically, within the EDI/EMC area of the Medicare Online Bulletin Board System (BBS). For information on accessing the BBS see page 43 of this publication. If you are unable to access the BBS, paper copies can be obtained by contacting the PES Marketing department at (904) 791-8767.❖

*This listing should not be construed as a recommendation or sponsorship by First Coast Services Options, Medicare Part A & B of Florida, or the Medicare administration, for any of the organizations that appear on this listing. Specific services and financial arrangements must be made between Vendor/Service Bureau and Provider/Supplier. Medicare Part A & B will not be a party to any such arrangement. This listing is being provided solely for convenience. This information is subject to change after the date of publication.

Electronic Submitter Identification Number

Any electronic submitter identification number issued to a physician, billing service, or clearinghouse that has not been used within the last six months may be deleted from our files. Those who are still interested in transmitting Medicare Part B claims electronically should call the Provider Electronic Services (PES) Marketing Department at (904)791-8767. ❖

FRAUD AND ABUSE

Patient Safety in Clinics

Health care fraud and abuse is a problem of great significance in south Florida. As licensed health care providers, physicians are entrusted with and expected to engage in activities that promote the health and well-being of their patients. Physician involvement in organizations where the physician's name/license/provider number are used — *KNOWINGLY OR UNKNOWINGLY* — to take advantage of patients and health care programs by providing inferior, unnecessary, fraudulent, and/or unsafe services *must be stopped.*

Of particular concern are situations where legitimate claims are submitted using the physician's name and provider number but then additional diagnostic tests and services not ordered by the physician are billed as well. Just as important as fraudulent claims, are the issues of the quality of the care and patient safety. Too often, medical clinic locations have no physician presence and medical services are being furnished by unlicensed personnel—in some cases, without the knowledge or involvement of physicians. Sometimes, sites are unclean and unsanitary. These conditions should not be acceptable to Florida's licensed physicians.

The Dade County Medical Association (DCMA), in conjunction with the State of Florida and the Health Care Financing Administration, has developed an initiative to inform physicians in Dade county concerning the nature and significance of this problem. It is the joint conviction of these three organizations that *every physician* must take personal responsibility for ongoing evaluation of his/her professional relationships with all entities. To accomplish this, we have begun sending reports to physicians reflecting the services that have been billed in their names. It is imperative that all physicians review the lists of services that have been billed in their names.

Posters for providers' offices have also been sent which outline the medical clinic and patient goals for quality health care. It is also very important that patients be informed of the name and qualifications of their licensed caregivers.

Physicians who permit their numbers to be used inappropriately should expect to be promptly disciplined by the Florida State Medical Licensure Board and to be investigated by state and federal law enforcement agencies. DCMA will be working with state and federal regulators to develop ways to better control the problems noted above and to achieve improved care quality.

Educational seminars will be conducted in south Florida beginning in July. These seminars will help physicians understand how they can protect the Medicare trust fund and avoid becoming a victim of health care fraud, themselves. Notice to physicians is forthcoming, concerning locations, dates, and time of these seminars.

Medicare encourages providers to join in this partnership to protect and improve the quality of care that patients receive in our community. ❖

GENERAL INFORMATION

Revised Date for CLIA Fee Grace Period

Effective with the May 15 update of the Clinical Laboratory Improvement Act (CLIA) certification files, laboratories whose certification expired between six months and two years ago will receive denials. Previously, a two-year grace period was afforded to labs with expired certification, but beginning with the May 15 update, the grace period is now six months.

Labs whose certificates have expired should contact their state CLIA contacts for payment of fees (waiver and PPMP) and scheduling of any required surveys for complex certificates. The current state agency telephone number is (850) 487-3109. ❖

Questions From Medifest

The following questions, answered below, were posed at the recent Tampa Medifest.

Q. How are the followup days determined on an unlisted code such as 47999?

A. The followup days on an unlisted procedure are determined on an individual consideration basis.

Q. How much can a provider (participating or non-participating) collect from a beneficiary on a service (assigned or non-assigned) that is denied due to medical necessity (such as utilization limits exceeded or diagnosis) when an acceptable advance notice has been given?

A. When patients signs a waiver, they are saying they will be responsible for the provider's billed amount. ❖

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 overpayment 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 May 5, 1999, the interest rate applied to Medicare overpayments is **13.375** percent based on the new revised PCR rate. The following table lists previous interest rates:

Period	Interest Rate
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%

❖

1999 Customer Service Hours of Operation

The normal hours of operation for the Medicare Part B of Florida Provider Telephone Customer Service department are from 9 a.m. until 4:30 p.m., Monday through Thursday, and from 8 a.m. until noon on Friday. The Automated Response Unit (ARU) system is available from 7:30 a.m. until 5:30 p.m. on Monday and 7:30 a.m. until 6:30 p.m. on Tuesday through Friday. However, certain holidays observed throughout the year affect our normal hours of operation. For the remainder of 1999, holiday observance and hours of business are as follows:

Monday, July 5, 1999	Independence Day observed
Monday, September 6, 1999	Labor Day observed
Wednesday, November 24, 1999	Closed at 2 p.m.
Thursday, November 25, 1999	Thanksgiving Day observed
Friday, November 26, 1999	Thanksgiving observed
Wednesday, December 22, 1999	Closed at 2 p.m.
Thursday, December 23, 1999	Christmas Day observed
Friday, December 24, 1999	Christmas Eve observed

The telephone number for Provider Customer Service is (904) 634-4994. The ARU can be accessed by dialing (904) 353-3205.❖

Changes to Practice Location Must Be Reported

When providers have recently moved or plan to make changes to their practice or group practices, a Change of Information application (HCFA 855C) must be completed. The application must be submitted to the Medicare Registration department at:

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

A Change of Information application is needed when:

- The practice location address, or the billing address changes.
- A provider is retiring, or will no longer be practicing in the state of Florida.
- A provider associated with a group is leaving the group.
- Individual name changes.
- Doing business as name changes.
- Telephone or fax number changes.
- Organization name changes (If the name change does not involve a change of ownership).
- Billing service / management service organization name changes.
- Deleting practice locations.
- Specialty changes.
- Deactivation request.
- Adding or deleting an authorized representative.
- Potential termination of current ownership.

If any of the above information has changed and a HCFA 855C has not been completed, or Medicare Registration has not been notified, please do so as soon as possible.

The Health Care Financing Administration (HCFA) requires any changes in the information reported on the original applications be reported to the Medicare Contractor within 30 calendar days.

Please contact the Customer Service Area at (904) 634-4994 to obtain the correct forms needed for any of the above changes. ❖

Hepatitis C "Lookback"

Hepatitis C virus (HCV) is the most common blood-borne infection in the United States. An estimated four million Americans have been infected with HCV, of whom about seven percent may have acquired their infection from blood transfusions. Because HCV is a chronic, often asymptomatic disease that may ultimately have serious health consequences, a nationwide effort is now underway to identify people who may have been infected.

At public meetings held in April and August 1997, the Public Health Service (PHS) Advisory Committee on Blood Safety and Availability discussed improvements in the treatment and management of HCV infection and improvements in testing for the HCV antibody. The Advisory Committee then recommended that, over the next few months, blood establishments and hospitals notify previous recipients of blood components from donors who tested positive for HCV upon a subsequent donation. Following the Department of Health and Human Services acceptance of recommendations from the PHS Advisory Committee, the Food and Drug Administration (FDA) developed industry guidelines for testing, quarantining and notification of HCV. These guidelines were finalized in September 1998 and mark the beginning of a change in the standard of practice for the testing of blood for HCV, the quarantine of blood and blood products, and the notification of patients who may have received HCV infected blood and blood products.

HCFA is currently developing a proposed rule regarding the "HCV lookback" and blood safety issues that will mirror the FDA's proposed rule and industry guidelines.

The FDA's current guidelines are entitled: *Guidance for Industry—Current Good Manufacturing Practice for Blood and Blood Components: (1) Quarantine and Disposition of Units from Prior Collections from Donors with Repeatedly Reactive Screening Tests for Antibody to Hepatitis C Virus (Anti-HCV); (2) Supplemental Testing, and the Notification of Consignees and Blood Recipients of Donor Test Results for Anti-HCV.* These guidelines are on the Internet at www.fda.gov/cber/guidelines.htm.

Medicare covers HCV testing for patients believed to have been exposed to HCV-infected blood, including those identified through the FDA look-back process. Patients who have been exposed are: (1) those receiving blood from a donor who tested negative at the time of donation but subsequently test repeatedly reactive for the antibody to HCV on a later donation; or (2) those receiving blood from a donor who tested positive on the FDA-licensed, more specific test or other followup testing recommended or required by FDA, and for whom the timing of seroconversion cannot be precisely estimated. ❖

Crossover Updates

The following updates have been performed to the Medicare Part B of Florida Crossover Insurers list. These changes can be viewed on the Florida Medicare Online Bulletin Board System (BBS) in the Medigap Crossover Listing section. For additional information concerning Medicare Part B Crossover, please refer to the *"A Closer Look"* section of the September/October 1998 edition of the *Medicare B Update!*

Automatic Crossover

- New Crossover Insurers

The following private insurers have been added to our list of Automatic Crossover Insurers.

Health Data Management Corporation (HDM)
Administers Plans for:
American Republic
Highmark Services
North American Insurance
Principal Financial Group
World Insurance

Horizon BCBS of New Jersey

Medigap Crossover

- Name Change

Number	Former Name	New Name
53035	Hill Country Life	Columbia Universal

- Address Change

Number	Insurer Name/Address
50010	Colonial Life & Accident PO Box 190240 Atlanta GA 31119
53131	National Security Life PO Box 91502 Arlington TX 76015

- Exempt "Non-Medigap Insurers"

The following insurers do not offer and/or process Medicare Supplemental plans and are exempt from the Medigap crossover process.

The Medigap insurer list has been updated to change each insurer identification number listed below to an exempt status. Each number listed is inactive and payment information will not be crossed over to these insurers.

Number	Insurer Name
19679	American Family Life
35059	Business Mens Assurance
42196	ILGWU Service Center
23131	Insurance Co of America
45082	Maine Insurance Agency
19775	Mepco
19937	National Health Agency
40055	Capital Administrator
24036	Federated Insurance
40064	HIP of New Jersey
37019	National Indemnity❖

DMERC Physician Information Sheet for Parenteral Nutrition and Hospital Beds

Medicare coverage of durable medical equipment is administered through the durable medical equipment regional carriers (DMERCs).

The region C DMERC Medical Director has developed the attached Physician Information Sheets (PHYISs) for parenteral nutrition and hospital beds. Though only summaries of the DMERC's Regional Medical Review Policy (RMRP), the PHYISs emphasize those things physicians might find interesting and helpful by providing indications and Medicare's coverage criteria for reimbursement.

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 Sheet (PHYIS) is 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 29202-3141

DMERC REGION C PHYSICIAN INFORMATION SHEET (PHYIS): PARENTERAL NUTRITION

The following is a summary for physicians of the Durable Medical Equipment Regional Carrier's Regional Medical Review Policy on Parenteral Nutrition.

Parenteral nutrition, the administration of nutrients intravenously, is covered by Medicare under the Prosthetic Benefit. This means that it is covered when being used to replace the malfunction of the primary organ that normally accomplishes nutrient intake, transport and absorption – the gastrointestinal (GI) system. If the GI system is functioning sufficiently to maintain the patient's weight and strength commensurate with the patient's overall health status, then parenteral nutrition is not covered (nor should it be, as the medically appropriate approach to insufficient nutritional status is to first use the more physiologically adapted GI system to its maximum capacity, before resorting to the more limiting avenue of intravenous nutrition, with its known complications.) For this reason, the **Parenteral** Benefit does not cover such conditions as swallowing disorders (tube feedings are covered under a separate **Enteral** Benefit), temporary defects in gastric emptying associated with metabolic or electrolyte disorders, psychological disorders impairing food intake such as depression, metabolic disorders inducing anorexia such as cancer, physical disorders impairing food intake such as the dyspnea of severe pulmonary or cardiac disease, side effects of medication, or renal failure with or without dialysis (another separate Medicare benefit).

If intravenous nutrients administered during dialysis treatments are to be covered (intradialytic parenteral nutrition or IDPN) there must be demonstration that all effort has been made to utilize the GI tract to its full potential (or that such effort is precluded by obvious functional impairment due to concurrent GI disease). This too is medically reasonable as patients in renal failure have strict fluid balance requirements and more concentrated nutrients may be introduced into a still functioning GI tract even using tube feedings, over a longer period of administration (up to 24 hours, seven days per week), than can be accomplished during only 3 or 4 dialysis sessions, lasting a few hours each, and using the vulnerable intravenous hemodialysis access port.

The GI impairment must not only be of sufficient degree to warrant intravenous nutrition, but it must also be of a **permanent** nature (of long and indefinite duration – ordinarily at least 3 months). It is not covered for temporary impairments and treatment regimens (less than 3 months) such as bowel rest associated with completed or anticipated surgical procedures.

For these reasons, all effort must be made to maximize the functional capacity of the GI tract before resorting to IV nutrient administration. Physicians, and other health care professionals should be attempting modifications in the composition of the oral (and enteral, tube-fed) diet, for example, using nutrients that are lactose free, gluten free, low in long-chain triglycerides, substituting medium chain triglycerides, providing protein as peptides or amino acids, etc. Therapeutic modalities should be fully utilized to address treatable causes of malabsorption, such as pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, antiulcer medication, etc.

The following clinical conditions of either malabsorption or GI dysmotility would be covered for parenteral nutrition based on their degree of functional severity:

A. Recent (within the past 3 months) small bowel resection leaving 5 feet or less of small bowel beyond the ligament of Treitz, or

B. Short bowel syndrome severe enough to result in loss of fluids and electrolytes such that, even with an intake of at least 2.5 liters/day, GI loss exceeds 50% and urine output is less than 1 liter/day, or

C. For treatment of symptomatic pancreatitis (with or without pseudocyst), severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula is not possible, and bowel rest is needed for any of these for at least 3 months and IV nutrients will supply 20-35 Cal/Kg/day, or

D. Complete mechanical small bowel obstruction where surgery is not an option, or

E. Significant malnourishment (10% weight loss over 3 months or less and serum albumin < 3.4 gm/DL) **along with** severe fat **malabsorption** (fecal fat exceeds 50% of oral/enteral intake on a diet of at least 50 grams of fat/day as measured by a 72 hour fecal fat test), or

F. Significant malnourishment (defined in E above) **along with** severe **motility disturbance** of the stomach and/or small intestine, which is unresponsive to prokinetic medication and is demonstrated either (1) scintigraphically (solid meal gastric emptying study shows isotope failing to reach the right colon by 6 hours after ingestion) or (2) radiographically (barium or radiopaque pellets failing to reach the right colon by 6 hours after ingestion). These studies must be performed when the patient is not acutely ill (temporary ileus) and is not on any medication which would decrease bowel motility.

In cases where the above conditions exist but are not of a degree of functional severity to meet the parameters described above, the need for intravenous administration of nutrients would have to be demonstrated by means of a **failed trial of tube feeding**. Attempted successful introduction and maintenance of a feeding tube in appropriate stomach or intestinal position must reflect sufficient effort by qualified personnel, and gradually increasing introduction of appropriate enteral nutrients. More specific details of the tube feeding trial may be found in the DMERC RMRP, which is available from the supplier servicing your patient or directly from the Region C DMERC office of Provider Relations.

Patients who initially qualify for coverage of parenteral nutrition must be recertified for continued coverage after 6 months, as even many of the qualifying conditions often improve to a level where continued intravenous feeding is no longer necessary.

In addition to a properly completed certificate of medical necessity, other documentation is usually required to furnish the necessary details discussed above in order for the DMERC to determine payment for claims for parenteral nutrition. Physicians are encouraged to work with suppliers of this therapy in obtaining and conscientiously completing this documentation so that patients truly needing it may have it reimbursed by Medicare.

DMERC REGION C PHYSICIAN INFORMATION SHEET (PHYIS): HOSPITAL BEDS

Description of Equipment:

An ordinary bed (not a hospital bed) is one which is typically sold as furniture. It consists of a frame, box spring and mattress. The frame is a fixed height from the floor and has no head or leg elevation adjustments. An ordinary bed will accommodate most transfers to a chair, wheelchair or standing position. If needed, it can almost always be adjusted to accommodate these transfers. The need for a particular height from the floor would rarely by itself justify the need for a hospital bed.

Hospital beds allow the patient's position to be changed at the head and foot of the bed, as well as the distance of the bed frame from the floor. Hospital beds may be:

Totally Manual and of **Fixed Height**, having manual (a cranking mechanism) head and leg elevation adjustments, but no height adjustment;

Totally Manual and with **Variable Height**, having additionally, manual height adjustment;

Semi-Electric, having electric head and leg adjustment, but still manual height adjustment;

Total Electric, having electric head and leg adjustment, plus electric height adjustment.

Indications for Hospital Beds:

Fixed Height (One or more of the following):

A patient who requires positioning of the body in ways not feasible with an ordinary bed, for the alleviation of pain.

A patient who requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges should first have been considered.

A patient who requires traction equipment which can only be attached to a hospital bed.

Variable Height (In addition to one of the above):

The patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

Semi-Electric:

In addition to the above indications, the patient requires frequent or immediate changes in body position.

Total Electric: (Not covered by Medicare):

The additional feature allowing for motorized adjustment of the height of the bed frame from the floor is strictly for the convenience of the caregiver. While the caregiver may have true limitations in his/her ability to minister to the patient, the laws upon which Medicare national payment policy is based do not allow for consideration to be extended to the patient's caregiver. Therefore, this added feature is not covered. However, this does not mean that the more basic (semi-electric) feature of the bed will be denied. If the indications for a semi-electric bed are met, then payment will be made by Medicare at the level of a semi-electric bed.

Comment:

It is rarely necessary for a patient to require changes from one type of hospital bed to another (e.g., variable height to semi-electric) once, in the judgment of the physician, a particular level of bed has been ordered. It is inconceivable that a patient should "progress" from a higher to a lower level bed (e.g., semi-electric to a variable height). Medicare should not pay for two beds, when the needs of the patient could have been anticipated based on the clinical condition originally judged to require a hospital bed.

Documentation:

The supplier of your patient's equipment must submit a Certificate of Medical Necessity (CMN) with the claim in order to obtain Medicare reimbursement. Section B of the CMN contains questions pertaining to the medical necessity of the equipment which may not be completed by the supplier. The physician or another health care clinician involved in the care of the patient may complete Section B, **BUT ONLY THE PATIENT'S PHYSICIAN MAY SIGN THE CMN, INDICATING THAT HE/SHE HAS REVIEWED SECTION B OF THE CMN FOR ACCURACY AND COMPLETENESS.** In addition, the physician should review Section A to affirm that this is the appropriate patient, and Section C to ascertain that this is the equipment that has been ordered, and that the supplier's charges and expected Medicare reimbursement have been entered onto the form for the physician's review.

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

This article was contributed by Dr. Paul D. Metzger, Medical Director of Region C DMERC, Palmetto Government Benefits Administrators, Columbia, SC.❖

Request for Telephone Review Form

Medicare's Customer Service department can conduct telephone reviews for providers. Please use the form on the following page to obtain a telephone review.❖

REQUEST FOR TELEPHONE REVIEW

Date Faxed: _____

Confirmation Number: _____

(A new confirmation number must be obtained for each FAXED review request by calling Medicare Part B at (904) 634-4994.)

Customer Service Representative/Supervisor Name: _____

Contact Person (First and Last Name): _____

Contact Phone Number: _____

_

Provider Number: _____ Tax ID/SSN: _____

Health Insurance Claim Number	Date of Service	Internal Control Number	Reason for Review Request

PLEASE FAX NO MORE THAN 10 PAGES PER DAY. ❖

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. ❖

FREE Medicare Training Courses

The Health Care Financing Administration (HCFA), through its Medicare contractor, First Coast Service Options, Inc. (FCSO) now offers a free Medicare Online Training Web Site (**www.medicaretraining.com**), designed to capitalize on the emerging Internet-based training market. Users may access the site to download free Medicare computer-based training (CBT) courses to help them develop their Medicare billing skills and knowledge.

Each course is national in scope. CBT users may apply what they learn, no matter what state they are from. There are seven courses currently available and three more courses are planned for 1999!

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

Here's how it works:

Users visit the Medicare Online 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.

Computer Based Training 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 may take as long as they want to complete each lesson, and may take the lessons 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 On-line Training Web Site at **www.medicaretraining.com**. ❖

Build Your Practice This Flu Season!

It seems an unlikely thought during the summer, but now is the time for providers to think about how to build their practice this flu season. Think about it…not only does Medicare cover the cost of the drug and the administration for the flu vaccine, but patients will be grateful for the personal attention.

Recently, the Health Care Financing Administration (HCFA) hosted a national satellite broadcast on increasing adult immunizations. Providers who tuned in heard from physicians who really believe that promoting flu and PPV immunizations builds a stronger practice. One physician said that his office has prepared and mailed patient flu reminders during the summer for many years. After 5 or 6 years they decided to skip the process. They thought patients would come for the flu shot regardless. They didn't. Patients really listen to physicians about immunizations, and that year the number of flu shots given decreased. In another story, a patient told her doctor that she shares her flu shot reminder with her friends at the senior center. She also said her friends were so impressed that her doctor cared enough to send a personal letter that they were going to change physicians.

Why not consider a flu campaign this season? Build revenue and improve patient health with just a little effort.

Look for more on this topic and how to use the quick and easy roster billing method in future issues of the *Medicare B Update!*

More satellite broadcasts may be planned for late 1999. For additional information including a complete list of courses, host sites, dates and times, please visit the Medicare Online Training Web site at **www.medicaretraining.com.** ❖

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 Dates and Locations

LOCATION	ADDRESS
ORLANDO *Medifest* *August 17-18* *Specialty Seminars* *August 19*	Orlando Airport Marriott 7499 Augusta National Drive Orlando, FL 32822 (407) 851-9000 Hotel: Orlando Airport Marriott ask for the Medifest Seminar hotel rate of $85.00 until 7/25/99
MIAMI *Medifest* *Sept 21-22* *Specialty Seminars* *Sept 23*	Radisson Mart Center 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

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.

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.*

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.*

Medifest/Specialty Seminar Registration Form
August - 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*

Please ✓check the location and Medifest/Specialty Seminars you will be attending

Orlando Medifest - August 17 & 18

_____ Medifest - August 17 & 18, 1999
(payment and registration must be received by August 9, 1999)
_____ Specialty Seminars - August 19, 1999
(payment and registration must be received by August 9, 1999)

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

August - September 1999

Registrant's Name: _____

Please register for only one class per time slot.

Day 1

August 17
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

August 18
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)

Your registration form must accompany your class schedules

Specialty Seminar Class Schedule (Only $99)

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

Registrant's Name _____

Tampa - July 15, 1999

A.M. 8:30 - 12:00

300 ☐ Oncology (B)
301 ☐ Podiatry (B)
302 ☐ Medicare Part A Symposium (A)
316 ☐ Orthopaedics (B)
318 ☐ CORF/ORF (A)
319 ☐ Dermatology (B)

Orlando - August 19, 1999

A.M. 8:30 - 12:00

302 ☐ Medicare Part A Symposium (A)
306 ☐ Radiology (B)
307 ☐ Cardiology (B)
309 ☐ Mental Health (B)
317 ☐ Anesthesia (B)
320 ☐ Ambulatory Surgical Center (ASC) (B)

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 schedule

Index to Publications by Topic

A

B

C

D

E

F

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

R

S

T

U

Y

MODIFIERS

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

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: _____

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