

January/February 1999 Update! Publication

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HCFA

Health Care Financing Administration

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FIRST COAST SERVICE OPTIONS, INC.

A HCFA Contracted Carrier and Intermediary

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Highlights

A Physician's Focus (p.3)

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Additional HCPCS Changes (p.9)

Volume 12, Number 1 January/February 1999

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The Millennium Is Just Around The Corner!!

As everyone knows by now, there's less than a year before we hit the "2000" date. Are you ready? There are several articles in this issue that might be helpful as you prepare for the millennium change.

These articles can be found in the "Year 2000" section, beginning on page 68.

"The Year 2000 Is HCFA's #1 Priority"

This article includes information on the following topics:

What Is The Year 2000 (aka Y2K) Challenge And Why Is It Important?

What Is HCFA's Action Plan To Be Y2K Ready?

HCFA's Commitment Of Resources To Year 2000 Compliance.

What Is HCFA Doing To Ensure The Work Will Be Completed On Time?

Some Changes To Systems Have Been Suspended.

Some Provisions Of The HIPAA And BBA May Have To Be Postponed.

Will HCFA Systems Function In The Year 2000?

"How Providers May Be Affected By The Year 2000 Challenge"

Outlines potential problem areas and related information in such areas as:

Financial

Legal

What Providers Can Do:

Awareness

Assessment

Testing

Development

"Sample Provider Y2K Readiness Checklist"

A sample guide related to readiness.

"Y2K Web Site Reference"

A list of helpful sites on the World Wide Web pertaining to Y2K topics.

...and in "What's New for EMC"

"Are You Ready For The Millennium?"

Important information for Electronic Billers.

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What's New

Grace Period for 1999 ICD-9-CM Update Expires December 31, 1998

As a reminder, the 90-day grace period for the latest revision to the ICD-9-CM diagnosis coding structure that took effect October 1, 1998 is set to expire at the end of the year. Medicare

continues to receive a substantial volume of claims using the "old" coding structure. Most notably, deleted ICD-9-CM code 780.7 is still being received in large numbers.

Effective for claims processed on or after January 1, 1999, services billed with invalid ICD-9-CM codes will be returned as unprocessable (assigned) or developed for a complete diagnosis (unassigned).

Please refer to the July/August 1998 Medicare Part B Update! (page 19) for more information and where to obtain ICD-9-CM coding materials, and the November/December 1998 Update! (page 7) for specific Medical Policy impacts.

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1999 HCPCS Changes Affect Medical Policies

As a result of the 1999 changes to the Health Care Financing Administration's Common Procedure Coding System (HCPCS) that are effective January 1, 1999, numerous medical policies have been revised. These revisions are necessitated by the procedure code and modifier additions, changes, and deletions outlined in the December 1998 HCPCS Special Issue Update!

The impacted medical policies can be found beginning on page 12.

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Medicare B Update!

Vol. 12 No. 1

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A Physician's Focus

What's New, Doctor?

As most of you know, several changes have been made to the Medicare program this year. Major changes occurred as a result of the 1999 HCPCS update and the Final Rule. Among these are:

Registration of NPs, CNSs, and PAs

Effective for dates of service on or after January 1, 1999, Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants must use their carrier-assigned Provider Identification Number (PIN) to submit claims to Medicare when those services are not submitted incident to a physician's service. (If the service is submitted incident to a physician's service, the physician's PIN should be used.) Reimbursement may vary, so be sure to check the guidelines for this change on page 74 of this issue of the Medicare B Update!

Teleconsultations in a Rural Health Professional Shortage Areas (HPSA)

Teleconsultation services may be covered in rural areas only. Under certain conditions, a consulting provider may use audio-video equipment permitting two-way, real-time consultations to a patient and the referring practitioner. Telephone, facsimile machines, and electronic mail do not meet the criteria of interactive telecommunications systems. Guidelines for this

benefit can be found on page 5 of this issue of the Medicare B Update!

#### Outpatient Physical Therapy, Speech Therapy and Occupational Therapy Financial Limitations

Outpatient physical therapy and speech therapy have been combined for an annual financial limitation of \$1,500 per beneficiary (the current cap is \$900 for physical therapy). Occupational therapy has a separate annual limitation of \$1,500 per beneficiary. Guidelines for these limitations can be found on page 8 of this issue.

#### New Influenza Vaccine Codes

Providers should not use the new procedure codes for influenza vaccines (90657, 90658, 90659) until April 1, 1999. Due to required Year 2000 testing, Medicare cannot accept the new codes until that date.

#### New Outpatient Hospital/ASC Modifiers - 73 and 74

Modifiers 73 and 74 were developed to use when an outpatient hospital or ambulatory surgical center (ASC) procedures are discontinued before surgery. Additional information can be found on page 9 of this issue.

#### Facility Pricing Replaces Site-of-Service

Providers should note that the site-of-service differential was replaced with "facility pricing" for physician services rendered in place of service 21, 22, 23, 24, 31, 51, 61, and 62. This revised pricing excludes the cost of overhead for Part B and increases the facility rate for Part A. Information about facility pricing was published on page 41 of the December 1998 Medicare B Update! Special Issue: 1999 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Update.

#### Practice Expense Relative Value Unit Transition Begins

The Balanced Budget Act (BBA) requires Medicare to implement new Physician Based Practice Expense Relative Values. These changes must be made in a budget neutral way. The new values will be phased in over a four year period starting Jan 1, 1999. Under this approach, physician practice expenses were allocated to individual codes based on direct costs and work relative values. The new method generally redistributes payments from hospital based services/specialties to office based services/specialties. Twenty-five percent of the change will be implemented each year starting in 1999.



Important Resource For New Changes

Providers can learn of many new changes coming to Medicare by monitoring the Federal Register over the Internet at [www.access.gpo.gov/su\\_docs/](http://www.access.gpo.gov/su_docs/) or at [www.HCFA.gov](http://www.HCFA.gov).

These are the highlights of the Medicare changes for this year. Several other changes are discussed in this issue of the Update!, and providers should become familiar with those changes that affect their practice. We look forward to helping providers meet the challenges posed by the changing Medicare program.

Sincerely,

Sidney R. Sewell, M.D.

Medical Director

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Advance Notice Requirement

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

Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.

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

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

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

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

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

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

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

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

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#### General Information About the Medicare B Update!

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

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

Distribution of the Update! is limited to individual providers and PA groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers who meet this criteria are sent one

complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing a copy of each issue to each provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. For additional copies, providers may purchase a separate annual subscription for \$75 (order form in FYI section), or download the text version from our on-line service, the Medicare Online BBS (see this issue for more information).

Medicare Part B of Florida uses the same mailing address for all correspondence, and cannot designate that each issue of the Update! be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their mailing addresses current with the Medicare Provider Registration Department.

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Page 5

General Information

Medicare Physician Fee Schedule (MPFS)

Physician Interpretation Codes

The December 1998 HCPCS Special Issue Update! provided an explanation of the various rules regarding procedure codes paid under the Medicare Physician Fee Schedule. This article corrects the list of procedure codes considered to be physician interpretation codes (page 40). Due to changes made in the Health Care Financing Administration's Common Procedure Coding System (HCPCS), only one procedure code remains on this list - 85060. Procedure codes P3001-26 and 88141 are no longer appropriate for this rule.

\*\*\*\*\*  
Limiting Charges for Injectable Drugs: Correction

The limiting charges provided in the July/August 1998 Medicare Part B Update! (beginning on page 22) were incorrect. While the participating and nonparticipating allowances were correct, and therefore reimbursement was not affected, nonparticipating providers should not use the limiting charges found on this table. These providers should use instead the limiting charges provided in the November/December 1998 Update! (pages 9-18), the 1999 Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, and the December 1998 HCPCS Special Issue Update! (page 89).

\*\*\*\*\*  
Coverage of Teleconsultations in a Rural Health Professional Shortage Area

Effective January 1, 1999, Medicare provides for coverage of teleconsultations in a rural Health Professional Shortage Area

(HPSA). A new modifier, GT, has been established for reporting these services (GT - Via interactive audio and video telecommunications systems).

Medicare will pay for professional consultations furnished by means of interactive telecommunications systems if the following conditions are met:

The consulting practitioner is -

a physician, described as a doctor of medicine or osteopathy as set forth in section 1861(r)(1) of the Social Security Act (referred to hereafter as the Act),

- a physician assistant,
- a nurse practitioner,
- a clinical nurse specialist, or
- a nurse midwife.

The referring practitioner is any of those listed above, plus -

- a clinical psychologist, or
- a licensed clinical social worker

Registered nurses and other medical professionals not included within the definition of a practitioner in section 1842(b)(18)(c) of the Act are not permitted to act as presenters during telconsultations.

The services must be furnished to a beneficiary who resides in a rural HPSA. For purposes of this requirement, the beneficiary is deemed to be residing in such an area if the teleconsultation presentation takes place in a rural HPSA. Refer to the May/June 1998 Medicare Part B Update! (page 58) for more information concerning rural HPSA designations.

The medical examination of the beneficiary is under control of the consulting practitioner.

The teleconsultation must involve the participation of the referring practitioner, or a practitioner described in section 1842(b)(18)(C) of the Act (other than a CRNA or Anesthesia Assistant) who is an employee of the referring practitioner, as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consultant. The beneficiary must be present at the time of presentation.

The teleconsultation must result in a written report by the consultant that is furnished to the referring practitioner.

For purposes of this benefit, interactive telecommunications systems means multimedia communications equipment that includes at a minimum, audio and video equipment that permits real-time consultation between the consultant and referring practitioner (as described above) and the beneficiary. Telephones, fax machines, and electronic mail systems do not meet this definition.

Medicare payment for teleconsultations will not exceed the current Medicare Physician Fee Schedule amount applicable to the consulting practitioner for the service provided, and does not include reimbursement for any telephone line charges or any facility fees. The beneficiary may not be billed for telephone line charges or facility fees. Medicare deductible and coinsurance requirements, as well as the payment differential for non-participating physicians apply. Non-physician practitioners who are required to accept assignment for all services submitted to Medicare must also submit claims for teleconsultations on an assigned basis.

Only the consulting practitioner may bill Medicare for teleconsultations. Payment for these services is meant to be shared by the consultant and referring practitioner, with 25 percent of any payment received from Medicare (including any applicable deductible and coinsurance amounts) to be provided to the referring practitioner by the consultant.

Procedure codes applicable to this benefit:

99241 - 99245, 99251 - 99255, 99261 - 99263 and 99271 - 99275.

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#### Coverage of Prodrugs

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) provided for coverage of certain oral drugs used to treat people with cancer. Under the original interpretation of the law, Medicare has paid for certain oral anti-cancer drugs only if that drug has the same active ingredients as a non-self administerable drug. In addition, both the injectable and oral drug must have the same chemical and generic name, and be approved for the same indications.

Based on recent advances in drug technology, Medicare has reexamined its initial interpretation and now allows for coverage of certain oral anti-cancer drugs called Prodrugs (i.e., Prodrugs specifically used as anti-cancer drugs) when they are approved by the FDA. Prodrugs have the same active ingredients in the body as injectable anti-cancer drugs. An oral drug may have a different chemical composition from an injectable drug at the outset, but once the body metabolizes the oral drug, it will have the same chemical composition as the injectable drug. Hence, this broader

interpretation permits coverage of alternative forms of administration of the same drug.

Medicare allows 95 percent of the average wholesale price (AWP) for these drugs when furnished by a physician or supplier. The physician or supplier (with a valid license to dispense prescription drugs) bills the DME Regional Carrier (DMERC) for these drugs on the HCFA-1500 claim form (or its electronic equivalent) using the appropriate National Drug Code, unless oral anti-emetic drugs are being billed at the same time. In these cases, providers bill the local carrier (Medicare Part B of Florida) using the appropriate HCPCS code. The use of specific anti-cancer Prodrugs must be associated with a cancer diagnosis.

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#### Additional Changes to Injectable Drugs Fees for 1999

There have been changes and additions to the Injectable Drugs Fees that were provided in the 1999 Medicare Physician Fee Schedule book and in the 1999 HCPCS Special Issue Update! (page 89). The following list provides these codes and their associated fees. Please remember not to use the new codes for influenza, pneumococcal, and hepatitis B virus vaccines until April 1, 1999. Please refer to the 1999 HCPCS Special Issue Update! (page 2) for more information regarding the codes for these vaccines.

CODE	DESCRIPTION	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
90281	"Immune Globulin (IG), Human for Intramuscular Use"			
NC	NC	NC		
90283	"Immune Globulin (IGIV), Human for Intravenous Use"			
NC	NC	NC		
90287	"Botulinum Antitoxin, Equine, any route"		NC	NC
NC				
90288	"Botulinum Immune Globulin Human, for intravenous"			
NC	NC	NC		
90291	"Cytomegalovirus Immune Globulin (CMV-IGIV) Human, for intravenous use"	NC	NC	NC
90296	"Diphtheria Antitoxin, Equine, any route {replaces 90711}"	NC	NC	NC
90371	"Hepatitis B immune globulin (HBIG), Human, for Intramuscular "	IC	IC	IC
90375	"Rabies Immune globulin (RIG), Human, for Intramuscular use {replaces 90726}"	NC	NC	NC
90376	"Rabies Immune globulin, Heat-treated (RIG-HT), Human for Intramuscular use {replaces 90726}"	NC	NC	NC
90379	"Respiratory Syncytial Virus Immune globulin (RSV-IGIV), Human, for intravenous "	IC	IC	IC
90384	"RHO (D) immune globulin , human, for Intramuscular USE, Full-Dose {replaces 90742}"	NC	NC	NC
90385	"RHO (D) immune globulin , human, for Intramuscular use, Mini-Dose {replaces 90742}"	NC	NC	NC
90386	"RHO (D) immune globulin , human, for Intramuscular use {replaces 90742}"	NC	NC	NC

90389 "Tetanus Immune globulin (TIG), human, for  
 Intramuscular use {replaces 90742}" NC NC NC  
 90393 "Vaccinia Immune globulin, human, for Intramuscular use  
 {replaces 90742}" NC NC NC  
 90396 "Varicella-Zoster Immune globulin, Human, for  
 Intramuscular use {replaces 90742}" NC NC NC  
 90399 unlisted immune globulin NC NC NC  
 90476 "Adenovirus vaccine, type 4, LIVE, for oral use " IC  
 IC IC  
 90477 "Adenovirus vaccine, type 7, LIVE, for oral use" IC  
 IC IC  
 90581 "Anthrax vaccine, for subcutaneous use" NC NC NC  
 90586 "Bacillus Calmette-Guerin Vaccine (BCG) for bladder  
 cancer, LIVE, for intravesical use {replaces 90728}" NC NC NC  
 90592 "Cholera vaccine, LIVE, for oral use" IC IC IC  
 90632 "Hepatitis A vaccine, Adult Dosage, for Intramuscular  
 use {replaces 90730}" NC NC NC  
 90633 "Hepatitis A vaccine, Pediatric/Adolescent Dosage-2  
 dose schedule, for Intramuscular use {replaces 90730}" NC NC  
 NC  
 90634 "Hepatitis A vaccine, Pediatric/Adolescent Dosage-3  
 dose schedule, for Intramuscular use {replaces 90730}" NC NC  
 NC  
 90636 "Hepatitis A and Hepatitis B vaccine (Hepa-Hepb), adult  
 dosage, for Intramuscular use {replaces 90730}" NC NC NC  
 90645 "Hemophilus Influenza B vaccine (HIB), HBOC conjugate  
 (4 dose schedule), for Intramuscular use {replaces 90737}" NC  
 NC NC  
 90646 "Hemophilus Influenza B vaccine (HIB), PRP-D conjugate  
 for booster use only, for Intramuscular use {replaces 90737}"  
 NC NC NC  
 90647 "Hemophilus Influenza B vaccine (HIB), PRP-OMD  
 conjugate (3 dose schedule), for Intramuscular use {replaces  
 90737}" NC NC NC  
 90648 "Hemophilus Influenza B vaccine (HIB), PRP-T conjugate  
 (4 dose schedule), for Intramuscular use {replaces 90737}" NC  
 NC NC  
 90657 "Influenza virus vaccine, split virus, 6-35 months  
 dosage, for Intramuscular or jet injection use {replaces 90724}"  
 \$5.01 \$4.76 \$5.47  
 90658 "Influenza virus vaccine, split virus, 3 years and  
 above, for Intramuscular or jet injection use {replaces 90724}"  
 \$5.01 \$4.76 \$5.47  
 90659 "Influenza virus vaccine, split virus, whole virus,  
 for Intramuscular or jet injection use {replaces 90724}" \$5.01  
 \$4.76 \$5.47  
 90660 "Influenza virus vaccine, LIVE, for intranasal use"  
 NC NC NC  
 90665 "LYME disease vaccine, adult dosage, for Intramuscular  
 use" NC NC NC  
 90669 "Pneumococcal conjugate vaccine, polyvalent, for  
 Intramuscular use" \$12.15 \$11.54 \$13.27  
 90675 "Rabies vaccine, for Intramuscular use {replaces  
 90726}" NC NC NC  
 90676 "Rabies vaccine, for intradermal use (replaces 90726)"  
 NC NC NC

90680 "Rotavirus vaccine, tetravalent, Live, for oral use"  
 NC NC NC  
 90690 "Typhoid vaccine, LIVE, oral {replaces 90714}" NC  
 NC NC  
 90691 "Typhoid vaccine, VI capsular polysaccharide (VICPS),  
 for Intramuscular use {replaces 90714}" NC NC NC  
 90692 "Typhoid vaccine, Heat - and phenol-inactivated(H-P),  
 for subcutaneous or intradermal use {replaces 90714}" NC NC  
 NC  
 90693 "Typhoid vaccine, acetone-killed, dried, (AKD), for  
 subcutaneous or jet injection use (US military) {replaces 90714}"  
 NC NC NC

NOTE: The procedures listed below are not subject to the non-  
 par differential or the limiting charge. LOC 01/02 LOC 03  
 LOC 04

90471 "Immunization administration, (includes percutaneous,  
 intradermal, subcutaneous, Intramuscular and jet injections  
 and/or intranasal or oral administration: single or combination  
 vaccine/toxoids "\$4.08 \$4.54 \$4.93  
 90472 "Immunization administration, (includes percutaneous,  
 intradermal, subbutaneous, Intramuscular and jet injections  
 and/or intranasal or oral administration: two or more single or  
 combination vaccine/toxoids " \$4.08 \$4.54 \$4.93

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Prospective Payment System for Outpatient Rehabilitation Services  
 and Application of Financial Limitation

The Balanced Budget Act (BBA) of 1997 requires payment under a  
 prospective payment system for outpatient rehabilitation  
 services. Outpatient rehabilitation services include the  
 following services:

Physical therapy, (which includes outpatient speech-language  
 pathology); and occupational therapy.

:

This payment system also applies to certain audiology and  
 Comprehensive Outpatient Rehabilitation Facility (CORF) services.  
 Audiology and CORF services are identified by the procedure codes  
 listed below. The Medicare Physician Fee Schedule (MPFS) will be  
 used as the prospective payment system for these services.

The MPFS is currently the basis of payment for outpatient  
 rehabilitation services furnished by physical therapists in  
 independent practice (PTIPs) and occupational therapists in  
 independent practice (OTIPs), physicians, and certain  
 nonphysician practitioners or incident to the services of such  
 physicians or nonphysician practitioners.



## Financial Limitation

The BBA also requires application of a financial limitation to all rehabilitation services. An annual per beneficiary limit of \$1500 will apply to all outpatient physical therapy services (including speech-language pathology services). A separate \$1500 limit will also apply to all occupational therapy services. The annual limitations do not apply to services furnished directly or under arrangements by a hospital to an outpatient or to an inpatient who is not in a covered Medicare Part A stay. This limitation applies to expenses incurred on or after January 1, 1999. Beginning 2002, these limits will be increased by the percentage increase in the Medicare Economic Index. By 2001, a report must be submitted to Congress recommending a revised coverage policy for outpatient rehabilitation services in place of the \$1500 limitation.

## Application of Financial Limitation

Effective for claims with dates of service on or after January 1, 1999, the current dollar limitation on all rehabilitation services increases from \$900 to \$1500. This increase applies to PTIPs and OTIPs who bill the Medicare Part B carrier.

In addition, as a transitional measure, effective for claims with dates of service on or after January 1, 1999, physicians and other practitioners who are not currently subject to the financial limitation will also be held accountable for tracking incurred expenses for each beneficiary. Physicians and other practitioners must assure that they do not bill Medicare for patients who have met the annual \$1500 limitation at their facility for each separate limitation. Once the \$1500 limitation has been met, the provider should bill using procedure code A9270 for the purposes of receiving a denial notice from Medicare in order to bill other insurers.

## Outpatient Rehabilitation Procedure Codes

The applicable procedure codes for reporting outpatient rehabilitation services are as follows:

11040	11041	11042	11043	11044	29065	29075	29085
29105	29125	29126	29130	29131	29200	29220	29240
29260	29280	29345	29365	29405	29445	29505	29515
29520	29530	29540	29550	29580	29590	64550	90901
90911	92506	92507	92508	92510	92525	92526	92597
92598	95831	95832	95833	95834	95851	95852	96105
96110	96111	96115	97001	97002	97003	97004	97010***
97012	97014	97016	97018	97020	97022	97024	97026
97028	97032	97033	97034	97035	97036	97039	97110
97112	97113	97116	97124	97139	97140	97150	97250
97504**	97520	97530	97535	97537	97542	97545	97546
97703	97750	97770*	97799	V5362	V5363	V5364	

\*Procedure code 97770 is not considered to be an outpatient rehabilitation service when delivered by a clinical psychologist, psychiatrist, or clinical social worker for treatment of a psychiatric condition.

\*\*Procedure code 97504 should not be reported with procedure code 97116.

\*\*\*Procedure code 97010 is a bundled procedure. Therefore, payment cannot be made for procedure code 97010 when billed alone.

#### Audiological Procedure Codes

The applicable procedure codes for reporting audiological services are as follows:

92552	92553	92555	92556	92557	92561	92562	92563
92564	92565	92567	92568	92569	92571	92572	92573
92575	92576	92577	92579	92582	92583	92584	92587
92588	92589	92596	V5299				

#### Outpatient Rehabilitation Service Modifiers

Physicians are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service (not the payment designation) or, if the service was not delivered by a therapist, then the discipline of the plan of treatment/care under which the service is delivered should be reported:

GN Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care;

GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care; or,

GP Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.

\*\*\*\*\*

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#### HCPCS Codes

##### Modifier 73, 74: Billing for ASC Facility Charges for Terminated Procedures

Effective January 1, 1999, modifiers 73 and 74 have been added to replace modifier 53 when an Ambulatory Surgery Center (ASC) bills for procedures that were terminated prior to surgery. When a

procedure is terminated due to medical complication which increase the risk to the patient, payment or partial payment can be made by Medicare to allow the ASC to recover the cost of supplies and resources expended prior to such termination.

Modifier 73 is used if the procedure is terminated after the patient has been prepared and taken to the operating room but before anesthesia has been induced. Medicare will generally allow 50% of the appropriate ASC facility rate in these cases. Modifier 74 is used if the procedure is terminated after the patient has been prepared and taken to the operating room and anesthesia has been induced. Medicare will generally allow the full ASC facility reimbursement in these cases, since the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. In either case, however, if the procedure involved would have used an Intraocular Lens implant (IOL), the allowance for the unused IOL will be deducted from the ASC facility rate prior to reimbursement.

Physicians should not use these new modifiers, they should continue to submit claims for terminated procedures using the 53 modifier, accompanied by an operative report. It is not necessary for ASC facilities billing modifiers 73 or 74 to submit documentation.

Medicare will not reimburse for procedures that are terminated for nonmedical reasons, or for medical reasons (e.g., the patient complains of a cold or flu) if the termination is prior to the expenditure of substantial resources.

\*\*\*\*\*  
G0001, P9603, P9604: Collection of Specimens and Travel Allowance

Information concerning per mileage and flat rate per trip travel fees for collection of specimens (P9603, P9604) was provided in the September/October 1998 Medicare Part B Update! (pg. 27).

As a reminder, travel allowance, and routine venipuncture for collection of specimens (G0001), are not Medicare benefits unless such services are being done in order to obtain the specimen for a covered laboratory service.

\*\*\*\*\*  
P9612: Catheterization for Collection of Specimen

Effective January 1, 1999, new procedure code P9612 (catheterization for collection of specimen, single patient, all places of service) must be used to bill for any catheterization for collection of specimen in all places of service including physicians' offices. Procedure code P9612 replaces the temporary code Q0162 that was created due to the inappropriate billing of procedure codes P9610 (catheterization for collection of specimen(s), single homebound) and procedure code 53670 for specimen collection in a physician's office. Procedure code P9612 is priced at the same rate as deleted code P9610. Procedure codes P9610 and 53670 were deleted effective April 1, 1998, without a

grace period Also refer to the September/October 1998 Medicare Part B Update! (pg. 27) for information concerning per mileage and flat rate per trip travel fees for collection of specimens (codes P9603 and P9604).

\*\*\*\*\*  
R0075: Travel Allowance for Portable X-Ray - Multiple Patients

Information was provided in the 1999 HCPCS Special Issue Update! (page 4) that instructed portable x-ray suppliers to bill a number of service of 1 (one) for each patient. This was due to changes in the 1999 Medicare Physician Fee Schedule. Those changes have been rescinded. For 1999, procedure code R0075 will be processed, and should be billed, in the same manner as in 1998. That is, providers should continue to give the number of patients seen. If this information is not provided, Medicare will assume the number billed to be four (4); the claim will be priced accordingly.

Note for Electronic Claim submitters: When billing procedure code R0075 for dates of service January 1, 1999, and later, continue to enter the number of patients seen (as specified above). For National Standard Format (NSF) claims, enter the number of patients seen in field 18.0 of the FA0 record. Providers submitting American National Standards Institute (ANSI) claims in the X12 837 version 3051.3B.01 format, must submit the number of patients seen in Table 2, position 370-SV104. Providers using the X12 837 version 3032.2B.00, will enter this information in Table 2, position 290-SV105

Pricing for procedure code R0075 will continue to be based on the allowance for procedure code R0070. The 1999 fees for these procedure codes are:

Code: R0070  
Loc 01/02: \$55.02  
Loc 03: \$59.16  
Loc 04: \$58.52

Code: R0075  
Loc 01/02: \$55.02  
Loc 03: \$59.16  
Loc 04: \$58.52

\*\*\*\*\*  
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80049-80054, 80058: Automated Multichannel Laboratory Tests

As a result of the 1999 HCPCS update, several procedure code changes have affected the coding and coverage for automated multichannel laboratory test as follows:

82247 - 82248, 82251: Bilirubin

Effective January 1, 1999, new procedure codes 82247 (Bilirubin; total) and 82248 (Bilirubin; direct) replace procedure code 82250 (Bilirubin; total or direct). The new procedure codes 82247 and 82248 are subject to the existing payment policies for automated multi-channel laboratory tests.

Effective January 1, 1999, procedure code 82250 (Bilirubin; total or direct) has been deleted. Procedure code 82250 reflects duplicate service of procedure codes 82247, 82248, 82251, 80054, and 80058 and will not be allowed if it is billed with one of these other codes during the grace period through March 31, 1999.

Procedure code 82247 has been added to the automated test panel 80054 (comprehensive metabolic panel). Procedure codes 82247 and 82248 have been added to the automated test panel 80058 (hepatic function panel).

Within the revised procedure code 80058 (Hepatic function panel), 82251 (Bilirubin; total and direct) is replaced with the two new codes (82247 and 82248) and is priced accordingly. If procedure code 82251 (Bilirubin; total and direct) is billed individually, it is processed as a two test panel. Therefore, effective January 1, 1999, because codes 82247 and 82248 are component parts of the panel codes 80054 and 80058, Medicare will ensure that they are not allowed as duplicate payments. Unless indicated with modifier QR, codes 82247 and 82248 are not allowed if billed with codes 80051, 80054, or 80058. See the January/February 1998 Medicare Part B Update! (pg. 14) for instructions on the use of modifier QR. Procedure codes 82247 and 82248 should only be used to individually bill for one of these laboratory tests.

#### Reimbursement

Claims for automated laboratory tests are reimbursed based on the total number of tests allowed:

Number of Tests: 1 or 2  
Reimbursement Amount: \$7.20

Number of Tests: 3  
Reimbursement Amount: \$9.18

Number of Tests: 4  
Reimbursement Amount: \$9.69

Number of Tests: 5  
Reimbursement Amount: \$10.81

Number of Tests: 6  
Reimbursement Amount: \$10.84

Number of Tests: 7  
Reimbursement Amount: \$11.29

Number of Tests: 8  
Reimbursement Amount: \$11.70

Number of Tests: 9  
Reimbursement Amount: \$12.00

Number of Tests: 10  
Reimbursement Amount: \$12.00

Number of Tests: 11  
Reimbursement Amount: \$12.21

Number of Tests: 12  
Reimbursement Amount: \$12.48

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

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

Number of Tests: 19  
Reimbursement Amount: \$15.28

Number of Tests: 20  
Reimbursement Amount: \$15.78

Number of Tests: 21  
Reimbursement Amount: \$16.27

Number of Tests: 22  
Reimbursement Amount: \$16.77

\*\*\*\*\*  
80050-80054: Organ and Disease Oriented Panels

Similar to prior years, the pricing amount for each organ and disease panel was derived by summing the lower of the fee schedule amount or the national limitation amount for each individual test included in the panel.

Effective January 1, 1999, test for carbon dioxide (bicarbonate) procedure code 82374 has been added to the comprehensive metabolic panel (procedure code 80054). Enhancing an organ and disease panel code to include an increasing number of tests results in mapping procedure code 80054 to reflect the increased number of tests.

Procedure code 80050 (general health panel) does not meet the statutorily required definition of a panel of laboratory tests performed to diagnose specific medical conditions. It is therefore a noncovered service for Medicare. The individual tests comprising the panel may be separately covered if each one of the tests is documented to be medically necessary to diagnose a specific medical condition and is in accordance with the local medical review policy.

\*\*\*\*\*

84484, 84512: Troponin

There has been further clarification of the use of procedure codes 84484 and 84512 for the billing of troponin. For Medicare purposes, a claim for one test of troponin relates to one order by the physician for code 84484 or code 84512 regardless of the number of subtypes of troponin measured.

\*\*\*\*\*  
84999-QW: Laboratory Test to Detect Elevated Vaginal pH

Effective January 1, 1999, claims for a laboratory test to detect elevated vaginal pH (currently sold under the name FemExam) should be reported using 84999-QW (to indicate it has waived status under CLIA standards). It will be priced at the sum of codes 83986 and 84525. Note that this amount is only for claims for FemExam and not for claims for other tests reported using 84999.

Usage of Modifier QW

The 1999 laboratory fee schedule also includes codes that may have a QW modifier to indicate the laboratory test is granted waived status under the CLIA standards. The price for each code with a QW modifier has been verified to the price of the same code without a QW modifier.

\*\*\*\*\*  
85610: Prothrombin Time - Correction

The fee for procedure code 85610 was published incorrectly in the 1999 HCPCS Special Issue Update! (page 84). The correct fee is \$5.43.

\*\*\*\*\*  
98940-98942 - Manual Manipulation of the Spine

Effective January 1, 1999, if the beneficiary refuses to have the X-ray to demonstrate sUBLUXATION of the spine, the correct chiropractic procedure code (98940-98942) must be billed followed by the new modifier GX - Service not Covered By Medicare. Claims submitted with modifier GX will be denied by Medicare. The beneficiary is held liable for these services. The use of modifier GX provides a more accurate denial information for secondary payers.

\*\*\*\*\*  
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Local and Focused Medical Review Policies

This section of the Medicare B Update! features new and revised medical policies developed as a result of either the Local

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

#### Effective Dates

The policies contained in this section are effective for claims processed January 1, 1999, and after, unless otherwise noted.

#### Sources of Information

The sources of information used in the development of these policies may be obtained by accessing the Medicare Online BBS

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Policy Changes Relating to the 1999 HCPCS Update

The HCPCS update for 1999 is effective for services furnished January 1, 1999, and after. Lists of procedure codes added, revised, and deleted as part of the update were published in the December 1998 Medicare B Update! Special Issue: 1999 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule

Database Update. While there is a grace period during which deleted or invalid procedure codes may still be used for 1999 service dates (received before April 1, 1999), we encourage all providers to complete the transition to the new 1999 codes as soon as possible to prevent possible delays in claim payment. The coverage for the following procedure, which have been either added or revised for 1999, have been incorporated into existing policies. To assist provider in adjusting to the new coding structure, a reference to publications outlining Medicare's coverage requirements is outlined:

Added/Revised Code(s): J0270  
Related Code(s) or Policy: Alprostadil injection  
Publication: July/August 1998, pg. 35 March/April 1998, pg. 50

Added/Revised Code(s): 17004  
Related Code(s) or Policy: Benign or premalignant skin lesion destruction, 15 or more  
Publication: January/February 1998, pg. 19

Added/Revised Code(s): 67208, 67210, 67220, QY modifier  
Related Code(s) or Policy: Ocular procedures  
Publication: March/April 1998, pg. 44

Added/Revised Code(s): 76977 (replaces G0133)  
Related Code(s) or Policy: Bone mineral density studies  
Publication: Sept/Oct. 1998, pg. 35 Jan/Feb. 1998, pg. 22

Added/Revised Code(s): 82247, 82248, 82250, 82251, 82374  
Related Code(s) or Policy: Automated Multichannel Tests  
Publication: May/June 1998, pg. 39 March/April 1998, pg. 35

Added/Revised Code(s): 93320, 93321, 93325  
Related Code(s) or Policy: Transthoracic and doppler echocardiography, and doppler color flow velocity mapping  
Publication: Nov/Dec 1998, pg. 38 May/June 1998, pg. 40 Jan/Feb 1998, pg. 28

Added/Revised Code(s): 94060, 94070  
Related Code(s) or Policy: Spirometry  
Publication: Nov/Dec. 1998, pg. 38 July/Aug. 1998, pg. 54

Added/Revised Code(s): 94620, 94621  
Related Code(s) or Policy: Pulmonary Stress Testing  
Publication: July/August 1998, page 57

\*\*\*\*\*  
Medicare of Florida Evaluates Annual Procedure Code Update

The Health Care Financing Administration's Common Procedure Code System (HCPCS) is used to administer the Medicare Part B program for all carriers. The HCPCS section is updated annually to reflect changes in the practice of medicine and provisions of health care. The purpose of this article is to communicate the non-coverage status of various new 1999 HCPCS effective for dates of service January 1, 1999.

National Noncoverage Decision

A4261 Cervical cap for contraceptive use

Local Noncoverage Decision (due to being investigational)

G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

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

77380 Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment set-up and verification images

77381 Proton beam treatment to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment set-up and verification images

82016 Acylcarnitines; qualitative, each specimen

82017 Acylcarnitines; quantitative, each specimen

82379 Carnitine (total and free), quantitative, each specimen

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

88271 Molecular cytogenetics; DNA probe, each (eg. FISH)

88272 Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)

88273 Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)

88274 Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells

88275 Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells

\*\*\*\*\*

Advance notice requirement applies due to investigational status of these services.

#### Local Noncoverage Decision

- 89264: Sperm identification from testis tissue, fresh or cryopreserved
- 90476: Adenovirus vaccine, type 4, live, for oral use
- 90477: Adenovirus vaccine, type 7, live, for oral use
- 90581: Anthrax vaccine, for subcutaneous use
- 90585: Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
- 90586: Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
- 90632: Hepatitis A vaccine, adult dosage, for intramuscular use
- 90633: Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
- 90634: Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
- 90645: Hemophilus Influenza B vaccine (HIB), HBOC conjugate (4 dose schedule), for intramuscular use
- 90646: Hemophilus Influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use
- 90647: Hemophilus Influenza B vaccine (HIB), PRP-OMP conjugate (3 dose schedule), for intramuscular use
- 90648: Hemophilus Influenza B vaccine (HIB), PRP-T conjugate (4 dose schedule), for intramuscular use
- 90660: Influenza virus vaccine, live, for intranasal use
- 90665: Lyme Disease vaccine, adult dosage, for intramuscular use
- 90680: Rotavirus vaccine, tetravalent, live, for oral use
- 90690: Typhoid vaccine, live, oral
- 90691: Typhoid vaccine, VI Capsular Polysaccharide (VICPS), for intramuscular use
- 90692: Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use
- 90693: Typhoid vaccine, Acetone-Killed, Dried (AKD), for subcutaneous or jet injection use (U.S. Military)

94014: Patient initiated spirometric recording per 30 day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation

94015: Patient initiated spirometric recording per 30 day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)

94016: Patient initiated spirometric recording per 30 day period of time; physician review and interpretation only

#### Advance Notice Requirement

Applies to medical necessity requirements ( see page 4).

Advance notice requirement applies due to investigational status of these services.

\*\*\*\*\*

J0256: Alpha 1 Proteinase Inhibitor, Human

Alpha 1 proteinase inhibitor (alpha 1-pl; alpha 1-antitry PSIN) is a sterile stable, lyophilized preparation of purified human alpha 1-proteinase inhibitor used in patients with pancreatic emphysema who have alpha 1-antitrypsin deficiency.

#### Indications and Limitations of Coverage and/or Medical Necessity

Alpha 1-proteinase inhibitor (human) will be considered medically reasonable and necessary if the following diagnosis is reported (see Covered ICD-9 Codes).

#### HCPCS Codes

J0256 Injection, alpha 1-proteinase inhibitor-human, 10 mg

#### ICD-9 Codes That Support Medical Necessity

492.8

#### Documentation Requirements

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

#### Other Comments

The administration of drugs and biologicals (90782, 90783, 90784, 90788) may be paid for separately only if no other service(s) was provided by the same provider

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

\*\*\*\*\*

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J7315, J7320, 20610: Viscosupplementation Therapy for the Knee

Osteoarthritis (OA) is a degenerative joint disease caused by loss of elastoviscosity in the synovial fluid. The elastoviscosity of the synovial fluid is entirely due to hyaluronan content. The large molecules made up of hyaluronan exhibit both viscous fluid characteristics when movement is slow, as well as, elastic characteristics when movement is increased.

Major traumas and repetitive joint use contribute to the development of this disease. In addition, obesity is another cause of the development of osteoarthritis. Genetic factors also may play a role in the development of osteoarthritis. Pain is the major symptom and effects mostly the knee and hip.

Because of the loss of elastoviscosity, the substance used for viscosupplementation must have a greater elastoviscosity due to dilution with the pathological fluid in the joint. Therefore, to compensate for this dilution, the viscosupplementation must provide the same or better protection for the cells and surrounding joints and tissues as the normal synovial fluid.

In the pathological joint, synovial fluid is more abundant and less viscous, i.e., the concentration of hyaluronan is decreased. Viscosupplementation attempts to return the synovial fluid to its pre-pathological state.

By dividing the effects of viscosupplementation into short term and long term components one may analyze its mode of action. The overall effect of viscosupplementation is the restoration of the physiological homeostasis of the joint. In a pathological joint, such as an OA joint, this means providing the means for the joint to function normally. Maintaining homeostasis allows the joint to move more freely. Reduction of pain and resulting increase in joint mobility are requisite for maintenance of the joint improvement.

However, this effect does not last indefinitely because the cause of the original problem is not resolved, i.e., the structure of the joint is still compromised. Therefore, the problem will

resurface when the joint homeostasis is impaired again.

Synvisc and Hyalgan are new drugs used for viscosupplementation of the knee's synovial space for those patients with mild to moderate osteoarthritis of the knee.

#### Indications and Limitations of Coverage and/or Medical Necessity

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

The patient must have mild to moderate osteoarthritis of the knee, and

The patient must have an intolerance to non-steroidal anti-inflammatory drugs (NSAIDs) with a condition such as peptic ulcer disease, and

Mild analgesics such as acetaminophen have not been effective in pain reduction, and/or

The patient has failed other conservative treatment, and

The patient must not have large effusions of the knee, which may be characterized as a tense, bulging knee, and/or

The patient should not be markedly obese, and

The joint(s) injected must be the knee(s), and

The patient has not had a previous reaction to an earlier administration of one of these medications.

#### HCPCS Codes

J7315 Sodium Hyaluronate, 20mg, for intra-articular injection

J7320 Hylan G-F 20, 16mg, for intra-articular injection ]

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

#### ICD-9 Codes That Support Medical Necessity

715.96

#### Reasons for Denial

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

Also, when the patient receives more than one injection per week times 3 weeks with Synvisc and more than one injection per week times 5 weeks with Hyalgan, the additional dosage(s) may be

denied. In addition, a sequence of either of these medications should be given no more than once every six months.

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

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

#### Noncovered ICD-9 Code(s)

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

\*\*\*\*\*

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#### Coding Guidelines

For each injection given, procedure code J7315 or J7320 and 20610 (Arthrocentesis, aspiration and/or injection major joint or bursa (eg, shoulder, hip, knee joint, subarcromial bursa) may be billed when viscosupplementation of the knee is performed.

#### Documentation Requirements

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

#### Other Comments

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



Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

\*\*\*\*\*

J9212-J9216: Interferon

Interferon alfa is a protein produced by recombinant DNA techniques. It is obtained from a strain of Escherichia coli bearing a genetically engineered plasmid containing an interferon alfa gene from human leukocytes.

Indications and Limitations of Coverage and/or Medical Necessity

Interferon will be considered medically reasonable and necessary if one of the following diagnoses is reported (see Covered ICD-9 Codes).

HCPCS Codes

- J9212 Interferon, alfacon-1, recombinant, 1 mcg
- J9213 Interferon, alfa-2a, recombinant, 3 million units
- J9214 Interferon, alfa-2b, recombinant, 1 million units
- J9215 Interferon, alfa-n3, (human leukocyte derived, 250,000 IU)
- J9216 Interferon, gamma 1-b, 3 million units

ICD-9 Codes That Support Medical Necessity:

0 42 07 0.4 1 -070 .49 070. 51-070 .5 9 070.6  
070. 9 078 .10-0 78.19 1 40.0-149.9 153.0-153.9  
154.0-154.8 172.0-172. 9 173.0-17 3.9 174.0- 174.9  
175 .0-175.9 176 .0-176.9 1 83.0 183. 2 184.0-184.9  
187.1 -187. 9 188 .0-188.9 189. 0-189.9 190.0-  
190.9198.0198.1198.6198.81198.82 200.00-200.08200.10-  
200.18200.20-200.28202.00-202.08 202.10-202.18202.40-  
202.48202.80-202.88203.00-203.01 203.10-203.11203.80-  
203.81205.00-205.01205.10-205.11 205.20-205.21205.30-  
205.31205.80-205.81205.90-205.91  
212.1232.5233.0233.3233.7233.9236.2236.3236.7236.91238.2  
238.3238.6239.2239.3239.4239.5571.49V07.39

Reasons for Denial

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

The self administration of Interferon.

Coding Guidelines

For the administration of drugs, refer to either Therapeutic or Diagnostic Infusion/Injections (90780)

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Chemotherapy Administration Codes.\_Chemotherapy administration codes 96400 through 96450, 96542, 96545, and 96579 are used only in reporting chemotherapy administration when the drug being administered is an antineoplastic and the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer or the administration of antineoplastics to patients with a diagnosis other than cancer must be reported with codes 90780 through 90784, as appropriate.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must substantiate the medical necessity for use of Interferon by clearly indicating the condition for which it is being given. This documentation is usually found in the history and physical and/or the office/progress notes.

Advance Notice Requirement

Applies to medical necessity (see page 4).

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01996, 94656-94657, 99217-99239: Concurrent Care

Concurrent care is the provision of similar services, e.g., hospital visits, to the same patient by more than one physician on the same day.

Indications and Limitations of Coverage and/or Medical Necessity

Concurrent Care Guidelines:

Concurrent Care visits rendered by more than one physician are covered inpatient services provided at least one of the following circumstances exists:

the physicians are of different specialties or subspecialties; and/or

the patient's illness involves more than one medical condition.

Concurrent care services provided by both the in primary care physician and the intensivist are covered services on the same day if review criteria is met.

#### HCPCS Codes

01996 Daily management of epidural or subarachnoid drug administration

94656 Ventilation assist and management initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day

94657 subsequent days

99217-99239 Hospital observation services

99295-99298 Neonatal intensive care services

#### Reasons for Denial

When documentation does not support the medical necessity for services billed.

#### Coding Guidelines

Each physician should only submit the diagnosis(es) for which he is treating the patient. Submission of all diagnoses may cause erroneous denials of claims.

#### Documentation Requirements

Required medical documentation for medical necessity is:

The physician's progress notes for the visit being reviewed.

If the ICD-9-CM diagnoses are the same, the documentation should include a narrative statement of medical necessity.

If both a primary care physician and intensivist are billing on the same day, both services may be paid if the following review criteria is met:

There is a written request for the intensivist by the primary physician;

The intensivist bills for a consultation or critical care, but not both; and

The hospital record justifies payment to the primary physician by documenting that he/she contributed substantially to the patient's care.

Advance Notice Statement

Applies to medical necessity (see page 4).

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36430-36460: Transfusion Medicine

Blood transfusions are used to restore blood volume after hemorrhage, to improve the oxygen carrying capacity of blood in severe anemia, and to combat shock in acute hemolytic anemia.

Indications and Limitations of Coverage and/or Medical Necessity

Transfusion

Medically necessary transfusion of blood, regardless of the type, may generally be a covered service under both Part A and Part B of Medicare. Coverage does not make a distinction between the transfusion of homologous, autologous, or donor-directed blood. Transfusions are covered under Medicare when treatment is reasonable and necessary for the individual patient.

Blood is a biological and can be covered under Part B only when furnished by a physician or incident to his services.

HCPCS Codes

- 36430 Transfusion, blood or blood components
- 36440 Push transfusion, blood, 2 years or under
- 36450 Exchange transfusion, blood; newborn
- 36455 other than newborn
- 36460 Transfusion, intrauterine, fetal

Blood Products

Blood products refer to the unit of whole blood or components of the whole blood such as red blood cells, platelets or plasma (not a complete list of the components).

Only the provider which actually supplies the blood or blood product should be billing for HCPCS Level II P9010-P9022 codes.

Once a physician or supplier accepts a replacement unit of whole blood or packed red cells from a beneficiary or another individual acting on his behalf, the beneficiary may not be charged for the blood.

#### HCPCS Codes

P9010 Blood (whole), for transfusion, per unit  
P9011 Blood (split-unit), specify amount  
P9012 Cryoprecipitate, each unit  
P9013 Fibrinogen unit  
P9016 Leukocyte-poor blood, each unit  
P9017 Plasma, single donor, fresh frozen, each unit  
P9018 Plasma protein fraction, each unit  
P9019 Platelet concentrate, each unit  
P9020 Platelet-rich plasma, each unit  
P9021 Red blood cells, each unit  
P9022 Washed red blood cells, each unit

#### Blood Processing:

For Medicare coverage purposes, it is important to distinguish between a transfusion itself and preoperative blood services, e.g., collection, processing, storage. With respect to the coverage of the services associated with the preoperative collection processing, and storage of autologous and donor-directed blood, the following policies apply:

Hospital-Part A Coverage-Medicare payment is made to the hospital, under PPS or cost reimbursement, for coverage inpatient and outpatient services, and it is intended to reflect payment for all costs of furnishing those services.

Nonhospital Part B Coverage-The collection, processing, and storage of blood either autologous or donor-directed for later transfusion into the beneficiary is not recognized as a separate service under Part B.

#### HCPCS Codes

86850 Antibody screen, RBC, each serum technique

86860 Antibody elution (RBC), each elution

86870 Antibody identification, RBC antibodies, each panel for each serum technique

86880 Antihuman globulin test (Coombs test); direct, each antiserum

86885 indirect, qualitative, each antiserum

86886 indirect, titer, each antiserum

86890 Autologous blood or component, collection processing storage; predeposited

86891 intra-or postoperative salvage

86900 Blood typing; ABO

86901 Rh (D)

86903 antigen screening for compatible blood unit using reagent serum, per unit screened

86904 antigen screening for compatible unit using patient serum, per unit screened

86905 RBC antigens, other than ABO or Rh (D), each

86906 Rh phenotyping, complete

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

86911 each additional antigen system

86915 Bone marrow, modification or treatment of eliminate cell (e.g., T-cells, metastatic carcinoma)

86920 Compatibility test each unit; immediate spin technique

86921 incubation technique

86922 antiglobulin technique

86927 Fresh frozen plasma, thawing, each unit

86930 Frozen blood, preparation for freezing, each unit

86931 with thawing

86932 with freezing and thawing

86940 Hemolysins and agglutinins, auto, screen, each;

86941 incubated

86945 Irradiation of blood product, each unit

86950 Leukocyte transfusion

86965 Pooling of platelets or other blood products

86970 Pretreatment of RBC's for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each

86971 incubation with enzymes, each

86972 by density gradient separation

86975 Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each

86976 by dilution

86977 incubation with inhibitors, each

86978 by differential red cell absorption using patient RBC's or RBC's of known phenotype, each absorption

86985 Splitting of blood or blood products, each unit

86999 Unlisted transfusion medicine procedure

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#### Reasons for Denial

Procedure codes 86890 and 86891 are not recognized as a separate service under Medicare Part B for either autologous or donor-directed blood.

Procedure codes 86910 and 86911 have an "N" status and are noncovered by Medicare.

Procedure code 86927-Reimbursement for the thawing of fresh frozen plasma is included in the basic allowance of the transfusion of blood or blood components (Ref: Clinical Laboratory Task Force, HCFA December 1993). This was in effect through 12/31/95 at which time the national rebundling edits went into effect.

Routine screening laboratory work done for transfusions is not a benefit of Medicare B. As with all screening services, they are not performed to diagnose or treat a symptom, injury or illness.

#### Documentation Requirements

Should a medical review be necessary the physician would be expected to maintain specific patient information in the medical

record to justify the need for services, i.e., history, physical and office notes, if necessary.

Other Comments

Homologous Blood Transfusion: homologous blood transfusion is the infusion of blood or blood components that have been collected from the general public.

Donor Directed Blood Transfusion: a donor directed blood transfusion is the infusion of blood or blood components that have been precollected from a specific individual(s) other than the patient and subsequently infused into the specific patient for whom the blood is designated. For example, patient B's brother predeposits his blood for use by patient B during upcoming surgery.

Autologous Blood Transfusion: an autologous blood transfusion is the precollection and subsequent infusion of a patient's own blood.

Perioperative Blood Salvage: perioperative blood salvage is the collection and reinfusion of blood lost during and immediately after surgery.

Advance Notice Requirement

Applies to medical necessity (see page 4)..

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36470-36471 - Sclerotherapy of Varicose Veins

Sclerotherapy of varicose veins is generally performed for signs and symptoms of diseased vessels, as an adjunct to surgical therapy or for cosmetic purposes. The procedure generally involves isolating the varicosity, then compressing the proximal and distal ends of the isolated vein segment. As much blood as possible is evacuated from the segment and then a sclerosing agent is injected directly into the isolated empty vein. Sclerotherapy for venous telangiectasia is best accomplished using 23% saline and a small needle (25-30 gauge) to enter the vein. Various sclerosing solutions are available for larger veins. After injection, the treated area of the leg is compressed by tightly wrapping it with a non-elastic bandage and by having the patient wear reverse gradient compression hose. Compression is used so that the irritated walls stick together, thrombosing and ultimately obliterating the vein. The treated veins ideally fibrose and are reabsorbed.

Sclerotherapy is most useful for the treatment of incompetent perforating veins and for recurrent veins after surgery.

Medicare of Florida will cover the injection of sclerosing solution (procedure code 36470 and 36471) in the following circumstances:



signs and symptoms of significantly diseased vessels of the lower extremities, such as stasis ulcer of the leg, significant pain, or significant edema, that interferes with activities of daily living; and/or

in conjunction with surgical stripping or ligation

Duplex scanning or any ultrasound procedure performed for the purpose of guidance during the injection of sclerosing solution for the treatment of varicose veins is not considered medically necessary. Therefore, ultrasound guided sclerotherapy is not covered by Medicare of Florida.

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Page 20

To ensure that Medicare only reimburses for services that are considered medically reasonable and necessary, the injection of the sclerosing solution is covered only for the following diagnoses:

454.0

454.1

454.2

782.3

#### Reasons for Denial

The following conditions are not covered for sclerotherapy of varicose veins:

any vessel that is asymptomatic

spider veins

for cosmetic purposes

#### Documentation Requirements

Medical record documentation maintained by the physician must indicate the medical necessity for performing this procedure. Documentation of the symptoms requiring the surgery, the location of the vessels, and the number of veins involved would be expected to be found in the patient's medical record. This information is usually found in the history and physical and/or office/progress notes and/or operative report.

#### Advance Notice Statement

Applies to medical necessity (see page 4).

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55250, 55400, 55450, 56301-56302, 57170, 58300-58301, 58600,  
58605, 58611, 58615: Sterilization

Sterilization is used as a means of preventing pregnancy.

#### Indications and Limitations of Coverage and/or Medical Necessity

##### Covered Conditions

Payment may be made only where sterilization is a necessary part of the treatment of an illness or injury, e.g., removal of a uterus because of a tumor, removal of diseased ovaries (bilateral oophorectomy), or bilateral orchidectomy in a case of cancer of the prostate. Deny claims when the pathological evidence of the necessity to perform any such procedures to treat an illness or injury is absent; and

Sterilization of a mentally retarded beneficiary is covered if it is a necessary part of the treatment of an illness or injury.

Monitor such surgeries closely and obtain the information needed to determine whether in fact the surgery was performed as a means of treating an illness or injury or only to achieve sterilization.

##### Noncovered Conditions

Elective hysterectomy, tubal ligation, and vasectomy, if the stated reason for these procedures is sterilization;

A sterilization that is performed because a physician believes another pregnancy would endanger the overall general health or the woman is not considered to be reasonable and necessary for the diagnosis or treatment of illness or injury. The same conclusion would apply where the sterilization is performed only as a measure to prevent the possible development of, or effect on, a mental condition should the individual become pregnant; and

Sterilization of a mentally retarded person where the purpose is to prevent conception, rather than the treatment of an illness or injury.

Insertion of an IUD (intrauterine device) (58300) is not a benefit of Medicare.

Removal of an IUD (intrauterine device) (58301) for birth control purposes is not a covered service, however,

Removal of an IUD (58301) for medical necessity such as infection, would be a covered service.

Insertion, implantable contraceptive capsules (11975) and removal with reinsertion (11977) are not covered services.

Removal, implantable contraceptive capsules (11976) is not a covered service unless it is done for a medical reason, such as the site has become infected.

The codes contained in this policy are all related to sterilization only procedures, therefore, all will be denied as not medically necessary on initial claim submitted. If there are true medical necessity issues to be presented, they will be handled on a post-payment basis. This decision has been made because of the number of procedures involved and the extremely rare circumstances where payment would be considered.

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#### HCPCS Codes

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

55400 Vasovasostomy, vasovasorrhaphy

55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

56301 Laparoscopy, surgical; with fulguration of oviducts (with or without transection)

56302 with occlusion of oviducts by device (e.g., band, clip, or Falope ring)

57170 Diaphragm or cervical cap fitting with instructions

58300 Insertion of intrauterine device (IUD)

58301 Removal of intrauterine device (IUD)

58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)

58615 Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach

11975 Insertion, implantable contraceptive capsules

11976 Removal, implantable contraceptive capsules

11977 Removal with reinsertion, implantable contraceptive capsules

#### Reasons for Denial

Not medically necessary

#### Coding Guidelines

For sterilization procedures, which do not reflect medical necessity, use ICD-9 V code appropriate to condition; V25 (range) encounter for contraceptive management.

#### Documentation Requirements

The provider has the responsibility to ensure the medical necessity for this procedure and must maintain documentation for the possibility of postpayment review.

#### Advance Notice Statement

Applies to medical necessity (see page 4).

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58340: Infertility

Infertility is defined as the inability to conceive (produce offspring) and is of (2) types: (1)primary\_never having conceived; (2) secondary\_referring to individuals who have previously conceived. There are many causes of infertility for both male and female, as well as multiple approaches to treatment/correction of the condition.

#### Diagnostic Treatment Procedures:

Reasonable and necessary services associated with treatment for infertility are covered under Medicare. Infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally is expected to be fertile to seek medical consultation and treatment.

Payment is made for diagnostic and/or therapeutic procedures necessary to restore the beneficiary to a state where normal conception can occur. The following is a list of procedures commonly associated with the diagnosis of infertility; it may not be all inclusive.

HCPCS Codes

58340 Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography

58345 Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography

58350 Chromotubation of oviduct, including materials

58750: Tubotubal anastomosis

58760: Fimbrioplasty

89300: Semen analysis; presence and/or motility of sperm including Huhner test (post coital)

89310: motility and count

89320: complete (volume, count, motility and differential)

89325: Sperm antibodies

89329: Sperm evaluation; hamster penetration test

89330: cervical mucus penetration test, with or without spinnbarkeit test

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

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Reasons for Denial

Documentation does not support the procedure as appropriate. Inadequate documentation is provided. InVitro procedures and other methods of artificial insemination are not considered as treatments for infertility but rather as means of producing pregnancy. This is artificial conception as opposed to conventional and is not covered by Medicare.

Procedures listed below are not covered by Medicare:

58321 Artificial insemination; intra-cervical

- 58322 intra-uterine
- 58323 Sperm washing for artificial insemination
- 58970 Follicle puncture for oocyte retrieval, any method
- 58974 Embryo transfer, intrauterine
- 58976 Gamete, zygote, or embryo intrafallopian transfer, any method
- 89250 Culture and fertilization of oocyte(s)
- 89251 Culture and fertilization of oocyte(s); with co-culture of embryos
- 89252 Assisted oocyte fertilization, microtechnique (any method)
- 89253 Assisted embryo hatching, microtechniques (any method)
- 89254 Oocyte identification from follicular fluid
- 89255 Preparation of embryo for transfer (any method)
- 89256 Preparation of cryopreserved embryos for transfer (includes thaw)
- 89257 Sperm identification from aspiration (other than seminal fluid)
- 89258 Cryopreservation; embryo
- 89259 Cryopreservation; sperm
- 89260 Sperm isolation; simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis
- 89261 Sperm isolation; complex prep (e.g., per col gradient, albumin gradient) for insemination or diagnosis with semen analysis
- 89264 Sperm identification from testis tissue, fresh or cryopreserved

#### Coding Guidelines

Individual consideration is given to each claim submitted for these procedures.

#### Documentation Requirements

A comprehensive history and physical and laboratory procedural reports which support the diagnosis of infertility is needed.

Other Comments

Procedures done in a laboratory for evaluation of specimens of varied substances, e.g., blood, semen, cervical mucus are covered procedures. Any review of claims regarding infertility will be performed by Level III (MD) review.

Refer to policy 55250 (Sterilization) and 54900 (Epididymovasostomy) for related services.

Advance Notice Statement

Applies to medical necessity (see page 4).

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61855, 61880-61888, 64999, 95970-95971: Deep Brain Stimulation

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

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

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

Indications and Limitations of Coverage and/or Medical Necessity

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

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

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

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

#### HCPCS Codes

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

61880 Revision or removal of intracranial neurostimulator electrodes

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

61888 Revision or removal of cranial neurostimulator pulse generator or receiver

64999 Unlisted procedure, nervous system

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, 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

#### ICD-9 Codes That Support Medical Necessity

332.0

333.1

#### Reasons for Denial

Deep Brain Stimulation for tremors caused by conditions other than those associated with Parkinson's Disease or Essential



Tremor. These include tremors due to: trauma, Multiple Sclerosis, degenerative disorders, metabolic, infectious diseases and drug induced movement disorders.

The patient is suffering from advanced dementia.

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

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

The patient has in place other operating pacemakers.

The implantation of simultaneous bilateral DBS of the VIM thalamus.

#### Coding Guidelines

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

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

It is expected that procedure code 95970 or 95971 would be submitted periodically to evaluate the status of the generator system.

#### Documentation Requirements

The medical records must include the following information:

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

medications the patient is currently taking for the tremors;

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

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

description of the surgical procedure.

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

#### Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

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#### 64573, 64585-64595, 95970-95971: 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 the use as an adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age with partial onset seizures, which are refractory to anti-epileptic medications.

These patients must have complex partial seizures with or without secondary generalization that are not controlled by other types of therapies. These patients have failed multiple drug therapies, which includes both conventional (ex: Phenytoin, Carbamazepine, Primidone, Valproate) and new anticonvulsant drugs (ex: Felbamate, Lamotrigine, Gabapentine, Vigabatrine, Topiramate, Tiagabine) as add-on treatments in controlling seizures and do not qualify for or choose to have brain surgery.

Vagus nerve stimulation is indicated only for left vagus nerve stimulation. It is not indicated for stimulation of the right vagus nerve or any other nerve, muscle, or tissue.

#### HCPCS Codes

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 (eg, 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

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.

A person who is 12 years old or younger

A person who has seizures with treatable underlying etiology

A person who has seizures that are controlled with medication

A person who has had a prior vagotomy procedure

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Noncovered ICD-9 Code(s)

When CPT codes 64573, 64585, 64590, 64595, 95970, and 95971 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

Patients may require periodic reprogramming of the pulse generator. Procedure code 95971 should be billed for the reprogramming of the pulse generator.

When CPT codes 64573, 64585, 64590, 64595, 95970, and 95971 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 long history of partial (simple or complex, or both) seizures should be documented;

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.

Advance Notice Requirement

Applies to medical necessity (see page 4).

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77336, 77370: Radiation Physics Consultations

Medical radiation physics services under Medicare regulations, consist of specific tests, measurements, calculations and fabrication of materials that are deemed necessary by the radiation oncologist, and ultimately selected and used by the radiation oncologist for the benefit of a patient undergoing radiation therapy. Often these procedures are necessary for the development and implementation of a final treatment plan. Some procedures may be necessary only to verify or validate that the treatment plan is correct, or that the ongoing treatment is being correctly applied. Under all circumstances, the physician is responsible for ordering the patient related physics services and ultimately placing them into clinical use.

Medicare Part B in Florida has not previously published a specific policy concerning radiation physics consultation. The purpose of this policy is to define the circumstances for which Medicare Part B in Florida will consider radiation physics consultations to be medically necessary and therefore covered.

Indications and Limitations of Coverage and/or Medical Necessity

These services are only payable when a patient is undergoing radiation therapy.

Continuing medical radiation physics consultation in support of therapeutic radiologist including continuing quality assurance reported per week of therapy (CPT code 77336) includes the overall quality control, machine calibration, film badge service, and a host of other physics related procedures that assure the radiation oncologist that the quality control functions have been appropriately carried out. These activities are also beneficial

to each patient on a weekly basis and is an integral part of the radiation oncologist's treatment service.

Special medical radiation physics consultation (CPT code 77370) is used when the medical radiological physicist is called for a consultation to coordinate the complex dose calculations resulting from multiple treatment field interactions.

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

#### HCPCS Codes

77336 Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy

77370 Special medical radiation physics consultation

#### Coding Guidelines

The physics services rendered under codes 77336 and 77370 are technical services only and are billed with any combination of radiation therapy codes.

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#### Documentation Requirements

Medical record documentation maintained by the order/referring physician must clearly indicate the medical necessity for a radiation physics consultation covered by the Medicare program. Also, the results of the radiation physics consultation covered by the Medicare program must be included in the patient's medical record.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated in writing to the requesting physician or other appropriate source.

#### Advance Notice Requirement

Applies to medical necessity (see page 4).  
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77419-77431: Weekly Radiation Therapy Management

Weekly radiation therapy management represents the professional services of the physician managing a course of radiation therapy. In most instances this involves daily administration of clinical radiation therapy, usually five days a week. In some situations, a patient may be treated on other schedules such as every other day, three days a week, once a week, hyperfractionation (two times a day) or other individualized treatment plans. The physician's management involves a continual assessment of how the treatment is being delivered as well as the patient's response to the treatment.

#### Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part B will consider weekly radiation therapy management to be medically necessary in documented cases of neoplasm in a patient where a treatment course of radiation therapy has been established.

It is generally considered acceptable standards of practice for a course of non-hyperfractionated radiation therapy to be delivered over a period of two to ten weeks. In cases of hyperfractionation one may see a treatment course lasting up to 14 weeks.

Weekly radiation therapy management; conformal (77419): One would see this code used in a treatment course ranging two to ten weeks (non-hyperfractionated).

Weekly radiation therapy management; simple (77420): One would expect to see this code used for a treatment course ranging two to five weeks.

Weekly radiation therapy management; intermediate (77425): One would expect to see this code used for a treatment course ranging two to seven weeks.

Weekly radiation therapy management; complex (77430): One would expect to see this code used for a treatment course ranging two to nine weeks.

#### HCPCS Codes

77419 Weekly radiation therapy management; conformal

77420 Weekly radiation therapy management; simple

77425 Weekly radiation therapy management; intermediate

77430 Weekly radiation therapy management; complex

77431 Radiation therapy management with complete course of therapy consisting of one or two fractions only

#### Coding Guidelines

For billing purposes, HCFA has indicated that one weekly radiation therapy management service is equal to five fractions or "sessions" of radiation treatment delivery that a patient receives, regardless of the period of time it takes for the sessions to be delivered. Examples:

One fraction equals one "session" of radiation therapy

Five fractions equal one weekly radiation therapy management service

One weekly radiation therapy management code can be reimbursed for each "set" of five fractions. Therefore, if a patient receives treatments twice a day for five days, two weekly radiation therapy management services will be reimbursed for that calendar week.

If at the end of a treatment course, three or four fractions remain, then one unit of weekly radiation therapy management will be reimbursed.

If at the end of a treatment course, only one or two fractions remain, then no reimbursement will be made.

If a patient's entire treatment course consists of only one or two fractions, the physician should bill CPT code 77431 (radiation therapy management with complete course of therapy consisting of one or two fractions only). This code should not be used to be reimbursed for the remaining treatments at the end of a long course of therapy.

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Weekly radiation therapy management is reported using the following guidelines:

77419 Weekly radiation therapy management; conformal multiple custom megavoltage treatment beams focused on a large 3-D reconstructed target.

77420 Weekly radiation therapy management; simple-a single treatment area will be treated using single or parallel opposed ports and simple blocks.

77425 Weekly radiation therapy management; intermediate. Two separate areas are treated, using three or more ports on a single treatment area and special blocks.



77430 Weekly radiation therapy management; complex. Three or more areas are treated using tangential ports, highly complex blocking, wedges, rotational compensators or other special beam considerations.

It is a HCFA requirement that providers must indicate the number of radiation treatments on each claim when seeking reimbursement for weekly radiation therapy management.

For each weekly radiation therapy management code billed, the actual number of radiation treatments the patient received must be indicated in the "days or units" field on the claim.

Each weekly radiation therapy management service should be billed on a separate detail line.

The date of service should be the beginning date for each treatment week.

Payment should only be made after the fifth treatment has been delivered, not before. However, payment will be made for one weekly radiation therapy management service if the entire treatment course consists of only three or four fractions.

HCFA has indicated that no separate payment will be made for any of the following services rendered by the radiation oncologists or in conjunction with weekly radiation therapy management:

11920 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.0 sq. cm or less

11921 6.1 to 20.0 sq. cm

11922 each additional 20.0 sq. cm (List separately in addition to code for primary procedure)

16000 Initial treatment, first degree burn, when no more than local treatment is required

16010 Dressings and/or debridement, initial or subsequent; under anesthesia, small

16015 under anesthesia, medium or large, or with major debridement

16020 without anesthesia, office or hospital, small

16025 without anesthesia, medium (e.g., whole face or whole extremity)

16030 without anesthesia, large (e.g., more than one extremity)

36425 Venipuncture, cut down age 1 or over

53670 Catheterization, urethra; simple

53675 complicated (may include difficult removal of balloon catheter)

90780 IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour

90781 each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)

90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to face with the patient;

90805 with medical evaluation and management services

90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to face with the patient;

90807 with medical evaluation and management services

90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to face with the patient;

90809 with medical evaluation and management services

90816 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to face with the patient;

90817 with medical evaluation and management services

90818 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to face with the patient;

90819 with medical evaluation and management services

90821 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to face with the patient;

90822 with medical evaluation and management services

90847 Family psychotherapy (conjoint psychotherapy) with patient present

99050 Services requested after office hours in addition to basic service

99052 Services requested between 10:00 pm and 8:00 am in addition to basic service

99054 Services requested on Sundays and holidays in addition to basic service

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99058 Office services provided on an emergency basis

99071 Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician

99090 Analysis of information data stored in computers (e.g., ECG, blood pressures, hematologic data)

99150 Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery, standby for newborn care following cesarean section); 30 minutes to one hour

99151 more than one hour

99180 Hyperbaric oxygen therapy initial

99182 subsequent

99185 Hypothermia; regional

99211 Office or other outpatient visit, established patient; Level I

99212 Level II

99213 Level III

99214 Level IV

99215 Level V

99238 Hospital discharge day management

99281 Emergency department visit, new or established patient; Level I

99282 Level II

99283 Level III

99284 Level IV

99285 Level V

99371 Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals; simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)

99372 intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate a new plan of care)

99373 complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services or several different health professionals working on different aspects of the total patient care plan)

Anesthesia (whatever code billed)

Care of infected skin (whatever code billed)

Checking of treatment charts

Verification of dosage, as needed (whatever code billed)

Continued patient evaluation, examination,

Written progress notes, as needed (whatever code billed)

Final physical examination (whatever code billed)

Medical prescription writing (whatever code billed)

Nutritional counseling (whatever code billed)

Pain management (whatever code billed)

Review and revision of treatment plan (whatever code billed)

Routine medical management of unrelated problem (whatever code billed)

Special care of ostomy (whatever code billed)

Written reports, progress note (whatever code billed)

Follow-up examination and care for 90 days after last treatment (whatever code billed)

Documentation Requirements

Documentation maintained in the patient's medical record must include the following:

radiation therapy treatment plan

record of radiation treatments delivered

physician's documentation of weekly management

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78460-78465, 78478-78480: Myocardial Perfusion Imaging

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

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

#### Indications and Limitations of Coverage and/or Medical Necessity

Myocardial perfusion imaging will be considered medically reasonable and necessary, by Medicare of Florida if any one of the following circumstances is present:

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

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

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

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

Patient has known coronary artery disease (or recent myocardial infarction) and myocardial perfusion imaging is being done to determine the significance of/or the extent of myocardial ischemia (or scar) resulting from coronary artery disease or to assess myocardial viability.

The patient has undergone cardiovascular re-perfusion (CABG, PTCA, thrombolysis) and perfusion imaging is being done to evaluate the effectiveness of the intervention.

The patient has developed congestive heart failure and a silent MI is suspected.

The patient has a ventricular wall motion abnormality demonstrated by another imaging modality and perfusion imaging is needed to further evaluate the abnormality.

The patient has severe peripheral vascular disease and is a candidate for peripheral vascular reperfusion by balloon angioplasty or bypass surgery and myocardial perfusion imaging is being done pre-operatively because of concern about possible significant coronary artery disease.

Follow-up within 48 hours of an abnormal multiple myocardial perfusion scan to determine whether the perfusion defect is related to myocardial scarring or myocardial ischemia. Usually only a single study is needed to evaluate this indication.

#### HCPCS Codes

78460 Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification

78461 multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and distribution and/or rest injection, with or without quantification

78464 tomographic SPECT, single study, at rest or stress (exercise and/or pharmacologic), with or without quantification

78465 tomographic SPECT, multiple studies, at rest and/or stress (exercise and/or pharmacologic), and distribution and/or rest injection, with or without quantification

78478 Myocardial perfusion study with wall motion, qualitative or quantitative study

78480 Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure):

ICD-9 Codes That Support Medical Necessity

411 .0            411 .1            41 1.81            411.8 9            412 4 13.0  
413.1            413.9            414.00            414.01            414.02            414.03  
414.04            414.05            414.10            414.11            414.19            414.8            414.9  
424.0            426.2426.3 426.4 426.50 426.51 426.52 426.53 4 26.54  
426.6 426.7427.31 428.0428.1428.9440.21-  
440.24794.31960.7995.2E942.0 E942.1V67.0V67.51V67.59

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Reasons for Denial

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

When performed for any indication not listed in the AIndications and Limitations of Coverage and/or Medical Necessity@ section of this policy.

Coding Guidelines

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

When performing both the rest and stress portions of the myocardial perfusion imaging for any one of the covered indications, a multiple study procedure code (78461, 78465) should be billed regardless of whether the imaging occurs on the same day or two different days.

Procedure codes 78478 and 78480 should be billed in conjunction with the appropriate primary procedure code: 78460, 78461, 78464, or 78465.

Documentation Requirements

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

by the Medicare program must be included in the patient's medical record. This information is normally found in the office/progress notes and/or test results.

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

#### Advance Notice Requirement

Applies to medical necessity (see page f).

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80061, 82172, 82465, 83715-83721 and 84478: Lipid Profile/Cholesterol Testing

The local medical review policy for Lipid Profile/Cholesterol Testing has been revised to add the conditions of 577.0 - 577.1 (Diseases of pancreas) to the covered ICD-9 list for procedure code 84478 (triglycerides testing).

Lipids are fatty substances made up of cholesterol, cholesterol esters (liquid compounds), triglycerides, nonesterized fatty acids, and phospholipids which provide energy for metabolism, serve as precursors of steroid hormones (adrenals, ovaries, and testes) and bile acids, and play an important role in cell membrane development. Very low density lipoproteins (VLDL) carry only a small amount of cholesterol. However, they are the predominant carriers of blood triglycerides. Lipoprotein measurements are diagnostic indicators for hyper- and hypolipidemia. A lipid profile usually includes cholesterol, triglycerides, LDL, HDL, and VLDL may also be included.

#### Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider Lipid Profile/Cholesterol Testing to be medically reasonable and necessary for those patients undergoing the following current treatments:

#### Dietary Treatment:

Some patients may be managed during diet therapy on the basis of their total cholesterol levels. If the total cholesterol monitoring goal is met, the LDL cholesterol should be measured to confirm the desired LDL cholesterol level has been achieved.

Monitoring for adherence to dietary therapy would be expected at approximately 4 to 6 weeks from initiation and at 3 months. If the desired LDL and cholesterol levels have been achieved,



quarterly monitoring for the first year and twice yearly thereafter would be expected. In addition, triglyceride levels at the same frequency may also require monitoring to assess that desired levels have been achieved.

Drug Treatment:

After drug therapy is initiated the serum cholesterol, serum triglyceride, LDL, VLDL and HDL level (as applicable to the drug therapy) would be expected to be measured at approximately 4 to 6 weeks and again at 3 months. If the drug therapy response is adequate (i.e., the LDL, serum cholesterol and triglyceride goal has been achieved) it would be expected that every 4 months or more frequently when drugs requiring closer follow-up are used to monitor the cholesterol response and possible side effects of therapy, would be required.

Lipid Profile/Cholesterol Testing for those patients with normal blood cholesterol, HDL, and LDL levels would be considered screening and not payable by Medicare.

Other Indications:

Triglyceride testing (84478) can be performed on a patient to rule out hypertriglyceridemia as the cause of pancreatitis.

Note:Once lipid profile testing is performed to rule out the cause of a condition and/or symptom (i.e., chest pain, thyroid disord etc.) it is not considered medically necessary to repeat the test(s) unless the results indicate a lipid disorder or the patient exhibits new symptomology.

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HCPCS Codes

80061 Lipid panel (this panel must include 82465, 83718 and 84478) .

82172 Apolipoprotein, each

82465 Cholesterol, serum, total

83715 Lipoprotein, blood; electrophoretic separation and quantitation

83716 high resolution fractionation and quantitation of lipoprotein cholesterol (eg, electrophoresis, nuclear magnetic resonance, ultracentrifugation) ]

83718 Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)

83719 direct measurement, VLDL cholesterol

83721 direct measurement, LDL cholesterol

84478 Triglycerides

CD-9 Codes That Support Medical Necessity:

240.0-246.9 272.0-272.9 401.0-405.99 410.00-410.92  
411.0-411.89 412 413.0-413.9 414.00-414.05 414.10-414.19  
414.8 414.9 429.2 431-437.9 438.0-438.9  
440.0-440.9 441.00-441.9 443.9 444.0-444.89 577.0-577.1 ( for  
us e with procedure code 84478)786.50E942.2

Reasons for Denial

Lipid Profile/Cholesterol Testing will not be covered on a routine or screening basis.

Apolipoprotein (82172) is considered to be a screening test and therefore, non-covered by Medicare.

Calculated LDL determination will be denied.

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

Coding Guidelines

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

Procedure code 83721 represents only those LDL cholesterol levels done by direct measurement. It is not appropriate to bill 83721 for LDL cholesterol levels done by the calculated method.

Documentation Requirements

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

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).  
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80500-80502: Clinical Pathology Consultation and Clinical  
Laboratory Interpretation Services

A clinical pathology consultation and clinical lab interpretation are services generally rendered by the pathologist to assist the attending physician in planning care for his/her patient.

A clinical pathology consultation results from a request from the attending physician

for assistance in interpreting the results of a test (or tests) and advice on the plan of care for the patient in light of the patient's clinical condition. This consultation includes a written report containing the interpretive judgment and clinical recommendations of the pathologist.

A clinical lab interpretation service provides a written interpretation of the result of a specific lab test by the pathologist for a specific patient, at the request of the attending physician. This interpretation includes a written narrative report by the pathologist and may include computer generated findings. Computer generated findings may not, however, substitute for, or be the only information provided, in the interpretation by the pathologist.

Indications and Limitations of Coverage and/or Medical Necessity

Clinical Pathology Consultations:

Clinical consultations are reimbursed by Medicare Part B if all of the following requirements are met:

Medical necessity requirements. A Clinical Pathology Consultation is considered medically reasonable and necessary when the ordering physician is unsure of the clinical relevance of the result(s) of a complex or infrequently ordered test(s) and requires the medical judgement of a Pathologist to appropriately apply the data to the management of his/her patient. The results of the test(s) would generally be reviewed by the ordering physician prior to a consultation being requested to determine the need for further consultation by a pathologist.

Are requested specifically by the patient's attending physician. The clinical record/medical documentation must clearly indicate that the attending physician requested a clinical pathology consultation and specifically what test or tests the consultation is to address. The need for this consultation must also be clear in the patient's record. The ordering of the test itself does not constitute an order for the consultation.

NOTE: Prior to 01/01/98, standing orders were allowed as a substitute for the individual request by the patients attending physician to meet this requirement of a clinical consult.

Effective 01/01/98, standing orders may not be used as a substitute for the individual request by the attending physician.

Relate to a test result or results that lies outside the clinically significant normal or expected range in view of the condition of the patient. It is not considered medically reasonable and necessary for a consult to be performed on test results that are not outside the clinically significant normal or expected range in view of the condition of the patient. Again, unless the medical reason for the clinical consultation is clearly documented in the clinical record / medical documentation, consultations performed on patients with normal test results will not be considered medically reasonable and necessary.

Result in a written narrative report included in the patient's record. This may be in the form of a consultative report, a clear notation in the progress notes or a narrative on the lab slip indicating the pathologist performing the service. Routine conversations a laboratory director has with attending physicians about test orders or results are not consultations unless all five requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. These contacts do not constitute clinical consultations. However, if in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is paid under the fee schedule.

Require the exercise of medical judgment by the consultant physician/pathologist.

Clinical pathology consultations are commonly billed for the following test result(s). In order to determine whether these consultations meet the above coverage requirements including medical necessity requirements, supporting medical documentation may be required. However, we would expect the need for consultative advice on these tests to be infrequent.

Cardiac Enzymes (82552, 83625)

Unusual Urine Sediment with exam and report

Coagulation Profiles (Clotting inhibitors or anticoagulants  
[85300])

Minimum Inhibitory Concentrations

Glucose Tolerance Tests (82951-82952)

Endocrine Chemistry Battery

Lipoprotein Electrophoresis (83715, 83716)

Drug Screens (80100-80101)

Electrophoretic technique, not elsewhere classified (Alkaline  
Phosphatase Isoenzymes) [82664]

Body Fluid Cell counts and differential (89051)

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Ova and Parasites direct smears, concentration and identification  
(87177)

Dark field exam, any source, without collection (87166)

Sensitivity studies, antibiotic; microtiter, minimum inhibitory  
concentration (MIC), any number of antibiotics (87186)

Hemoglobin, fractionation and quantitation; electrophoresis (eg,  
A2, S, C [ and/or F ] ) (83020)

Molecular diagnostics; interpretation and report (83912)

Protein; electrophoretic fractionation and quantitation (84165)

Western Blot, with interpretation and report, blood or other body  
fluid (84181)

Western Blot, with interpretation and report, blood or other body  
fluid, immunological probe for band identification, each (84182)

Fibrinolysins; or coagulopathy screen, interpretation and report  
(85390)

Platelet; aggregation (in vitro) any agent (85576)

Fluorescent noninfectious agent antibody; screen, each antibody  
(86255)

Fluorescent antibody; titer, each antibody (86256)

Immunolectrophoresis; serum (86320)

Immunolectrophoresis; other fluids (eg, urine, CSF) with  
concentration (86325)

Immunolectrophoresis; crossed (2 dimensional assay) (86327)

Immunofixation electrophoresis (86334)

Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection (87164)

Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (eg, malaria, kala azar, herpes) (87207)

Protein analysis of tissue by Western Blot, with interpretation and report (88371)

Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each (88372)

Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine) (89060)

The coverage of Clinical Pathology Consultations for laboratory test(s) not listed above will be determined in a similar fashion. However, we would expect the medical reasonableness and necessity of such consultations to be uncommon.

#### HCPCS Codes

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

80501 comprehensive, for a complex diagnostic problem, with review of patient's history and medical records

#### Clinical Laboratory Interpretation Service

There are a limited number of clinical laboratory codes that have been identified as needing the pathologist to furnish an interpretation. Therefore, only for the laboratory tests listed below, will the clinical laboratory interpretation service be considered medically necessary. Additionally the following criteria must be met for the clinical laboratory interpretive service to be covered by Medicare Part B:

Are requested by the patient's attending physician;

Result in a written narrative report included in the patient's medical record; and

Require the exercise of medical judgment by the consultant physician.

In addition, the general criteria for physicians' services in the hospital must be met. These are:

the services are personally furnished for an individual beneficiary by a physician;

the services contribute to the diagnosis or treatment of an individual beneficiary; and

the services ordinarily require performance by a physician

Clinical Interpretative Services do not involve the patient's history or condition of the patient. When clinical interpretative services are performed on these tests, the applicable procedure code with a modifier 26 (professional component) should be billed. It is not appropriate to bill for a clinical pathology consultation (procedure codes 80500 or 80502) in addition to the interpretation unless the five requirements for a consultation are met. Finally, although computer generated findings may be included with the interpretation, they cannot serve as the medical judgment of the pathologist. Therefore, the documentation of the interpretation should include a narrative statement from the pathologist.

HCPCS Codes

83020 Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)

83912 Molecular diagnostics; interpretation and report

84165 Protein; electrophoretic fractionation and quantitation

84181 Western Blot, with interpretation and report, blood or other body fluid

84182 Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each

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85390 Fibrinolysins; or coagulopathy screen, interpretation and report

85576 Platelet; aggregation (in vitro) any agentFluorescent noninfectious agent antibody; screen, each antibody

86255 Fluorescent noninfectious agent antibody screen, each antibody

86256 Fluorescent antibody; titer, each antibody

86320 Immunoelectrophoresis; serum

86325 Immunoelectrophoresis; other fluids (eg, urine, CSF) with concentration

86327 Immunoelectrophoresis; crossed (2 dimensional assay)

86334 Immunofixation electrophoresis

87164 Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection

87207 Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (eg, malaria, kala azar, herpes)

88371 Protein analysis of tissue by Western Blot, with interpretation and report

88372 Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each

89060 Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

#### Coding Guidelines

We expect the need for more than one Clinical Pathology Consultation per day to be an infrequent occurrence. However, if additional consultations are billed, they must meet all the criteria of medical necessity and reasonableness.

When clinical interpretation services are performed on the tests identified in the HCPCS code section, the applicable procedure code with a modifier 26 should be billed.

#### Documentation Requirements



For Clinical Pathology Consultation services, the clinical record/medical documentation must clearly indicate that the attending physician requested a clinical pathology consultation and specifically what test or tests the consultation is to address. The medical necessity for this consultation must also be clear from documentation in the patients record. In addition, a copy of the lab test(s) result(s), and the written narrative of the pathologists findings is required.

For Clinical Laboratory Interpretation Services, the medical documentation must support that one of the eighteen listed procedure codes were ordered. In addition, the patient record must contain the lab results and a written narrative report from the pathologist.

#### Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

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#### 82105: Tumor Markers

Recent medical literature and clinical studies have demonstrated the effectiveness of the following FDA approved tumor markers; CA 15-3 for breast cancer and bladder tumor antigen testing for bladder cancer. Therefore, the Tumor Marker policy has been revised to expand coverage for procedure code 86316, (Immunoassay for tumor antigen). The coverage requirements have not been published since the article in the May/June 1998 Medicare B Update! therefore, the policy is being published in its entirety.

Tumor markers are hormones, enzymes, or antigens produced by tumor cells and measurable in the blood or in some cases in the urine (e.g., bladder tumor associated antigens) of persons with malignancies. Tumor markers are measured by monoclonal antibodies designed to identify specific antigens. These tumor markers may reflect tumor size and grade and may be helpful in monitoring response to treatment. However, tumor markers are not useful for making a differential diagnosis of cancer since the sensitivity and specificity of these tests make it unreliable.

#### Indications and Limitations of Coverage and/or Medical Necessity

Alpha - fetoprotein; serum

Medicare Part B of Florida will consider Alpha-fetoprotein; serum (CPT code 82105) to be medically reasonable and necessary for:

evaluating the extent of involvement of hepatocellular carcinoma and germ cell tumors of the testis, ovary and extragonadal sites

choosing therapy and predicting tumor behavior (prognosis)

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Predicting effects of therapy and detecting recurrent cancer of hepatocellular carcinoma and germ cell tumors of the testis, ovary, and extragonadal sites.

HCPCS Codes

82105 Alpha-fetoprotein; serum

ICD-9 Codes That Support Medical Necessity

155.0-155.2

183.0

186.0

186.9

197.7

198.6

198.82

V10.43

V10.47

Gonadotropin, Chorionic (hCg)

Gonadotropin is a glycoprotein hormone which is normally produced by the developing placenta and aberrantly produced by gestational trophoblastic tumors, seminomatous and nonseminomatous testis cancer and ovarian tumors.

hCg is considered medically reasonable and necessary for:

evaluating the extent of involvement of specific types of cancer (see covered ICD-9 list).

Monitoring therapy response and evaluating the patient's prognosis.

HCPCS Codes

84702 Gonadotropin, chorionic (hCg); quantitative

84703 qualitative

ICD-9 Codes That Support Medical Necessity

181

183.0

186.0

186.9

198.6

198.82

V10.43

V10.47

CA 125

The cancer antigen CA 125 is recognized by a monoclonal antibody OC-125. It is increased in most patients with advanced, nonmucinous (serous) ovarian cancer.

CA 125 is a covered service for patients with ovarian cancer (see covered ICD-9 list). CA 125 is considered investigational for diagnoses other than ovarian cancer.

CA 125 is not covered for making a differential diagnosis of pelvic masses since the sensitivity and specificity of the test makes it unreliable.

CA 125 is advocated for prognostic information. When measured serially, it may also be useful in the detection of relapse and as a monitor of patient response to chemotherapeutic agents.

HCPCS Codes

86316 Immunoassay for tumor antigen (e.g. Cancer antigen 125), each

ICD-9 Codes That Support Medical Necessity

183.0

198.6

V10.43

CA27.29

The cancer antigen CA27.29 is a mucinous glycoprotein that can be detected by monoclonal antibodies. The CA27.29 marker is a tumor-associated marker available for monitoring the treatment and recurrence of carcinoma of the breast.

Medicare of Florida will consider CA27.29 (CPT code 86316) to be medically reasonable and necessary for the following conditions:

CA 27.29 is used as an aid to predict recurrent breast cancer in patients with previously treated Stage II or Stage III disease;  
or

CA 27.29 is used as an aid in monitoring response to therapy in patients with Stage IV breast cancer. A partial or complete response to treatment will be confirmed by declining levels. Likewise, a persistent rise of CA 27.29 levels despite therapy strongly suggests progressive disease.

Additionally, only those tests which are FDA approved, are covered by Medicare.

CA27.29 is not indicated as a screening test.

HCPCS Codes

86316 Immunoassay for tumor antigen

ICD-9 Codes That Support Medical Necessity

174.0-174.9

175.0-175.9

V10.3

CA15-3

The mucin glycoprotein-detecting assay CA 15-3 is a valuable tool for monitoring the course of disease in breast cancer patients. Assays of CA15-3 are based on the use of two monoclonal antibodies to polymorphic epithelial mucin (PEM).

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Medicare of Florida will consider CA15-3 (CPT code 86316) to be medically reasonable and necessary for the following condition:

To aid in the management of Stage II and Stage III breast cancer patients. Serial testing for patient CA15-3 assay values should

be used in conjunction with other clinical methods for monitoring breast cancer.

Additionally, only those tests which are FDA approved, are covered by Medicare.

CA15-3 is not indicated as a screening test.

#### HCPCS Codes

86316

Immunoassay for tumor antigen

#### ICD-9 Codes That Support Medical Necessity

174.0-174.9

175.0-175.9

V10.3

#### Bladder Tumor Antigen

There are immunoassay devices that use monoclonal antibodies to detect the presence of bladder tumor associated antigens in the urine of persons diagnosed with bladder cancer.

Medicare of Florida will consider testing for bladder tumor antigens (CPT code 86316) to be medically reasonable and necessary for the following condition:

To be used with standard cystoscopic examination as an aid in the management of bladder cancer.

Testing for bladder tumor antigens is not indicated as a screening test for bladder cancer. Coverage may only be extended for its use in patients with a prior or known diagnosis of bladder cancer. Therefore, it will be allowed for follow-up of treatment for bladder cancer, to monitor for eradication of the cancer, or recurrences after eradication.

Evaluation of bladder tumor antigen has been proposed as an alternative to urine cytology; therefore, there is no medical necessity for the simultaneous performance of both tests.

#### HCPCS Codes

86316 Immunoassay for tumor antigen

ICD-9 Codes That Support Medical Necessity

188.0-188.9

V10.51

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.

Testing performed for tumor markers by investigational methods that are not approved by the FDA are not covered by Medicare.

Routine screening services are not covered by Medicare of Florida.

All other tumor markers including those listed below are considered investigational and therefore, ineligible for payment.

A2-PAG pregnancy-associated alpha2 glycoprotein

BCM breast cancer mucin

CA19-9 Cancer antigen 19-9

CA50 Cancer antigen 50

CA72-4 Cancer antigen 72-4

CA195 Cancer antigen 195

CA242 Cancer antigen 242

CA549 Cancer antigen 549

CA-SCC Squamous cell carcinoma

CAM17-1 Monoclonal antimucin antibody 17-1

CAM26 Monoclonal antimucin antibody 26

CAM29 Monoclonal antimucin antibody 29

CAR3 Antigenic determinant recognized by monoclonal antibody AR3

DU-PAN-2 Sialylated carbohydrate antigen DU-PAN-2

MCA Mucin-like carcinoma associated antigen

NSE Neuron-specific enolase

P-LAP Placental alkaline phosphatase

PNA-ELLA Peanut lectin bonding assay

SLEX Sialylated Lewis X-antigen  
SLX Sialylated SSEA-1 antigen  
SPAN-1 Sialylated carbonated antigen SPAN-1  
ST-439 Sialylated carbonated antigen ST-439  
TAG12 Tumor-associated glycoprotein 12  
TAG72 Tumor-associated glycoprotein 72  
TAG72.3 Tumor-associated glycoprotein 72.3  
TATI Tumor-associated trypsin inhibitor  
TNF-a Tumor necrosis factor alpha  
TPA tissue polypeptide antigen

Coding Guidelines

Claims for tumor antigen tests will be denied unless medical necessity is established by use of one or more of the above procedure and diagnosis codes.

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

Documentation Requirements

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

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

When billing for procedure code 86316, documentation must also indicate the specific antigen being tested.

Advanced Notice Requirement

Applies to medical necessity (see page 4).

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### 83013: Breath Test for Helicobacter Pylori (H. Pylori)

The Local Medical Review Policy for the Breath Test for Helicobacter Pylori (H. Pylori) was published in the Nov./Dec. 1998 Medicare Part B Update (pages 30-31). The article also included the Gap-fill allowances for H. Pylori. Since that time, HCFA has established new codes for H. Pylori, as well as laboratory fee schedule amounts for these codes. The policy has been revised to reflect these 1999 HCPCS changes and the 1999 laboratory fee schedule amounts for H. Pylori.

Helicobacter pylori is a gram-negative rod that is adapted to survive in the highly acid gastric environment. It plays a major role in the pathogenesis of peptic ulcer disease and to the development of chronic active gastritis. H. pylori infection is an independent risk factor for gastric cancer and primary gastric malignant lymphoma.

The breath test for H. pylori is a non-invasive diagnostic procedure utilizing analysis of breath samples to determine the presence of H. pylori. The test is positive when an active H. pylori infection is present, and is negative with eradication of the infection. The breath test can detect H. pylori colonization with reported 95% accuracy. There are several different types of breath tests available, depending on the use of 13C or 14C isotope.

The carbon-13 breath test (not radioactive) consists of analysis of breath samples before and after ingestion of 13C-urea. 13C-urea will decompose to form 13CO<sub>2</sub> and NH<sub>4</sub> in the presence of urease, which is produced by H. pylori in the stomach. The 13CO<sub>2</sub> is absorbed in the blood, then exhaled in the breath. The exhaled breath sample is then analyzed and compared with the baseline breath sample which was obtained before the ingestion of the 13C-urea.

The 14C-urea breath test (radioactive) is performed by having the patient swallow a capsule containing C-14 urea. A breath sample is collected in a balloon or vial 10 minutes later. The sample is then mixed with scintillation fluid and analyzed by a scintillation counter.

There are other tests that can aid in the detection of peptic ulcer disease. These include EGD (Esophagogastroduodenoscopy) with tissue examination, serum antibody test, and radiological examination.

#### Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the breath test for H. pylori to be medically reasonable and necessary for the following conditions:



A patient has uncomplicated symptoms of peptic ulcer disease (i.e., epigastric pain, dyspepsia, nausea, and anorexia) and antibiotic therapy is planned if the H. pylori breath test is positive, and no gastrointestinal endoscopy has been done within the preceding six weeks or is planned;

An upper gastrointestinal contrast series has been done which shows duodenal ulcer or significant gastritis and/or duodenitis, and no endoscopy has been done within the preceding six weeks or is planned; and/or

There are persistent or recurrent symptoms six weeks after appropriate antibiotic and H3 antagonist treatment for a documented H. pylori infection and no endoscopy has been planned.

Medicare of Florida will consider the breath test for H. pylori not medically necessary in the following situations:

Patients who are being screened for H. Pylori infection in the absence of documented upper gastrointestinal tract symptoms and/or pathology;

Patients who have had an upper gastrointestinal endoscopy within the preceding six weeks or for whom an upper gastrointestinal endoscopy is planned;

Patients who have new onset dyspepsia responsive to conservative treatment (withdrawal of nonsteroidal antiinflammatory drugs and/or use of antisecretory agents);

Patients who have non-specific dyspeptic symptoms with a negative H. pylori serum antibody test, and/or

Patients who are asymptomatic after treatment of an H. pylori infection (either proven or suspected). Therefore, repeating the breath test for mere confirmation of treatment success will not be covered.

#### HCPCS Codes

83013 Helicobacter pylori, breath test analysis; (Note: use this code for 13C and 14C Breath Test)

83014 drug administration and sample collection (Note: use this code for 13C and 14C Breath Test)

#### ICD-9 Codes That Support Medical Necessity

151.0-151.9  
531.30-531.31  
531.70-531.71  
532.30-532.31  
532.70-532.71  
534.30-534.31  
534.70-534.71  
535.00  
535.10  
789.01  
789.02  
789.06

Reasons for Denial

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

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Documentation Requirements

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

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.

Laboratory Fee Schedule Amounts

The following laboratory fee schedule amounts are effective for January 1, 1999:

83013	\$88.80
83014	\$10.86

Advance Notice Statement

Applies to medical necessity (see page 4).

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84066: Phosphatase, Acid: Prostatic

Acid Phosphatase (84066) levels are used to aid in the diagnosis of metastatic cancer of the prostate gland and to follow the effectiveness of treatment. This laboratory procedure is rarely used except to confirm other procedures that are more specific

and sensitive, (Prostate Specific Antigen) in diagnosis of Prostatic disease. It is known that elevated levels of acid phosphatase are seen in patients with prostate cancer that has metastasized beyond the capsule to other parts of the body, especially the bone. It is believed that once resulting in an increase in the blood level. The prostatic fraction procedure specifically measures the concentration of prostatic acid phosphatase secreted by cells of the prostate gland in contrast to the total enzyme activity, which is an indirect measurement.

#### Indications and Limitations of Coverage and/or Medical Necessity

Acid Phosphatase (84066) is a covered service under the Medicare program, when it is performed by or under the direct supervision of a physician.

The acid phosphatase is indicated to aid in the diagnosis and staging of metastatic cancer of the prostate and to monitor the effectiveness of treatment.

#### HCPCS Codes

84066

Phosphatase, acid; prostatic

#### ICD-9 Codes That Support Medical Necessity:

185  
198.5  
199.0  
199.1  
222.2  
233.4  
236.5  
239.5  
790.93  
V10.46

#### Reasons for Denial

Phosphatase acid; prostatic (84066) is considered noncovered as a screening mechanism.

#### Coding Guidelines

V70.0-70.9 (General medical examination) should be used in the absence of any signs or symptoms to indicate screening.

A prostate specific antigen; total (84153) and/or an Immunoassay for tumor antigen (86316) often will be drawn in conjunction with an acid phosphatase (84066).

Procedure code 84066 is reimbursable under the clinical laboratory fee schedule.

#### Documentation Requirements

Medical record documentation (i.e., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, a copy of the test 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 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.

#### Other Comments

The Focused Medical Review process has revealed that the billing for Acid Phosphatase (84066) exceeds acceptable standards. The most commonly billed diagnoses are general symptoms and laboratory examination. A diagnosis appendix has been created to assist in establishing medical necessity. All claims filed by Independent Clinical Laboratories (specialty 69) not having an appropriate diagnosis will suspend for further medical review.

#### Advance Notice Requirement

Applies to medical necessity (see page 4).

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#### 85007-85031: Complete Blood Count

The complete blood count (CBC) is a series of tests of the peripheral blood that provides a tremendous amount of information about the hematologic system and many other organ systems, prognosis, response to treatment, and recovery. The CBC consists of the following tests that determine number, variety, percentage, concentrations and quality of blood cells: White blood count (WBC), Differential white cell count (Diff), Red blood count (RBC), Hematocrit (HCT), Hemoglobin (HGB), red blood cell indices: Mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), mean corpuscular hemoglobin concentration (MCHC), blood smear, and platelet count (PLT).

The major function of the white blood cell (leukocyte) is to fight infection, react against foreign bodies or tissues, and to produce, or at least transport and distribute antibodies in the immune response. The WBC count has two components. One is a count of the total number of WBC's in 1 mm<sup>3</sup> of peripheral venous blood.

The other component, the differential count, measures the percentage of each type of leukocyte (i.e., neutrophils, lymphocytes, monocytes, eosinophils and basophils) present in the same specimen. An increased total WBC count (leukocytosis) usually indicates infection, inflammation, tissue necrosis, or leukemic neoplasia. Leukopenia (i.e., a decreased WBC count) occurs in many forms of bone marrow failure (e.g., following antineoplastic chemotherapy or radiation therapy, overwhelming infections and autoimmune diseases).

The Red Blood Cell Count (Erythrocyte) determines the total number of circulating red blood cells in a cubic millimeter of blood. It is an important measurement in the determination of anemia or polycythemia. This test in conjunction with the other red blood cell production tests (HCT and HGB) are closely related. The same underlying conditions will cause an increase/decrease in each of these three tests.

The Hematocrit is an important measurement in the determination of anemia or polycythemia. The purpose of this test is to determine the red blood cell mass by measuring space occupied by packed red blood cells. The results are expressed as the percentage of red cells in the volume of whole blood. Normal values range from 42% to 52% for men and 37%-47% in women.

Hemoglobin, the main component of erythrocytes, serves as the vehicle for the transportation of oxygen and carbon dioxide. It also serves as an important buffer in the extracellular fluid. HGB is important in the evaluation of anemia. Normal values range from 13.5-18 g/dl in men and 12-16 g/dl in women.

The RBC indices provide information about the size (MCV and RDW), weight (MCH), and hemoglobin concentration (MCHC) of RBC's. Cell size is indicated by the terms normocytic, microcytic and macrocytic. Hemoglobin content is indicated by the terms normochromic, hypochromic, and hyperchromic. Additional information about the RBC size, shape, color, and intracellular structure can be obtained from the blood smear study. The RBC indices are discussed below:

1)

Mean corpuscular volume: The MCV is a measure of the average volume or size of a single RBC, and is therefore, used in classifying anemias. MCV is derived by dividing the hematocrit by the total RBC count. Normal values vary according to age and gender. When the MCV value is increased, the RBC is said to be abnormally large, or macrocytic. This is most frequently seen in megaloblastic anemias (e.g., vitamin B12 or folic acid deficiency). When the MCV value is decreased, the RBC is said to be abnormally small, or microcytic. This is associated with iron deficiency anemia or thalassemia.

2)

Mean corpuscular hemoglobin: The MCH is a measure of the average amount (weight) of hemoglobin within an RBC. MCH is derived by dividing the total hemoglobin concentration by the number of RBCs. Because macrocytic cells generally have more and microcytic cells less hemoglobin, the causes for these values closely resemble those for the MCV value.

3)

Mean corpuscular hemoglobin concentration: The MCHC is a measure of the average concentration or percentage of hemoglobin within a single RBC. MCHC is derived by dividing the total hemoglobin concentration by the hematocrit. When values are decreased, the cell has a deficiency of hemoglobin and is said to be hypochromic (frequently seen in iron deficiency anemia and thalassemia). When values are normal, the anemia is said to be normocytic (e.g., hemolytic anemia).

4)

Red blood cell distribution width: The RDW is an indication of the variation in RBC size. It is calculated by a machine using the MCV and RBC values. Variations in the width of the RBCs may be helpful when classifying certain types of anemia. The RDW is essentially an indicator of the degree of anisocytosis, a blood condition characterized by RBCs of variable and abnormal size.

The blood smear is the most informative of all hematologic tests. All three hematologic cell lines (RBC's, WBC's, platelets) can be examined. Microscopic examination of the RBC's can reveal variation in RBC size (anisocytosis), shape (poikilocytosis), color, or intracellular content.

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Classification of RBCs according to these variables is most helpful in identifying the causes of anemia.

The WBCs are examined for total quantity, differential count, and degree of maturity. An increased number of immature WBCs may indicate leukemia. A decreased WBC count indicates failure of marrow to produce WBCs, resulting from drugs, chronic disease, neoplasia, or fibrosis.

The platelet count is an actual count of the number of platelets (thrombocytes) per cubic milliliter of blood. Platelet activity is essential to blood clotting. Counts of 150,000 to 400,000/mm<sup>3</sup> are considered normal. Counts less than 100,000/mm<sup>3</sup> may indicate thrombocytopenia. Causes of thrombocytopenia include:

Reduced production of platelets (secondary to bone marrow failure or infiltration of fibrosis, tumor, etc.);

Sequestration of platelets (secondary to hypersplenism);

Accelerated destruction of platelets (secondary to antibodies, infections, drugs, prosthetic heart valves);

Consumption of platelets (secondary to disseminated intravascular coagulation); and/or

Platelet loss from hemorrhage.

Thrombocytosis is said to exist when platelet counts are greater than 400,000/mm<sup>3</sup>. This may occur as a compensatory response to severe hemorrhage. Other conditions associated with thrombocytosis include polycythemia vera, leukemia, postsplenectomy syndrome and various malignant disorders.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part B will consider a complete blood count medically reasonable and necessary for the following conditions:

Presence of abnormal signs or symptoms such as pallor, weakness, significant tiredness, abnormal bleeding, etc. which may suggest an anemic condition. The ICD diagnosis code normally billed for this indication may include: 780.2, 780.4, 780.7, 782.61, 782.62, 782.7, 785.0, 786.09;

Monitoring of patients with previously diagnosed anemias (i.e., iron deficiency, aplastic, hemolytic, etc.). The ICD diagnosis code normally billed for this indication may include: 280.0-285.9;

Evaluation of patients on medications or treatments that affect blood components (i.e., chemotherapy, radiation therapy, antibiotics, aspirin, etc.). Note: there are certain medications especially Gold Salt and penicillamine, used in the rheumatology field that require CBC'S every 2-4 weeks during therapy. The ICD diagnosis code normally billed for this indication may include: E934.0-E934.1;

Patients with known acute or chronic diseases (i.e., acute or recurrent peptic disease, renal failure, systemic lupus erythematosus, liver disease, rheumatoid arthritis, eating disorders, etc.), injury, leukemia, infections, reaction to inflammation, dehydration if the results can be expected to contribute to the management of the patient;

Patients with acute or chronic blood loss;

Patients with splenomegaly (includes post splenectomy). The ICD diagnosis code normally billed for this indication may include: 789.2; and/or

Patients undergoing a major surgical procedure (ie., abdominal, thoracic, carotid, cranial or femoral/popliteal surgery) in which significant blood loss may result.

Platelet counts with a hemogram would be clinically indicated when a condition falls into one of the following categories:

When signs and symptoms suggest a possible hemorrhagic condition;

To assess the effects of chemotherapy or radiation therapy on platelet formation. The ICD diagnosis code normally billed for this indication may include: V58.61-V58.69, V67.1, V67.2, E934.2-E934.9, E935.3;

To aid in the diagnosis of thrombocytopenia and thrombocytosis. The ICD diagnosis code normally billed for this indication may include: 286.0-289.9; or

To confirm a visual estimate of platelet number and morphology from a previous stained blood film.

A complete blood count can be ordered initially if indications for testing are met. Repeat testing for a CBC or portions thereof will be allowed if it can be expected to provide information for further management or to evaluate a response to therapy (e.g., several days after iron therapy for an iron deficiency anemia). Frequent testing is not expected except under unusual circumstances (i.e., acute bleeding, etc.).

#### HCPCS Codes

85007 Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)

85008 manual blood smear examination without differential parameters

85009 differential WBC count, buffy coat

85013 spun microhematocrit

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85014 other than spun hematocrit



85018 hemoglobin

85021 hemogram, automated (RBC, WBC, Hgb, Hct and indices only)

85022 hemogram, automated, and manual differential WBC count (CBC)

85023 hemogram and platelet count, automated, and manual differential WBC count (CBC)

85024 hemogram and platelet count, automated, and automated partial differential WBC count (CBC)

85025 hemogram and platelet count, automated, and automated complete differential WBC count (CBC)

85027 hemogram and platelet count, automated

85031 Blood count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)

Reasons for Denial

85029 (additional automated hemogram indices e.g., red cell distribution width (RDW), mean platelet volume, white cell histogram; one to three indices) and 85030 (four or more indices) are not reimbursable as they are computerized calculations. Medicare does not pay for manual or automated percentage, ratios, or calculations. Effective January 1, 1999, HCPCS Codes 85029 and 85030 will not be valid for Medicare.

Complete blood count screening (including routine pre-op) performed on apparent normal and asymptomatic individuals or in the absence of known disease, injury or abnormal signs or symptoms is considered noncovered. Screening CBC's should be billed utilizing diagnosis V72.6 (Special investigations and exam, laboratory).

Noncovered ICD-9 Code(s):

V01.9 V07.8-V07.9 V40.0-V40.9 V58.9 V64 .0-V  
64.4 V67. 59 V67.6 V67.9 272.0-272 .9 278.00  
278.1 2 90.0- 290.9 29 5.00-295.95 298.0-298.9  
307.80-307.89 307.9 331.0 331.1 331.2 332.0-332.1 366.00-3  
66.9 369. 00-369.9380.4401.0-401.9455.0455.3455.6627.3700701.0-  
701.9 702.0-702.8 724.00-724.09735.00-735.9736.00-736.9737.0-  
737.9 739.0-739.9743.30-743.39780.31-780.39780.50-780.59780.8  
780.9796.2799.0-799.9840.0-848.9

Coding Guidelines

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

Certain laboratory tests are included in the composite rate when performed for End Stage Renal Disease (ESRD) beneficiaries within the frequency identified in the Medicare Carrier's Manual. The following hematology tests are included in the composite rate at the frequency indicated below:

Hct and Hgb every month for patients undergoing continuous ambulatory peritoneal dialysis (CAPD).

Hct and Hgb per treatment; CBC every month, for patients undergoing hemodialysis/hemofiltration, peritoneal dialysis and continuous cyclical peritoneal dialysis.

Certain laboratory tests for CAPD patients are billed separately when performed at independent dialysis facilities. The following hematology tests are not included in the composite rate and are separately billable when performed at the frequency identified in the Medicare Carrier's Manual:

WBC, RBC and platelet count every three months.

CPT codes 85023, 85024, 85025, or 85027 should be billed when a complete blood count with platelet is medically indicated. If there are no clear medical indications for the platelet count, the CPT code will be down coded to 85022 and reimbursed accordingly.

CBC's performed for rheumatoid arthritis patients being treated with the following medications should submit the indicated diagnosis on the claim:

Diagnosis code E933.1 for patients on antineoplastic and immunosuppressive drugs such as Methotrexate and Imuran;

Diagnosis code E935.6 (Antirheumatics) for patients on Gold Salts; or

Diagnosis code E933.8 (Other systemic agents not elsewhere classified) for patients on a penicillamine.

#### Documentation Requirements

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

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.

#### Other Comments

Routine testing is not allowed to secure a baseline for minor surgical procedures when performed without associated signs and symptoms or a disease process that demonstrates an anemic condition.

#### Advance Notice Requirement

Applies to medical necessity (see page 4).

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88141-88145, 88150-88155, 88164-88167: Pap Smears

Pap Smear (Papanicolaou Smear/Test) is a cytologic examination of a vaginal smear for early detection of cancer (especially of the cervix and uterus), employing exfoliated cells and a special staining technique which differentiates diseased tissue.

#### Indications and Limitations of Coverage and/or Medical Necessity

##### Diagnostic Pap Smear

Diagnostic Pap smears and related services are covered under Medicare Part B when ordered by a physician under one of the following conditions:

Previous cancer of the cervix, uterus or vagina that has been or is presently being treated

Previous abnormal Pap smear

Abnormal findings of the vagina, cervix, uterus, ovaries or adnexa

Significant complaint pertaining to the female reproductive system

Any signs or symptoms that the physician judges to be reasonably related to a gynecologic disorder. The carrier's medical staff determines whether a previous malignancy at another site is an indication for a diagnostic Pap smear or whether the test must be considered a screening Pap smear.

#### HCPCS Codes

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

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

88143 with manual screening and rescreening under physician supervision

88144 with manual screening and computer-assisted rescreening under physician supervision

88145 with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

88150 Cytopathology, slides, cervical or vaginal; manual screening under physician supervision

88152 with manual screening and computer-assisted rescreening under physician supervision

88153 with manual screening and rescreening under physician supervision

88154 with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

88155 Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services)

88164 Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision

88165 with manual screening and rescreening under physician supervision

88166 with manual screening and computer-assisted rescreening under physician supervision

88167 with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

ICD-9 Codes That Support Medical Necessity

016.7 0 -016.76 05 4.1 0 054.11 054 .12 078.0  
078.10 -078.19 09 0.0-0 99.9 11 2.1 11 2.2 13  
1.00- 131.9 170 .6 171 .6 179 18 0.0-1 80.9  
181 182 .0-18 2.8 183. 0-183 .8 184. 0-184 .9 19 8.6 1  
98.82 218.0-218.9 219.0-219 .9 220 221.0-221.9 233.0-  
233.3 233.9 236.0-236.3 239.5 256.0-256.9 616.0 616.10-  
616.11 616.2 616.50-616.51 616.8  
616.96 17.0 617.96 20.0 620.16 20.2 620.86 21.0 621.16 21.2 621.86 22.0  
622.16 22.7 622.86 23.0 623.56 23.7 623.86 24.6 624.86 26.2 626.66 26.7  
626.86 26.9 627.16 27.2 627.36 27.8 627.96 28.0-628.96 54.10-654.14 795.0

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Screening Pap (P3000)

Screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioners (e.g., a certified nurse midwife, physician assistant, or nurse practitioner) under one of the following conditions: ]

No prior test for the preceding 3 years use ICD-9 code V76.2

There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years (use ICD-9 code V15.89)

There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical or vaginal cancer (use ICD-9 code V15.89).

Note: Payment is not made for a screening Pap smear for women at high risk or who qualify under the childbearing provision more frequently than once every year.

The high risk factors for cervical cancer include:

Early onset of sexual activity (under 16 years of age)

Multiple sexual partners (five or more in a lifetime)

History of a sexually transmitted disease (including HIV infection)

Fewer than 3 negative Pap smears within the previous 7 years

The high risk factors for vaginal cancer include:

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

HCPCS Codes

G0123

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

G0124

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

G0143

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

G0144

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

G0145

Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted

reevaluation using cell selection and review under physician supervision

P3000

Screening Papanicolaou smear, cervical or vaginal, up to three smears, (any reporting system), evaluation by cytotechnologist under physician supervision

P3001

Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

Q0091

Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

ICD-9 Codes That Support Medical Necessity

V15.89

V76.2

Reasons for Denial

Payment will not be allowed for a diagnostic pap smear (88141-88145; 88150-88155; 88164-88167) and a screening pap smear (G0123-G0124; G0143-G0145; P3000-P3001, Q0091) on the same date of service.

All diagnostic ICD-9 codes not listed as covered.

A screening Pap smear performed more than once in 3 years and high risk factors are not present.

Coding Guidelines

G0124 and P3001 are professional component only codes effective 1/1/99. Use G0123 or P3000 for the technical components of these screening exams.

For services on or after January 1, 1999, separate payment is allowed under the physician fee schedule for pap smear exams for patients in any setting if the laboratory screening personnel suspect an abnormality, and the physician reviews and interprets the pap smear (G0124, P3001, or 88141).

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The pap smear codes are grouped by three code families. Choose the one code that best describes the screening method(s) used. The code families are 88142-88145; 88150-88154 and 88164-88167.

No payment is recognized for code 85060 furnished to hospital outpatients or nonhospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

Code 88142 is not an add-on code. It is not appropriate to report this code in addition to a code from the 88150-88154 or 88164-88167 series if the only laboratory procedures performed was a pap smear with thin layer preparation.

#### Documentation Requirements

Documentation required for medical review includes history, physical, progress notes and the pathology report. This should be maintained in the patient's permanent record, to be made available in the event of a review request.

#### Other Comments

Effective January 1, 1998, as a result of legislation included in the Balanced Budget Act of 1997, Medicare Part B now covers screening Pap smears every 3 years or more frequent coverage for women (1) at high risk for cervical or vaginal cancer, or (2) of childbearing age who have had a Pap smear during any of the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality.

\*\*\*\*\*  
88230, 88269, 88280-88299: Cytogenetic Studies

Cytogenetics is the study of chromosomes by light microscopy. Cytogenetic testing is used to study an individual's chromosome makeup. The term karyotyping refers to the arrangement of cell chromosomes in order from the largest to the smallest to analyze their number and structure. Cytogenetic testing involves the determination of chromosome number and structure; variations in either can produce numerous abnormalities. With cytogenetic testing, the total chromosome count is determined first, followed by the sex chromosome complement and then by any abnormalities. A normal karyotype of chromosomes consists of a pattern of 22 pairs of autosomal chromosomes and a pair of sex chromosomes; XY for the male, and XX for the female. A plus (+) or minus (-) sign indicates, respectively, a gain or loss of chromosomal material.

Specimens for cytogenetic analysis can be obtained for routine analysis from the peripheral blood, in which case T lymphocytes are examined; from amniotic fluid for culture of amniocytes; from trophoblastic cells from the chorionic villus; from bone marrow; and from cultured fibroblasts, usually obtained from a skin biopsy. Enough cells must be examined so that the chance of



missing a cytogenetically distinct cell line (a situation of mosaicism) is statistically low. For most clinical indications, 20 mitoses are examined and counted under direct microscopic visualization, and two are photographed and karyotypes are prepared. Observation of aberrations usually prompts more extended scrutiny and in many cases further analysis of the original culture.

#### Indications and Limitations of Coverage and/or Medical Necessity

Medicare considers cytogenetic studies (88230-88299) to be medically reasonable and necessary for the diagnosis and treatment of the following conditions:

Effective for services on or after October 1, 1979

Genetic disorders (e.g., mongolism) in a fetus; (758.0-758.9)

Failure of sexual development; or (259.0)

Chronic myelogenous leukemia. (205.10-205.11)

Effective for services performed on or after July 16, 1998

Acute leukemias lymphoid (FAB L1-L3), Acute leukemias myeloid (FAB M0-M7), and Acute leukemias unclassified; or (204.00-204.01, 205.00-205.01, 208.00-208.01)

Myelodysplasia. (238.7)

#### HCPCS Codes

88230 Tissue culture for non-neoplastic disorders; lymphocyte

88233 skin or other solid tissue biopsy

88235 amniotic fluid or chorionic villus cells

88237 Tissue culture for neoplastic disorders; bone marrow (myeloid) cells

88239 solid tumor

88240 Cryopreservation, freezing and storage of cells, each cell line

88241 Thawing and expansion of frozen cells, each aliquot

88245 Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells

88248 baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)

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88249 score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)

88261 Chromosome analysis; count 5 cells, 1 karyotype, with banding

88262 count 15-20 cells, 2 karyotypes, with banding

88263 count 45 cells for mosaicism, 2 karyotypes, with banding

88264 analyze 20-25 cells

88267 Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding

88269 Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding

88271 Molecular cytogenetics; DNA probe, each (eg, FISH)

88272 chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)

88273 chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)

88274 interphase in situ hybridization, analyze 25-99 cells

88275 interphase in situ hybridization, analyze 100-300 cells

88280 Chromosome analysis; additional karyotypes, each study

88283 additional specialized banding technique (eg, NOR, C-banding)

88285 additional cells counted, each study

88289 additional high resolution study

88291 Cytogenetics and molecular cytogenetics, interpretation and report

88299 Unlisted cytogenetic study

ICD-9 Codes That Support Medical Necessity:

204.00-204.01  
205.00-205.01  
205.10-205.11

208.00-208.01  
238.7  
259.0  
758.0-758.9

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.

Documentation Requirements

All claims for procedure code 88299 (Unlisted cytogenetic studies) must be submitted with medical record documentation.

The medical record documentation must indicate the medical necessity for performing the test. In addition, documentation that the service was performed including the test results should be in the patient's medical record. This information is usually found in the history and physical, office/progress notes, and/or laboratory results.

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

Advance Notice Requirement

Applies to medical necessity (see page 4).

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90657-90659, G0008: Influenza Virus Vaccine

Influenza virus vaccine is indicated for immunization against influenza viruses containing antigens related to those in the vaccine. This is strongly recommended for those people who are at an increased risk of complications from influenza. Although the current influenza virus vaccine can contain one or more antigens used in previous years, annual immunization using the current vaccine is necessary because immunity declines in the year following immunization.

Indications and Limitations of Coverage and/or Medical Necessity

Reimbursement for influenza virus vaccine 90657, 90658, 90659 and its administration (G0008) is a covered service under Medicare Part B regardless of the setting in which it is furnished. Reimbursement is at 100% of the reasonable charge. Medicare does

not require that the flu vaccine be administered under a physician's order or under physician supervision. Up to two influenza virus vaccinations may be allowed per rolling calendar year.

Although ICD-9 code V04.8 is the appropriate diagnosis for the Influenza Virus Vaccine, all diagnoses will be accepted. This is done because the goal of the program is to improve beneficiary health by the increased use of covered preventative services.

#### HCPCS Codes

G0008 Administration of influenza virus vaccine

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

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

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

#### Coding Guidelines

For services on or after October 1, 1994, G0008 (administration of influenza virus vaccine) should be used with 90724.

Effective January 1, 1999 HCPCS Code 90724 is being deleted. There will be a 90 day grace period for 90724. After January 1, 1999, influenza virus vaccine should be reported with 90657, 90658, and 90659. Administration of influenza virus vaccine G0008 should be used with 90657, 90658, and 90659.

Note: Providers should continue to use procedure code 90724 until April 1, 1999 to ensure prompt payment of claims. Due to Year 2000 systems testing, the new influenza virus vaccine codes 90657, 90658, and 90659 should not be billed until April 1, 1999.

#### Documentation Requirements

When the number of influenza vaccine services exceed parameters, a medical review will be required. Providers will need to submit office records or a narrative statement indicating that a different or new vaccine was administered for a new or different influenza season/epidemic.

Electronic Media Claims can be submitted for these services.

#### Advance Notice Requirement

The influenza virus vaccine is covered by Medicare Part B if it is furnished within the accepted standards of medical practice.

For services which exceed the accepted standards of medical practice, an acceptable advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for the service.

\*\*\*\*\*  
90669, 90732, G0009: Pneumococcal Vaccinations

Pneumococcal vaccine is available to reduce the chances of developing pneumonia in patients considered to be at high risk of acquiring a pneumococcal infection.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part B reimburses pneumococcal vaccinations (90669 and 90732) at 100% of the reasonable charge if it is ordered by a physician who is a doctor of medicine or osteopathy. The presence of a physician is not required if a previously written physician order or standing order exists which specifies that the following conditions are met for any person receiving the vaccine:

- the person's age, health, and vaccination status have been determined
- a signed consent was obtained
- the vaccine is administered only to persons at high risk of pneumococcal disease and have not been previously vaccinated, and

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revaccination with pneumococcal vaccine is covered when ordered by a physician for patients at highest risk of pneumococcal disease

a record of vaccination is provided.

Persons considered to be at high risk include, but are not limited to, the following:

all people age 65 and older

immunocompetent adults at increased risk due to chronic disease (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks), and

individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation

individuals who have been shown to have a rapid decline in pneumococcal antibody levels.

In the event that a pneumococcal vaccine is being administered via a standing order to a patient who was previously vaccinated or who has an unknown vaccination record, the patient must be referred to the personal physician or, a specific physician order for that patient (written or by telephone) must be obtained prior to vaccination.

#### HCPCS Codes

90669 Pneumococcal conjugate vaccine, polyvalent, for intramuscular use

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

G0009 Administration of pneumococcal vaccine

#### Reasons for Denial

Patient is not at high risk (definition determined from Indications and Limitations of Coverage).

#### Coding Guidelines

Code administration of pneumococcal vaccine with G0009. Code pneumococcal vaccine with 90669 and 90732.

#### Documentation Requirements

Medical records must contain sufficient information to show the medical necessity of the service. See Indications and Limitations of Coverage.

#### Other Comments

Reimbursement is not be made for administration if payment is not made for the vaccine.

#### Advance Notice Requirement

The pneumococcal vaccine is covered by Medicare Part B if it is furnished within the accepted standards of medical practice. For services which exceed the accepted standards of medical practice, an acceptable advance notice of Medicare's denial of payment must

be provided to the patient when the provider does not want to accept financial responsibility for the service.

\*\*\*\*\*

90744-90747, G0100: Hepatitis B Vaccine

Hepatitis B is a viral disease caused by the Hepatitis B virus causing inflammation of the liver. The virus is shed in all body fluids by individuals with acute or chronic infections and by asymptomatic carriers.

Indications and Limitations of Coverage and/or Medical Necessity

Reimbursement may be made for Hepatitis B Vaccine when administered to a patient who is at high or intermediate risk for contracting Hepatitis B.

High risk

End-Stage Renal Disease (ESRD) patients,

Hemophiliacs who receive Factor VIII or IX concentrates,

Clients of institutions for the mentally retarded,

Persons who live in the same household as a Hepatitis B Virus (HBV) carrier,

Homosexual men,

Illicit injectable drug abusers

Intermediate risk

Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

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Exception

Persons in the above-listed groups would not be considered at high or intermediate risk of contracting Hepatitis B if there is laboratory evidence positive for antibodies to Hepatitis B. (ESRD patients are routinely tested for Hepatitis B antibodies as part of their continuing monitoring and therapy).

A charge separate from the ESRD composite rate will be recognized and paid for the administration of the vaccine to ESRD patients.

Reimbursement for the administration of Hepatitis B vaccine (G0010) is a covered service in conjunction with Hepatitis B vaccine.

The following list of covered ICD-9 codes is not an all inclusive list. Claims with other than listed diagnoses will be reviewed for medical necessity.

#### HCPCS Codes

90744 Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use

90745 Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use

90746 Hepatitis B vaccine, adult dosage, for intramuscular use

90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use

G0010 Administration of Hepatitis B vaccine

#### ICD-9 Codes That Support Medical Necessity

#### Reasons for Denial

Hepatitis B vaccine is not a benefit when administered to a beneficiary who is not at high or intermediate risk of contracting the disease.

#### Coding Guidelines

Bill using the correct procedure code and related diagnosis.

#### Documentation Requirements

Claims submitted with any diagnosis not listed as covered ICD-9 code must have additional documentation to show medical necessity as stated in Indications and Limitations. This information may be in the form of:

office medical records

history and physical

narrative statement by the physician



For claims submitted with a covered ICD-9 code, the office medical records must contain sufficient information to show medical necessity as stated in Indications and Limitations.

\*\*\*\*\*  
90780-90799: Therapeutic or Diagnostic Infusion/Injections

Therapeutic or diagnostic injections are administered either as prolonged IV infusion or as intradermal, subcutaneous, intramuscular or routine IV drug injections. Codes exist for all types of drug administration.

Indications and Limitations of Coverage and/or Medical Necessity

Hydration therapy intravenous (IV) infusion (90780-90781) is considered bundled into the payment for CPT codes 96410, 96412, 96414 (chemotherapy IV infusion) when billed for on the same day by the same physician.

Reimbursement for infusion injection codes (90780-90781) are allowed in addition to the evaluation and management visit, and chemotherapy administration (96410, 96412, 96414) and the cost of the drug(s) when billed on the same date of service using the GB modifier.

Reimbursement for therapeutic or diagnostic injections codes (90782-90788) are only paid if there are no other services payable under the physician fee schedule when billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. Separate payment will be made for the cost of the drug(s).

Multiple administrations may be reported in conjunction with chemotherapy administration codes only if two separate IV routes are established.

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HCPCS Codes

90780 IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour

90781 each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)

90782 Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular

90783 Intra-arterial

90784 Intravenous

90788 Intramuscular injection of antibiotic (specify)

90799 Unlisted therapeutic or diagnostic injection

#### Reasons for Denial

If a noncovered drug is administered, both the drug (or injected substance) and the administration (90780-90799) are noncovered items. It is not appropriate to bill a covered CPT -IV code for the administration. The claim should be reported with code A9270 (noncovered item or service).

#### Coding Guidelines

Services encompassing prolonged IV injections (90780-90781) require the presence or direct supervision of the physician during the infusion.

Intravenous (90784) administration should be billed when an IV therapeutic injection such as an anti-emetic is administered on the same day as chemotherapy services.

EPO-Procrit is usually given subcutaneously. The appropriate code to use would be 90782.

Refer to codes 95115-95117 for allergy immunizations injections.

Refer to codes 96400-96450 for chemotherapy administration injections.

#### Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

\*\*\*\*\*  
92081-92083 - Visual Field Examination

Recently, a revision of the local medical review policy for visual field examination was performed. Since the policy has not been published within the last year, it is being republished in its entirety.

The visual field is the area within which objects may be seen when the eye is fixed. To standardize testing, several automated and computerized perimeters are available. However, manual perimeters are also utilized.

Visual field examinations (procedure codes 92081, 92082, and 92083) will be considered medically necessary under any of the following conditions:

The patient has inflammation or disorders of the eyelids potentially affecting the visual field.

The patient has a documented diagnosis of glaucoma.

Please note that the stabilization or progression of glaucoma can be monitored only by a visual field examination, and the frequency of such examinations is dependent on the variability of intraocular pressure measurements (i.e., progressive increases despite treatment indicate a worsening condition), the appearance of new hemorrhages, and progressive cupping of the optic nerve.

The patient is a glaucoma suspect as evidenced by an increase in intraocular pressure, asymmetric intraocular measurements of greater than 2-3 mm Hg between the two eyes, or has optic nerves suspicious for glaucoma which may be manifested as asymmetrical cupping, disc hemorrhage, or an absent or thinned temporal rim.

The patient has a documented disorder of the optic nerve, the neurologic visual pathway, or retina.

Please note that patients with a previously diagnosed retinal detachment do not need a pretreatment visual field examination. Additionally, patients with an established diagnosed cataract do not need a follow-up visual field unless other presenting symptomatology is documented. In patients who are about to undergo cataract extraction, who do not have glaucoma and are not glaucoma suspects, a visual field would not be indicated.

The patient has a recent intracranial hemorrhage, an intracranial mass or a recent measurement of increased intracranial pressure with or without visual symptomatology.

The patient has a recently documented occlusion or/and stenosis of cerebral and precerebral arteries, a recently diagnosed transient cerebral ischemia or giant cell arteritis.

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The patient having an initial workup for buphthalmos, congenital anomalies of the posterior segment or congenital ptosis.

The patient has inflammation or disorders of the orbit, potentially affecting the visual field.

The patient has sustained a significant eye injury.

The patient has an unexplained visual loss which may be described as "trouble seeing or vision going in and out."

The patient has a pale or swollen optic nerve documented by a visual exam of recent origin.

The patient is having some new functional limitations which may be due to visual field loss (i.e., reports by family that patient is running into things).

The patient is being evaluated initially for macular degeneration or has experienced central vision loss resulting in vision measured at or below 20/70.

The patient is receiving or has completed treatment of a high-risk medication that may cause visual side effects, (i.e., a patient on plaquenil may develop retinopathy).

Please note that repeated examinations for a diagnosis of macular degeneration or an experienced central vision loss are not necessary unless changes in vision are documented or to evaluate the results of a surgical intervention.

ICD-9 Codes That Support Medical Necessity:

094.81-094.89  
095.8  
190.0-190.9  
191.0-191.9  
192.0  
192.1  
198.4  
224.0-224.9  
225.1  
227.3  
234.0  
237.0  
237.1  
237.70  
239.7  
239.8  
242.00-242.01  
242.10-242.11  
250.50-250.53  
259.8  
264.0-264.9  
282.60-282.69  
300.11  
346.00-346.01  
346.10-346.11  
346.20-346.21

346.80-346.81  
346.90-346.91  
348.2  
360.00-360.03  
360.04  
360.11  
360.12  
360.13  
360.14  
360.19  
360.20  
360.21  
360.23  
360.24  
360.29  
360.30  
360.31  
360.32  
360.33  
360.34  
360.40-360.44  
360.50-360.59  
360.60-360.69  
360.81-360.89  
360.9  
361.00-361.07  
361.10-361.19  
361.2  
361.30-361.33  
361.81-361.89  
361.9  
362.01-362.02  
362.10-362.18  
362.21-362.29  
362.30-362.37  
362.40-362.43  
362.50-362.57  
362.60-362.66  
362.70-362.77  
362.81-362.89  
362.9  
363.00-363.08  
363.10-363.15  
363.20-363.22  
363.30-363.35  
363.40-363.43  
363.50-363.57  
363.61-363.63  
363.70-363.72  
363.8  
363.9  
364.00-364.05  
364.10-364.11  
364.21-364.24  
364.3  
364.41-364.42  
364.51-364.59

364.60-364.64  
364.70-364.77  
364.8  
364.9  
365.00-365.04  
365.10-365.15  
365.20-365.24  
365.31-365.32  
365.41-365.44  
365.51-365.59  
365.60-365.65  
365.81-365.89  
365.9  
366.00-366.09  
366.10-366.19  
366.20-366.23  
366.30-366.34  
366.41-366.46  
366.50-366.53  
366.8  
366.9  
368.00-368.03  
368.10-368.16  
368.2  
368.30-368.34  
368.40-368.47  
368.51-368.59  
368.60-368.69  
368.8  
368.9  
369.00-369.08  
369.10-369.18  
369.20-369.25  
369.3  
369.4  
369.60-369.69  
369.70-369.76  
369.8  
369.9  
370.00-370.07  
370.20-370.24  
370.31-370.35  
370.40-370.49  
370.50-370.59  
370.60-370.64  
370.8  
370.9  
371.00-371.05  
371.10-371.16  
371.20-371.24  
371.30-371.33  
371.40-371.49  
371.50-371.58  
371.60-371.62  
371.70-371.73  
371.81-371.89  
371.9

373.00-373.02  
373.11-373.13  
373.2  
373.31-373.34  
373.8  
373.9  
374.00-374.05  
374.10-374.14  
374.20-374.23  
374.30-374.34  
374.41-374.46  
374.50-374.56  
374.81-374.89  
374.9  
376.00-376.04  
376.10-376.13  
376.21-376.22  
376.30-376.36  
376.40-376.47  
376.50-376.52  
376.6  
376.81-376.89  
376.9  
377.00-377.04  
377.10-377.16  
377.21-377.24  
377.30-377.39  
377.41-377.49  
377.51-377.54  
377.61-377.63  
377.71-377.75  
377.9  
378.00-378.08  
378.10-378.18  
378.20-378.24  
378.30-378.35  
378.40-378.45  
378.50-378.56  
378.60-378.63  
378.71-378.73  
378.81-378.87  
378.9  
379.500-379.59  
379.92  
431  
432.0-432.9  
433.00-433.01  
433.10-433.11  
433.20-433.21  
433.30-433.31  
433.80-433.81  
433.90-433.91  
434.00-434.01  
434.10-434.11  
434.90-434.91  
435.0-435.9  
436

437.0-437.9  
446.5  
743.20-743.22  
743.52-743.58  
743.61-743.69  
921.0-921.9  
930.0-930.9  
950.0-950.9  
951.0  
V58.69  
V67.51

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#### Documentation Requirements

Medical record documentation must indicate the medical necessity for performing the test. In addition, documentation that the service was performed including the results of the Visual Field Examination should be available. This information is normally found in the office notes, progress notes, history and physical, and/or hard copy of the test results.

If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and 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 this order for the test.

#### Advance Notice Statement

Applies to medical necessity (see page 4).

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#### 98925-98929: Osteopathic Manipulative Treatment

Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

#### Indications and Limitations of Coverage and/or Medical Necessity

Manual manipulation of the rib cage contributes to the treatment of respiratory conditions such as bronchitis, emphysema, and asthma as part of a regimen which includes other elements of therapy, and is covered only under such circumstances.

Manipulation of the occipitocervical or temporomandibular regions of the head, when indicated for conditions affecting those portions of the head and neck, is a covered service.



HCPCS Codes

- 98925 Osteopathic manipulative treatment (OMT); one to two body regions involved
- 98926 three to four body regions involved
- 98927 five to six body regions involved
- 98928 seven to eight body regions involved
- 98929 nine to ten body regions involved

Coding Guidelines

Evaluation and management services may be reported separately if, and only if, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure.

Only one OMT procedure code should be billed per day, based on the description of the procedure code. For example, if a patient has three body regions treated in one day, the provider should bill procedure code 98926 (osteopathic manipulative treatment [OMT]; three to four body regions involved). Do not indicate a quantity billed on the HCFA-1500 claim form or on an electronic claim.

Documentation Requirements

The provider has the responsibility to ensure medical necessity for these procedures and must maintain documentation for the possibility of postpayment review

Advance Notice Requirement

Applies to medical necessity requirements (see page 4).

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92980-92984, 92995-92996: Interventional Cardiology

Percutaneous transluminal coronary interventions have, since Gruentzig's 1979 report of coronary balloon angioplasty, substantively altered the management of individuals with symptomatic arteriosclerotic heart disease. Balloon angioplasty rapidly expanded from single to multiple vessels and simple to complex anatomic substrates. Transluminal interventions now encompass balloon dilation, a variety of atherectomy devices and two stents approved for coronary placement. Complementing medical therapy and aortocoronary bypass, transluminal interventions have emerged as a third therapeutic option for the management of

patients with chronic angina, acute coronary insufficiency and evolving myocardial infarction.

In this policy, the Carrier relates existing procedural descriptors, defines indications for coverage and provides documentation and submission instructions. These definitions and instructions are provided to emphasize HCFA policy and philosophic intent, and to provide a flexible framework to meet the challenges of evolving technology and advances in physician experience and expertise. Much of this information has been previously published. It is repeated for clarification and coherence.

#### Indications and Limitations of Coverage and/or Medical Necessity

##### Interventional Cardiology

Transluminal coronary interventions are appropriately considered in those patients who manifest either acute or chronic signs and symptoms of coronary insufficiency, who have not responded adequately to optimize medical therapy, for whom a probative alternative is aortocoronary bypass, who have objective evidence of myocardial ischemia and have lesions amenable to transluminal intervention. Medicare recognizes only three coronary arteries when considering first and additional vessel interventions; the left anterior descending, the left circumflex and the right coronary arteries.

##### HCPCS Codes

92980 Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

92981 each additional vessel (List separately in addition to code for primary procedure)

92982 Percutaneous transluminal coronary balloon angioplasty; single vessel

92984 each additional vessel (List separately in addition to code for primary procedure)

92995 Percutaneous transluminal coronary atherectomy, by mechanical or other method with or without balloon angioplasty; single vessel

92996 each additional vessel (List separately in addition to code for primary procedure)

##### ICD-9 Codes That Support Medical Necessity:

410.00-410.02

410.10-410.12

410.20-410.22  
410.30-410.32  
410.40-410.42  
410.50-410.52  
410.60-410.62  
410.70-410.72  
410.80-410.82  
410.90-410.92  
411.1  
411.81  
411.89  
413.0  
413.9  
414.01-414.03  
414.11  
414.8

#### Intravascular Ultrasound (Coronary Vessel or Graft)

Intravascular ultrasound takes the ultrasound transducer directly to the inside of the more distant vessels, and by using high frequencies is able to provide the most exquisite detail of these structures.

Codes 92978 and 92979 are add-on codes that should be reported in addition to the specifically listed therapeutic intervention procedures when ultrasound is being performed. Codes 92978 and 92979 will only be allowed when billed in conjunction with the following therapeutic services:

92975 Thrombolysis, coronary

92980 Placement of intracoronary stent(s)

92981 each additional vessel (List separately in addition to code for primary procedure)

92982 Coronary balloon angioplasty

92984 each additional vessel (List separately in addition to code for primary procedure)

92995 Coronary atherectomy

92996 each additional vessel (List separately in addition to code for primary procedure)

Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention, (stent placement).

HCPCS Codes

92978 Intravascular ultrasound (coronary vessel or graft) during therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)

92979 each additional vessel (List separately in addition to code for primary procedure)

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#### Reasons for Denial

Use of an interventional device, or technologic modification, that has not received FDA approval.

Additional vessel codes applied to vessels other than the named major coronary arteries as recognized by Medicare and defined above.

#### Coding Guidelines

When a single interventional modality is utilized in more than one of these three vessels, the first vessel is to be identified using the respective "single vessel" code. Each additional major coronary instrumented is to be identified using the "each additional vessel" code. Branch vessels are considered an integral part of these three parent, major, named coronary arteries. Interventions in branch vessels are considered a part of and included with intervention in the named parent vessel.

Anatomic variants, (large ramus or marginal branches, unbalanced circulatory patterns, etc.), should be referenced as precisely as possible to a corresponding named vessel. Bypass conduits are considered, for nomenclature and coding purposes, integral to the vessel of distal anastomosis. Special consideration will be provided when multiple bypass conduits have a common named vessel distal anastomosis and when transluminal interventions are performed on both native vessels and bypass conduits. In the presence of bypass conduits, for purposes of these definitions, the left main coronary artery is considered a part of the major left system vessel receiving antegrade flow.

Medicare also recognizes a hierarchical scheme in technical complexity when multiple types of coronary intervention are employed in a single session. Generally, stent placement supersedes atherectomy which supersedes angioplasty. The CPT-95 explanatory notes accompanying the instant codes define further this hierarchical ordering. When multiple transluminal interventions are combined during a single setting, coding should reflect this ranking order; the most complex intervention is identified by using that intervention's "single vessel" code and other interventions using the appropriate "each additional vessel" code. This same format is applicable when multiple interventions are performed in bypass conduits and/or native vessels and bypass conduits.

Three new modifiers have been added effective 1/1/97

LC-Left circumflex coronary artery

LD-Left anterior descending coronary artery

RC-Right coronary artery

These modifiers will be needed to identify treatment of multiple arteries.

#### Documentation Requirements

The provider has the responsibility to ensure medical necessity for all services and must maintain documentation for the possibility of a postpayment audit.

If medical necessity is in question or for postpayment review, submit the following:

History and physical, and

Operative report

#### Advance Notice Requirement

Applies to medical necessity (see page 4).

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93268: Patient Demand Single or Multiple Event Recorder -  
Correction

The Advance Notice Statement for this policy was inadvertently omitted from the article that was provided in the November/December 1998 Medicare Part B Update! (pages 35-37). Advance notice, as it applies to medical necessity (see page 4 of this issue), is required for procedure codes covered under this policy.

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93619, 93631, 93640-93642, 93737-93738: Intracardiac  
Electrophysiological Evaluation

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

#### Indications and Limitations of Coverage and/or Medical Necessity

Electrophysiological Evaluation:

Electrophysiological studies routinely require vascular access, injections/infusions, continuous monitoring. In the course of an electrophysiological study, an advanced pacing device is routinely used to stimulate and record intracardiac activities.

HCPCS Codes

93619 Comprehensive electrophysiological evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; without induction of arrhythmia (This code is to be used when 93600 is combined with 93602, 93603, 93610, 93612)

93620 with induction of arrhythmia (This code is to be used when 93618 is combined with 93619)

93621 with left atrial recordings from coronary sinus or left atrium, with or without pacing, with induction or attempted induction of arrhythmia

93622 with left ventricular recordings, with or without pacing, with induction or attempted induction of arrhythmia

93623 Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure) (Use 93623 in conjunction with codes 93620, 93621, 93622)

93624 Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia

93631 Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction

ICD-9 Codes That Support Medical Necessity:

426.0  
426.10-426.13  
426.2  
426.3  
426.4  
426.50-426.54  
426.6  
426.7  
426.9  
427.0  
427.1  
427.2  
427.31-427.32  
427.41-427.42

427.5  
427.6  
427.69  
427.81  
427.89  
427.9  
746.9  
780.2

Electrophysiological Evaluation of Cardioverter-defibrillator:

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

a documented episode of life threatening ventricular tachyarrhythmia; or

cardiac arrest not associated with myocardial infarction

HCPCS Codes

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

93641 with testing of cardioverter-defibrillator pulse generator

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

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

93738 with reprogramming

ICD-9 Codes That Support Medical Necessity

427.1  
427.5

Coding Guidelines

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

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

#### Documentation Requirements

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

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97010-97036, 97110-97124, 97140-97504, 97520, 97770: Physical Medicine and Rehabilitation

Rehabilitation that is concerned with the restoration of function following disease, injury, or loss of body part is the primary goal of physical medicine. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet, and massage are used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living.

#### Indications and Limitations of Coverage and/or Medical Necessity

##### Hot Or Cold Modality

As of 1/1/97, payment for the application of Hot or Cold Packs are bundled into the payment for other services not specified.

The application of Hot or Cold Packs may be considered medically necessary if the following conditions are present and documented in the patient's medical records maintained by the provider.

##### For Hot Packs:

The patient has a painful superficial condition for which heat is beneficial (for example, neuropathy) or

The patient has muscle spasm for which heat application has been ordered and

The patient's condition is acute or subacute, and

The heat packs are utilized in preparation for a more complete therapeutic program.



It is usually not medically necessary to have more than one form of heat treatment (CPT codes 97010, 97018, 97026) for a condition per day.

#### For Cold Packs

The patient has muscle spasm, inflammation of bursa, tendon, joint, muscle, or other local condition requiring analgesia and

The condition is acute or subacute and

The cold packs are utilized in preparation for a more complete therapeutic program.

#### HCPCS Codes

97010 Application of a modality to one or more areas; hot or cold packs

#### Traction/Mechanical Modality

The application of mechanical traction may be considered medically necessary if the following conditions are present and documented in the patient's medical record maintained by the provider:

The patient has cervical radiculopathy or

The patient has lumbar radiculopathy.

#### HCPCS Codes

97012 Application of a modality to one or more areas; traction, mechanical

#### Electrical Stimulation Modality

The application of electrical stimulation (unattended) may be considered medically necessary if the following conditions are present and documented in the patient's medical records maintained by the provider:

The patient has an acute or subacute condition that requires iontophoresis,

The patient has a painful condition that requires analgesia or muscle spasm that requires reduction prior to an exercise program,

The patient has a condition that requires an educational program for self-stimulation of denervated muscle (consisting of 5-7 sessions), or

The patient has a condition that requires muscle re-education involving a training program, i.e., functional electrical stimulation and

Documentation must clearly indicate that a TENS machine was not used and/or a TENS treatment was not given.

HCPCS Codes

97014 Application of a modality to one or more areas; electrical stimulation (unattended)

Vasopneumatic Devices Modality

The application of vasopneumatic devices may be considered medically necessary if the following conditions are present and documented in the patient's medical records maintained by the provider:

The patient must have lymphedema of an extremity; or

The patient must require education on the use of a lymphedema pump for home use.

HCPCS Codes

97016 Application of a modality to one or more areas; vasopneumatic devices

Paraffin Bath Modality

The application of a paraffin bath may be considered medically necessary if any one of the following conditions is present and documented in the patient's medical record maintained by the provider:

The patient has contractures as a result of rheumatoid arthritis,  
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The patient has contractures as a result of scleroderma,

The patient has acute synovitis,

The patient has post-traumatic conditions,

The patient has hypertrophic scarring,

The patient has degenerative joint disease,

The patient has osteoarthritis,

The patient has post surgical conditions (e.g., carpal tunnel release) or tendon repairs, or

The patient is status post sprains or strains.

It is usually not reasonable or medically necessary to have more than one form of superficial heat treatment (CPT codes 97010, 97018, 97026) for a condition per day.

#### HCPCS Codes

97018 Application of a modality to one or more areas; paraffin bath

#### Microwave Modality

The application of microwave therapy may be considered medically necessary if there is evidence of a need for deep heat therapy to muscles or joints documented in the patient's medical records maintained by the provider.

#### HCPCS Codes

97020 Application of a modality to one or more areas; microwave

#### Whirlpool Modality

The application of whirlpool therapy may be considered medically necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has a condition (such as post-polio; neuropathy; polymyositis, etc.) that requires the buoyancy of water to exercise weak muscles,

The patient has open wounds that require cleaning (with or without debridement),

The patient has a burn that requires whirlpool to facilitate dressing changes,

The patient has an acute or sub-acute arthritis for which whirlpool is used to facilitate joint range of motion,

The patient has a condition (i.e., amputee or reflex sympathetic dystrophy) that requires whirlpool treatments to improve circulation, or

The patient's condition necessitates the reduction of sensitivity of the skin.

It may not be medically necessary to have more than one form of hydrotherapy (CPT codes 97022, 97036 and 97113) for a condition per day.

#### HCPCS Codes

97022 Application of a modality to one or more areas; whirlpool

#### Diathermy Modality

The application of diathermy may be considered medically necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has osteoarthritis, rheumatoid arthritis or traumatic arthritis,

The patient has sustained a strain or sprain,

The patient has acute or chronic bursitis,

The patient has pelvic inflammatory disease,

The patient requires treatment after a traumatic injury,

The patient has a joint dislocation or subluxation,

The patient requires treatment for a post surgical condition,

The patient has adhesive capsulitis, or

The patient has joint contractures.

#### HCPCS Codes

97024 Application of a modality to one or more areas; diathermy

#### Infrared Modality

The application of infrared therapy may be considered medically necessary if any one of the following conditions is present and documented in the patient's medical records maintained by the provider:

To promote healing and analgesia or

As adjunct therapy for a physical medicine procedure during the same treatment session for muscle weakness and limited range of motion.

It is usually not medically necessary to have more than one form of superficial heat (CPT codes 97010, 97018, 97026) for a condition per day.

HCPCS Codes

97026 Application of a modality to one or more areas; infrared

Ultraviolet Modality

The application of ultraviolet therapy may be considered medically necessary if there is evidence of a condition that requires heat therapy combined with the drying effect of the ultraviolet light present and documented in the patient's medical records maintained by the provider.

HCPCS Codes

97028 Application of a modality to one or more areas; ultraviolet

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Electrical Stimulation (Manual)

The application of electrical stimulation (manual) may be considered medically necessary if the following conditions are present and documented in the patient's medical records maintained by the provider:

The patient has an acute or subacute condition that requires iontophoresis,

The patient has a painful condition that requires analgesia or a muscle spasm that requires reduction prior to an exercise

program, or

The patient has a condition that requires muscle re-education involving a training program, i.e., functional electrical stimulation, and

Documentation must clearly indicate that a TENS machine was not used and/or a TENS treatment was not given.

#### HCPCS Codes

97032 Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

#### Iontophoresis

The application of iontophoresis may be considered medically necessary if any one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has tendinitis or calcific tendinitis,

The patient has bursitis,

The patient has adhesive capsulitis, or

The patient has hyperhidrosis.

#### HCPCS Codes

97033 Application of a modality to one or more areas; iontophoresis, each 15 minutes

#### Contrast Baths

The application of contrast baths may be considered medically necessary if any one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has rheumatoid arthritis,

The patient has reflex sympathetic dystrophy, or

The patient has sprains or strains resulting

from an acute injury.

#### HCPCS Codes

97034 Application of a modality to one or more areas; contrast baths, each 15 minutes

#### Ultra Sound

The application of ultra sound may be considered medically necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has a condition that requires deep heating in a muscle, bone, joint, tendon, ligament, and/or nerve,

The patient has tightened structures limiting joint motion (i.e., contractures, arthritis, etc.) that require an increase in extensibility,

The patient has symptomatic soft tissue calcification, or

The patient has symptomatic plantar warts, neuromas or herpes zoster pain.

#### HCPCS Codes

97035 Application of a modality to one or more areas; ultrasound, each 15 minutes

#### Hubbard Tank

The application of Hubbard tank therapy may be considered medically necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has wounds or burns or

The patient has a neuromuscular condition (e.g., multiple sclerosis, Guillain Barre, muscular dystrophies, paraparesis, amyotrophic lateral sclerosis) or musculoskeletal condition (e.g., rheumatoid arthritis, osteoarthritis, fractures).

It is usually not medically necessary to have more than one form of hydrotherapy (CPT codes 97022, 97036 and 97113) for a condition per day.

#### HCPCS Codes

97036 Application of a modality to one or more areas; hubbard tank, each 15 minutes

#### Physical Medicine Therapeutic Procedures

Therapeutic exercises may be considered medically necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problem, balance and/or coordination deficits, abnormal posture, muscle imbalance, or

The patient needs to improve mobility, stretching, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or re-education.

#### HCPCS Codes

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

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#### Neuromuscular Reeducation

Neuromuscular reeducation can be considered reasonable and necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers,

The patient has nerve palsy, such as peroneal nerve injury causing foot drop, or

The patient has muscle weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had spinal cord disease or trauma.

#### HCPCS Codes

97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception

#### Aquatic Therapy

Aquatic therapy with therapeutic exercises may be considered reasonable and necessary if at least one of the following



conditions is present and documented in the patient's medical records maintained by the provider:

The patient has rheumatoid arthritis,

The patient has had a cast removed and requires mobilization of limbs,

The patient has paraparesis or hemiparesis,

The patient has had a recent amputation,

The patient is recovering from a paralytic condition or

The patient requires limb mobilization after a head trauma.

It is usually not medically necessary to have more than one form of hydrotherapy (CPT codes 97022, 97036 and 97113) for a condition per day.

#### HCPCS Codes

97113 Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

#### Gait Training

Gait training may be considered reasonable and necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has an injury or condition that requires instruction in the use of a walker, crutches, or cane,

The patient has been fitted with a brace prosthesis and requires instruction in ambulation, or

The patient has a condition (such as stroke, Parkinson disease, arthritis, paralysis of lower extremity) that requires retraining in stairs/steps, chair transfer or ambulation/gait pattern.

#### HCPCS Codes

97116 Therapeutic procedure, one or more areas, each 15 minutes; gait training

#### Massage Therapy

Massage therapy, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) may be considered

reasonable and necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has paralyzed musculature contributing to impaired circulation,

The patient has excessive fluids in interstitial spaces or joints,

The patient has sensitivity of tissues to pressure,

The patient has tight muscles resulting in shortening and/or spasticity of affected muscles,

The patient has abnormal adherence of tissue to surrounding tissues,

The patient requires relaxation in preparation for neuromuscular re-education or therapeutic exercise, or

The patient has contractures and decreased range of motion.

#### HCPCS Codes

97124 Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

#### Manual Traction

Manual traction may be considered reasonable and necessary if cervical radiculopathy is present and documented in the patient's medical records maintained by the provider.

#### Myofascial Release

Myofascial release/soft tissue mobilization can be considered reasonable and necessary if at least one of the following conditions is present and documented in the patient's medical records maintained by the provider:

The patient has restricted joint motion in an extremity or

The treatment is necessary as an adjunct to other physical therapy interventions.

#### Manipulations

Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist), performed by a physican may be considered reasonable and

necessary if there is fibromyositis or chronic pain syndrome present and documented in the patient's medical records maintained by the provider.

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#### Joint Mobilization

Joint mobilization (peripheral or spinal) may be considered reasonable and necessary if restricted joint motion is present and documented in the patient's medical records maintained by the provider.

#### HCPCS Codes

97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

#### Therapeutic Procedure(s):

Therapeutic procedure(s), group (2 or more individuals) is considered reasonable and necessary when the indications are met for the specific therapy being administered.

#### HCPCS Codes

97150 Therapeutic procedure(s), group (2 or more individuals)

#### Orthotics Training

Orthotics fitting and training, upper and/or lower extremities may be considered reasonable and necessary if there is an indication for education for the application of orthotics and the functional use of orthotics is present and documented in the patient's medical records maintained by the provider.

Orthotics fitting and training, upper and/or lower extremities, reflects the fitting as well as the training, as the training in the use of the orthotic is done at the time of the fitting.

In addition, the casting and strapping codes should not be reported in addition to code 97504. If casting a strapping of a fracture, injury, or dislocation is performed, procedure codes 29000, 29590 should be reported.

#### HCPCS Codes

97504 Orthotics fitting and training, upper and/or lower extremities, each 15 minutes

## Prosthetic Training

Prosthetic training may be considered reasonable and necessary if there is an indication for education for the application of a prosthetic and the functional use of a prosthetic is present and documented in the patient's medical records maintained by the provider.

## HCPCS Codes

97520 Prosthetic training, upper and lower extremities; each 15 minutes

## Other Therapeutic Procedures

Development of cognitive skills to improve attention, memory, problem solving may be considered reasonable and necessary for patients having neurologic conditions such as head injury or trauma, stroke, muscular dystrophy, multiple sclerosis. Reassessment of the patient's progress should occur every 2-3 months with documentation indicating drastic improvement, opposed to slow/subtle improvement. This service is not considered to be outpatient physical therapy and is, therefore, noncovered when billed by an Independent Practicing Physical Therapist (Specialty 65).

## HCPCS Codes

97770 Development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct (one on one) patient contact by the provider, each 15 minutes

## Reasons for Denial

Diapulse and rolfing (A9270) treatment is a noncovered service.

High Voltage Pulsed Current (HVPC) Therapy (A9270) is a noncovered service under the Medicare Part B Program.

Vertebral Axial Decompression (VAD) therapy is the only noninterventional method to relieve pressure on vital lumbar structures. The technique is a preferred alternative to surgery in relieving neurocompression and is described as follows:

utilizing Vax-D equipment (the patient is placed in a patented harness, then positioned in the device);

protocols (the patient is put through alternating one minute cycles of lumbar disc decompression followed by relaxation for 30-40 minutes);

Cycles are completed (the patient rests for 5-10 minutes);

Various therapy modalities are performed for the next 15 minutes (to limit muscle spasm and swelling in the lower back);

The patient spends approximately one hour in the clinic.

VAD therapy should be billed with code A9270 (noncovered item or service). This service is considered "investigational" and is a noncovered service under Medicare Part B.

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical therapy services for Medicare purposes.

Work hardening/conditioning (CPT codes 97545-97546) is a noncovered service by the Carrier. These services are related solely to specific work skills and do not provide any diagnostic or therapeutic benefit for the patient that requires physical rehabilitation. The professional component of a diagnostic test (i.e., nerve conduction study, EMG, biofeedback, neuro-muscular junction test) is not considered to be outpatient physical therapy and is therefore, noncovered when billed by an Independent Practicing Physical Therapist (Specialty 65).

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Electrotherapy for the treatment of facial nerve paralysis is the application of electrical stimulation (97014) to affected facial muscles to provide muscle innervation with the intention of preventing muscle degeneration. A device that generates an electrical current with controlled frequency, intensity, wave form and type (galvanic or faradic) is used in combination with a pad electrode and a hand applicator electrode to provide electrical stimulation.

Electrotherapy for the treatment of facial nerve paralysis, commonly known as Bell's Palsy (ICD-9 codes 351.0) is not covered under Medicare because its clinical effectiveness has not been established.

Diathermy (97024) or ultrasound (97035) heat treatments performed for respiratory conditions or diseases (ICD-9 codes 460-519.9 ) are investigational under the Medicare B program.

#### Coding Guidelines

Physical therapy services which exceed a recommended frequency will be reviewed for medical necessity.

Physicians may report Evaluation and Management services on the same day as physical medicine treatments provided the services are separately identifiable.

For all physical medicine procedures, a physician or therapist is required to be in constant attendance.

#### Documentation Requirements

The medical record must indicate that the patient is under the care of a physician for the presenting diagnosis.

Documentation should indicate the potential prognosis for restoration of functions in a reasonable and generally predictable period of time.

All providers billing for physical therapy services are required to maintain an established plan of treatment as a permanent part of the patient's clinical record. The plan must be established before the treatment is begun. The physician must see the patient at least every 30 days during the course of therapy. The physician must review, initial and date the plan of treatment at least every 30 days. The plan must be kept on file in the physician's office and available for Carrier review if requested.

A physical therapy plan of treatment must include the type, amount, frequency, and duration of the services that are to be furnished and indicate the diagnosis and anticipated goals. Any changes in the treatment plan must be made in writing and signed by the physician.

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of each physical therapy modality covered by the Medicare programs.

#### Advance Notice Requirement

Applies to medical necessity (see page 4).

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97001-97004, 97110, 97140, 97535: Complex Decongestive  
Physiotherapy

The lymphatic system has two primary immunologic functions: activating the inflammatory response and controlling infections. In addition, the lymphatic system drains protein-containing fluid from the tissue and conducts it in a unidirectional flow to the circulatory system. When there is a blockage in this drainage, the result is the swelling of a body part, often an extremity. This is referred to as lymphedema, an abnormal accumulation of lymph fluid.

Lymphedema is categorized as primary or secondary. Primary lymphedema is defined as impaired lymphatic flow due to lymph vessel aplasia, hypoplasia, or hyperplasia. This type is an inherited deficiency in the lymphatic channels of unknown origin.

Secondary lymphedema is caused by known precipitating factors. The most common causes in the United States are surgical removal of the lymph nodes (i.e., in connection with a mastectomy), fibrosis secondary to radiation, and traumatic injury to the lymphatic system. Filariasis is the leading cause of lymphedema throughout much of the tropical world.

Currently, lymphedema can be treated by many methods such as: Compressive garments, wrapping, elevation, surgery, pneumatic compression devices or Complex Decongestive Physiotherapy (CDP). This policy addresses only the CDP method.

Complex Decongestive Physiotherapy has been referred to by several terms including: non-invasive complex lymphedema therapy (CLT), early conservative lymphedema management, complicated physiotherapeutics, manual lymphedema treatment (MLT), multi-modal lymphedema therapy, and palliative lymphedema therapy. For purposes of consistency, the term CDP will be used.

Each CDP session normally consists of four phases:

Skin care including cleansing, lubrication, debriding and administration of antimicrobial therapy;

Manual lymph drainage involving a gentle massage technique that is carried out in a predetermined manner aimed at redirecting lymph and edema fluid towards adjacent, functioning lymph systems;

Multi-layered compression wrapping (bandages) to prevent any reaccumulation of excavated edema fluid and to prevents the ultrafiltration of additional fluid into the interstitial space; and

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Individualized exercises with the bandage to enhance lymphatic flow from peripheral to central drainage components. These exercises are aimed at augmenting muscular contraction, enhancing joint mobility, strengthening the limb, and reducing the muscle atrophy that frequently occurs secondary to lymphedema.

Indications and Limitations of Coverage and/or Medical Necessity

As mentioned earlier, CDP consists of skin care, manual lymph drainage, compression wrapping, and exercises. Although there is no means for Medicare to allow payment of the total treatment via one treatment code, payment will be allowed for the physical therapy services associated with the treatment. Other services such as skin care and the supplies associated with the compression wrapping are included in the physical therapy services performed during each session.

The goal of this therapy is not to achieve maximum volume reduction, but to ultimately transfer the responsibility of the care from the clinic, hospital, or doctor, to home care by the patient, patient's family or patient`s caregiver. Unless the patient is able to continue therapy at home, there is only temporary benefit from the treatment. The endpoint of treatment is not when the edema resolves or stabilizes, but when the patient and/or their cohort are able to continue the treatments at home. Patients who do not have the capacity or support system to accomplish these skills in a reasonable time are not good candidates for Complex Decongestive Physiotherapy.

It is expected that physical therapy education sessions would usually last for 1 to 2 weeks, with the patient attending 3-5 times per week, depending on the progress of the therapy. After that time, there should have been enough teaching and instruction that the care could be continued by the patient or patient caregiver in the home setting. The maximum benefits of treatment are not expected unless the patient continues treatment at home.

The physical therapy billed in conjunction with the manual lymph drainage therapy will be subject to all national and local policies for physical therapy.

The coverage of the physical therapy would only be allowed if all of the following conditions have been met:

There is a physician documented diagnosis of lymphedema; and the physician specifically orders CDP.

The patient is symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety.

The patient or patient caregiver has the ability to understand and comply with home care continuation of treatment regimen.

The services are being performed by a health care professional who has received specialized training in this form of treatment.

Currently, Medicare covers services for lymphedema by the lymphedema pump. Some providers are proposing noninvasive Complex lymphedema therapy as an alternative to pumps. A patient requiring both modes of treatment should be rare. In addition, it is not expected that PT and OT would be performed concurrently; (i.e., both PT and OT providing the therapeutic exercise portion of the session).

The physical therapy services for CDP must be provided either by or under the direct personal supervision of the physician or independently practicing therapist.

HCPCS Codes



- 97001 Physical therapy evaluation
- 97002 Physical therapy re-evaluation
- 97003 Occupational therapy evaluation
- 97004 Occupational therapy re-evaluation
- 97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- 97535 Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes

ICD-9 Codes That Support Medical Necessity

- 457.0
- 457.1
- 757.0

Reasons for Denial

Invalid provider billing for services.

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

Coding Guidelines

It is expected that procedure code 97140 will be utilized when the manual lymph drainage is performed, procedure code 97535 for the instruction of bandaging, exercises and self care, and procedure code 97110 when performing the individual exercises.

When an initial evaluation or periodic re-evaluation is performed, separate reimbursement may be made. For these evaluations, physical and occupational therapists should use codes 97001, 97002, 97003, and 97004, and physicians should use the applicable Evaluation and Management codes.

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It is not appropriate to automatically bill with an evaluation and management service each time a patient goes for the physical

therapy treatment. An evaluation and management should not be used unless all of the components of the visit have been met.

#### Documentation Requirements

The medical record documentation maintained by the provider must clearly document the medical necessity of the services being performed.

The documentation for the initial evaluation and treatment must include the following:

a physician documented diagnosis of lymphedema and a specific order for CDP.

a statement as to the ability of the patient/patient caregiver to follow through with the continuation of treatment on a long term home treatment plan.

history and physical including: the cause of the lymphedema and any prior treatment, measurements of body part/extremity prior to treatment, specific areas of indurated tissue, hardness of edema, condition of nails and skin, infected sites, scars, distal pulses, pain, discomfort and the affect's the lymphedema has on the patients Activities of Daily Living (i.e, symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety).

treatment plan identifying specific short and long term goals; the type, amount, frequency and duration of the services.

the services/modalities performed including a response to treatment.

The documentation for any subsequent treatment must include:

a report showing the progress of the therapy including periodic measurements of the applicable extremity(ies).

the response of the patient /patient caregiver to the education and their understanding and ability to take on some of the responsibilities of the treatment.

the services/modalities performed including a response to treatment.

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98940-98943: Chiropractor

Chiropractic services involve manual manipulation of the spine by a licensed chiropractor, to alleviate painful symptomatology due to subluxation of the spine.

Indications and Limitations of Coverage and/or Medical Necessity

Treatment by a chiropractor is a covered service under the Medicare program.

Coverage extends only to manual manipulation of the spine (98940-98942), provided it is for the purpose of correcting a subluxation which is documented by an X-ray taken at a time reasonably proximate to the initiation of the course of treatment.

A licensed chiropractor who meets uniform minimum standards is a physician for specified services. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray, provided such treatment is legal in the state where performed. All other services furnished or ordered by chiropractors are not covered.

An X-ray obtained by a chiropractor for his or her own diagnostic purposes before commencing treatment may suffice for claims documentation purposes. This means that if a chiropractor orders, takes, or interprets an X-ray to demonstrate a subluxation of the spine, the X-ray can be used for claims processing purposes. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

In addition, in performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.

The beneficiary must have a significant neuromusculoskeletal health problem (subluxation) necessitating manual manipulation (98940-98942) by the Chiropractor, and the manipulation must have a beneficial therapeutic relationship to the patient's condition.

Chiropractic manipulation (98940-98942) has an associated HCFA mandated screen, which requires manual review of claims involving an unusually large number of manipulations of a beneficiary's spine, for medical necessity.

HCPCS Codes

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions

98941 spinal, three to four regions

98942 spinal, five regions

98943 extraspinal, one or more regions

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ICD-9 Codes That Support Medical Necessity (98940-98942):

346.00-346.91  
350.1-350.9  
352.0-352.9  
353.0-353.4  
355.0  
355.1  
356.0  
356.1  
356.4  
356.8  
715.00  
715.08  
715.10  
715.18  
715.20  
715.28  
715.30  
715.38  
715.80  
715.88  
715.90  
716.10  
716.90  
720.0  
720.1  
720.2  
720.81  
720.9  
721.0-721.91  
722.0  
722.10-722.11  
722.2  
722.30-722.32  
722.4  
722.51-722.52  
722.70  
722.71  
722.72  
722.73  
722.80  
722.81  
722.82  
722.83  
722.90  
722.91  
722.92  
722.93  
723.0-723.9  
724.00  
724.01  
724.02  
724.09  
724.1  
724.2

724.3  
724.4  
724.6  
724.71-724.79  
724.8  
726.5  
726.90  
728.10  
728.11  
728.12  
728.2  
728.3  
728.4  
728.5  
728.81  
728.85  
729.0  
729.1  
729.2  
733.00  
733.01  
733.02  
733.03  
733.09  
737.0  
737.10  
737.12  
737.20  
737.21  
737.22  
737.30  
737.31  
737.32  
737.34  
737.8  
738.2  
738.4  
738.6  
756.11  
756.12  
756.13  
756.14  
756.15  
756.16  
756.17  
756.2  
784.0  
846.0  
847.0  
847.1  
847.2  
847.3  
847.4  
848.3  
848.41  
848.42  
848.5

905.1  
905.6  
907.3  
953.0-953.5  
954.0  
954.1  
956.0

#### Reasons for Denial

Any diagnostic service, including X-rays, that is billed to Medicare by any provider (chiropractor, M.D., D.O., Radiology Center, Independent Physiological Lab., etc.) will be denied payment when the referring/ordering or billing physician is a chiropractor.

Services would not be considered medically reasonable and necessary in the absence of pain or symptomatology resulting from a subluxation of the spine.

Procedure code 98943 is a noncovered service.

Effective January 1, 1999:

If the beneficiary refuses to have the X-ray to demonstrate subluxation of the spine, the claim will be denied.

#### Coding Guidelines

All claims submitted for (98940-98942) by specialties other than specialty 35 (Chiropractor) (i.e., specialty 03, Allergy) will be denied.

Procedure codes 98940-98942 do not represent add-on codes wherein more than one is required to report additional regions. For example, to report CMT of five spinal regions you report only code 98942 as this code includes all five regions.

One would expect to see this service performed in the following place of service:

- 11 Office (O)
- 12 Home (H)
- 21 Inpatient Hospital (IH)
- 22 Outpatient Hospital (OH)
- 31 Skilled Nursing Facility (SNF)
- 31 Nursing Home (NH)

Effective January 1, 1999:

If the beneficiary refuses to have the X-ray to demonstrate the existence of a subluxation, the chiropractor must use one of the following HCPCS Codes for chiropractic manipulation in addition to modifier GX: 98940, 98941, 98942. The claim will be denied as a technical denial.

#### Documentation Requirements

Chiropractic claims that exceed the utilization limits will be reviewed for medical necessity. The following documentation must be maintained in the patient's file.

Date of X-ray documenting the precise level of subluxation; the specific X-ray(s) report indicated by the date documented on the claim must be available for carrier review; the X-ray report must demonstrate the existence of the subluxation at the specified level of the spine.

The documenting X-ray must have been taken at a time reasonably proximate to the initiation of the course of treatment:

No more than twelve (12) months prior or three (3) months following initiation of the course of treatment.

In the case of chronic subluxation (i.e., scoliosis) an older X-ray maybe accepted provided the beneficiary history or health record indicates and that there are reasonable grounds for concluding that the condition is permanent.

Acceptable forms of X-rays include flat plates, MRI's and CT scans.

Date of initiation of treatment; indicates the date the patient was first seen by the Chiropractor and spinal manipulations were initiated.

Patient prognosis/condition; stated by indicating whether this is an acute, chronic or acute manifestation of a chronic condition type of injury. This information will substantiate if the date of X-ray is proximate to the time/type of injury.

A modifier must be utilized when submitting paper or common format EMC claims:

AT ` Acute condition/treatment

WC ` Chronic condition

XC ` Acute manifestation of a chronic condition

Acute: Strain, sprain

Chronic: Loss of joint mobility

Nerve Root: Pinching numbness pain

Treatment of acute disorders may require up to three (3) months of manipulations and usually follows a predictable path.

frequency will decrease as the patient improves

With chronic joint problems there is increased likelihood that the involved joints will have developed fixed fibrotic tissue which may require an increased length of treatment however not increased frequency of manipulations.

The beneficiary must have a significant neuromusculoskeletal health problem necessitating treatment, and the manipulative treatment must have a direct therapeutic relationship to the patient's condition.

Examples of submitted diagnoses that do and do not meet the therapeutic/improvement guidelines are:

YES:

Spinal Axis Ache  
Strain  
Sprain  
Nerve Pain  
Functional/Mechanical disability

NO:

Rheumatoid Arthritis  
Muscular Dystrophy  
Multiple Sclerosis  
Pneumonia  
Emphysema

Most other diseases and pathological disorders do not prove grounds for the therapeutic benefit.

Examples of Level Specification:

List exact bones (C5, D1, T7, L3)

The area may suffice if it implies only specific bones:



occipito-atlantal (occiput & C1/Atlas)

lumbosacral (L5 & Sacrum)

sacroiliac (S1 & ilium)

Examples of acceptable descriptive term for the nature of the abnormality/subluxation:

off centered

misalignment

incomplete

dislocation

lithiasis

- antero
- postero
- retro
- lateral
- spondylo

malpositioning

rotation

motion

- limited
- lost
- restricted
- flexion
- extension

spacing

- abnormal
- altered
- decreased
- increased

Other terms may be used if they are clear to mean bone/joint space, position or motion changes of the vertebral elements.

A statement of "pain" is insufficient. The location must be described and noted if the particular vertebrae is capable of producing the pain in the stated area.

Symptoms should refer to the location:

Spine

- pondylo
- vertebral

Bone  
-osseo  
-osteo

Nerve  
-neuro

Rib

-costo  
-costal muscle  
-myo

Joint  
-arthro

The symptoms should be reported as type:

Pain  
-algia

Inflammation  
-itis

Swelling

Spasticity

Symptoms should then be labeled as outcome/causing:

headaches

arm problems

shoulder problems

hand problems

leg pain

foot pain

numbness

rib pain

rib/chest pain  
- must relate to the spine

Follow-up manipulations:

Date(s) of re-examinations with documentation to include only the affected area(s) under treatment. Each visit must be described in

the progress notes/treatment plan and must include (THESE MUST BE LEGIBLE AND IN ENGLISH):

Response to treatment

Any changes in treatment plan

Change in diagnosis/prognosis if indicated

Advance Notice Requirement

Applies to medical necessity (see page 4).

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Independent Physiological Laboratory (IPL)

The Health Care Financing Administration has charged the Carrier with the responsibility of ensuring that procedures are not only "medically necessary", but also reasonable and appropriate in order to protect the welfare of the beneficiary community. Medical reasonableness includes ascertaining that, among other things, services are safe, effective, and performed in an appropriate setting by qualified personnel. This Local Medical Review Policy defines the scope and intensity of the Independent Physiological Laboratory benefit in the state of Florida by allowing coverage for only those services that have been deemed reasonable and appropriate by the Carrier for the Independent Physiological Laboratory to perform.

An Independent Physiological Laboratory (IPL) is an uncertified provider of diagnostic physiological services which operates independent of a hospital, physician's office, or rural health clinic.

Indications and Limitations of Coverage and/or Medical Necessity

Services covered when performed by an Independent Physiological Laboratory will be limited to the CPT codes identified in the "HCPCS Codes" section of this policy. Services performed in an IPL other than those listed will be denied as not "medically reasonable and necessary" regardless of the billing provider.

When the technical component of a procedure is performed in an Independent Physiological Laboratory and the procedure is not identified by the Carrier as a covered service when performed by an Independent Physiological Laboratory, the technical service will be denied.

An Independent Physiological Laboratory performing diagnostic ultrasound services is required to have a medical director who generally supervises the services.

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

For indications and limitation of coverage for an individual CPT code, refer to the specific Local Medical Review Policy for that code.

HCPCS Codes

Cardiology:

G0004	G0005	G0006	G0015	R0076	93000	93005	93012
93040	93041	93224	93225	93226	93230	93231	93232
93235	93236	93268	93270	93271	93278		

Telephonic Pacemaker Analysis:

93733	93736
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Diagnostic Ultrasound:

76506	76536	76604	76645	76700	76705	76770	76775
76778	76800	76805	76810	76815	76816	76818	76856
76857	76870	76880	76970	76977	76999		

Echocardiography:

93303	93304	93307	93308	93320	93321	93325
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Neurology and Neuromuscular:

92585	95812	95813	95816	95819	95900	95903	95904
95921	95922	95923	95925	95926	95927	95930	95934
95936	95937	95950	95953	95956	95957		

Noninvasive Vascular Diagnostic Studies:

54240	93875	93880	93882	93886	93888	93922	93923
93924	93925	93926	93930	93931	93965	93970	93971
93975	93976	93978	93979	93980	93981	93990	

Pulmonary:

94010	94150	94200	94240	94250	94260	94350	94360
94370	94375	94720	94725	94750	94760	94761	97462

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78000	78001	78003	78006	78007	78010	78011	78015
78016	78018	78070	78075	78099	78102	78103	78104
78110	78111	78120	78121	78122	78130	78135	78140
78160	78162	78170	78172	78185	78190	78191	78195
78199	78201	78202	78205	78215	78216	78220	78223
78230	78231	78232	78258	78261	78262	78264	78270
78271	78272	78278	78282	78290	78291	78299	78300
78305	78306	78315	78320	78350	78399	78414	78428
78445	78455	78457	78458	78460	78461	78464	78465
78466	78468	78469	78472	78473	78478	78480	78481
78483	78499	78580	78584	78585	78586	78587	78591
78593	78594	78596	78599	78600	78601	78605	78606
78607	78610	78615	78630	78635	78645	78647	78650
78660	78699	78700	78701	78704	78707	78710	78715
78725	78726	78727	78730	78740	78760	78761	78799
78800	78801	78802	78803	78805	78806	78807	78999
93017							

\*Nuclear medicine procedures are noncovered when billed by an IPL effective with services performed on or after 3/1/96

#### ICD-9 Codes That Support Medical Necessity

For covered ICD-9 codes for an individual CPT code, refer to the specific Local Medical Review Policy for that code.

#### HCFA National Coverage Policy

Under Medicare Part B, payment may be made for a diagnostic physiological service furnished by a laboratory which operates independently of a hospital, physician's office or rural health clinic, if the laboratory meets applicable state and local licensure laws, the service is ordered by a referring physician, and the service is "reasonable and necessary" as defined in Section 1862 (a)(1)(A) of the Social Security Act. (MCM2070.5)

An Independent Physiological Laboratory can bill for the global service or the technical component of a service. When a global service is billed, the professional component of this service must have been rendered by a physician or medical group who did not order the service. Also, if the professional component of a service is billed by a physician or medical group who is in any way affiliated with the Independent Physiological Laboratory, this physician or medical group cannot have seen the patient or ordered the test. (MCM 3060.5)

#### Reasons for Denial

Medicare Part B cannot provide coverage for services performed for screening purposes.

#### Coding Guidelines

Radiopharmaceuticals (A4641, A4642, A9600 (J3005 prior to 01/01/98) J0150, J1245, Q0142, Q0143, W4125-W4158, 79900) associated with the performance of nuclear medicine procedures will be covered and reimbursed separately in addition to the CPT code for the services rendered. Procedure code A4641 (supply of radiopharmaceutical diagnostic imaging agent) can be billed when a specific code does not exist for the agent used. Effective with services rendered on or after 3/1/96, radiopharmaceuticals will be noncovered when billed by an IPL.

#### Documentation Requirements

An Independent Physiological Laboratory 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.

The provider number of the physician interpreting a test performed by an Independent/Physiological Laboratory must be provided on the claim.

The UPIN (Unique Physician Identification Number) of the physician referring the beneficiary for a test performed by an IPL must be provided on the claim.

#### Other Comments

Transportation of portable EKG to facility or location (R0076) was a covered service from 1/1/96 until 1/1/97. As of 1/1/97, code R0076 had a B status which meant payment for covered services were always bundled into payment for other services not specified. As of 1/1/98 code R0076 is no longer bundled. As of 1/1/99, R0076 will be bundled.

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#### R0070: Portable X-ray Supplier Services

Portable x-ray supplier services are those radiology services that may be safely performed at the patient's bedside using portable equipment, e.g., C-arm or swing arm.

#### Indications and Limitations of Coverage and/or Medical Necessity

Diagnostic x-ray services furnished by a supplier not under the direct supervision of a physician are considered medically reasonable and necessary when the following criteria are met:

The health and safety standards are approved under the State of Florida;

Diagnostic x-ray tests must be furnished in a place of residence used as the patient's home;

Covered portable x-rays are skeletal films involving arms, legs, pelvis, vertebral column, and skull, chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examination);

Abdominal films which do not involve the use of contrast media.

Scope of Portable X-ray Benefit.\_In order to avoid payment for services which are inadequate or hazardous to the patient, the scope of the covered portable x-ray benefit is defined as:

skeletal films involving arms and legs, pelvis, vertebral column, and skull;

chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations); and

abdominal films which do not involve the use of contrast media.

#### HCPCS Codes

70100  
70110-70134  
70140-70160  
70190-70220  
70250-70260  
71010  
71020-71022  
71030  
71035  
71100-71101  
71110-71130  
72020  
72040  
72070  
72080  
72100  
72170  
72200-72220  
73000-73010  
73020-73030  
73050  
73060  
73070-73080

73090  
73100-73110  
73120-73140  
73500-73520  
73550-73565  
73590  
73600-173610  
73620-173630  
73650-73660  
74000-74022  
93000-93005  
93224-93226  
93230-93232  
93235-93236  
R0070  
R0075  
Q0092  
R0076

#### Reasons for Denial

Procedures and examinations which are not covered when performed by portable x-ray suppliers include procedures involving fluoroscopy, the use of contrast media; procedures requiring the administration of a substance to the patient, or injection of a substance into the patient, and/or special manipulation of the patient; procedures which require special medical skill or knowledge possessed by a physician (M.D. or D.O.) or which require that medical judgment be exercised; procedures requiring special technical competency and/or special equipment or materials; routine screening procedures; and procedures which are not of a diagnostic nature.

#### Coding Guidelines

Effective for services on or after January 1, 1992, a set-up fee is allowed for each radiological procedure using procedure code Q0092. This is not to be allowed more than once when a procedure has to be repeated at the same visit and is not to be used for EKG services.

A transportation charge is allowed for portable x-ray equipment to a home or nursing home using procedure codes R0070 (Transportation of portable x-ray equipment to home or nursing home, per trip to facility or location, one patient seen) and R0075 (more than one patient seen per patient). These codes are not to be used for EKG services.

Effective 1/1/96, until 1/1/97, a transportation charge is allowed for EKG services 93000 and 93005 using procedure code R0076 (Transportation of portable EKG to facility or location, per patient). This code is not to be used for portable x-ray equipment. When multiple patients are tested, the number of patients should be submitted on the claim form. The full fee schedule will be reduced or prorated.



As of 1/1/97 code R0076 has a B status which means payment for covered services are always bundled into payment for other services not specified.

Effective 1/1/96, no transportation component (R0076) can be allowed with 24-hour EKG monitoring (93224-93226, 93230-93232 or 93235-93236). In no case is the set-up component (Q0092) payable.

As of 1/1/99, code R0076 (transportation of portable EKG equipment) is once again bundled into the payment for other services not specified.

#### Other Comments

CPT code 76075 is being deleted from policy R0070 which determines which procedures can be allowed by a portable x-ray supplier. Medicare will not allow payment of DEXA bone density studies performed by portable x-ray suppliers

#### Advance Notice Requirement

Applies to medical necessity (see page 4).

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#### YEAR 2000

Year 2000 section articles are considered informational and in no way represent an all-encompassing guide to millennium compliance. Additionally, Medicare does not endorse any web sites referenced; they are provided only as a convenience.

#### The Year 2000 Is HCFA's #1 Priority

What Is The Year 2000 (Also Known As The Y2K) Challenge And Why Is It Important?

Many computers use just two digits to record the year. If no action is taken, these computers will recognize "00" as the year 1900 rather than the year 2000, resulting in many potential problems for HCFA systems and the providers that treat those individuals that rely upon HCFA programs.

HCFA's computer systems and those of its business partners are critical to the processing of claims for 70 million Medicare and Medicaid beneficiaries. Dates are important to most of HCFA's mission critical systems. Critical dates may include, for example, the date a beneficiary became eligible for Medicare, the date a patient was admitted or discharged from a hospital, the date a wheelchair rental began, or the date an enrollee entered a Medicare managed care plan.

Date-related transactions such as these occur millions of times a day. If the Y2K challenge is not addressed, providers could experience delayed payments or disruptions in receiving HCFA data upon which they rely every day.

#### What Is HCFA's Action Plan To Be Y2K Ready?

Complying with the Year 2000 challenge is HCFA's number one priority.

The agency's goal is to ensure that, come January 1, 2000, providers continue to receive prompt and efficient payment for their services.

The Y2K problem presents one of the greatest information system challenges since the inception of the Medicare program. It requires identifying and renovating all computer and information systems that might have Year 2000 problems. It also requires testing the renovated systems multiple times to make sure the new corrections will work. About 49 million lines of code are being renovated and tested.

Year 2000 activities must take precedence over other projects that require changes to computer and information systems. Postponing other projects is necessary to focus resources and "freeze" systems so essential Y2K related systems work can be done.

#### HCFA's Commitment Of Resources To Year 2000 Compliance:

HCFA Administrator Nancy-Ann DeParle has committed significant staff and other resources to this goal. Following are some actions HCFA has taken:

setting up special teams of employees whose sole responsibility is making Year 2000 fixes;

hiring retired federal programmers to help with Year 2000 efforts;

hiring special contractors to make sure Year 2000 fixes are done right and to independently test systems to make sure they work properly;

amending agreements with the more than 60 Medicare fiscal intermediaries and carriers to ensure that they use information technology that is Year 2000 compliant;

closely tracking contractor progress to ensure that work is on schedule;

creating a special contingency planning unit to make sure disruptions do not result from any unexpected problems; and

working within the Administration and with the Congress to increase funding for Y2K renovation efforts.

HCFA and its more than 60 contractors, who process and pay nearly one billion Medicare claims each year, are following a rigorous schedule for fixing and testing its systems. Medicare contractors and managed care organizations with Medicare contracts must be Y2K ready by December 31, 1998. HCFA's internal systems renovations will also be completed and tested by December 31, 1998. That leaves a full year to continue to test. State Medicaid agencies are expected to be Y2K ready no later than March 31, 1999.

#### What Is HCFA Doing To Ensure The Work Will Be Completed On Time?

Work at HCFA and its contractors is well underway. HCFA has assessed all systems and have identified those in need of renovation. Most of the necessary renovation has been completed, or soon will be. Testing to verify that the systems will function properly is also underway. Further, HCFA has formed teams to monitor progress on at least a weekly basis and has sent representatives to 17 of the most critical Medicare contractor sites to monitor daily progress.

In addition, HCFA has hired two independent firms. The first is an independent verification and validation company (IV&V) to assess HCFA's and its contractors' ability to be Year 2000 compliant. The second is an independent testing organization that will confirm that all of the key HCFA systems will properly function in the year 2000.

The independent validation and verification (IV&V) experts recommended that HCFA require contractors to concentrate their efforts and resources exclusively on achieving Year 2000 compliance.

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The IV&V firm recommended that contractors stop making any "parallel" changes in their systems, such as those required to carry out some provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA). Based on these recommendations, HCFA determined that it must clear the decks of all major systems changes during the critical months right before and after the new year to concentrate on required extensive testing.

Some Changes To Systems Have Been Suspended

In April, final transitions to shared, uniform systems for Medicare Part A and Part B contractors were postponed to devote those programming resources to Year 2000 compliance. As a result, \$20 million in FY 1998 appropriated funds were redirected to Year 2000 compliance work.

#### Some Provisions Of The HIPAA And BBA May Have To Be Postponed

Some projects involve extensive computer and information system changes and are scheduled to be carried out during the time that systems must be frozen for final testing. Reluctantly, HCFA anticipates that it will have to suspend some BBA provisions until Year 2000 compliance can be assured. Provisions that may not be implemented timely include:

Calendar and Fiscal Year 2000 payment updates;

hospital outpatient prospective payment (will continue to pay under current methods);

home health prospective payment;

consolidated billing for skilled nursing facility residents receiving Part B services;

collection of outpatient and physician encounter data;

verification of social security numbers of new practitioners in the provider enrollment form; and

implementation of the ambulance fee schedule.

#### Will HCFA Systems Function In The Year 2000?

Yes, HCFA will do everything it must to ensure that its mission critical systems and those of its contractors will function in the Year 2000. Hospitals and physicians will continue to be paid and critical information will continue to be available. HCFA has also launched a provider outreach effort to assist medical providers in making their diagnostic equipment and office systems Y2K compliant. Being ready for the Year 2000 will not be easy, but HCFA and its partners are meeting the Y2K challenge.

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How Providers May Be Affected by the Year 2000 Challenge

The Year 2000 or Y2K conversion presents one of the greatest information system challenges since the inception of the Medicare program. This conversion is critical to smooth processing of health care claims for the 70 million beneficiaries enrolled in these programs.

Many computers use just two digits to record the year. If no action is taken, these computers may recognize "00" as 1900

rather than 2000, resulting in many potential problems for the providers and their patients.

Many provider practices will be affected, either directly or indirectly, by the year 2000 challenge. Taking proactive steps to identify and address potential impacts will be key to the success in meeting the needs of the Medicare beneficiaries. Some examples of how providers may be affected are:

Financially - If the provider's computer systems and those other systems that the provider interfaces are not Y2K ready, the transfer of information, including claims processing information, could be affected. Consequently, the provider's cash flow could also be affected. If the claims are billed to multiple entities (e.g., Medicare, Medicaid, private insurance companies, and managed care organizations), the provider could face some problems if the Y2K readiness with each of these entities is not ensured.

If a provider relies on another entity (e.g., a billing service or clearinghouse) to handle the claim filing procedures and the entity is not Y2K ready, it could add additional cost to the provider's business. This is particularly true if the payment for the services is based on the number of claims filings, since the billing vendor may file the claims more than once.

Legally - A provider may be held liable by his or her patients, customers, or business partners if there is a Y2K malfunction that causes personal or financial injuries. Neither the Health Care Financing Administration (HCFA) nor the Medicare contractors will assume any responsibility for the provider's Y2K compliance.

#### What Providers Can Do

There are key steps providers can take to become Y2K ready and many excellent sources of information available to help providers. Below are a few suggestions to consider. These suggestions are not intended to replace other steps and actions that providers may be taking towards their readiness plan.

Becoming aware of how the year 2000 can affect many systems. Anything dependent on a microchip or date entry could be affected. Entities that a provider depends on or who depend on the provider need to be identified. From a systems perspective, an inventory of both the hardware and software programs may be required. A list of the critical (cannot live without) items needs to be identified.

Assessing the readiness of everything on the list. Providers can do this by contacting their hardware or software vendor or accessing key information from various web sites. A list of important web site addresses can be found on page 71.

Maintenance and service contractors can help providers in determining readiness as well as system upgrades and or replacement options. In addition, there are many organizations offering services to assess business readiness. State associations and businesses can also provide assistance, particularly in the areas of biomedical equipment and medical devices.

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If a particular software program or form is not Y2K ready, providers need to decide whether to invest in the upgrade or the software replacement. In making this decision, providers need to be aware of the potential challenges that could be faced if the changes or upgrades are not made, particularly to programs that support the key business processes.

Testing the existing and newly purchased systems and software. The assumption that a system or a software program is Y2K ready cannot be made just because someone said it is. During the testing process, test plans and test output results should be maintained just in case a problem surfaces later.

Developing contingency plans for the continuity of business in the event that some equipment fails and by focusing on the issues and situations that would be most problematic for the providers and patients. For example, what will providers do if...

Claims cannot be sent in the right format to an insurer;

Laboratory or diagnostic facilities, where providers refer patients, cannot identify and accurately report to an insurer the dates providers submit on the order forms;

Output from monitoring and reporting equipment is not accurate or complete;

Electronic remittances from Medicare or Medicaid are not retrievable;

Account receivable systems do not work properly;

Checks cannot be deposited in the bank or credited accurately; or

Payroll systems do not function appropriately.

It is important to keep in mind the Y2K challenge is very broad. A checklist with a few examples of systems that may be affected by the Y2K challenge can be found below.

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Sample Provider Y2K Readiness Checklist

This checklist is intended as a supplemental guide in helping providers to determine their Y2K readiness. This list may be used along with other diagnostic and reference tools that providers may have obtained for this purpose. Providers may consider all types of equipment, systems, procedures, etc., that may in some way be time dependent and thereby affected by the Y2K "bug". This information is not all-inclusive.

ITEM	Y2K READY	NOT
Y2K READY		
Answering machines		
Bank debit/credit card expiration dates		
Banking interface		
Building access cards		
Claim forms		
Clocks		
Computer hardware (list)		
Computer software (list)		
Custom applications (list)		
Diagnostic equipment (list)		
Elevators		
Fire alarm		
Indoor lighting		
Insurance/pharmacy coverage dates		
Membership cards		
Monitoring equipment (list)		
Order forms		
Outdoor lighting		
Physician referral forms		
Smoke alarm		
Telephone system		
Television		
VCR equipment		
Sprinkler system		
Spreadsheets		
Treatment equipment (list)		
Safety vaults		

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Y2K WEB Site Reference

The following table lists several web sites you may want to visit which may help you determine your readiness and those that offer related services and information.

Information: Healthcare Related issues  
Address... <http://www.Rx2000.org>

Information: Commercial off the Shelf Software (COTS) -  
compliance information  
Address... <http://www.Y2K.policyworks.govmitre.org/technology/y2k>

Specific products and information regarding compliance

Information: Acer America (800-637-7000)  
Address... <http://www.acer.com>

Information: AST Computer (800-727-1278)  
Address... <http://www.ast.com>

Information: Compaq Computer (800-OK-COMPAQ)  
Address... <http://www.compaq.com>

Information: Dell computer Corporation (800-560-8324)  
Address... <http://www.dell.com>

Information: Gateway2000 (800-846-2301)  
Address... <http://www.gateway.com>

Information: Hewlett-Packard (800-752-0990)  
Address... <http://www.hp.com>

Information: Hitachi PC (800-555-6820)  
Address... <http://www.hitachipc.com>

Information: IBM (800-772-2227)  
Address... <http://www.us.pc.ibm.com>

Information: Intel (800-538-3373)  
Address... <http://www.intel.com>

Information: Micron Technology (800-349-6972)  
Address... <http://www.micron.com>

Information: Microsoft  
Address... <http://www.microsoft.com/year2000>

Information: NEC Computer Systems (800-456-9327)  
Address... <http://www.nec.com>

Information: Packard-Bell (800-733-4411)  
Address... <http://www.packardbell.com>

Information: Sony Electronics (800-352-7669)  
Address... <http://www.sel.sony.com>

Information: Texas Instruments (800-848-3927)  
Address... <http://www.ti.com>

Information: Toshiba (800-999-4273)  
Address... <http://www.toshiba.com>



Information: Commercial sector information  
Address... <http://www.year2000.com>

Information: Year 2000 Tools  
Address... <http://www.hp.com/year2000/cure.html>

Information: A simple, complete, and free PC hardware Year 2000 diagnostic  
Address... <http://www.righttime.com>

Information: The Complete Y2K website for COBOL  
Address... <http://www.pirkle-websites.com>

Information: The Computer Network  
Address... <http://www.cnet.com>

#### Federal Government

Information: HCFA (Health Care Financing Administration)  
Address... <http://www.hcfa.gov/y2k>

Information: Year 2000 provider outreach materials  
Address... <http://www.hcfa.gov/y2k/prmemorv.htm>

Information: This is a recommended place to start when researching information available from the Federal Government and its partners/contractors.  
Address... <http://www.fda.gov/cdrh/yr2000/year2000.html>

Information: Federal communications commission - information for consumers and industry  
Address... <http://www.fcc.gov/year2000>

Information: President's Council on the Year 2000 conversion  
Address... <http://www.y2k.gov>

Information: U.S. Small Business Administration  
Address... <http://www.sba.gov/y2k>

Information: General Services Administration (GSA)  
Address... <http://www.itpolicy.gsa.gov.mks.yr2000/y2khome.htm>

Information: Information technology (IT) - Information Technology Association of America  
Address... <http://www.ita.org/year2000.htm>

Information: The Health Alliance of Pennsylvania - provides statewide leadership in implementing the Pennsylvania Healthcare vision 2000.  
Address... <http://www.hap2000.org>

Information: Y2K Milestone markers  
Address... <http://www.everything2000.com>

Information: Real Time Solutions, Limited -Professional Assistance for IT problems  
Address... <http://www.rtsl.com>  
Address... <http://www.rts2000.demon.co.uk>

Information: Direct access services - Provides Y2K information and solutions for the millennium  
Address... <http://www.careconnect.com>

Information: Contingency planning of all health, safety, basic, and essential service related systems  
Address... <http://www.millennia-bcs.com>

Information: The Y2K information center - provides a forum for disseminating information about the year 2000 problem for discussion or possible solutions  
Address... <http://www.year2000.com>

Information: An on-line magazine dedicated to providing the latest information on handling Year 2000 projects and issues  
Address... <http://www.y2kjournal.com>

Information: Electronic Data Interchange (EDI)  
Address... <http://www.hcfa.gov/medicare/edi/edi.htm>

Information: Biomedical Equipment & Engineering  
Address... <http://www.is.ufl.edu/bawb015h.htm>

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#### GENERAL INFORMATION

##### Medicare + Choice Scams

Fraud, waste and abuse is costing the Medicare program billions of dollars each year \_ money from taxpayers which is used to pay for illegitimate claims. Although Medicare contractors, the federal government, and various law enforcement agencies are working hard to deter fraud and abuse in the Medicare program, health care providers and Medicare recipients can also join in the fight against fraud, waste and abuse.

Medicare contractors have been notified of Medicare + Choice scams which are emerging in certain states. (Medicare + Choice is an alternative health benefit program from the traditional Medicare program.) There are three scams which have been identified:

A well-dressed man is going door to door and telling Medicare beneficiaries that he will "change over" their Medicare benefits for \$60. He is also asking the beneficiaries for their Social Security numbers.

Medicare beneficiaries are receiving calls from individuals who attempt to make appointments to visit the beneficiary's home that evening to "fix their Medicare" on their Medicare card.

Medicare beneficiaries are receiving calls from individuals offering to help them with their Medicare and asking for their credit card numbers.

We are asking for your assistance in protecting the Medicare program and its beneficiaries from these scams. Please notify your patients about these scams and remind them of the following:

Medicare beneficiaries should guard their Social Security and Medicare numbers as securely as they would guard a credit card number.

No Medicare official charges to "fix" Medicare problems.

No Medicare official makes home visits.

If you or your patients encounter any of these scams or any other fraud, please call the OIG Fraud Hotline at (800)HHS-TIPS or your Medicare customer service department at one of the following numbers:

Beneficiaries: 1-800-333-7586 or

Providers: 904-634-4994

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Region C DMERC Physician Information Sheet: Enteral Nutrition

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 cooperation that Medicare can

provide beneficiaries with the 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.

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.

Medicare Durable Medical Equipment Regional Carrier Physician Information Sheet: Enteral Nutrition

Enteral nutrition is the provision of nutritional requirements through a tube into the stomach or small intestine.

It is covered by Medicare for patients with diseases or structural defects of the alimentary tract that interfere with transport, digestion or absorption of nutrients to a degree that oral ingestion proves inadequate to maintain weight and strength commensurate with overall health status. Such conditions may include anatomic obstructions such as head and neck cancers, or motility disorders such as dysphagia or gastroparesis. Even neurological disorders (e.g., Alzheimer's) resulting in this degree of ingestional dysfunction would qualify for coverage. The severity of these conditions which warrants coverage is reflected in the physician's decision to insert and maintain a feeding tube in the patient. Coverage is possible for patients with partial impairments - e.g., a patient with dysphagia who can swallow small amounts of food or a patient with Crohn's disease who requires prolonged infusion of enteral nutrients to overcome a problem with absorption. Questions often arise about patients whose conditions are either improving or deteriorating and may be transitioning to or from a tube-feeding situation. They may be getting some of their nutrients orally, but requiring tube feedings to maintain their nutritional status. So long as the physician sees fit to maintain the enteral tube, Medicare will cover those nutrients administered via that tube.

In order to be covered, the physician must judge the condition to be permanent - expected to last greater than three months, or until the patient's death, whichever is shorter.

Conditions which are not covered (even though they may involve tube feedings) include anorexia and nausea secondary to mood disorders and end-stage diseases not directly involving the gastrointestinal tract.

Only those nutrients administered via the feeding tube are covered by Medicare. (Enteral nutrients taken orally are not

covered by Medicare.) Baby food and blenderized grocery products are not covered, even if administered via a feeding tube.

Medicare pays for supplies required for different methods of administering tube feedings (gravity, syringe or a pump). Medical records should reflect medical conditions requiring controlled administration of nutrients through a pump. More than one nasogastric tube per month or one gastrojejunostomy tube every 3 months are rarely medically necessary. (While disoriented patients may remove their own tubes leading to the use of more tubes, such an occurrence is not considered strictly an issue of medical necessity and is not reimbursable.) Dressings used for the insertion site of enteral tubes are reimbursed as part of the "administration kit," and are not separately payable.

Most enteral nutrient products sufficient to achieve and maintain adequate nutritional status are grouped into a basic HCPCS billing code (B4150) and are reimbursed at the same rate. Products made of natural intact protein (B4151) are covered for patients who have demonstrated an allergy or intolerance to the basic semi-synthetic products. Special, more highly reimbursed products (B4153-5) need to be justified for each patient. The physician must document why he or she is ordering these products (such as those that are disease-specific).

Documentation:

If you order enteral nutrition for your patient, it is necessary to complete a Certificate of Medical Necessity (CMN), in order for the supplier to be reimbursed by Medicare. The physician is expected to have seen the patient within 30 days prior to initially certifying the need for enteral nutrition, or document why not, and what monitoring methods were used to evaluate the patient's enteral nutrition needs. Routine recertifications are no longer required. However, changes in your orders may require completion of revised CMNs.

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Important Information for Billing of Nurse Practitioner (NP), Physician Assistant (PA) and Clinical Nurse Specialist (CNS) Claims

Provider Identification Number Required; Continued Use of Discontinued Modifiers

For dates of service on or after January 1, 1999, NPs, CNSs and PAs must use their carrier-assigned Provider Identification Number (PIN) to submit claims to Medicare. Additionally, although the January 1, 1999 HCPCS discontinues modifiers specific to these providers effective December 31, 1998 (plus a 90-day grace period), claims submitted without the appropriate modifier cannot be processed at this time. Any claims for these provider types received without the use of the appropriate modifier will be rejected until further notice. We will provide further

information concerning the deletion of these modifiers in future issues of the Medicare Part B Update!

The modifiers affected by this delay are:

AK- Nurse Practitioner, rural, team member;

AL-Nurse Practitioner, non-rural, team member;

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

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

AV-Nurse Practitioner, rural non-team member;

AW-Clinical Nurse Specialist, non-team member; and

AY-Clinical Nurse Specialist, team member.

#### Discontinue Use of the Surrogate UPIN

Effective January 1, 1998, sections 4511 and 4512 of the Balanced Budget Act of 1997 removed the restrictions on the type of areas and settings in which the professional services of NPs, CNSs, and PAs are paid by Medicare. Accordingly, payments are allowed for services furnished by these non-physician practitioners in all areas and settings permitted under applicable State licensure laws. However, the provision maintains the current policy that no separate payment may be made to one of these non-physician practitioners when a facility or other provider payment or charge is also made for such professional services.

The use of the surrogate UPIN "NPP000" is being discontinued effective January 1, 1999. "NPP000" has been used by NPs, CNSs, and PAs, because a permanent UPIN had not been issued to them. A mass mailing of letters containing language generated from HCFA Central Office and permanent UPINs for all NPs/CNSs/PAs, who are currently enrolled as Medicare providers, will be sent from Transamerica Occidental Life Insurance Company shortly. These non-physician practitioners should begin using their permanent UPINs immediately. Medicare is issuing a permanent UPIN to any new NP/CNS/PA who is applying to become a Medicare provider. In the future, claims containing the surrogate UPIN "NPP000" will be returned as unprocessable.

Physicians and non-physician providers who order or refer services must submit their names and their UPINs on Form HCFA-1500. This information must appear in block 17 and 17a of Form HCFA-1500. For National Standard Format (NSF) claims, the UPIN must appear in record/field EA0.20 as the ordering/referring provider. Providers submitting American National Standards Institute (ANSI) claims in the X12 837 version 3051.3B format must submit the referring/ordering UPIN in table 2, position

500.E-NM109. Providers using the X12 837 version 3032.2B will use table 2, position 420.E-NM109 for the referring/ordering UPIN

Services of a NP or a CNS who is working in collaboration with, but independent of, a physician would be considered covered services as defined in sections 1861(s)(1) and 1861(s)(2)(A) of the Social Security Act. Therefore, a NP or CNS who is treating the beneficiary can order or prescribe items of durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) and can complete Section D of the Certificate of Medical Necessity (CMN) if he or she is permitted to prescribe items of DMEPOS by the State in which the services were rendered. The NP and CNS must bill using their own provider number, and they must attest, the same as a physician, that they have treated the beneficiary and that all information presented in Section B of the CMN, or on the order, is true, accurate, and complete to the best of their knowledge. The name and UPIN of the NP or CNS are required on the CMN.

#### Nurse Practitioner And Physician Assistant Guidelines

Page 21 of the March/April 1998 and page 16 of the July/August 1998 Medicare B Update contains information regarding nurse practitioner and physician assistant services. These articles reference that these practitioners may obtain Medicare Part B provider numbers for billing the Medicare Part B Program directly. If nurse practitioners and physician assistants are rendering services incident to a physicians service, services should be billed under the physicians provider number. In this instance, a provider number for the nurse practitioner and/or physician assistant is not needed. When nurse practitioners and/or physician assistants render services which are incident to a physicians service, a provider number is needed.

When physician assistants initially apply for a Medicare Part B provider number, completion of a General Enrollment Application (HCFA 855) and Reassignment of Benefits (HCFA 855R) is required. Reimbursement for physician assistant services can not be made directly to the physician assistant. Reimbursement must be made payable to their employer; therefore, a HCFA 855R is required. In this instance, employer means a W2 employee or 1099 contractor of the entity.

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#### Changes to Health Professional Shortage Area Designations

Medicare has received the individual Health Professional Shortage Area (HPSA) designation changes which added geographic designation as urban HPSAs for the following counties:

Gadsden County (all)

Nassau County

Cities of Callahan and Hilliard

Census Tracts 0504.00 and 0505.00

The new counties are effective for services rendered on or after December 1, 1998.

For more information regarding HPSA designations, refer to the May/June 1998 Medicare Part B Update! (page 58).

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Copying the HCFA-855

We have recently been advised that an applicant may copy the HCFA 855 and its attachments. On page 3 of the HCFA-855 application, the applicant is instructed to copy section 6 for each additional practice location he/she needs to submit. Copying of the application is not limited to only certain sections of the application. It is therefore permissible to copy the HCFA-855 as long as there is an original signature for each application submitted.

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Billing Tips In Submitting Medigap Information To Insure A Successful Crossover

The Medicare Claims Processing department is working hard to reduce provider billing errors. Billing errors cost the Medicare Program thousands of dollars each year. Billing errors generally cause the claim to suspend for manual handling. Claim processing timeliness is affected. Errors can also result in claim denial.

The Medigap Crossover process is a financial benefit available to all participating providers. With one claim filing, regardless of the method of claim transmission, a provider may receive two insurer claim payments. However, for the Medigap crossover process to be successful, providers must submit Medigap information that is complete, accurate and in the prescribed format.

Below we are providing the two top billing errors providers are making when submitting Medigap information to the Medicare carrier.

Submitting the complete name, address, city and state of the Medigap insurer, but failing to provide a valid five digit Medigap carrier ID number, or submitting no ID number at all. This situation requires manual intervention by Medicare Part B, which could impact the processing time of the claim.

Failure to submit the five digit Medigap carrier ID number and the name, address, city and state of the Medigap insurer is not



complete. This situation will result in the claim not being crossed over to the patient's supplemental insurer

Please examine the format of the Medigap information you are currently submitting to Medicare to determine if your office may be causing one of the billing errors identified above. We ask your assistance in helping us to process your claim in a timely and efficient manner by making sure all of the required Medigap information is properly submitted. Together, we can make a difference.

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#### Correct Coding Initiative

The newest version of the Correct Coding Initiative (CCI) is scheduled to be implemented on January 1, 1999. Providers who have concerns about correct coding edit pairs should submit those concerns in writing to:

#### The Correct Coding Initiative

AdminaStar Federal  
P.O. Box 50469  
Indianapolis, IN 46250-0469

As a reminder, the carrier cannot make any changes to the correct coding edit pairs.

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#### Crossover Updates

The following updates have been performed to the Medicare Part B of Florida Crossover Insurers. 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 September/October 1998 Medicare B Update! A Closer Look section (page 42)

#### Automatic Crossover

The following private insurer has been added to the automatic crossover insurer listing.

#### Blue Cross of California (Administered by Mutual of Omaha)

As a reminder, this type of crossover does not require the submission of policy information on the claim; instead Medicare

claims are automatically sent to the private insurer based on the patient's eligibility (as defined by his or her policy) for the electronic transfer.

Medigap Crossover - Name Change:

Number: 27004  
Former Name: BCBS of Kentucky  
Changed To: Anthem BCBS\*

\*Anthem BCBS located in Louisville, Kentucky

Exempt "Non-Medigap Insurers"

The following insurers do not offer 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 is inactive and payment information will not be crossover to these insurers.

Number: 19570  
Insurer Name: Amer Life and Health Svcs

Number: 34010  
Insurer Name: Commonwealth National Life

Number: 19590  
Insurer Name: Life and Casualty

Number: 20075  
Insurer Name: Life and Casualty

Number: 45128  
Insurer Name: Ohio Graphic Arts

Number: 15122  
Insurer Name: Risk Management

Number: 19504  
Insurer Name: Southern Life

Number: 19586  
Insurer Name: Southern Life

Number: 29004  
Insurer Name: UNUM

What's New for EMC?

Are You Ready For the Millennium?

If you or your billing company currently submits Part B claims electronically with six-digit dates of service or dates of birth, in the format YYMMDD (for example, 981231), you will need to change your billing system so it can submit and receive an eight digit date in the format of CCYYMMDD (for example, 19981231). HCFA will begin rejecting electronic claim submissions with six-digit dates sometime in 1999. While you will be notified well in advance of such rejects being implemented, DON'T DELAY - MAKE YOUR FORMAT CHANGES NOW!

PC-ACE(tm) users, please be advised that while you do not see dates in the eight digit format in your software, the two digits indicating the century are systematically populated when the transmission is processed through the NSF output file.

If you have questions concerning the electronic format change, please call us at (904) 354-5977.

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General EMC Information

Reporting UPIN Information for EMC

Physicians and non-physician providers who order or refer services must submit their names and their UPINs on Form HCFA-1500. This information must appear in block 17 and 17a of Form HCFA-1500. For National Standard Format (NSF) claims, the UPIN must appear in record/field EA0-20.0 as the ordering/referring provider. Providers submitting American National Standards Institute (ANSI) claims in the X12 837 version 3051.3B format must submit the referring/ordering UPIN in Table 2, position 500.E-NM109. Providers using the X12 837 version 3032.2B, will use Table 2, position 420.E-NM109 for the referring/ordering UPIN.

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IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

Chiropractic Claims  
Medicare Part B Chiropractic Unit  
P. O. Box 44067  
Jacksonville, FL 32231-4067

Ambulance Claims  
Medicare Part B Ambulance Dept  
P. O. Box 44099  
Jacksonville, FL 32231-4099

Medicare Secondary Payer  
Medicare Part B Secondary Payer Dept.  
P. O. Box 44078  
Jacksonville, FL 32231-4078

ESRD Claims  
Medicare Part B ESRD Claims  
P.O. Box 45236  
Jacksonville, FL 32232-5236

#### COMMUNICATIONS

##### Review Requests

Medicare Part B Claims Review  
P. O. Box 2360  
Jacksonville, FL 32231-0018

Fair Hearing Requests  
Medicare Part B Fair Hearings  
P. O. Box 45156  
Jacksonville, FL 32232-5156

Administrative Law Judge Hearing  
Administrative Law Judge Hearing  
P.O. Box 45001  
Jacksonville, FL 32231-5001

Status/General Inquiries  
Medicare Part B Correspondence  
P. O. Box 2360  
Jacksonville, FL 32231-0018

Overpayments  
Medicare Part B Financial Services  
P.O. Box 44141  
Jacksonville, FL 32231-0048

#### DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims

Palmetto GBA  
Medicare DMERC Operations

P.O. Box 100141  
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries  
Medicare EDI  
P. O. Box 44071  
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:  
Medicare Part B Claims  
P. O. Box 2537  
Jacksonville, FL 32231-2537

Over 40 days of initial request:  
Submit the charge(s) in question, including information  
requested, as you would a new claim to:

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

MISCELLANEOUS

Fraud and Abuse  
Medicare Fraud Branch  
P.O. Box 45087  
Jacksonville, FL 32231

Medicare Claims for Railroad Retirees:  
MetraHealthRRB Medicare  
P. O. Box 10066  
Augusta, GA 30999-0001

Provider Change of Address:  
Provider Registration Department  
Blue Cross Blue Shield of Florida  
P. O. Box 41109 Jacksonville, FL 32231-1109

and

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

Provider Education:  
For Educational Purposes and Review of Customary/Prevailing  
Charges or Fee Schedule:  
Medicare Part B Provider Education Department

P. O. Box 2078  
Jacksonville, FL 32231-0048

For Seminar Registration:  
Medicare Part B Provider Education Department  
P. O. Box 45157  
Jacksonville, FL 32231

Limiting Charge Issues:

For Processing Errors:  
Medicare Part B  
P.O. Box 2360  
Jacksonville, FL 32231-0048

For Refund Verification:  
Medicare Part B Compliance Monitoring  
P.O. Box 2078  
Jacksonville, FL 32231-0048

Provider Participation and Group Membership Issues;  
Written Requests for UPINs, Profiles & Fee Schedules:  
Medicare Registration P.O. Box 44021 Jacksonville, FL 32231

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MEDICARE ONLINE  
ELECTRONIC BULLETIN BOARD (BBS)

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

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Order Form - 1999 Part B Materials

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(contact Provider Customer Service Area)

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PHONE NUMBERS

PROVIDERS

Express Line/ARU  
Status Inquiries:  
904-353-3205

Specialty Customer Service Reps:  
904-634-4994

Medicare Online BBS

Access:  
1-800-838-8859  
1-904-791-6991

Technical Problems:  
1-904-791-8384

BENEFICIARY

Outside Duval County (in Florida):  
1-800-333-7586

Duval County (or outside Florida):  
904-355-3680

Hearing Impaired:  
1-800-754-7820

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

EMC

EMC Format Issues:  
904-354-5977

EMC Start-Up:  
904-791-8767

EMC Front-End Edits/Rejects:  
904-791-8767

Electronic Remittance Advice:  
904-791-6895

Electronic Claim Status:  
904-791-6895

Electronic Eligibility:  
904-791-6895

PC-ACE Support:  
904-355-0313

Testing:  
904-354-5977

Help Desk (Confirmation/Transmission):  
904-791-9880

OCR

Printer Specifications/Test Claims:  
904-791-6912

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