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

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HCFA
Health Care Financing Administration

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

Highlights

Reader Survey (page 43)

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Implementation of HCFA Y2K Outreach Toll-Free Line

The Health Care Financing Administration (HCFA) has established a Year 2000 (Y2K) Outreach toll-free telephone line. The number is (800) 958-HCFA [4232]. The Y2K information line is limited to:

- Upcoming HCFA outreach conferences and other Y2K activities,

- Policies HCFA has established about Y2K, and

- Y2K provider supply, facilities and business issues.

As appropriate, calls from Medicare providers about contractor-specific issues will be referred by HCFA to the carrier. Providers who wish to contact the Florida Medicare Part B carrier directly should call (904) 634-4994 for general information or (904) 791-8769 for Electronic Media Claims.

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What's New

Continued Modifier Use for ARNP/PA/CNS Practitioners

As a result of the 1999 HCPCS and CPT procedure code changes, the modifiers for advanced registered nurse practitioners (ARNPs), clinical nurse specialists (CNSs), and physician assistants (PAs) were deleted effective for services rendered on or after March 31, 1999. However, it is imperative that these practitioners continue to use the appropriate modifiers until June 30, 1999, even if the practitioner has a provider identification number (PIN) from Medicare, in order to assure proper reimbursement. Claims received from these practitioners lacking the appropriate modifiers will be denied payment. As it becomes available, more information will be provided in future editions of the Medicare B Update! Additionally, the professional societies representing these practioners will be notified of fruther changes to this requirement.

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Important Information for Independent Physiological Laboratories

Independent Physiological Laboratories (IPLs) that have not converted to Independent Diagnostic Testing Facilities (IDTFs) will have their claims returned as unprocessable effective March 29, 1999. See page 10 for more information.

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We Need Your Help!

The publications staff is continually looking for ways to improve the Medicare B Update! Included in this issue on page 43 is a readers' survey we hope you will take the time to complete. You

may fax or mail your responses.Please help us improve your Update!

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"Doctor, Are You Connected?"

At a recent Florida Medicare Carrier Advisory Committee, several members inquired what Web sites might be available for them to learn more about Medicare and other medical topics. The number of sites available are far too numerous to list in this short article. However, there are several Web sites you might want to visit in order to learn more about Medicare policies, to remain current in coverage decisions and to anticipate future decisions.

Probably the most important site, from a Medicare standpoint, is www.hcfa.gov. This site has multiple links to various government publications, including the Federal Register. At one of the sites, you will learn that HCFA is considering coverage for five new treatments that are currently not covered by Medicare. They are:

Enhanced External Counterpulsation Therapy (EECP)

- Cryosurgery Ablation of the Prostate

- Cardiac Monitoring by Electrical Bioimpedence

- Transmyocardial Revascularization (TMR)

- Positron Emission Tomography (PET)

Please note that only the first step has been taken towards making coverage of these services effective. Manual instructions must be prepared and approved and the necessary billing and claims processing instructions must be prepared. In addition, changes must be made to build processing systems that would allow payment to be made. Consequently, the effective date of service will not be known until the instruction clearance process has been completed and effective dates have been assigned . More details can be found on the HCFA Web page.

Of course, we still have our Medicare bulletin board system (BBS). This site contains all of our current local medical review policies (LMRP), a UPIN directory, a Medigap listing, the Physician Fee Schedule, a MEDPARD directory, Florida Medicare publications from 1992 to the present, information on educational seminars, Y2K information, a health maintenance organization (HMO) directory, and electronic media claims (EMC) format specifications.

For details of the BBS, review the article on page 40 of this issue. Instructions for connecting to the BBS are included on page 41.

A relatively new site is www.medicaretraining.com. This new site was created by First Coast Service Options, Inc. for HCFA to provide a multi-state educational resource. There are several free computer-based training courses available. Y2K information, the schedule for future satellite broadcasts for various Medicare educational topics, and several related links are available to expand your exploration of Medicare related subjects.

Finally, you might want to check out this web site: www.quackwatch.com. There you will find articles on several procedures, tests, equipment, and treatments that have been found to be lacking supporting scientific evidence.

If you visit all of the above sites and their related links, you should be busy for a long time and gain a lot of knowledge. Hope you find the information helpful. Happy surfing!

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Advance Notice Requirement

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

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

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

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

Schedule and Registration

<see Medifest or Educational Events at Main Menu of Medicare>

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Elimination of Coverage for Independent Physiological Laboratories (IPLs)

IPLs were notified by the Medicare Registration Department on November 23, 1998, of a new regulation (CFR section 410.33) entitled "Independent Diagnostic Testing Facility (IDTF)." This regulation eliminated coverage of IPLs effective January 15, 1999 (later extended to March 29, 1999). The regulation was published in the Federal Register on October 31, 1997.

The first phase of the credentialing requirements for IDTFs was provided in the March/April 1999 Medicare B Update! (pages 48-56). Additional credentialing requirements will be provided in future issues of the Update! Note that an IPL that has not converted to IDTF status must complete a new HCFA 855 Form and return it to Medicare Registration. In addition, a new EDI enrollment agreement is necessary for the new entity to bill electronic media claims to Medicare of Florida. For more information concerning EDI enrollment, providers can refer to the March/April 1999 Update! (pages 63-65).

For services performed on and after March 29, 1999, all claims submitted by an IPL that has not converted to IDTF status will be returned as unprocessable.

To obtain a copy of HCFA 855 Form, please call Customer Service at (904) 634-4994.

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Correct Coding Initiative

Version 5.1 of the Correct Coding Initiative (CCI) was installed in the Florida Medicare B claims processing system on March 29, 1999. Version 5.2 is scheduled for implementation July 1, 1999.

Although carriers are prohibited from publishing specific Correct Coding Edits (CCE), this information can be obtained by ordering a National Correct Coding Policy Manual from the National Technical Information Service (NTIS).

To request a single issue of the National Correct Coding Policy Manual, call (703) 605-6000.

For a subscription to the National Correct Coding Policy Manual, call (703) 605-6060, or (800) 363-2068.

To receive information from NTIS by mail, call (800) 553-6847.

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New Pricing for Injectable Drugs

On page 21 of the March/April 1999 Medicare B Update!, a new method for calculating reimbursement for injectable drugs was described. This new method was used in calculating the allowances

for injectable drugs that can be found on the following five pages. These amounts were effective for claims with 1999 dates of service, processed on or after March 29, 1999.

On the following list, "NC" represents services that are non-covered; "IC" represents services paid on an individual consideration basis. A dashed line (- - - - -) means that the concept does not apply (for example, if a dashed line appears in the "non-par allowance" and "limiting charge" columns, that means there is no five percent reduction for non-participating providers, and the service is not subject to limiting charge requirements).

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INJECTABLE DRUG ALLOWANCES

CODE	PAR	NON-PAR	LIMITING CHARGE
90371	$405.74	-----	-----
90657	$1.66	-----	-----
90658	$3.32	-----	-----
90659	$3.32	-----	-----
90669	NC	NC	NC
90703	$2.90	$2.76	$3.17
90732	$10.83	-----	-----
90744	$13.36	-----	-----
90745	$13.36	-----	-----
90746	$50.06	-----	-----
90747	$172.23	-----	-----
J0120	$11.56	$10.98	$12.63
J0130	$513.01	$487.36	$560.46
J0150	$26.45	$25.13	$28.90
J0151	$212.56	$201.93	$232.22
J0170	$1.00	$0.95	$1.09
J0190	$3.16	$3.00	$3.45
J0205	$37.52	$35.64	$40.99
J0207	$350.31	$332.79	$382.71
J0210	$8.97	$8.52	$9.80
J0256	$2.09	$1.99	$2.29
J0270	$1.91	$1.81	$2.08
J0275	$18.76	$17.82	$20.49
J0280	$1.30	$1.24	$1.43
J0285	$15.77	$14.98	$17.23
J0286	$92.15	$87.54	$100.67
J0290	$1.06	$1.01	$1.16
J0295	$13.73	$13.04	$15.00
J0300	$2.02	$1.92	$2.21
J0330	$0.08	$0.08	$0.09
J0340	$7.87	$7.48	$8.60
J0350	$2,517.57	$2,391.69	$2,750.44
J0360	$7.62	$7.24	$8.33
J0380	$1.12	$1.06	$1.22
J0390	$16.20	$15.39	$17.70
J0395	$182.40	$173.28	$199.27
J0400	$27.17	$25.81	$29.68

J0460	$1.98	$1.88	$2.16
J0470	$23.67	$22.49	$25.86
J0475	$215.65	$204.87	$235.60
J0476	$74.10	$70.40	$80.96
J0500	$1.66	$1.58	$1.82
J0510	$5.47	$5.20	$5.98
J0515	$3.46	$3.29	$3.78
J0520	$5.16	$4.90	$5.64
J0530	$6.12	$5.81	$6.68
J0540	$12.24	$11.63	$13.37

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J0550	$24.48	$23.26	$26.75
J0560	$7.50	$7.13	$8.20
J0570	$12.24	$11.63	$13.37
J0580	$24.48	$23.26	$26.75
J0585	$4.38	$4.16	$4.78
J0590	$4.17	$3.96	$4.55
J0600	$36.44	$34.62	$39.81
J0610	$1.01	$0.96	$1.10
J0620	$0.34	$0.32	$0.37
J0630	NC	NC	NC
J0635	$12.82	$12.18	$14.01
J0640	$35.47	$33.70	$38.76
J0670	NC	NC	NC
J0690	$1.96	$1.86	$2.14
J0694	$10.83	$10.29	$11.83
J0695	$24.79	$23.55	$27.08
J0696	$10.24	$9.73	$11.19
J0697	$6.09	$5.79	$6.66
J0698	$12.12	$11.51	$13.24
J0702	$4.39	$4.17	$4.80
J0704	$3.21	$3.05	$3.51
J0710	$1.55	$1.47	$1.69
J0713	$9.67	$9.19	$10.57
J0715	$6.15	$5.84	$6.72
J0720	$6.18	$5.87	$6.75
J0725	$1.62	$1.54	$1.77
J0730	$0.33	$0.31	$0.36
J0735	$48.45	$46.03	$52.93
J0740	$723.90	$687.71	$790.87
J0743	$13.67	$12.99	$14.94
J0745	$0.86	$0.82	$0.94
J0760	$4.78	$4.54	$5.22
J0770	$39.03	$37.08	$42.64
J0780	$2.62	$2.49	$2.86
J0800	$4.55	$4.32	$4.97
J0810	$2.76	$2.62	$3.01
J0835	$12.44	$11.82	$13.59
J0850	$485.86	$461.57	$530.81
J0895	$11.46	$10.89	$12.52
J0900	$1.51	$1.43	$1.64
J0945	$0.52	$0.49	$0.56
J0970	$1.61	$1.53	$1.76
J1000	$0.80	$0.76	$0.87

J1020	$0.47	$0.45	$0.52
J1030	$0.95	$0.90	$1.04
J1040	$3.33	$3.16	$3.63
J1050	$13.10	$12.45	$14.32

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J1060	$1.03	$0.98	$1.13
J1070	$1.21	$1.15	$1.32
J1080	$2.25	$2.14	$2.46
J1090	$0.60	$0.57	$0.66
J1095	$4.45	$4.23	$4.86
J1100	$0.47	$0.45	$0.52
J1110	$12.52	$11.89	$13.67
J1120	$29.64	$28.16	$32.38
J1160	$2.30	$2.19	$2.52
J1165	$0.57	$0.54	$0.62
J1170	$1.18	$1.12	$1.29
J1180	$5.28	$5.02	$5.77
J1190	$150.56	$143.03	$164.48
J1200	$2.78	$2.64	$3.04
J1205	$9.31	$8.84	$10.17
J1212	$34.67	$32.94	$37.88
J1230	$0.71	$0.67	$0.77
J1240	$0.69	$0.66	$0.76
J1245	$21.34	$20.27	$23.31
J1250	$11.40	$10.83	$12.45
J1260	$1.48	$1.41	$1.62
J1320	$0.85	$0.81	$0.93
J1325	$16.53	$15.70	$18.06
J1330	$4.50	$4.28	$4.92
J1362	$5.95	$5.65	$6.50
J1364	$11.07	$10.52	$12.10
J1380	$0.70	$0.67	$0.77
J1390	$1.25	$1.19	$1.37
J1410	$46.20	$43.89	$50.47
J1435	$0.19	$0.18	$0.21
J1436	$63.64	$60.46	$69.53
J1440	$163.85	$155.66	$179.01
J1441	$260.68	$247.65	$284.80
J1455	$11.60	$11.02	$12.67
J1460	IC	IC	IC
J1470	IC	IC	IC
J1480	IC	IC	IC
J1490	IC	IC	IC
J1500	IC	IC	IC
J1510	IC	IC	IC
J1520	IC	IC	IC
J1530	IC	IC	IC
J1540	IC	IC	IC
J1550	IC	IC	IC
J1560	IC	IC	IC
J1561	$61.56	$58.48	$67.25
J1562	$380.00	$361.00	$415.15

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J1565	$661.77	$628.68	$722.98
J1570	$33.88	$32.19	$37.02
J1580	$2.16	$2.05	$2.36
J1600	$11.22	$10.66	$12.26
J1610	$36.52	$34.69	$39.89
J1620	$61.95	$58.85	$67.68
J1626	$17.67	$16.79	$19.31
J1630	$6.91	$6.56	$7.54
J1631	$29.94	$28.44	$32.71
J1642	$0.26	$0.25	$0.29
J1644	$0.37	$0.35	$0.40
J1645	$13.25	$12.59	$14.48
J1650	$5.32	$5.05	$5.81
J1670	$58.90	$55.96	$64.35
J1690	$3.89	$3.70	$4.26
J1700	$0.83	$0.79	$0.91
J1710	$4.94	$4.69	$5.39
J1720	$2.80	$2.66	$3.06
J1730	$93.00	$88.35	$101.60
J1739	$1.29	$1.23	$1.41
J1741	$2.71	$2.57	$2.96
J1742	$196.51	$186.68	$214.68
J1760	$35.81	$34.02	$39.12
J1770	$89.54	$85.06	$97.82
J1780	$179.09	$170.14	$195.66
J1785	$3.75	$3.56	$4.09
J1790	$3.65	$3.47	$3.99
J1800	$5.79	$5.50	$6.33
J1810	$7.02	$6.67	$7.67
J1820	$2.66	$2.53	$2.91
J1825	$202.35	$192.23	$221.06
J1830	$68.40	$64.98	$74.73
J1840	$3.19	$3.03	$3.48
J1850	$2.88	$2.74	$3.15
J1885	IC	IC	IC
J1890	$10.26	$9.75	$11.21
J1910	$12.04	$11.44	$13.16
J1930	$3.93	$3.73	$4.29
J1940	$0.93	$0.88	$1.01
J1950	$418.59	$397.66	$457.31
J1955	$34.20	$32.49	$37.36
J1956	$18.81	$17.87	$20.55
J1960	$3.69	$3.51	$4.04
J1970	$21.55	$20.47	$23.54
J1980	$5.06	$4.81	$5.53
J1990	$13.79	$13.10	$15.07
J2010	$0.95	$0.90	$1.04

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J2060	$8.33	$7.91	$9.10
J2150	$3.26	$3.10	$3.57
J2175	$0.57	$0.54	$0.62
J2180	$3.69	$3.51	$4.04

J2210	$3.22	$3.06	$3.52
J2240	$1.28	$1.22	$1.40
J2250	$2.07	$1.97	$2.27
J2260	$37.43	$35.56	$40.89
J2270	$0.97	$0.92	$1.06
J2271	$13.18	$12.52	$14.40
J2275	$7.41	$7.04	$8.10
J2300	$1.44	$1.37	$1.58
J2310	$2.03	$1.93	$2.22
J2320	$5.20	$4.94	$5.68
J2321	$4.94	$4.69	$5.39
J2322	$12.64	$12.01	$13.81
J2330	$1.84	$1.75	$2.01
J2350	$0.11	$0.10	$0.12
J2355	$236.31	$224.49	$258.16
J2360	$2.26	$2.15	$2.47
J2370	$2.37	$2.25	$2.59
J2400	NC	NC	NC
J2405	$5.80	$5.51	$6.34
J2410	$2.64	$2.51	$2.89
J2430	$219.55	$208.57	$239.86
J2440	$3.56	$3.38	$3.89
J2460	$0.89	$0.85	$0.98
J2480	$3.24	$3.08	$3.54
J2510	$3.13	$2.97	$3.42
J2512	$35.48	$33.71	$38.77
J2515	$0.88	$0.84	$0.97
J2540	$0.39	$0.37	$0.43
J2545	$92.62	$87.99	$101.19
J2550	$0.24	$0.23	$0.26
J2560	$2.26	$2.15	$2.47
J2590	$0.56	$0.53	$0.61
J2597	$4.67	$4.44	$5.11
J2640	$0.66	$0.63	$0.72
J2650	$0.34	$0.32	$0.37
J2675	$0.96	$0.91	$1.05
J2680	$15.20	$14.44	$16.61
J2690	$11.02	$10.47	$12.04
J2700	$2.00	$1.90	$2.19
J2710	$0.70	$0.67	$0.77
J2720	$0.77	$0.73	$0.84
J2725	$23.45	$22.28	$25.62
J2730	$60.92	$57.87	$66.55

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J2760	$28.91	$27.46	$31.58
J2765	$1.90	$1.81	$2.08
J2790	$41.32	$39.25	$45.14
J2792	$20.54	$19.51	$22.44
J2800	$3.99	$3.79	$4.36
J2810	$1.44	$1.37	$1.58
J2820	$25.62	$24.34	$27.99
J2860	$8.21	$7.80	$8.97
J2910	$13.14	$12.48	$14.35
J2912	$1.10	$1.05	$1.21

J2920	$2.01	$1.91	$2.20
J2930	$3.54	$3.36	$3.86
J2950	$0.45	$0.43	$0.49
J2970	$5.57	$5.29	$6.08
J2994	$2,612.50	$2,481.88	$2,854.16
J2995	NC	NC	NC
J2996	$261.25	$248.19	$285.42
J3000	$5.65	$5.37	$6.18
J3010	$1.49	$1.42	$1.63
J3030	$18.54	$17.61	$20.25
J3070	$3.17	$3.01	$3.46
J3080	$9.73	$9.24	$10.63
J3105	$2.14	$2.03	$2.33
J3120	$0.57	$0.54	$0.62
J3130	$1.14	$1.08	$1.24
J3140	$0.39	$0.37	$0.43
J3150	$0.95	$0.90	$1.04
J3230	$1.90	$1.81	$2.08
J3240	$190.18	$180.67	$207.77
J3250	$2.39	$2.27	$2.61
J3260	$10.80	$10.26	$11.80
J3265	$1.89	$1.80	$2.07
J3270	$2.21	$2.10	$2.42
J3280	$5.01	$4.76	$5.47
J3301	$0.40	$0.38	$0.44
J3302	$0.17	$0.16	$0.18
J3303	$2.26	$2.15	$2.47
J3305	$60.19	$57.18	$65.76
J3310	$6.30	$5.99	$6.89
J3320	$22.12	$21.01	$24.16
J3350	$80.20	$76.19	$87.62
J3360	$1.71	$1.62	$1.86
J3364	$56.61	$53.78	$61.85
J3365	$466.16	$442.85	$509.28
J3370	$5.19	$4.93	$5.67
J3390	$23.20	$22.04	$25.35
J3400	$11.85	$11.26	$12.95

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J3410	$0.62	$0.59	$0.68
J3420	$0.05	$0.05	$0.06
J3430	$2.24	$2.13	$2.45
J3450	$2.00	$1.90	$2.19
J3470	$8.48	$8.06	$9.27
J3475	$0.28	$0.27	$0.31
J3480	$0.10	$0.10	$0.12
J7030	$10.39	$9.87	$11.35
J7040	$10.30	$9.79	$11.26
J7042	$10.73	$10.19	$11.72
J7050	$10.90	$10.36	$11.91
J7051	$0.55	$0.52	$0.60
J7060	$9.56	$9.08	$10.44
J7070	$10.85	$10.31	$11.86
J7100	$27.01	$25.66	$29.51
J7110	$107.52	$102.14	$117.46

J7120	$12.67	$12.04	$13.85
J7130	$6.79	$6.45	$7.42
J7190	$0.85	-----	-----
J7191	$2.09	-----	-----
J7192	$1.12	-----	-----
J7194	$0.31	-----	-----
J7196	$1.42	-----	-----
J7197	$0.81	-----	-----
J7310	$3,800.00	$3,610.00	$4,151.50
J7315	$125.59	$119.31	$137.21
J7320	$204.86	$194.62	$223.81
J7500	$110.79	-----	-----
J7501	$77.52	-----	-----
J7503	$5.53	-----	-----
J7504	$249.16	-----	-----
J7505	$684.00	-----	-----
J7506	$0.12	-----	-----
J7507	$2.27	$2.16	$2.48
J7508	$11.37	$10.80	$12.42
J7610	$1.29	$1.23	$1.41
J7615	$1.54	$1.46	$1.68
J7620	$0.38	$0.36	$0.41
J7625	$0.67	$0.64	$0.74
J7627	$4.98	$4.73	$5.44
J7630	$0.66	$0.63	$0.72
J7640	$0.77	$0.73	$0.84
J7650	$0.37	$0.35	$0.40
J7651	$0.23	$0.22	$0.25
J7652	$0.31	$0.29	$0.33
J7653	$0.37	$0.35	$0.40
J7654	$0.47	$0.45	$0.52

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J7655	$1.73	$1.64	$1.89
J7660	$2.35	$2.23	$2.56
J7665	$2.56	$2.43	$2.79
J7670	$1.30	$1.24	$1.43
J7672	$1.05	$1.00	$1.15
J7675	$1.30	$1.24	$1.43
J8530	$1.84	$1.75	$2.01
J8560	$38.42	$36.50	$41.98
J8600	$1.97	$1.87	$2.15
J8610	$3.22	$3.06	$3.52
J9000	$29.35	$27.88	$32.06
J9015	$529.62	$503.14	$578.61
J9020	$51.94	$49.34	$56.74
J9031	$140.12	$133.11	$153.08
J9040	$289.37	$274.90	$316.14
J9045	$91.44	$86.87	$99.90
J9050	$94.57	$89.84	$103.32
J9060	$40.06	$38.06	$43.77
J9062	$200.34	$190.32	$218.87
J9065	$51.42	$48.85	$56.18
J9070	$5.97	$5.67	$6.52
J9080	$11.34	$10.77	$12.39

J9090	$23.80	$22.61	$26.00
J9091	$47.64	$45.26	$52.05
J9092	$95.26	$90.50	$104.08
J9093	$6.12	$5.81	$6.68
J9094	$11.63	$11.05	$12.71
J9095	$24.42	$23.20	$26.68
J9096	$48.85	$46.41	$53.37
J9097	$97.74	$92.85	$106.78
J9100	$6.27	$5.96	$6.85
J9110	$27.29	$25.93	$29.82
J9120	$12.73	$12.09	$13.90
J9130	$12.66	$12.03	$13.83
J9140	$25.32	$24.05	$27.66
J9150	$80.03	$76.03	$87.43
J9151	$59.18	$56.22	$64.65
J9165	$2.69	$2.56	$2.94
J9170	$270.14	$256.63	$295.12
J9181	$12.37	$11.75	$13.51
J9182	$104.50	$99.28	$114.17
J9185	$217.13	$206.27	$237.21
J9190	$2.52	$2.39	$2.75
J9200	$129.56	$123.08	$141.54
J9201	$81.15	$77.09	$88.65
J9202	$446.49	$424.17	$487.80
J9206	$110.10	$104.60	$120.29

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J9208	$127.45	$121.08	$139.24
J9209	$31.84	$30.25	$34.79
J9211	$241.44	$229.37	$263.78
J9212	$35.15	$33.39	$38.40
J9213	$33.22	$31.56	$36.29
J9214	$8.73	$8.29	$9.53
J9215	$7.55	$7.17	$8.25
J9216	$133.00	$126.35	$145.30
J9217	$513.59	$487.91	$561.10
J9218	$64.12	$60.91	$70.05
J9230	$11.00	$10.45	$12.02
J9245	$346.50	$329.18	$378.56
J9250	$0.45	$0.43	$0.49
J9260	$4.51	$4.28	$4.92
J9265	$173.49	$164.82	$189.54
J9266	$1,321.64	$1,255.56	$1,443.89
J9268	$1,562.75	$1,484.61	$1,707.30
J9270	$84.29	$80.08	$92.09
J9280	$121.64	$115.56	$132.89
J9290	$413.71	$393.02	$451.97
J9291	$869.33	$825.86	$949.74
J9293	$193.02	$183.37	$210.88
J9310	$400.28	$380.27	$437.31
J9320	$100.85	$95.81	$110.18
J9340	$100.30	$95.29	$109.58
J9350	$546.44	$519.12	$596.99
J9360	$4.10	$3.90	$4.49
J9370	$30.16	$28.65	$32.95

J9375	$36.33	$34.51	$39.69
J9380	$154.57	$146.84	$168.87
J9390	$66.23	$62.92	$72.36
J9600	$2,444.75	$2,322.51	$2,670.89
Q0136	$11.40	-----	-----
Q0156	$166.25	-----	-----
Q0157	$71.25	-----	-----
Q0160	$0.85	-----	-----
Q0163	$0.06	-----	-----
Q0164	$0.52	-----	-----

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Q0165	$0.76	-----	-----
Q0166	$42.60	-----	-----
Q0167	$3.37	-----	-----
Q0168	$6.73	-----	-----
Q0169	$0.06	-----	-----
Q0170	$0.01	-----	-----
Q0171	$0.25	-----	-----
Q0172	$0.57	-----	-----
Q0173	$0.36	-----	-----
Q0174	$0.03	-----	-----
Q0175	$0.61	-----	-----
Q0176	$0.74	-----	-----
Q0177	$0.19	-----	-----
Q0178	$0.20	-----	-----
Q0179	$24.11	-----	-----
Q0180	$65.20	-----	-----
Q0181	IC	IC	IC
Q9920	$11.40	$10.83	$12.45
Q9921	$11.40	$10.83	$12.45
Q9922	$11.40	$10.83	$12.45
Q9923	$11.40	$10.83	$12.45
Q9924	$11.40	$10.83	$12.45
Q9925	$11.40	$10.83	$12.45
Q9926	$11.40	$10.83	$12.45
Q9927	$11.40	$10.83	$12.45
Q9928	$11.40	$10.83	$12.45
Q9929	$11.40	$10.83	$12.45
Q9930	$11.40	$10.83	$12.45
Q9931	$11.40	$10.83	$12.45
Q9932	$11.40	$10.83	$12.45
Q9933	$11.40	$10.83	$12.45
Q9934	$11.40	$10.83	$12.45
Q9935	$11.40	$10.83	$12.45
Q9936	$11.40	$10.83	$12.45
Q9937	$11.40	$10.83	$12.45
Q9938	$11.40	$10.83	$12.45
Q9939	$11.40	$10.83	$12.45
Q9940	$11.40	$10.83	$12.45

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Medicare Physician Fee Schedule for 1999 - Multiple Procedure Rules

The December 1998 Medicare B Update! Special Issue 1999 HCFA Common Procedure Coding System (HCPCS) and Medicare Physician Fee Schedule (MPFS) Update included numerous tables that outline various reimbursement rules that pertain to the MPFS. It has been noted that Appendix V (procedures subject to standard multiple surgery rules, page 48) was incomplete. An additional 67 procedures that are subject to multiple surgery were not listed. These codes are:

69949
69950
69955
69960
69970
69979
78306
78306
78306
78320
78320
78320
78802
78802
78802
78803
78803
78803
78806
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78806
78807
78807
78807
92975
92980
92982
92986
92987
92990
92992
92993
92995

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93501
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93505
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93530
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93536
96405
96406

For a complete explanation of MPFS multiple surgery rules, see page 36 of the December 1998 HCPCS Special Issue Update!

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Procedure Code Modifiers for Hospital-to-Hospital Ambulance Services

The following article is being reprinted from the September/October 1993 Medicare Part B Update! Ambulance suppliers should use the following four procedure code modifiers for hospital-to-hospital ambulance transportation. These modifiers allow ambulance suppliers to advise Medicare Part B if the patient was transported to another facility because the initial facility did not have adequate facilities to provide the care needed by the patient, and whether the patient was admitted to the destination hospital. All hospital-to-hospital ambulance claims must meet the following requirements for coverage under Medicare Part B guidelines:

- The patient was transported because the appropriate facilities needed to treat/diagnose the patient were not available at the originating hospital.

- The patient was admitted to the destination hospital.

The modifiers and descriptions are:

Modifier: WL
Description: Facilities - Yes, Admitted - Yes

Used when the appropriate facilities were: not available at the originating hospital and the patient was admitted to the destination hospita
Medicare Coverage: Yes

Modifier: WN
Description: Facilities - No, Admitted - Yes
Used when the appropriate facilities were: available at the originating hospital and the patient was admitted to the destination hospita
Medicare Coverage: No

Modifier: WQ
Description: Facilities - Yes, Admitted - No
Used when the appropriate facilities were: not available at the originating hospital and the patient was not admitted to the destination hospital
Medicare Coverage: No

Modifier: WV
Description: Facilities - No, Admitted - No
Used when the appropriate facilities were: available at the originating hospital and the patient was not admitted to the destination hospital
Medicare Coverage: No

These modifiers are not origin and destination modifiers and must be submitted in addition to procedure code modifier HH (hospital-to-hospital).

Prior to the creation of these modifiers, Medicare Part B was required to request this information on all claims where it was omitted. Providers may use these modifiers on both electronic and paper claims eliminating the need for such requests. Use of these modifiers reduces unnecessary delays and allow faster claim payments.

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Nurse Practitioner Services

On pages 17-19 of the July/August 1998 Medicare B Update!, a list of procedure codes that an advanced registered nurse practitioner (ARNP) or a certified nurse specialist (CNS) could perform (and potentially receive Medicare reimbursement) was published. The following list contains the additional new 1999 HCPCS codes/services that an ARNP/CNS could potentially perform and may potentially be covered by Medicare of Florida.

Although an ARNP/CNS is licensed or authorized to perform the services indicated on the list, Medicare may not reimburse for

these services due to existing national or local medical review policies.

HCPCS Level II Codes for Use by ARNP/CNS

G Codes - Temporary Procedures/Professional Services:

G0108, G0109, G0127, G0130-G0132

J Codes -Drugs Administered:

J0130, J0151, J0275, J0285, J0286, J0395, J0476, J1260, J1956, J2271, J2355, J2792, J2994, J7315, J7320, J7513, J9151, J9212, J9310

P Codes -Pathology and Laboratory Services:

P9612

Q Codes -Temporary Miscellaneous Services:

Q0160, Q0161, Q0163-Q0181, Q0183-Q0185

CPT Codes for Use by ARNP/CNS

Radiology:
76006, 76977, 77380, 77381, 78020, 78206, 78494, 78496, 78588

Chemistry:
82016, 82017, 82127, 82136, 82139, 82247, 82248, 82261, 82379, 82492, 82541-82544, 82657, 82658, 82726, 82731, 83013, 83014, 83021, 83080, 83716, 83788, 83789, 83891, 83893, 83897, 83901, 83903-83906, 83919, 84154, 84376-84379

Hematology and Coagulation:
85046

Anatomic Pathology:
88143-88145, 88147, 88148, 88153, 88154, 88164-88167, 88240, 88241, 88249, 88264, 88271-88275, 88291, 89264

Immune Globulin:
90296, 90371, 90375, 90376, 90379, 90385, 90389, 90393, 90396

Immunization (Administration for Vaccines/Toxoids):
90471, 90472

Vaccines, Toxoids:
90476, 90477, 90581, 90585, 90586, 90592, 90632-90648, 90657-90659, 90660, 90665, 90669, 90675, 90676, 90680, 90690-90693

Special Ophthalmological Services:
92135

Pulmonary:
94621

Neurology and Neuromuscular Procedures:
95970-95975

Physical Medicine and Rehabilitation:
97140

Neonatal Intensive Care:
99298

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Nurse Practitioners: Revised Guidelines

In the July/August 1998 issue of the Medicare B Update! (page 17), a list was provided that outlined the procedure codes representing services that could potentially be performed by an ARNP and could potentially be covered by Medicare Part B of Florida. The list has been revised, effective for services processed on and after April 19, 1999.

The following procedure codes have been added to the services that could potentially be performed by an ARNP:

20600:Arthrocentesis, aspiration and/or injection; small joint, bursa, or ganglion cyst (e.g., fingers, toes)

20605:intermediate joint, bursa, or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

20610:major joint or bursa (e.g., shoulder, hip, knee joint, subacromialbursa)

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The following information is based on a fraud alert issued by the Office of the Inspector General (OIG). The fraud alert may be viewed in its entirety by accessing the OIG Internet site at:

www.dhhs.gov/proorg/oig/frdalrt/index.htm

The Medicare program only pays for health care services that are medically necessary. In determining what services are medically necessary, Medicare primarily relies on the professional judgment of the beneficiary's treating physician, since he or she knows the patient's history and makes decisions such as admitting the patient to the hospital; ordering tests, drugs, and treatments; and determining the length of treatment. The physician has a key role in determining both the medical need for, and utilization of, many health care services, including those furnished and billed by other providers and suppliers.

Congress has allowed payment for many Medicare items and services on a certification signed by a physician attesting that the item or service is medically necessary. For example, physicians are routinely required to certify the medical necessity for any service for which they submit bills to the Medicare program.

Physicians also are involved in attesting to medical necessity when ordering services or supplies that must be billed and provided by an independent supplier or provider. Medicare requires physicians to attest the medical necessity for many of these items and services through prescriptions, orders, or, in certain specific circumstances, certificates of medical necessity (CMNs). These documentation requirements substantiate that the physician has reviewed the patient's condition and has determined that services or supplies are medically necessary.

Two areas where the documentation of medical necessity by physician certification plays a key role are home health services and durable medical equipment (DME). Through various Office of the Inspector General (OIG) audits, it has been discovered that physicians sometimes fail to discharge their responsibility to assess their patients' conditions and need for home health care. Similarly, the OIG has found numerous examples of physicians who have ordered DME or signed CMNs for DME without reviewing the medical necessity for the item or even knowing the patient.

Physician Certification for Home Health Services

Medicare pays a Medicare-certified home health agency for home health care provided under a physician's plan of care to a patient confined to the home. Covered services may include skilled nursing services, home health aide services, physical and occupational therapy and speech language pathology, medical social services, medical supplies (other than drugs and biologicals), and DME.

As a condition for payment, Medicare requires a patient's treating physician to certify initially and recertify at least every 62 days (2 months) that:

the patient is confined to the home;

the individual needs or needed

(i) intermittent skilled nursing care,

(ii) speech or physical therapy or speech-language pathology services, or

(iii) occupational therapy or a continued need for occupational therapy (payment for occupational therapy will be made only upon an initial certification that includes care under [i] or [ii] or a recertification where the initial certification included care under [i] or [ii]),

a plan of care has been established and periodically reviewed by the physician, and

the services are (were) furnished while the patient is (was) under the care of a physician.

The physician must order the home health services, either orally or in writing, before the services are furnished. The physician certification must be obtained when the plan of treatment is established or as soon thereafter as possible. The physician certification must be signed and dated before the claim is submitted to Medicare. If a physician has any questions about the application of these requirements, the physician should contact the appropriate Medicare fiscal intermediary or carrier.

Physician Orders and Certificates of Medical Necessity for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Home Use

DME is equipment that can withstand repeated use, is primarily used for a medical purpose, and is not generally used in the absence of illness or injury. Examples include hospital beds, wheelchairs, and oxygen delivery systems. Medicare will cover medical supplies that are necessary for the effective use of DME, as well as surgical dressings, catheters, and ostomy bags. However, Medicare will only cover DME and supplies that have been ordered or prescribed by a physician. The order or prescription must be personally signed and dated by the patient's treating physician.

DME suppliers that submit bills to Medicare are required to maintain the physician's original written order or prescription in their files. The order or prescription must include:

- The beneficiary's name and full address

- The physician's signature

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- The date the physician signed the prescription or order

- A description of the items needed

- The start date of the order (if appropriate)

- The diagnosis (if required by Medicare program policies) and a realistic estimate of the total length of time the equipment will be needed (in months or years).

For certain items or supplies, including supplies provided on a periodic basis and drugs, additional information may be required. For supplies provided on a periodic basis, appropriate information on the quantity used, the frequency of change, and the duration of need should be included. If drugs are included in the order, the dosage, frequency of administration, and, if applicable, the duration of infusion and concentration should be included.

Medicare further requires that claims submitted for certain kinds of DME be accompanied by a CMN signed by a treating physician (unless the DME is prescribed as part of a plan of care for home health services). When a CMN is required, the provider or supplier must keep the CMN containing the treating physician's original signature and date on file.

Generally, a CMN has four sections:

- Section A contains general information on the patient, supplier, and physician. Section A may be completed by the supplier.

- Section B contains the medical necessity justification for DME. This cannot be filled out by the supplier. Section B must be completed by the physician, non-physician clinician involved in the care of the patient, or a physician employee. If the physician did not personally complete Section B, the name of the person who did complete Section B and his or her title and employer must be specified.

- Section C contains a description of the equipment and its cost. Section C is completed by the supplier.

- Section D is the treating physician's attestation and signature, which certifies that the physician has reviewed

Sections A, B, and C of the CMN and that the information in Section B is true, accurate, and complete. Section D must be signed by the treating physician. Signature stamps and date stamps are not acceptable.

By signing the CMN, the physician attests that:

- He or she is the patient's treating physician and the information regarding the physician's address and unique physician identification number (UPIN) is correct;

- The entire CMN, including the sections filled out by the supplier, was completed prior to the physician's signature; and

- The information in Section B relating to medical necessity is true, accurate, and complete to the best of the physician's knowledge.

Improper Physician Certifications Foster Fraud

Unscrupulous suppliers and providers may steer physicians into signing or authorizing improper certifications of medical necessity. In some instances, the certification forms or statements are completed by DME suppliers or home health agencies and presented to the physician, who then signs the forms without verifying the actual need for the items or services. In many cases, the physician may obtain no personal benefit when signing these unverified orders and is only accommodating the supplier or provider. Although a physician's signature on a false or misleading certification made through mistake, simple negligence, or inadvertence will not result in personal liability, the physician may unwittingly be abetting the perpetration of Medicare fraud by suppliers or providers. When the physician knows the information is false or acts with reckless disregard as to the truth of the statement, the physician risks criminal, civil, and administrative penalties.

Sometimes, a physician may receive compensation in exchange for his or her signature. Compensation can include cash payments, free goods, or any other item of value. These cases may trigger additional criminal and civil penalties under the anti-kickback statute.

The following are examples of inappropriate certifications uncovered by the OIG in the course of its investigations of fraud in the provision of home health services and medical equipment and supplies:

- A physician knowingly signs a number of forms provided by a home health agency that falsely represent that skilled nursing

services are medically necessary in order to qualify the patient for home health services.

- A physician certifies that a patient is confined to the home and qualifies for home health services even though the patient tells the physician that her only restrictions are due to arthritis in her hands, and she has no restrictions on her routine activities, such as grocery shopping.

- At the prompting of a DME supplier, a physician signs a stack of blank CMNs for transcutaneous electrical nerve stimulators (TENS) units. The CMNs are later completed with false information in support of fraudulent claims for the equipment. The false information purports to show that the physician ordered and certified to the medical necessity for the TENS units for which the supplier has submitted claims.

- A physician signs CMNs for respiratory medical equipment falsely representing that the equipment was medically necessary.

- A physician signs CMNs for wheelchairs and hospital beds without seeing the patients, then falsifies his medical charts to indicate that he treated them.

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- A physician accepts anywhere from $50 to $400 from a DME supplier for each prescription he signs for oxygen concentrators and nebulizers.

Potential Consequences for Unlawful Acts

A physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence. However, knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties including:

- Criminal prosecution,

- Fines as high as $10,000 per false claim plus treble damages, or

- Administrative sanctions including: exclusion from participation in federal health care programs, withholding or recovery of payments, and loss of license or disciplinary actions by state regulatory agencies.

Physicians may violate these laws when:

- They sign a certification as a "courtesy" to a patient, service provider, or DME supplier when they have not first made a determination of medical necessity,

- They knowingly or recklessly sign a false or misleading certification that causes a false claim to be submitted to a federal health care program, or

- They receive any financial benefit for signing the certification (including free or reduced rent, patient referrals, supplies, equipment, or free labor).

Even if they do not receive any financial or other benefit from providers or suppliers, physicians may be liable for making false or misleading certifications.

What to Do if You Have Information About Fraud and Abuse Against Medicare or Medicaid Programs

If you have information about physicians, home health agencies, or medical equipment and supply companies engaging in any of the activities previously described, contact the Medicare contractor

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Medicare Coverage of Abortion Services

Abortions are not covered under the Medicare program except for instances where:

The pregnancy is the result of rape or incest; or

The woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Procedure code modifier G7 is used to identify this situation. Modifier G7 is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening." Modifier G7 is effective for dates of service on or after October 1, 1998.

One of the following procedure codes must be used with modifier G7:

59840
59841

59850
59851
59852
59855
59856
59857
59866

When submitting a claim for payment using modifier G7, physicians are certifying that one of the above situations exists. These services may be subject to post-payment review.

Advance notice applies to medical necessity (see page 4).

****

Reimbursement for Ambulance Services to Non-Hospital-Based Dialysis Facilities

Beginning February 24, 1999, claims for end-stage-renal disease (ESRD) patients with a destination of non-hospital-based dialysis facility (origin and destination modifier J) are covered in accordance with 42 CFR section 410.40. Ambulance suppliers can refer to the Special Medicare B Update!, "Notification of Changes to Ambulance Coverage Regulations," dated April 5, 1999, for information on this and other changes that were effective February 24. Additional changes to Medicare ambulance coverage regulations will be provided in future editions of the Medicare B Update!

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DME Regional Carriers Processing Claims When a Chiropractor is the Supplier

Except for restrictions to chiropractor services as stipulated in sections 1861(s)(1) and 1861(s)(2)(A) of the Social Security Act, chiropractors can bill for durable medical equipment if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse.

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G0125-G0126: Date Correction on the Coverage of Positron Emission Technology (PET) Lung Imaging

On page 30 of the May/June 1998 Medicare B Update!, the effective coverage date for positron emission technology (PET) lung imaging (procedure codes G0125 and G0126) was incorrectly published as December 18, 1997. Medicare coverage of PET lung imaging is effective for services rendered on or after January 1, 1998.

NOTE: All PET imaging must be performed using PET scanners that have been approved or cleared for marketing by the Food and Drug Administration as PET scanners.

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J3490, J9999: Not Otherwise Classified Drugs

Billing for oral or injectable drugs under an unlisted or not otherwise classified (NOC) procedure code, such as J3490 or J9999, requires the submission of the following information:

Method of administration,

Name of the drug, and

Strength and dosage of the drug.

This information must be reported on the narrative record of an electronic claim, or in block 19 of the HCFA-1500 claim form.

Providing this information at the time of submission prevents delays in claim processing and incorrect payment for the unlisted drug.

Reminder: If billing for a new ly approved drug, the Food and Drug Administration (FDA) approval

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Q0163-Q0181: Oral Anti-Emetic Drugs

Effective for services processed on or after July 1, 1999, the billing requirements for oral anti-emetic drugs (procedure codes Q0163-Q0181), used as a full therapeutic replacement for an intravenous dosage form as part of a cancer chemotherapeutic regimen, are changing based on the specialty of the billing provider.

Billing Requirements

Physicians prescribing oral anti-emetic drugs must indicate on the prescription form that the patient is receiving the therapeutic oral anti-emetic drug as a full replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen.

Oral anti-emetic drugs provided in the physician's office and submitted for payment using procedure codes Q0163-Q0181 are processed by the local Medicare carrier.

Oral anti-emetic drugs supplied by a pharmacy under a physician's prescription and submitted for payment using procedure codes Q0163-Q0181 are processed by the durable medical equipment regional carrier (DMERC).

Reimbursement

Medicare reimbursement for oral anti-emetic drugs is based on the 95 percent of the median average wholesale price (AWP), the same as injectable drugs. The list of injectable drugs pricing on pages 11-15 include the reimbursement amounts for oral anti-emetics.

Services for oral anti-emetic drugs are subject to the Medicare deductible and coinsurance guidelines.

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Page 22

78478: Correction to 1999 CPT

Medicare contractors were recently advised that the 1999 CPT Manual contains an error. The error in the manual is as follows:

The note following CPT code 78478 states, "see 78478 in conjunction with codes 78460, 78461, 78464, 78475." This last code, 78475, is an error, which has been verified by the AMA's CPT staff. The last code should be 78465.

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96400 - 96450, 96542, 96545, and 96549: Chemotherapy Administration

Medicare allows for the administration of chemotherapy drugs (procedure codes 96400-96450, 96542, 96545, and 96549) when the drug administered is an antineoplastic agent and the patient has been diagnosed with cancer.

Providers billing Medicare for the administration of other drugs, such as growth factors, saline, and diuretics, to patients with a diagnosis other than cancer, must report these services with the appropriate procedure code within the range 90780 through 90784.

Advance notice applies to medical necessity (see page 4).

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90989, 90993: Fee Schedule Amount

Several inquiries have been received concerning "omission" of procedure codes 90989 and 90993 from the 1999 Medicare Part B Physician and Non-Physician Fee Schedule (MPFS) book. These procedure codes are for dialysis training services, and are not reimbursed from the MPFS. The pricing for these codes has remained constant since their implementation in 1991. The reimbursement is provided below:

Procedure Code: 90989
Description: Dialysis training, patient, including helper where applicable, any mode, completed course
Allowance: $500.00

Procedure Code: 90993
Description: Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session
Allowance: $20.00

Reimbursement for these services is the same for all localities. There is no reduction if theprovider is non-participating; limiting charge does not apply.

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

Effective Dates

The policies contained in this section are effective for claims processed 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.

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Focused Medical Review Study on GA and 25 Modifier Use

As part of the focused medical review process required by the Health Care Financing Administration (HCFA), Medicare Part B of Florida evaluates specific billing aberrancies identified by comparing procedure code utilization in Florida against national utilization rates. Focused Medical Review initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice. Because the use of these modifiers was significantly higher in Florida than in the rest of the nation, at HCFA's request an analysis was performed on the use of modifiers GA and 25.

Modifiers Defined

GA

Waiver of Liability Statement on File

Claims for services which include modifier GA indicate that the provider of services has spent time counseling the patient that the service may not be reimbursed by the Medicare program. It is similar to an informed consent relative to financial responsibility for a medical service that may be deemed non-covered for various reasons.

25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service

The physician may need to indicate that on the day a procedure or service (identified by a procedure code) was performed, the patient's condition required a significant, separately identifiable Evaluation and Management (E/M) service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. NOTE: This modifier is not used to report an E/M service that resulted in a decision to perform surgery (see modifier 57).

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Rationale for Analysis

GA

For fiscal year 1997, Florida encompassed 25 percent of all paid dollars for the nation. Florida was the highest state in the nation for percent of paid dollars, followed by 5.6 percent by the next highest contractor. The top specialties submitting claims with a GA modifier, in order of highest billed/paid specialty, are: Diagnostic Radiology, Internal Medicine, Clinical Laboratory, Cardiology, Family Practice, Chiropractic, Orthopedic Surgery, General Practice, Podiatry, Dermatology, and Pulmonary Medicine.

25

Florida encompassed 16.22 percent of all paid dollars for the nation. Florida was the highest state in the nation for percent of paid dollars, followed by 7.1 percent, by the next highest contractor.

Based on the previously mentioned statistics, a small-scale medical record review was performed on the top providers submitting claims with modifiers GA and 25. This was done to assess the appropriateness of their claims for an additional E/M service or appropriateness of the waiver/advance notice form. Medical records were requested and analyzed for appropriateness of utilization and coding.

Summary Results/Conclusions

GA

Florida providers use modifier GA appropriately in the majority of circumstances. The analysis of the waiver forms indicated that some providers failed to specify the anticipated rationale for Medicare's denial. This information is required for each service listed on the waiver form, and must be clear and specific. Another issue arose when one provider identified that he had not kept copies of the original patient waiver forms in his office records. Instead he had sent them with his "superbills" to his billing agency. When claims are submitted with an associated GA modifier, it is the payee's responsibility to maintain those records.

25

There were significant issues with the use of this modifier. In particular, findings revealed that a clear indication of the need for actual documentation of the services rendered separately from the procedure or other service being performed did not exist. Medicare does not cover E/M services if rendered on the same day as a procedure if there is no clear indication of a significant, separately identifiable service being performed. Services that are incidental to the procedure are not reimbursed separately.

Providers must ensure that they are in compliance with the coverage guidelines for use of modifier 25 and that their waiver forms meet Medicare's requirements. Non-compliance will result in the recovery of inappropriately paid dollars.

For a complete list of articles that address the use of the GA and 25 modifiers, providers can access the Medicare Online Bulletin Board System (see page 40 for BBS information).

****

J0001: Self-Administered Drugs - Correction

The local medical review policy (LMRP) for self-administered drugs was provided in the March/April 1999 Medicare B Update! (page 43). The effective date of the policy was inadvertently omitted from that article. The effective date is April 19, 1999.

****

52281: Cystourethroscopy Update

This information is in addition to the original article published in the November/December 1998 Medicare B Update! (pg. 23).

Issues have been raised related to those patients who present for a urological work-up with signs and symptoms of an obstruction. At this point, urethral stenosis and stricture are part of the differential diagnosis list, but are not necessarily proven. These patients require a full urologic evaluation including a cystourethroscopy. In this scenario, if the patient presents with documented obstructive symptoms requiring a cystourethroscopy which ultimately requires calibration, the patient's medical record must reflect the symptomatology, the findings associated with the obstruction, the exact method of treatment applied, and the follow-up needs. The presence of a stenosis or stricture, however, may not be required.

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70450: Computerized Tomography Correction

The medical policy guidelines for computerized tomography were published in the March/April 1999 Medicare B Update! (pages 57-58). The advance notice statement was inadvertently omitted from that article.

Advance notice is required for the services outlined in that policy as they apply to medical necessity (see page 4).

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Page 25

90999: ESRD Laboratory Services and Diagnostic Services Clarification

This is a clarification to an article that was published in the March/April 1999 Medicare B Update! (page 59). The information in the "Coding Guidelines" section of that article, while correct, was provided in a manner that may be confusing. That section appears below, with spacing that makes it easier to understand.

Coding Guidelines

Separately billable tests for Hemodialysis and IPD

Serum Aluminum (82108) - one every 3 months

Serum Ferritin (82728) - one every 3 months

Guidelines for CAPD

WBC (85048) - one every 3 months

RBC (85041) - one every 3 months

Platelet Count (85585, 85590, 85595) - one every 3 months

Residual Renal Function (78725, 82575) - one every 6 months

24 Hour Urine Volume (81050) - one every 6 months

Any of the separately billable services with a professional component are included in the monthly capitation payment. The technical component is payable in addition to the monthly capitation payment.

The remainder of the information published in the March/April Update! article remains as published.

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92499: Coverage of Computerized Corneal Topography

NOTE: This policy was published in the November/December 1998 Medicare B Update! (page 34). Some of the indications listed in this policy require dual diagnoses. To ensure reimbursement for these indications, both diagnoses must be submitted. However, the specific diagnoses this requirement applies to were inadvertently omitted. The entire policy is reprinted below; the dual diagnosis requirements are highlighted in bold type.

While evaluating this policy it was determined that enhancements to the policy were needed to better define the service and the conditions under which Medicare will consider computerized corneal topography medically necessary. As a result, the policy was revised to further define these indications.

Corneal topography (also called videokeratography) combines the principle of keratoscopy (using concentric ring targets) with data analysis using computer programs. The procedure is a computer assisted diagnostic technique where a special instrument projects a series of light rings on the cornea, creating a color coded map of the corneal surface as well as a cross-section profile. The computer then analyzes the reflected images and an algorithm transforms the two-dimensional pattern into a three-dimensional map. The product is typically a color-coded contour map of corneal surface power. Cool colors represent low corneal powers and warm colors suggest high corneal powers. The power range measured by the topographical systems is wide, permitting better description of the corneal periphery and of unusually steep or flat corneas. The opportunity to quantify early corneal dystrophies, such as keratoconus, is enhanced with corneal topography.

This procedure can be helpful with selected suture lysis to minimize postoperative astigmatism after some of the eye surgeries such as penetrating keratoplasty and/or cataract surgery. The peripheral curvature information from topographical mapping allows more accurate assessment of the sutures to determine if further intervention is needed (e.g., tighten or loosen sutures).

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider computerized corneal topography (92499) medically necessary under any of the following conditions:

- post surgical or post traumatic astigmatism, measuring at a minimum of 3.5 diopters;

- post penetrating keratoplasty surgery;

- post surgical or post traumatic irregular astigmatism;

- corneal dystrophy;

- complications of transplanted cornea;

- post traumatic corneal scarring;

- keratoconus; and/or

- pterygium and/or corneal ectasia that cause visual impairment.

****

Radial keratotomy and keratoplasty to treat refractive defects are not covered by Medicare. Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered.

HCPCS Code

92499:Unlisted ophthalmological service or procedure

ICD-9 Codes That Support Medical Necessity

367.21 (must be accompanied by ICD-9 code V45.61 or V45.69)
367.22 (must be accompanied by ICD-9 code V45.61 or V45.69)
371.46
371.48

371.52
371.60
371.71
372.42
996.51
V42.5
V45.61 (must be accompanied by ICD-9 code 367.21 or 367.22)
V45.69 (must be accompanied by ICD-9 code 367.21 or 367.22)

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.

Corneal topography is noncovered if performed pre- or post operative in relation to a Medicare noncovered procedure, (e.g., radial keratotomy and/or refractive keratoplasty).

Noncovered ICD-9 Code(s)

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

Coding Guidelines

Computerized corneal topography is included in the general ophthalmological service codes (92002, 92004, 92012, 92014) when billed on the same day, and is not separately reimbursed.

Some of the indications listed in this policy require dual diagnoses. To ensure reimbursement for these indications both diagnoses must be submitted. See the "ICD-9 Codes That Support Medical Necessity" section for the codes that require dual diagnoses.

Documentation Requirements

Medical record documentation submitted by the ordering/referring physician must indicate the medical necessity for performing the procedure and the results derived from the corneal topography procedure. This information is usually found in the history and physical, office / progress notes and the photo exam interpretation.

Advance Notice Statement

Applies to medical necessity (see page 4).

****

93975, 93976, 93978, 93979: Coverage of Duplex Scanning

Duplex scanning describes an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

Indications and Limitations of Coverage and/or Medical Necessity

Arterial Inflow and Venous Outflow of Abdominal, Pelvic, and/or Retroperitoneal Organs:

Medicare may provide coverage for duplex scanning of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs (procedure codes 93975 and 93976) when performed for the following indications:

To evaluate patients presenting with signs or symptoms such as epigastric or periumbilical postprandial pains that last for 1-3 hours and/or with associated weight loss resulting from decreased oral intake which may indicate chronic intestinal ischemia.

To evaluate patients presenting with an acute onset of crampy or steady epigastric and periumbilical abdominal pain combined with minimal or no findings on abdominal examination and a high leukocyte count to rule out acute intestinal ischemia.

To evaluate a patient who has sustained trauma to the abdominal, pelvic and/or retroperitoneal area resulting in a possible injury to the arterial inflow and/or venous outflow of the abdominal, pelvic and/or retroperitoneal organs.

To evaluate a suspicion of an aneurysm of the renal artery or other visceral artery based on a patient's signs and symptoms of abdominal pain or noted as an incidental finding on another radiological examination.

To evaluate a hypertensive patient who has failed first line antihypertensive drug therapy in order to rule out renovascular disease such as renal artery stenosis, renal arteriovenous fistula, or renal aneurysm as a cause for the uncontrolled hypertension.

To evaluate a patient with signs and symptoms of portal hypertension. These may include abdominal discomfort and distention, abdominal collaterals (caput medusae), abdominal bruit, ascites, encephalopathy, esophageal varices, splenomegaly, etc.

****

To evaluate patients suspected of an embolism, thrombosis, hemorrhage or infarction of the portal vein, renal vein and/or renal artery. These patients may present with many different symptoms such as abdominal discomfort, hematuria, cardiac failure, diastolic hypertension, jaundice, fatigue, weakness, malaise, etc.

ICD-9 Codes That Support Medical Necessity:

401.9
442.1
442.84
452
453.3
557.0
557.1
572.3
593.81
782.4
783.2
785.9
789.00-789.09
789.1
789.2
789.30-789.39
789.5
793.6
902.20
902.25
902.27
902.31
902.32
902.39
902.41
902.42
902.87
902.9

Aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study:

Medicare may provide coverage for duplex scanning of aorta, inferior venacava, iliac vasculature, or bypass grafts (procedure codes 93978 and 93979) when performed for the following indications:

To confirm a suspicion of an abdominal or iliac aneurysm raised by a physical examination or noted as an incidental finding on another radiological examination. The physical examination usually reveals a palpable, pulsatile and nontender abdominal mass.

To monitor the progression of an abdominal aortic aneurysm. It is usually expected that monitoring occurs approximately every six months.

To evaluate patients presenting with signs and symptoms of a thoracic aneurysm. The symptoms usually associated with a thoracic aneurysm are substernal chest pain, back or neck pain described as deep and aching or throbbing as well as symptoms due to pressure on the trachea (dyspnea, stridor, a brassy cough), the esophagus (dysphagia), the laryngeal nerve (hoarseness), or superior vena cava (edema in necks and arms, distended neck veins).

To evaluate patients presenting with signs and symptoms of an abdominal aneurysm. The symptoms usually associated with an abdominal aneurysm are constant pain located in the midabdomen, lumbar region or pelvis which can be severe and may be described as having a boring quality. A leaking aneurysm is characterized by lower back pain, whereas, acute pain and hypotension usually occur with rupture.

To evaluate a patient presenting with signs and symptoms suggestive of an aortic dissection. A patient with an aortic dissection has symptoms such as a sudden onset of severe, continuous tearing or crushing pain in the chest that radiates to the back and is generally unaccompanied by EKG evidence of a myocardial infarction. On physical examination, the patient is agitated, has a murmur of aortic regurgitation, asymmetric diminution of arterial pulses and systolic bruits over the areas where the aortic lumen is narrowed.

Initial evaluation of a patient presenting with signs and symptoms such as intermittent claudication in the calf muscles, thighs and/or buttocks, rest pain, weakness in legs or feeling of tiredness in the buttocks, etc. which may suggest occlusive disease of the aorta and iliac arteries. The physical examination usually reveals decreased or absent femoral pulses, a bruit over the narrowed artery, and possibly muscle atrophy. If severe occlusive disease exists, the patient will have atrophic changes of the skin, thick nails, coolness of the skin with pallor and cyanosis.

To evaluate patients suspected of an abdominal or thoracic arterial embolism or thrombosis. These patients usually present with severe pain in one or both lower extremities, numbness, and symmetric weakness of the legs, with absent or severely reduced pulses below the embolism site.

To evaluate patients presenting with complaints of pain in the calf or thigh, slight swelling in the involved leg, tenderness of

the iliac vein, etc. which may suggest phlebitis or thrombophlebitis of the iliac vein or inferior vena cava.

To evaluate a patient who has sustained trauma to the chest wall and/or abdomen resulting in a possible injury to the aorta, inferior vena cava and/or iliac vasculature.

To assess the continued patency of both native venous and prosthetic arterial grafts following surgical intervention. Usually this is performed at six weeks, three months, then every six months.

To monitor the sites of various percutaneous interventions, including, but not limited to angioplasty, thrombolysis/thrombectomy, atherectomy, or stent placement. Usually this is performed at six weeks, three months, then every six months.

Note: Duplex testing should be reserved for specific indications for which the precise anatomic information obtained by this technique is likely to be useful. Therefore, it would be rare to see duplex scanning being performed for conditions in which another diagnostic test is recommended (e.g., an aortic dissection is better diagnosed with a chest

****

ICD-9 Codes That Support Medical Necessity:

440.21-440.24
441.00-441.03
441.2
441.4
441.7
441.9
442.2
443.9
444.0
444.1
444.81
450.84
453.2
729.5
782.0
785.9
786.50
789.00-789.09
789.30-789.39
793.6
902.10
902.53

902.54
V67.0
V67.59

Coding Guidelines

Reimbursement for non-invasive vascular diagnostic studies include the following:

patient care required to perform the studies

supervision of the studies

interpretation of study results with hard copy output for patient records, and

bidirectional vascular flow or imaging when provided

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported.

Documentation Requirements

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

If the provider of the duplex scan study(ies) 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.

Effective Date

This Local Medical Review Policy is effective for services processed on or after June 21, 1999.

Advanced Notice Statement

Applies to medical necessity (see page 4)

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99183: Hyperbaric Oxygen Therapy - National Coverage Policy

The Local Medical Review Policy (LMRP) for Hyperbaric Oxygen Therapy (HBO) was published in the March/April 1998 Medicare B

Update! (page 55). HCFA recently provided carriers with national diagnosis requirements for HBO that supersede those in the LMRP. These changes are effective for services processed on or after May 1, 1999. The physician supervision requirement (see the March/April 1999 Update!, page 62) has also been defined.

The only conditions for which Medicare will allow HBO therapy are:

Acute carbon monoxide intoxication, (ICD-9-CM diagnosis 986).

Decompression illness, (993.2, 993.3).

Gas embolism, (958.0, 999.1).

Gas gangrene, (040.0).

Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened. (902.53, 903.01, 903.1, 904.0, 904.41.)

Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened. (927.00- 927.03, 927.09-927.11, 927.20-927.21, 927.8-927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0, 929.9, 996.90-996.99.)

Progressive necrotizing infections (necrotizing fasciitis), (728.86).

Acute peripheral arterial insufficiency, (44421, 444.22, 444.81).

Treatment of compromised skin grafts, (996.52; excludes artificial skin graft).

Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management, (730.10-730.19).

Osteoradionecrosis as an adjunct to conventional treatment, (526.89).

Soft tissue radionecrosis as an adjunct to conventional treatment, (990).

Cyanide poisoning, (987.7, 989.0).

Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment, (039.0-039.4, 039.8, 039.9).

All other conditions not specified are non-covered.

Physician Supervision Requirement

For HBO therapy to be covered, the physician must be in constant attendance during the entire treatment. This is a professional activity that cannot be delegated in that it requires independent medical judgement by the physician. The physician must be present, carefully monitoring the patient during the HBO therapy session and be immediately available should a complication occur. This requirement applies in all settings: no payment will be made unless the physician is in constant attendance during the HBO therapy procedure.

The LMRP is being revised to reflect these changes. In addition, HCFA is establishing credentialing requirements for physicians who provide HBO therapy. These requirements, and the revised LMRP, will be provided in a future issue of the Update!

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(watch and work your claims as they process)

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The Feds Reduce Medicare Errors by $8 Billion

The federal government reduced Medicare overpayments by nearly $8 billion last year, from an estimated $20.3 billion to $12.6 billion, the Health and Human Services (HHS) Department announced recently.

According to an audit by HHS Inspector General June Gibbs Brown, the Medicare error rate for 1998 was an estimated 7.1 percent, down from 11 percent in 1997 and 14 percent in 1996. In 1996, Brown estimated that HHS' Health Care Financing Administration (HCFA), which oversees Medicare, made $23.2 billion in improper payments to hospitals, doctors and other health care providers.

"We don't pretend we have solved this problem: $12.6 billion is still too much money," said HHS Inspector General June Gibbs Brown. "But what we're saying is we have turned the corner."

The improper payments range from accidental mistakes to fraud and abuse. The Inspector General's office is unable to determine how many of the improper payments are due to fraud. Two major problems billing for services that were not medically necessary and "upcoding" claims to get higher reimbursements than were justified account for about $9.3 billion of the $12.6 billion total improper payments.

HCFA, along with the Justice Department and Brown's office, have launched a major effort called Operation Restore Trust to reduce fraud in recent years, girded by funding Congress set aside for combating improper Medicare payments.

Brown called the reduction in errors a "truly remarkable improvement." Just three years ago, the department had never performed a comprehensive audit of the Medicare program, and had thus never even identified how many Medicare payments were being made improperly.

The savings generated by the Florida contractor were also remarkable. During the fiscal year 1998, $458.3 million in savings were identified as a result of investigations, and pre-payment and post-payment reviews of claims and cost reports. The savings to administrative expense ratio for the fiscal year 1998 was a remarkable $17.72 to $1. This ratio represents the program

savings realized for every administrative dollar spent on safeguard activities.

HCFA has been recognized for its achievements, but also realizes that more work must be done to curb the fraud, waste and abuse in the Medicare program.

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Improper Billing for Surgical Assistants

It has been noted that some physicians may be utilizing registered nurses (RNs) (or other persons with training) as surgical assistants for surgeries performed in hospitals. Such individuals are not nonphysician practitioners that are recognized under the Social Security Act. These assistants are employees of the physician and are not covered under the Medicare law. This is not the same as a physician acting as an assistant surgeon.

Medicare has received inquiries on how such services might be billed. Some have asked whether these services can be billed as "incident to" with personal supervision. Others would want the beneficiary to sign an advance notice statement, submit the claim as a non-covered service (which would lead to a denial), then bill the beneficiary directly for the "non-covered" service.

Neither scenario is appropriate. "Incident to" services cannot be billed for inpatient services. The services of nursing personnel are bundled into the hospital's costs. This is not a non-covered service; it is a Part A covered service. An advance notice would be inappropriate, and no additional payment should be requested from the beneficiary for the surgical assistant's or nursing personnel's services. Such a claim would be denied by Part B as a bundled service, and the beneficiary would not be held liable.

Hospitals and/or physicians would be at risk of possible fraud or abuse if they knowingly allow non-hospital employees to perform services with the knowledge that the non-hospital employee (or the physician on her/his behalf), is billing the beneficiary.

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Beneficiary Right to Itemized Statement for Medicare Items and Services

A. Requirements of the Law

Effective January 1, 1999, section 4311(b) of the Balanced Budget Act of 1997 gives beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any Medicare item or service. The law requires that providers/suppliers furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of $100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the Medicare contractor to review specific issues (e.g., services not

provided, billing irregularities, and appropriate measures to recover any amount inappropriately paid).

Medicare contractors currently issue beneficiaries an Explanation of Medicare Benefits (EOMB) or a Medicare Summary (MSN). Information that may be listed include the following: date(s) of services, a description of services provided, number of services provided, benefit days used, noncovered charges, deductible and coinsurance, beneficiary liability, amount charged, claim number, name of provider/supplier submitting the claim, claim total paid by Medicare and referring physician (if applicable). Other information that may be included are deductibles, appeal rights or notices, and explanatory notes and general information regarding the specific claim. On April 1, 1999, at most Medicare contractors (including Florida Medicare) , these notices began to include the following statement: "You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement." The remaining Medicare contractors will print this message beginning July 1, 1999.

B. Guidance Concerning the Format and Substance of the Itemized Statement

Included below are suggestions regarding the types of information that might be helpful for the beneficiary to receive on an itemized statement. We hope this information will enable the beneficiary to reconcile the itemized statement with the Medicare notice. These are recommendations only. Since most providers/suppliers have established an itemized billing system for internal accounting procedures and billing of other payers, the furnishing of an itemized statement should not pose a significant additional burden. However, some providers/suppliers may not regularly create or furnish hardcopy itemized statements and may wish to reexamine their internal billing and tracking process to ensure that it has the capability to comply with this new requirement. Providers/suppliers should not charge beneficiaries for the itemized statement.

Itemized Statement Recommendations:

Name of beneficiary,

Date(s) of services,

Description of item or service furnished,

Number of services furnished,

Provider/supplier charges,

An internal reference or tracking number.

If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are:

Amounts paid by Medicare,

Beneficiary responsibility for co-insurance,

Medicare claim number.

The statement should also include a name and a telephone number for the beneficiary to call if there are further questions.

C. Reconciliation of the Itemized Statement with the MSN/EOMB

After receiving an itemized statement, beneficiaries may attempt to reconcile it with the MSN. In situations where there are questions, especially involving some services and payment methods, providers/suppliers are requested to assist beneficiaries in understanding any differences between the two documents.

In addition, although Medicare contractor customer service representatives may not have a copy of the itemized statement, they will also answer any beneficiary inquiries regarding the EOMB/MSN and attempt to reconcile it with the itemized statement. Where appropriate, customer service representatives will attempt to resolve any questions by generally explaining applicable Medicare reimbursement rules, (prospective payment systems, revenue codes, bundling, interim rates, HCPCS/CPT codes, etc.).

D. Beneficiary Right to Request Review of the Itemized Statement

Beneficiaries may submit a written request to their Medicare contractor for a review of a claim based on information they provide from their itemized statement. The request should identify the specific items or services that the beneficiary believes were not provided as claimed, or any other billing irregularity (including duplicate billing). A review will be conducted into the matter by the Medicare contractor and providers/suppliers may be requested to assist in the review of the itemized statement/Medicare claim. Contractors will review and take appropriate actions to resolve the complaint.

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Mandatory Submission of Claims

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) requires all providers/suppliers of Medicare Part B services to submit on behalf of all beneficiaries both assigned and unassigned claims

to Medicare carriers within one year of the date of service. The provider/supplier cannot charge the beneficiary a fee for completing/filing the claims.

The law applies to all potentially covered services performed on or after September 1, 1990, except in cases where the provider has "opted out" of Medicare and has established private contracts with beneficiaries.

Time Limit for Filing Claims to Medicare Part B

Service Rendered: Prior to 10/1/1997
File Claims By: 12/31/1998 (past deadline)

Service Rendered: 10/1/1997 9/30/1998
File Claims By: 12/31/1999

Service Rendered: 10/1/1998 9/30/1999
File Claims By: 12/31/2000

Service Rendered: 10/1/1999 9/30/2000
File Claims By: 12/31/2001

Service Rendered: 10/1/2000 9/30/2001
File Claims By: 12/31/2002

Service Rendered: 10/1/2001 9/30/2002
File Claims By: 12/31/2003

Penalties associated with late filing include:

- Assigned claims: A ten percent reduction will be applied to the Medicare allowed amount when a claim is filed more than one year after the date the service was rendered.

- Unassigned claims: Nonparticipating physicians filing unassigned claims can receive civil monetary fines of up to $10,000 per violation.

Exceptions for Late Filing

A patient (beneficiary) may file a claim to Medicare when one of these conditions exists:

- The service was performed outside the United States of America

- A Medicare Secondary Payer (MSP) claim when the physician does not know of the primary insurer's payment.

- For unusual or exceptional situations, as determined by the carrier.

****

Inactive Provider Numbers

Medicare Part B provider numbers not used for billing and/or performing services for four consecutive quarters will be canceled for inactivity. Professional association groups must bill using the group provider number and the provider number of the individual physician and/or practitioner actually performing the service(s). If a group has five members on file with Medicare, and all services are billed under one of its group member's provider number and does not use the other four group member numbers, the unused provider numbers will be canceled for inactive billing.

When a provider number is canceled for inactive billing, the provider must reapply for a Medicare number by completing a General Enrollment Application (HCFA 855) and/or a Reassignment of Benefits Application (HCFA 855R). Applications may be obtained by contacting the Medicare Part B Provider Customer Service Department at (904) 634-4994.

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Changes to Health Professional Shortage Area Designations

Effective February 1, 1998, Holmes county was reinstated as a Florida rural Health Professional Shortage Area (HPSA). Services furnished in the geographical designation of Holmes county on or after February 1, 1998, are eligible for the HPSA incentive payment.

Effective May 1, 1999, Hardee county has been reinstated as a Florida rural HPSA. Services furnished in the geographical designation of Hardee county on or after May 1, 1999, are eligible for the HPSA incentive payment.

For more information regarding HPSA designations, see page 58 of the May/June 1998 Medicare B Update!

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Additional Development Requests For First Quarter of Fiscal Year 1999

Requests for additional information costs the Medicare program millions of dollars. During the first quarter of fiscal year 1999, the Florida Medicare Part B carrier identified the top additional development requests (ADRs). Outlined below are the top ADR's and helpful tips on how to avoid receiving them.

ADR #085

Please clarify the procedure/service performed and provide the name and address of the facility where services were rendered.

Helpful Tips

Please ensure that the two-digit place of service code corresponds with the procedure code submitted. For example, if a consultation is provided to a hospital inpatient, report procedure code 99251 and place of service 21 on the HCFA-1500 claim form or the equivalent field for electronic claims.

A complete list of place of service definitions was published on page 18 in the September/October 1997 Medicare B Update! Please refer to this publication when filing claims to Medicare.

ADR #094

Please advise the full name, address, Medicare provider number and/or identification number of the doctor or supplier performing services.

Helpful Tips

When the billing provider is a professional association (PA) group, please indicate the provider identification number (PIN) from the provider that rendered the services in block 24K and the PA group's PIN in block 33 of the HCFA-1500 claim form or the equivalent field for electronic claims.

Only one provider number may be listed in block 33 of the HCFA-1500 claim form.

ADR #108

Please indicate the exact dates of service.

Helpful Tips

When billing a range of dates, please follow these guidelines:

List the date ranges in block 24A of the HCFA-1500 claim form or the equivalent field for electronic claims

Ensure that the dates of service are consecutive

Ensure that the dates of service are within the same month and the same year (e.g., 12121998 - 12141998)

Indicate the total number of days in block 24G of the HCFA-1500 claim form or the equivalent field for electronic claims.

Ensure that the number of days indicated in block 24G of the HCFA-1500 claim form, or the equivalent field for electronic claims, corresponds with the number of days listed in block 24A, or equivalent field.

ADR #425

Please indicate for each lab service billed, whether it was sent to an outside lab or performed in the office.

Helpful Tips

Please indicate modifier 90 if services were actually performed by an outside entity.

Remember to complete blocks 21 and 32 on the HCFA 1500 claim form or the equivalent fields for electronic claims.

ADR #080

Please provide a copy of the operative/procedure report.

Helpful Tip #1:

Only submit an operative/procedure report with your claim if the following situation(s) occur:

When billing for six or more surgical procedures and the procedures are all subject to multiple surgery guidelines

When billing for surgeries/procedures that require medical necessity determination (e.g., cosmetic versus reconstructive surgery)

When billing for unlisted surgeries/procedures, for surgeries/procedures that require individual consideration (IC), or surgeries/procedures that are not otherwise classified (NOC).

Helpful Tip #2:

Surgical procedures rendered during the post-operative period of another surgical procedure are included in the surgery unless one of the following situations occur:

Modifier: 58
Description: Staged or related procedure or service by the same physician during the postoperative period

Modifier: 78
Description: Return to the operating room for a related procedure during the postoperative period

Modifier: 79
Description: Unrelated procedure or service by the same physician during the postoperative period

****

Note: If these modifiers are not submitted with the surgical procedure (the second surgery), you may receive an ADR or a denial from Medicare. Please refer to the December 1998 of the Medicare B Update! Special Issue 1999 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Update for more information.

ADR #019

Please indicate the full name and UPIN of the referring/attending physician.

Helpful Tip:

A unique physician identification number (UPIN) is required for services rendered (and filed) by privately practicing physical and occupational therapists (PTs and OTs). The UPIN of the attending physician must be indicated in block 19 of the HCFA-1500 claim form. For claims filed electronically, refer to the charts below for the fields required.

ADR #411

Please provide the date the patient was last seen by the attending physician for physical/occupational therapy services.

Helpful Tip

For paper claims, indicate the date last seen by the attending physician (MMDDCCYY format) and the UPIN of the attending physician in block 19 of the HCFA 1500 form. If the claims are filed electronically, refer to the charts below for the fields required (CCYYMMDD format).

Development questions #019 and/or #411 may occur on the same or different claim.

Claim Form Example: Date Last Seen (block #19)

19. Reserved For Local Use
06211999 D12345

Electronic Filing Format for National Standard Format (NSF):
< not available in this format: for programing format specifications, refer to the EDI area>

Electronic Filing Format for American National Standard Institute (ANSI) 837:
< not available in this format: for programing format specifications, refer to the EDI area>

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Medicare Educational Materials Available for Sale

Medicare of Florida has developed several tools to help the provider community with the coverage guidelines of the Medicare Program. Manuals available for purchase include:

The 1999 Medifest Book contains guidelines on issues such as primary care; global surgery; evaluation and management services; advanced registered nurses and physician assistants; instructions on electronic billing; medical review processes; inquiry and appeal processes; reimbursement/office efficiency; and other topics of interest outlining various aspects of the Medicare program.

The 1999 Specialty Seminar books contain guidelines and information targeted to specific medical specialties such as cardiology, dermatology, oncology, podiatry, radiology and more.

These publications have been updated to include the coverage changes implemented during 1998 and the 1999 HCFA common procedure coding system update.

To purchase these valuable educational materials, see page 45 of this issue.

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The following updates have been performed to the Medicare Part B of Florida Crossover Insurer list. These changes can be viewed on the Florida Medicare Online bulletin board system (BBS) in the Medigap Crossover Listing section.

For additional information concerning the Medicare Part B Crossover Insurer List, refer to "A Closer Look" in the September/October 1998 edition of the Medicare B Update!

Automatic Crossover

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

New Crossover Insurers

BCBS of Massachusetts

BCBS of Oklahoma

Name Change

Providian Life and Health has changed its name to People's Benefit Life

Medigap Crossover

Name Change

Number: 17001
Former Name: BCBS of Connecticut
Changed To: Anthem BCBS of Connecticut

Address Change

Number: 53113
Insurer Name/Address: National Financial110 West 7th Street #300Ft Worth TX 76102

Number: 53003
Insurer Name/Address: National Financial110 West 7th Street #300Ft Worth TX 76102

Number: 58017
Insurer Name/Address: Mountain State BCBSPO Box 1948Parkersburg WV 26102

Exempt "Non-Medigap Insurers"

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

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

Number: 33025
Insurer Name: American Hardware Mutual

Number: 19545
Insurer Name: American State Ins Company

Number: 18056
Insurer Name: Champion HealthCare Inc.

Number: 45061
Insurer Name: C.H.P. of Ohio

Number: 42167
Insurer Name: Glass Ind Ins Fund

Number: 15023
Insurer Name: Health & Welfare Trust

Number: 21002
Insurer Name: HDS Medical Claims

Number: 42100
Insurer Name: Health Welfare Trans

Number: 37018
Insurer Name: Imperial Casualty & Indemnity

Number: 42076
Insurer Name: INA

Number: 19352
Insurer Name: I.N.E.D.

Number: 43008
Insurer Name: MCM Corp

Number: 19515
Insurer Name: Philips Circ Metro

Number: 40074
Insurer Name: Printers League

Number: 19261
Insurer Name: Underwriters Adjustment

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Additions and Changes to the Medicare Remarks Codes

The Health Care Financing Administration (HCFA) approves and mantains all remark codes and remark code messages for use on a line and a claim level in the Medicare electronic and paper remittance advice notices. A list of the approved remark codes and messages was published on pages 66-68 of the January/February 1998 of the Medicare B Update! The following are additions and changes recently provided by HCFA to that list. Add these to the previous article to make the complete approved list.

Medicare Line Level Remark Codes

Line level remark codes are used to relay service-specific Medicare informational messages that cannot be expressed with a reason code.

M33
Claim lacks the UPIN of the ordering/referring or performing physicia

M51
Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or unlisted procedure codes submitted without a narrative description. Refer to the HCFA Common Procedure Coding System directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.

M65
One interpreting physician can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.

M86
Service denied because payment already made for similar procedure within set time frame.

M87
Claim/service(s) subjected to CFO-CAP prepayment review.

M88
We cannot pay for laboratory tests unless billed by the laboratory that did the work.

M89
Not covered more than once under age 40.

M90
Not covered more than once in a 12 month period.

M91
Lab procedures with different CLIA certification numbers must be billed on separate claims.

M92

Services subjected to review under the Home Health Medical Review Initiative.

M93
Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.

M94
Information supplied does not support a break in therapy. A new capped rental period will not begin.

M95
Services subjected to Home Health Initiative medical review/cost report audit.

M96
The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.

M97
Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.

M98
Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.

M99
Incomplete/invalid/missing Universal Product Number.

M100
We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.

M101
Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.

M102
Service not performed on equipment approved by the FDA for this purpose.

M103
Information supplied supports a break in therapy. However, the medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.

M104

Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service.

M105
Information supplied does not support a break in therapy. The medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.

M106
Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service.

****

M107
Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.

M108
Must report the PIN of the physician who interpreted the diagnostic test.

M109
We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.

M110
Missing/invalid provider number for the provider from whom you purchased interpretation services.

M111
We do not pay for chiropractic manipulative treatment when the beneficiary refuses to have an X-ray taken.

M112
The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.

M113
Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.

M114
This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.

M115
This item is denied when provided to this patient by a nondemonstration supplier.

M116
Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a nondemonstration supplier. If you would like more information regarding this project, you may phone 1-888-289-0710.

M117
Not covered unless supplier files an electronic media claim (EMC).

M118
Letter to follow containing further information.

M119
National Drug Code (NDC) needed.

M120
Lacks UPIN of the substituting physician who furnished the services(s) under a reciprocal billing or loco tenens arrangement.

M121
Reserved for future use.

Medicare Claim Level Remarks Codes

Medicare Inpatient Adjudication (MIA) and Medicare Outpatient Adjudication (MOA) claim level remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. An appropriate appeal, limitation of liability or other message is used whenever applicable. A maximum of five MIA and five MOA claim level remarks codes may be used per claim.

MA47
Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.

MA52
Did not enter full 8-digit date (MM/DD/CCYY for paper form or CCYY/MM/DD for electronic format).

MA53
Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.

MA54

Physician certification or election consent for hospice care not received timely.

MA55
Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.

MA56
Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.

MA57
Patient submitted written request to revoke his/her election for religious non-medical health care services.

MA85
Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the Payer ID when effective.

MA93
Non-PIP claim.

****

MA101
A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

MA102
Did not complete or enter accurately the referring/ordering/supervising physician's/physician assistant's, nurse practitioner's, or clinical nurse specialist's name and/or UPIN.

MA103
Hemophilia Add On

MA105
Missing/invalid provider number for this place of service. Place of service shown as 21, 22, or 23 (hospital).

MA106
PIP claim

MA107
Paper claim contains more than three separate data items in field 19.

MA108
Paper claim contains more than one data item in field 23.

MA109
Claim processed in accordance with ambulance surgical guidelines.

MA113
ncomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.

MA117
This claim has been assessed a $1.00 user fee.

MA123
Your center was not selected to participate in this study, therefore, we cannot pay for these services.

MA124
Processed for IME only.

MA125
Per legislation governing this program, payment constitutes payment in full.

MA126
Pancreas transplant not covered unless kidney transplant performed.

MA130
Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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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 BParticipating Providers
P.O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims

Medicare Part B

Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims

Medicare Part B
Ambulance Dept
.P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer

Medicare Part B
Secondary Payer Dept
.P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD Claims

Medicare Part B ESRD Claims
P.O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Review Requests

Medicare Part BClaims Review
P. O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests

Medicare Part B Fair Hearings
P. O. Box 45156
Jacksonville, FL 32232-5156

Administrative Law Judge Hearing

Administrative Law Judge Hearing
P.O. Box 45001
Jacksonville, FL 32231-5001

Status/General Inquiries

Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments

Medicare Part B
Financial Services
P.O. Box 44141

Jacksonville, FL 32231-0048

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims

Palmetto GBA
Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries

Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:

Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-2537

Over 40 days of initial request:

Submit the charge(s) in question, including information requested, as you would a new claim to:

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

MISCELLANEOUS

Fraud and Abuse

Medicare Fraud Branch
P.O. Box 45087
Jacksonville, FL 32231

Medicare Claims for Railroad Retirees:

MetraHealth

RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Provider Change of Address:

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

and

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

Provider Education:

For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:

Medicare Part BMedicare Education and Outreach
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part BMedicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32231

Limiting Charge Issues:

For Processing Errors:

Medicare Part B
P.O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:

Medicare Part BCompliance 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 Bulletin Board (BBS)

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

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FREE Medicare Computer Based Training Courses

In 1998, the Health Care Financing Administration, through one of its Medicare contractors, First Coast Service Options, Inc. (FCSO) launched the Medicare Online Training Web Site (www.medicaretraining.com), designed to capitalize on the emerging Internet-based training market.

Users of the site can download free Medicare training courses to help them develop their Medicare billing skills and knowledge. Nine courses are currently available which are designed to be applicable to a national audience. Additional courses are being developed for release in 1999. The current library includes courses on:

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

Here is How it Works:

Users visit the Medicare Online Training Web Site at www.medicaretraining.com and click on "Computer Based Training''

to download the course of their choice. Once a course is loaded, users are able to take the courses at their leisure. The site gives users complete step-by-step instructions on how to download and set up the courses.

In every course, users are given the opportunity to practice what they have learned through quizzes and tests. After each test is taken, users are given full access to their results instantly. Users can take as long as they want to complete each lesson and they can take the lessons as often as they like.

Web-based training gives the Medicare contractors yet another channel to reach new audiences, build new partnerships, and deliver up-to-date materials and services.The lure for providers is the flexibility to have control over their learning environment.

To date, the Medicare Online Training Web Site has registered more than 20,000 course as being successfully completed. HCFA and FCSO welcome your participation in this overwhelmingly successful program. Please, visit the Medicare Online Training Web Site at www.medicaretraining.com.

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We are in the process of improving your Medicare B Update!

Your opinion matters, so we want to hear from you!!!

Please complete the questions below and fax to (904) 791-6035 by June 1, 1999. Responses can also be tri-folded and mailed to the address on the reverse.

PLEASE RANK THE FOLLOWING CATEGORIES

How do you feel about:

The publication overall;

___ very satisfied

___ satisfied

___ somewhat satisfied

___ not satisfied

The size/length of publication;

___ very satisfied

___ satisfied

___ somewhat satisfied

___ not satisfied

The "user-friendliness" of publication and ease in accessing information;

___ very satisfied

___ satisfied

___ somewhat satisfied

___ not satisfied

The order in which articles are presented;

___ very satisfied

___ satisfied

___ somewhat satisfied

___ not satisfied

The clarity of the articles;

___ very satisfied

___ satisfied

___ somewhat satisfied

___ not satisfied

Do you have any specific ideas or suggestionsabout the publication and how we can improve your resource? Use the lines provided below, or feel free to fax or mail any additional thoughts on an attachment.

We appreciate you taking the time to share your thoughts!
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ORDER FORM- 1999 PART B MATERIALS

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ORDER FORM - 1999 MEDIFEST AND SPECIALTY SEMINAR BOOKS

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Coming in the July/August Medicare B Update!

As this issue goes to press, HCFA has provided carriers with several new program changes. These will be explained in detail in the next Update!, or as more information becomes available. Below is a list of topics that will be discussed:

- Adjustment in Payment Amounts for New Technology Intraocular Lenses (NTIOLs) Furnished by Medicare Approved Ambulatory Surgical Centers (ASCs)

- Cryosurgery of the Prostate

- Enhanced External Counterpulsation (EECP)

- Establishment of Temporary National Modifiers to Allow Monitored Anesthesia Care (MAC) for Complex, Complicated, or Markedly Invasive Surgical Procedures and for At Risk Patients

- Expansion of Coverage for Positron Emission Tomography (PET) Scans

- Implantation Of Automatic Defibrillators

- New CLIA Waived Tests

- Pancreas Transplants

- Transmyocardial Revascularization (TMR) for Treatment of Severe Angina

Please look for these in our next issue, or find them online at the HCFA Web site, www.hcfa.gov.

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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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