

March/April 99 UPDATE! Publication

Medicare B Update!

Vol. 12 No. 2

March/April 1999

Publications Staff:

Bill Angel

Cynthia Moore

Millie C. Perez

Alan Tolleson

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:

Medicare Part B

Provider Education

P.O. Box 2078

Jacksonville, FL

32231-0048

HCFA

Health Care Financing Administration

FIRST COAST SERVICE OPTIONS, INC.

A HCFA Contracted Carrier and Intermediary

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

The ICD-9-CM codes and their descriptions used in this publication are copyright (c) 1998 under the Uniform Copyright Convention. All rights reserved.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

Page 1

Highlights

A Physician's Focus (p.3)

Medifest Schedule (p. 5)

Consolidated Billing for SNFs (p. 18)

Local and Focused Medical Review Policies (p. 33)

Volume 12, Number 2 March/April 1999

Are You Ready for Y2K?

The countdown to Year 2000 is on, and everyone should ask himself or herself, "Have I done everything possible to prepare for Year 2000?"

In January 1999, a special edition of the Medicare B Update! was published to advise providers that all Medicare Part B claims

received on or after April 5, 1999, must be Year 2000 (Y2K) compliant. Claims submitted to the carrier on or after April 5, 1999, that are not Y2K compliant will be returned as unprocessable. (Note that three forms are excluded from this requirement: the HCFA 1491, 1490S, and 1490U.) Claims specifications may be obtained at the HCFA Website at:

<http://www.hcfa.gov/medicare/edi/edi3.htm>
(for electronic claims)

or

<http://www.hcfa.gov/medicare/edi/edi5.htm>
(for paper claims)

Providers need to continue to ensure that their practices will be ready on all levels, not just from a claims filing standpoint. Issues such as the readiness of computer systems, other office equipment, banks, and utilities affect all aspects of a provider's business. Remember - anything that contains a microchip could be affected at the time of year 2000. Providers need to ensure that they have developed a contingency plan in case any area of their business is affected, and that plan needs to be tested well before January 1, 2000. Extensive information about preparation for Y2K was published in previous editions of the Medicare B Update!, and providers may wish to refer to those articles for additional information. The following editions of the Medicare B Update! contain information about Y2K:

January/February 1999
November/December 1998
September/October 1998
July/August 1998
May/June 1998
March/April 1998

Ensuring Y2K readiness is everyone's responsibility. The Health Care Financing Administration and this carrier are doing everything possible to ensure that critical systems are not affected by Y2K - are you?

What's New

HCPCS Grace Period Ends April 1, 1999

The grace period for use of procedure codes deleted/invalid for 1999 ends on April 1, 1999. Claims received on or after this date billed using deleted or invalid procedure codes will be returned as unprocessable. Providers will be notified that an invalid procedure code was submitted and the claims must be resubmitted with a valid procedure code. Providers should refer to their 1999 coding manual or to the December 1998 HCPCS Special Update! for a list of deleted/invalid codes and their replacements.

1999 MEDPARD Directory

The Medicare Directory of Participating Physicians and Suppliers (MEDPARD) contains the names, address, telephone numbers, and specialties of Medicare participating physicians and suppliers. Medicare participating physicians and suppliers have agreed to

accept assignment on all Medicare claims for covered items or services.
Effective for 1999, the MEDPARD is available only on the Medicare Online Bulletin Board System (BBS). For instructions on accessing the BBS, see page 76.

New Calculation Method for Injectable Drugs
A new method for calculating the reimbursement for injectable drugs has been developed. See page 21 for details.
Additionally, injectable drug fees can be found on page 27.

Page 2

Table Of Contents

----- FOR PHYSICIANS

Are You Ready for Y2K?.....1
What's New.....1
A Physician's Focus - The Winds
Of Change.....3
Advance Notice Requirement.....4
General Information About the Medicare B Update!.....4
Medifest and Specialty Seminar
Schedule.....5

COVERAGE

General Information

Routine Screening/Noncovered Diagnosis Codes.....16
UPIN Requirements - A Reminder.....17
Mammograms for Patients with Breast Implants.....17
Consolidated Billing for Skilled Nursing Facilities (SNFs).....18
Use of Modifier QR for Clinical Laboratory Procedures.....18
SNF/PPS Consolidated Billing -
Questions and Answers.....20
New Calculation Method for
Injectable Drugs.....21
Medicare Home Health Benefit:
A Physician's Guide.....22
Ordering a National Correct Coding Policy Manual.....22
Additional Commercial Edits.....22
"Incident To" Services.....25

HCPCS Codes

1999 Pricing for Radionuclide Material.....27
G0001, P9603, P9604: Collection of Specimens and Travel
Allowance.....28
J1260: Dolasetron Mesylate.....28
Q0163-Q0181 - Oral Anti-Emetic Drugs.....28
Additional Changes to Injectable Drugs
Fees.....28
Injectable Drugs Fees.....29

Anesthesia/Surgery

45305, 45385 - Endoscopic Biopsy,
Polyp and Tumor Removals.....30
First Quarter Changes to the Medicare Physician Fee
Schedule.....30
Diagnostic Tests

Revision to UPIN Requirements when Billing for a Diagnostic
Mammography Converted from a Screening Mammography.....31

Medicine

Contractor Review of E&M Services Begins March 1999.....31
Medicare Physician Fee Schedule (MPFS): Facility Pricing
Rule.....32

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

Billing for Optison.....33
Correction to Independent Physiological Laboratory (IPL)
Policy.....33
Viscosupplementation of the Knee.....34
A9270: Noncoverage.....34
E0782, E0783: Implantable Infusion Pumps.....38

J0001: Self-Administered Drugs.....43
J1950, J9217, J9218: Leuprolide Acetate.....44
J9999: Antineoplastic Drugs (Formerly Off-Label Use of
Chemotherapy Drugs).....45
Independent Diagnostic Testing Facility (IDTF).....48
51725 Urodynamic Testing.....56
70450: Computerized Tomography.....57
90780-90799: Therapeutic Or Diagnostic Injections/Infusions -
Correction.....58
90999: ESRD Laboratory Services and Diagnostic Services.....59
93268: Billing of Patient Demand Single or Multiple Event
Recorder.....60
93965, 93970, 93971: Non-Invasive Evaluation of Extremity Veins -
Correction.....60
95860-95864: Needle Electromyography.....60
99183: Hyperbaric Oxygen Therapy - Clarification.....62
Evaluation and Management Codes 99301-99303.....62

ELECTRONIC MEDIA CLAIMSPC-ACE(tm)
Customer Support Needs Your Help!.....63
EDI Enrollment Form.....63

FOR YOUR INFORMATION

The Medicare Fraud and Abuse Incentive Reward Program.....67
Compliance Programs Guidance Issued by the Office of the
Inspector General.....68
Enforcement of Child Support Provisions of the Debt Collection
Act of 1996.....69
Heart, Liver, and Lung Transplant Centers in Florida.....69
Ending Suppression of Medicare Summary Notices.....69

| | |
|---|----|
| Sanctioned Provider Information Available on the Internet..... | 69 |
| Medicare Enrollment of PTs and OTs in Private Practice..... | 70 |
| Overpayment Interest Rate..... | 70 |
| Medicare Payment for Teleconsultation in Rural HPSAs..... | 71 |
| Important Information From Medicare Registration | 72 |
| Nurse Practitioner/Physician Assistant Guidelines..... | 72 |
| UPIN Directory Available..... | 72 |
| 1999 Customer Service Hours of Operation..... | 72 |
| Financial Services Physician/Supplier Service Request Form..... | 73 |
| Medicare Online BBS..... | 76 |
| Using windows 95/NT/98 to Access Medicare Online BBS..... | 77 |
| FREE Medicare Computer Based Training Courses..... | 78 |
| Order Form - 1999 Part B Materials..... | 79 |
| Order Form - 1999 Medifest and Specialty Seminar Books..... | 80 |
| Index to Publications by Topic..... | 81 |

Page 3

A Physician's Focus - The Winds Of Change

The winds of change are blowing strongly for Medicare. Nationally the Balanced Budget Act of 1997 has brought some of the most sweeping changes to the Medicare program since its inception in 1966. Here at home, Blue Cross and Blue Shield of Florida (BCBSF) has launched First Coast Service Options (FCSO), Inc. to assume BCBSF's current Medicare contracts and pursue new business. FCSO (sounds like fix-so) is a wholly-owned subsidiary of BCBSF and, as such, you will continue to receive the same high levels of service and satisfaction that BCBSF has provided to the Medicare program for more than three decades.

As depicted by our logo, FCSO is a vessel under full sail, serving as our symbol that we are committed to staying our course through the high seas and winds of change now sweeping the ocean of health care. By making this change, we are making a long-term commitment to the Medicare program, a commitment that will benefit all Medicare beneficiaries and providers in Florida. The formation of FCSO reflects BCBSF's response to the Health Care Financing Administration's (HCFA) new contracting strategy which emphasizes enhanced customer service and Medicare program safeguard functions. This new approach also increases opportunities for partnerships that achieve economies of scale, and promotes innovations that will reduce costs and improve management of the Medicare program.

Like BCBSF, FCSO will serve as an intermediary for Medicare Part A claims and as the carrier for Medicare Part B claims.

Additionally, we will process claims for several other Medicare intermediaries, maintain the national Part A claims processing system for HCFA and provide beneficiary eligibility verification for Medicare contractors in Florida and Georgia.

Our 1,200 highly-talented employees and managers are the same individuals who oversaw the Medicare program as part of BCBSF. This brings the added benefits of excellence, experience, commitment and stability - the same as Floridians have come to expect from Blue Cross and Blue Shield of Florida's Medicare administration over the past 33 years. Indeed, as one of the largest Medicare contractors in the country, in 1999 we expect to process almost 55 million claims, issue approximately \$9 billion

in benefit payments and respond to almost 3 million customer inquiries from Florida's Medicare beneficiaries and providers. We believe our mission is to help Medicare beneficiaries improve their health by assisting them in receiving efficient, quality health care, and to deliver excellent, cost-effective administrative services. We also strongly believe that our transformation to FCSO will enhance the Medicare experience of beneficiaries and providers, and that we are perfectly situated to grow and evolve with Medicare through changes in the years to come. We look forward to continuing to serve you in our role as one of the nation's largest Medicare administrators. We are proud of our reputation for efficiency and our good standing amongst beneficiaries and providers, and anticipate that we will continue to excel at meeting your needs as stewards of the Medicare program.

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

Page 4

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.

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 (more information is in the FYI section). 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.

Page 5 - 15

MEDIFEST

The Medifest and Specialty information can be found on the Medicare Online BBS under Educational Events.

Page 16

Routine Screening/Noncovered Diagnosis Codes

Routine Screening Diagnosis Codes

Medicare Part B covers services which are reasonable and necessary for the patient's condition. Except for those services which are regulated under Medicare law (i.e., Screening Pelvic Examination - G0101, Screening Pap Smears - Q0091, P3000-P3001, Influenza Vaccinations - G0008, 90724, Pneumococcal Vaccinations - G0009, 90732, Screening Mammography - 76092, Hepatitis B Vaccine - G0010, 90731) services performed for screening purposes are noncovered. This includes services performed when there is no symptomatology to warrant the service.

The following diagnoses are considered screening because their descriptors denote that a screening service was performed. Services billed with any of these diagnoses will be denied payment. The patient may be held financially liable for any denied charges.

NOTE: When only a three digit diagnosis code is specified in the "ICD-9 DX CODE" column, all four and/or five digit codes beneath that designation will be denied for the same reason.

ICD-9 DX CODE
DESCRIPTION

V16
Family history of malignant neoplasm

V17
Family history of certain chronic disabling diseases

V18
Family history of certain other specific conditions

V19

Family history of other conditions

V20

Health supervision of infant or child

V21

Constitutional states in development

V28

Antenatal screening

V29

Observation and evaluation (without signs or symptoms) of newborns for conditions not found

V30-V39

Liveborn infants who are consuming health care (e.g., crib or bassinet occupancy)

V69

Problems related to lifestyles

V70

General medical examination

V71

Observation and evaluation for suspected conditions not found

V72-V72.7

Routine investigations and exams (eyes, ears, dental, gynecological, skin, pregnancy test, radiology exam, lab exam)

V72.8

Other specified examinations

V72.8

Other specified examination

V72.9

Unspecified examination

V73-V82

Special screening examinations

Noncovered Diagnosis Codes

The following diagnoses are considered noncovered because their descriptors denote that a noncovered service was performed. Services billed with any of these diagnoses will be denied payment. The patient may be held financially liable for any denied charges.

NOTE: When only a three digit diagnosis code is specified in the " ICD-9 DX CODE" column, all four and/or five digit codes beneath that designation will be denied for the same reason.

CD-9 DX CODE
DESCRIPTION

V03

Need for prophylactic vaccination and inoculation against bacterial diseases (i.e., cholera, typhoid, tuberculosis, plague, tularemia, diphtheria, pertussis, tetanus toxoid, hemophilus, etc)

V04

Need for prophylactic vaccination and inoculation against certain viral diseases (i.e., polio, smallpox, measles, rubella, yellow fever, rabies, mumps, common cold,,)

V05

Need for other prophylactic vaccination and inoculation against single diseases (i.e., encephalitis, other arthropod-borne viral diseases, leishmaniasis, hepatitis, varicella, etc)

V06

Need for prophylactic vaccination and inoculation against combinations of diseases (i.e., cholera & TAB, DTP, DTP & TAB, DTP & polio, measles/mumps/rubella, tetanus/diphtheria, pneumonia, etc)

V25

Encounter for contraceptive management

V26

Procreative management

V50

Elective surgery for purposes other than remedying health states

V52.3

Dental prosthetic device

V53.2

Fitting and adjustment of hearing aid

V53.4

Orthodontic devices

V60

Housing, household and economic circumstances

V61

Other family circumstances

V62

Other psychosocial circumstances

V63

Unavailability of other medical facilities for care

V65

Other persons seeking consultation without complaint or sickness

V68

Encounters for administrative purposes

302.50-302.53

Trans-sexualism

Page 17

UPIN Requirements - A Reminder

All claims billed to Medicare Part B for services and items that are the result of an order or referral by a physician (or physician assistant, nurse practitioner or clinical nurse specialist) must be filed with the Unique Provider Identification Number (UPIN) of the referring/ordering physician. This includes diagnostic laboratory services, diagnostic radiology services, and consultative services. It also includes services that are self referred - services where the referring/ordering physician is the same as the performing/billing physician (e.g.: lab or radiology services performed "in house").

In these self referrals, the performing/billing physician's UPIN must be provided in the referring/ordering physician field. This information must appear in block 17a of Form HCFA-1500. For National Standard Format (NSF) claims, the UPIN must appear in record/field EA0-20.0 as the ordering/referring provider. Providers submitting American National Standards Institute (ANSI) claims in the X12 837 version 3051.3B format must submit the referring/ordering UPIN in Table 2, position 500.E-NM109. Providers using ANSI X12 837 version 3032.2B, will use Table 2, position 420.E-NM109 for the referring/ordering UPIN.

Mammograms for Patients with Breast Implants

Recently, questions have been raised concerning whether or not mammograms for patients with implants are automatically considered diagnostic instead of screening.

The answer is that they are not. This question was raised in the development of the revised definition of "diagnostic mammography" in 42 CFR 410.34 (a)(1) of the Medicare regulations in 1994. Specifically, 410.34 defines "diagnostic mammography" to mean "a radiological procedure furnished to a man or woman with signs or symptoms of breast disease, or a personal history of breast disease, or a personal history of biopsy-proven benign breast disease." This definition does not allow for coverage of the breast implant patient unless the patient meets the specific terms of the diagnostic mammogram description.

In addition, 410.34(d)(1) of the same regulation was revised in 1994 to indicate that a screening mammography service "must be, at a minimum a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast." That is, the regulation recognizes that certain screening mammograms (e.g., in the case of a patient with an implant) may require more than a two-view exposure of each breast

Page 18

Use of Modifier QR for Clinical Laboratory Procedures
Effective June 1, 1999, for services furnished on and after January 1, 1998, modifier 76 will not be allowed for clinical laboratory procedures. Providers must use modifier QR to indicate that a test was performed more than once in separate encounters on the same day to obtain multiple results in the course of the treatment. If modifier 76 continues to be billed on clinical laboratory procedures, the service will be subject to a denial.

Consolidated Billing for Skilled Nursing Facilities (SNFs)
Section 4432b of the Balanced Budget Act (BBA) of 1997 modified the payment structure for SNFs. Effective with cost reporting periods beginning July 1, 1998, and after, SNFs are no longer paid on reasonable cost or through low volume prospectively determined rates, but instead are paid on the basis of a Prospective Payment System (PPS). Under PPS, the payment rates encompass all costs of furnishing covered skilled nursing services (e.g., routine, ancillary, and related costs). All SNFs that are reimbursed on the PPS are required to consolidate their billing for services its residents receive, except for certain excluded services. Consolidated Billing (CB) is required for SNFs that have transitioned to the PPS, for beneficiaries (residents) who are in a covered Medicare Part A stay. This provision requires SNFs to begin CB as of its PPS effective date.

How Does Medicare Define a SNF Resident?

A SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF (or to the nonparticipating portion of a nursing home that also includes a Medicare participating SNF) and Medicare Part A covers the stay. If the beneficiary leaves the facility, his or her status as a SNF resident (for CB purposes) ends when one of the following events occurs:

The patient is admitted as an inpatient to a Medicare participating hospital or Critical Access Hospital (CAH), or as a resident to another SNF, or

The beneficiary receives services from a Medicare participating Home Health Agency (HHA) under a plan of care, or

The beneficiary is formally discharged from the SNF unless he or she is readmitted to that or another SNF within 24 consecutive hours, or

The beneficiary receives outpatient services from a Medicare participating hospital or CAH (but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or comprehensive care plan).

What Is A Covered Part A Stay?

A covered Part A stay is a spell of illness or benefit period that payment may be made for up to 100 days of post hospital extended care services. Additional information may be obtained in HCFA Publication 12, section 260, of the Skilled Nursing Facility Manual.

Who Does Consolidated Billing Apply To?

CB applies to participating SNFs and any part of a Nursing Home that includes a designated SNF section. Additionally, CB applies to the providers of all services furnished to a SNF resident (e.g., physical therapy, occupational therapy, speech therapy, etc.), if the service is part of the resident's plan of care.

What Services Are Affected?

In terms of services, CB applies to all services furnished to a SNF resident (except for those services noted below under "Excluded Services"). This includes all post hospital SNF services for which benefits are provided under Part A, and all items and services for which (prior to July 1, 1998) payment has been made under Part B, except for excluded services furnished to a beneficiary during a Part A covered stay in a SNF. The following are examples of services that are subject to CB:

Diagnostic X-ray tests

Diagnostic laboratory tests

X-rays, radiological services, radium and radioactive isotope therapy

Surgical dressings, splints, casts and other devices used for the reduction of fractures and dislocations

Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes (including adjustment, repair, or replacement)

Vaccinations or inoculations specifically for influenza, PPV and hepatitis B

Approved oral cancer and anti-emetic drugs

Hemophilia clotting factor

Page 19

Ambulance services (see "Excluded Services" section, below)

Clinical Social Worker services

Orthotics/prosthetics

Ostomy/colostomy supplies

Sterile dressings/surgical dressings and supplies

Enteral/parenteral nutrition and supplies

Independent laboratories

Portable X-ray companies

Therapy professionals rendering physical therapy, occupational therapy or speech therapy services

Excluded Services
Physicians' services

Physician assistants working under a physician's supervision

Nurse practitioners and clinical nurse specialists working in collaboration with a physician

Certain nurse midwife services

Qualified psychologist services

Ambulance transports for the initial admission, final discharge, or for clearly medically necessary emergency transports that could not be part of the beneficiary's plan of care.

Certified registered nurse anesthetist (CRNA) services

Home dialysis supplies and equipment, self-care home dialysis support services and institutional dialysis services and supplies

Erythropoietin (EPO) for certain dialysis patients

Cardiac catheterization

Computerized axial tomography (CT) scans

Magnetic resonance imaging (MRIs)

Ambulatory surgery involving the use of an operating room

Emergency services

For more information regarding excluded services, please reference the May/June 1998 Medicare Part B Update! (pg. 15) For a list of services affected by CB, please reference the May/June 1998 Medicare Part B Update! (pg. 16) and HCFA Publication 12, section 260, of the Skilled Nursing Facility Manual.

How Should SNF Services Be Billed?

All services allowed under a Part A stay must be reported by the SNF on the HCFA-1450 (UB92) claims format using a line item ancillary revenue code and total charges for that service. Services required to be included on the Part A claim are those rendered within the facility (either directly or under arrangement) and those rendered "off site," if the services are related to the resident's care in the SNF (except those services excluded by the BBA). This includes services rendered by suppliers and contracted staff, and those services provided "under arrangement"

How Does CB Apply To Me?

Physicians should continue to bill Medicare Part B directly for physician services provided to beneficiaries who reside in a SNF. Examples of physician services include visits, consultations and surgical procedures. Providers of ancillary services may continue

to bill the Medicare Part B program directly for services rendered to patients in a SNF setting only if the SNF has not transitioned to PPS.

If the SNF has transitioned to PPS, the following guidelines will apply:

The SNF will be responsible for billing the Medicare Intermediary for all covered Part B services rendered to patients in a covered Part A stay;

Provider of services will be responsible for receiving payment directly from the SNF (for services rendered to patients in a covered Part A stay);

If the patient is not in a covered Part A stay, providers may bill the Medicare Part B Carrier directly for services rendered.

How Do I Know If A SNF Has Transitioned to PPS?

At this time, not all SNFs have transitioned to PPS. All SNFs will be transitioned to PPS no later than July 1, 1999. The Medicare Online Bulletin Board System (BBS) contains in the Part A misc. download library a complete listing of SNFs, their complete address, and their effective date for PPS. More information regarding the Medicare BBS can be obtained by calling (904)791-8384.

Page 20

SNF/PPS Consolidated Billing - Questions and Answers

The following is a list of common questions and answers concerning consolidated billing by Skilled Nursing Facilities (SNFs).

Q: What is the effective date of the Consolidated Billings (CB) provision?

A: The provision is effective for services performed on or after July 1, 1998. However, it is currently only applicable for those services that are rendered in a SNF that has converted to the Prospective Payment System (PPS) and only for those SNF residents that are in a covered Medicare Part A stay.

Q: What is the prospective payment system (PPS)?

A: PPS is the new payment methodology used when reimbursing covered SNF services.

Q: How is reimbursement calculated under PPS?

A: Part B providers should contact the SNF with which they are affiliated for specific information on PPS. Providers can also contact the Medicare Part A customer service area at (904) 355-8899 for additional information.

Q:How will providers know if the SNF they are affiliated with has transitioned to PPS?

A:Providers can contact the SNF directly or they may access the Medicare Bulletin Board System (BBS) for a listing of SNFs, their complete addresses, and their effective date for transitioning to PPS. Note that the BBS is the only place where this listing is available.

Q:Under what section of the Balanced Budget Act (BBA) are PPS and CB covered?

A:PPS is covered under section 4432(a) and CB is under section 4432(b). Providers can also reference the November 2, 1998, Federal Register for information on PPS and CB.

Q:Can portable x-ray suppliers continue to bill Medicare Part B for services rendered to SNF patients?

A:If the SNF has not yet transitioned to PPS and the patient is in a covered Part A stay, suppliers of ancillary services such as portable x-ray suppliers may continue to receive reimbursement from Medicare Part B. These providers may also be eligible to receive reimbursement from Part B if the beneficiary is not under a covered Part A stay.

If the SNF has transitioned to PPS and the services are rendered to a beneficiary who is under a covered Part A stay, the SNF must be contacted for reimbursement. Specifically, the provider must have a contractual arrangement with the SNF in order to receive reimbursement. Medicare, however, is not in any way involved with the contract that is formed between the SNF and the provider.

Q: If a Part B provider of ancillary services has received reimbursement from Part B for services rendered to a SNF resident in a covered Part A stay, should the money be refunded to Part B?

A: If the SNF has transitioned to PPS, technically yes. However, Part B providers of ancillary services will not be held accountable for any Part B payment received for services that should have been billed to Part A by the SNF. Additionally, Part A should not be billed by a SNF for services that Part B has already paid.

Q:Are physician services subject to CB?

A:No.

Q:Are podiatrist services subject to CB?

A:No. Podiatrists acting within the scope of their license are considered to be physicians and are therefore excluded from the CB provision.

Q:What about chiropractors, dentists and optometrists? Are these providers excluded from CB?

A:Yes. (These, too, are considered physicians based on the scope of their licenses.)

Q: Is CB applicable to ambulance trips?

A: Yes, CB is applicable to ambulance trips except those trips that transport a beneficiary to the SNF for the initial admission or those from the SNF following the final discharge.

Q: In what issue(s) of the Medicare Part B Update! can information regarding CB be found?

A:A comprehensive article can be found in the May/June 1998 issue, beginning on page 14. Additionally, information regarding CB can be obtained from the following HCFA web sites:
www.hcfa.gov/medicare/cbqa.htm and
www.hcfa.gov/medicare/ppsga.htm

Q: Are services that are "incident to" a physician service excluded from CB?

A: No. CB specifically excludes services that are personally performed by a physician and/or other medical practitioner (e.g.: Nurse Practitioner, Clinical Nurse Specialist, CRNA, etc.). This means that a professional service (modifier -26) performed in a SNF would be covered and reimbursed by Medicare Part B. However, a technical service (modifier -TC) would not be reimbursed by Part B. The reimbursement for the technical service would instead be included in the allowance given by Part A to the SNF.

Q: Is CB applicable to independent lab services rendered to a SNF resident?

A: Yes.

Q: When will all the SNFs be transitioned to PPS?

A: The scheduled date for all SNFs to be transitioned is currently July 1, 1999. A phase-in period was necessary because the transition to PPS is based primarily on the SNF's cost report date, which is different for each SNF. Providers can refer to the Medicare Online Bulletin Board System (BBS) for more information.

Q: How will beneficiaries be notified about CB?

A: The beneficiary should be notified by the SNF upon admission. Also, Medicare's Beneficiary Education and Outreach area will be holding seminars to educate the beneficiary population on this initiative.

Q: What is a covered Part A stay?

A: A covered Part A stay is a spell of illness or benefit period that payment may be made for the reasonable cost of services for up to 100 days of post hospital extended care.

Page 21

New Calculation Method for Injectable Drugs

Medicare determines pricing for injectable drugs based on 95 percent of the median average wholesale price (AWP) for generic and/or brand name drugs as published in the Drug Topics Red Book. A new method of calculating pricing for injectable drugs is being established for determining pricing for multi-source drugs. This change will be effective with the next drug pricing update, currently scheduled for March 29, 1999. Claims for 1999 dates of service processed on or after March 29, 1999, will be reimbursed according to these new guidelines.

Calculation of the Average Wholesale Price (AWP)

For a single-source drug or biological, the AWP equals the AWP of the single product. This is not a change from the current process.

For a multi-source drug or biological, the AWP was formerly calculated by determining the median AWP of all the generic forms of the drug unless the brand name product AWP was priced below this median. If the brand name product AWP was lower, a new median was calculated with the brand AWP included. Effective March 29, 1999, the AWP is equal to the lesser of the median AWP of all the generic forms or the brand name product AWP.

After determining the AWP, it is multiplied by 95 percent. This calculation is not rounded; there is no minimum amount. This, too, does not represent a change from the current process.

Page 22

Ordering a National Correct Coding Policy Manual

Information was provided in the March/April 1998 Medicare Part B Update! (page 17) concerning ordering of a National Correct Coding Policy Manual. Since that information was published, there are new telephone numbers for 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.

All other information provided in the March/April 1998 Update!
article remains the same.

Medicare Home Health Benefit: A Physician's Guide

Because of requests from many physicians themselves, the Health Care Financing Administration (HCFA), asked the Medicare Part B contractors to become involved in educating physicians about the home health benefit. A computer based training course has been developed and is available immediately on the Medicare Online Training site at www.medicaretraining.com.

The course looks at the conditions that must exist for a patient to qualify for the Medicare home health benefit and the physician's role and responsibilities. After completing the course, the physician will have an increased understanding of the benefit and the appropriate use of these services.

Additional Commercial Edits

[The clinical edits and the accompanying rationale, if any, ("Material") contained herein are proprietary data and trade secrets of HBO & Company and its Subsidiaries ("HBOC") and are intended solely for the educational purpose of this Provider Bulletin only. The Material may not be used, distributed, duplicated, or otherwise disseminated without the express written consent of HBOC.]

The following information has been provided to explain some of the guidelines used to create the additional commercial edits used by Medicare Part B. For further information on additional commercial edits, see page 13 of the September/October 1998 Medicare B Update!

Mutually Exclusive Denials

Definition

Mutually exclusive edits relate to procedures that:

Cannot reasonably be done in the same session

Represent two methods of performing the same service

Represent medically impossible or/improbable code combinations

CPT describes as inappropriate coding of procedure combinations

Payment

Medicare allows the procedure with the lowest RVU for payment.

Examples

I. Open and laparoscopic approach reported to treat the same medical condition:

Code: 47605

Description: Cholecystectomy; with cholangiography

Code:56341

Description: Laparoscopy, surgical; cholecystectomy with cholangiography

Code: 47605

Description: represents an open cholecystectomy that is performed through an incision in the upper abdomen. Cholangiography is performed to examine the common duct for calculi and/or abnormalities.

Code: 56341

Description: represents a cholecystectomy performed through a laparoscope. A cholangiography to examine the common duct for calculi and/or abnormalities is included. These procedures represent different methods of accomplishing a cholecystectomy with cholangiography. Thus, to report both a laparoscopic and an open surgical approach to accomplish the same clinical outcome represents duplicity of efforts and overlapping of services. Therefore, Medicare denies procedure 47605 as mutually exclusive to procedure 56341 when submitted with the same date of service.

II. Initial and subsequent services provided on the same date of service:

Code: 70450

Description: Computerized axial tomography (CAT), head or brain; without contrast material

Code: 76380

Description: Computerized tomography, limited or localized follow-up study

Code:70450

Description: describes a CAT scan of the head or brain. If suspicious areas are identified from this scanning, with a contrast enhanced study, or if clinical findings direct attention to a specific region, thinner sections or special scanning techniques such as coronal reconstruction may be performed to provide additional diagnostic information.

Page 23

[The clinical edits and the accompanying rationale, if any, ("Material") contained herein are proprietary data and trade secrets of HBO & Company and its Subsidiaries ("HBOC") and are intended solely for the educational purpose of this Provider Bulletin only. The Material may not be used, distributed, duplicated, or otherwise disseminated without the express written consent of HBOC.]

Cont.

Code: 76380

Description: is used to report a limited, localized follow-up computerized tomographic study that is performed as a comparison

study to check progress after treatment, or to document changes that may occur over time.

Both procedures represent CAT scans performed at different times and for different indications. Procedure 70450 represents an initial CAT scan indicated to diagnose a medical condition pertaining to the head or brain. Procedure 76380 represents a subsequent CAT scan that provides follow-up information relating to the original diagnosis. These procedures describe initial and subsequent services that are not typically performed on the same day of service.

Therefore, Medicare denies procedure 76380 as mutually exclusive to procedure 70450 when submitted with the same date of service.

III. CPT Definition:

Code: 88300

Description: Level I - Surgical pathology, gross examination only

Code: 88309

Description: Level VI - Surgical pathology, gross and microscopic examination

Procedure 88300 is used to report gross examination of a surgically obtained specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination.

Procedure 88309 is used to report a surgical pathology procedure performed on a specimens listed as Level VI, requiring both gross and microscopic examination as well as complex dissection in order to accurately identify the specimen.

Both procedures include gross examination of a given specimen.

Procedure 88300 states that the specimen is analyzed by means of gross examination only, implying that no further modalities need to be utilized to identify the specimen. Procedure 88309 includes gross and microscopic examination of the appropriate specimen that may be necessary to establish a definitive diagnosis. Thus, to report both procedures to accomplish the same clinical outcome on the same day of service represents a duplication of efforts and overlapping of services.

Therefore, Medicare denies procedure 88309 as mutually exclusive to procedure 88300 when submitted with the same date of service.

Component Edit Denials

Definition

Component edits relate to procedures that are:

Included as part of a more extensive procedure Specified as "separate procedures" by CPT Defined in CPT guidelines Misuse of column 2 code with column 1 code

Payment

Medicare allows the procedure with the higher RVU for payment.

Examples

I. More Extensive Procedure:

Code: 35474

Description: Transluminal balloon angioplasty, percutaneous;
femoral-popliteal

Code: 35493

Description: Transluminal peripheral atherectomy, percutaneous;
femoral-popliteal

Procedure 35474 is used to report percutaneous transluminal balloon angioplasty of the femoral-popliteal artery or vein. A catheter is placed percutaneously and advanced to the area of stenosis under fluoroscopic guidance. A guide wire is passed through the catheter and manipulated through the narrowing of the artery or vein. A balloon tip catheter replaces the introducer and is inflated to dilate the vessel.

Procedure 35493 is used to report percutaneous transluminal atherectomy of the femoral-popliteal artery or vein. A catheter is placed percutaneously and advanced to the area of stenosis under fluoroscopic guidance. A guide wire is passed through the catheter and manipulated through the narrowing of the artery or vein. A catheter with an atherectomy device replaces the introducer and removes the stenotic tissue from the vessel. Surgical treatment to reestablish patency of occluded arteries or veins may be accomplished by percutaneous transluminal atherectomy and/or balloon angioplasty depending on the nature of the occlusion. During the performance of an atherectomy, it may be necessary to dilate other stenotic areas. This is accomplished by replacing the atherectomy device with a balloon tip catheter. Thus, balloon angioplasty, if necessary, is considered clinically integral to the successful outcome of the primary atherectomy procedure.

Therefore, Medicare denies procedure 35474 as a component of procedure 35493 when performed during the same operative session.

II. Separate Procedure:

Code: 49505

Description: Repair initial inguinal hernia, age 5 years or over;
reducible

Code: 55520

Description: Excision of lesion of spermatic cord (separate
procedure)

Procedure 49505 is used to report the surgical repair of a reducible inguinal hernia in a child older than 5 years. This surgical repair is accomplished through an inguinal incision. Once the hernia sac is identified, it is either excised or reduced through the area of weakness. During a direct hernia repair, the "floor" of the inguinal canal is either repaired or replaced with a mesh patch

Page 24

[The clinical edits and the accompanying rationale, if any,
("Material") contained herein are proprietary data and trade

secrets of HBO & Company and its Subsidiaries ("HBOC") and are intended solely for the educational purpose of this Provider Bulletin only. The Material may not be used, distributed, duplicated, or otherwise disseminated without the express written consent of HBOC.]

cont.

Procedure 55520 is used to report the excision of a lesion of the spermatic cord. This can be accomplished by a transverse incision in the scrotum in older children. However, in adults an inguinal approach is usually used.

While performing an inguinal hernia repair, the surgeon makes an incision in the groin and dissects tissue to expose the hernia sac, internal oblique muscle and the spermatic cord that runs beside it. At the time of the hernia repair, any lesions identified on the spermatic cord can also be excised. Thus, excision of a spermatic cord lesion is considered a component of the comprehensive hernia repair procedure.

Therefore, Medicare denies procedure 55520 as a component of procedure 49505 when performed during the same operative session.

III. CPT Definition:

Code: 40490

Description: Biopsy of lip

Code: 88304

Description: Level III - surgical pathology, gross and microscopic examination

Procedure 40490 is used to report biopsy of a lesion on the lip. An incision is made in the lip and a portion of the lesion as well as some normal tissue is removed. This procedure is commonly performed to diagnose malignancies of the lip.

Procedure 88304 is used to report surgical pathology of a defined specimen as listed as a Level III specimen. This includes gross and microscopic examination and diagnosis of presumptively abnormal tissue removed from a patient.

CPT provides specific guidelines for the use of surgical pathology procedure codes. Pathologic examination of tissue as described in procedure 88304 does not correspond with the lip biopsy specimen obtained during procedure 40490. Thus the reporting of these two procedures with the same date of service is inappropriate.

Therefore, Medicare denies procedure 88304 when submitted with procedure 40490 with the same date of service.

IV. Misuse Of Column 2 Code With Column 1 Code:

Code: 20605

Description: Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (e.g., temporomandibular, acromioclavicle, wrist, elbow or ankle, olecranon bursa)

Code: 76001

Description: Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)

Procedure 20605 describes arthrocentesis that involves aspiration of fluid or injection of medication into an intermediate joint, bursa or ganglion cyst in joint locations such as the temporomandibular, wrist, elbow or ankle. The physician inserts a needle of the appropriate size and length into the affected joint and aspirates fluid with a syringe. If a medication is to be injected, this is easily performed through the same needle by switching syringes. This procedure is indicated for diagnostic or therapeutic purposes.

Procedure 76001 is used to report the use of fluoroscopy by a physician who assists a non-radiologic physician in the performance of a procedure. The fluoroscopic assistance requires more than one hour of the radiologist's time.

Typically, a general or orthopedic surgeon performs an arthrocentesis of an intermediate joint, bursa or ganglion cyst. This procedure usually does not require fluoroscopy.

Additionally, procedure 76001 describes fluoroscopy performed by a radiologist who is providing assistance to a surgeon or other non-radiologic physician who is performing a diagnostic or therapeutic procedure. Since the radiologist is generally not performing both procedures, reporting of both procedures by the same provider is inappropriate.

Therefore, Medicare denies procedure 76001 when submitted with procedure 20605 with the same date of service.

Applicability Of Modifiers

The rationale for each code combination is based on the interpretation of the individual codes as described by its nomenclature. However, according to the CPT manual, in those instances, where the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code", an applicable modifier should be attached to the relevant code. Such modifiers are those that add specificity to the services provided (e.g., anatomic differences, such as left/right or different site of procedure) or explain the circumstances under which one of the services was provided (e.g., at a later encounter on the same day.)

HCFA believes that modifiers are inherent part of the HCPCS. Therefore, each code combination in the commercial edits has been evaluated and a determination made as to whether or not the furnishing of the two procedures could appropriately be performed and explained by the use of a modifier. Code combinations that are correctly coded are not subject to automatic denials. Thus, practitioners are encouraged to use an appropriate modifier whenever documentation in the medical record would support the use of that modifier.

A comprehensive article regarding "incident to" was originally published in the March/April 1997 Medicare Part B Update! Subsequently, two additional articles were published - in the May/June 1998 Update! (page 14) and in the December 1998 HCPCS Special Issue Update! (page 40). These articles have generated some questions around what services fall under "incident to." As a result, we are reprinting the March/April 1997 article. We are also including additional information regarding "incident to" services rendered in a Skilled Nursing Facility (SNF) that has transitioned to the Prospective Payment System (PPS).

There are many important points in this article. Please keep the following in mind:

The lists of procedure codes in the articles referenced above were not all inclusive; provided all incident to requirements are met, virtually any service (evaluation and management service, diagnostic test, or even a minor surgical procedure) could be rendered incident to a physician's service.

Consolidated billing does not permit a physician to bill for any service in a facility unless the physician personally performs the service.

Coverage Under the "Incident to" Guidelines
Medicare Part B allows coverage for services and supplies furnished by a physician's personnel when they are furnished incident to the physician's professional services. To be covered incident to the services of a physician, the services and supplies must meet the following requirements:

The services/supplies are an integral, although incidental, part of the physician's professional services.

The services/supplies are of a type that are commonly furnished in a physician's office or clinic.

The services/supplies are furnished under the physician's direct personal supervision.

The services/supplies are furnished by an individual who qualifies as an employee of the physician.

Services/supplies which are furnished as incident to a physician's service may be billed as if the physician personally performed the service. The requirements for the "incident to" provision are outlined in detail as follows:

Incident to a Physician's Professional Services
Incident to a physician's professional services means that the services/supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury.

This does not mean, however, that the service of the physician's employee must be incident to the actual rendition of a personal service by the physician. Such a service/supply could be

considered to be "incident to" when furnished during the course of treatment of an illness/injury where the physician performs an initial service and subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment.

Commonly Furnished in Physicians' Offices

Services and supplies commonly furnished in physicians' offices are covered under the "incident to" provision. Where supplies are clearly of a type a physician is not expected to have on hand in the office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the "incident to" provision.

Direct Personal Supervision

Coverage of service/supplies incident to the professional services of a physician is limited to situations in which there is direct personal physician supervision. This applies to services of auxiliary personnel employed by the physician and working under his/her supervision (e.g., nurses, technicians, therapists, other aides, etc.). Thus, where a physician employs auxiliary personnel to assist in rendering services, the services of such personnel are considered incident to the physician's services if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct personal supervision by the physician.

Direct personal supervision in the office setting does not mean that the physician must be present in the same room with the aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

Employment

To be considered an employee, the nonphysician performing the services may be a part-time, full-time, or leased employee of the supervising physician, group practice, or legal entity that employs the physician who provides direct personal supervision. A leased employee is a nonphysician working under a written employee leasing agreement which provides that:

The nonphysician, although employed by the leasing company or working as an independent contractor, provides services as the leased employee of the physician or other entity; and
The physician or other entity exercises control over all actions taken by the leased employee with regard to the rendering of medical services to the same extent as the physician or other entity would exercise such control if the leased employee were directly employed by the physician or other entity.

Page 26

Services provided by auxiliary personnel not in the employ (either direct or leased) of the physician, group or other entity, even if provided on the physician's order or included in the physician's bill are not covered as incident to the physician's services.

Services of Nonphysician Practitioners

In addition to the coverage of services by nonphysician personnel (e.g., nurses, technicians, etc.), a physician may also have the services of certain nonphysician practitioners (e.g., physician assistants, nurse practitioners, clinical psychologists, etc.) covered as services incident to a physician's professional services.

Services performed by these nonphysician practitioners incident to a physician's professional services include not only services ordinarily furnished by a physician's office staff, but also services ordinarily performed by the physician (e.g., minor surgery, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition). However, the nonphysician practitioner must be licensed or certified to provide such services and the services must meet all the requirements under the "incident to" provision (i.e., direct supervision, incident to the physician's services, etc.).

A nonphysician practitioner, such as a physician assistant or nurse practitioner, may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without direct physician supervision and have the services covered by Medicare as a nonphysician practitioner's service. However, in order to have that same service covered as incident to a physician's service, it must be performed under the direct personal supervision of the physician as an incidental part of the physician's personal in-office service. This does not mean that each occasion of an incidental service by the nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her active participation in and management of the course of treatment. In addition, the physician must be in the office suite and immediately available to render assistance during the time the nonphysician practitioner is furnishing services which are incident to the physician's services.

Services in a Clinic

Services and supplies incident to a physician's service in a physician directed clinic or group are generally the same as a physician in independent practice.

A physician directed clinic is one where:

A physician or a number of physicians is present to perform medical services at all times the clinic is open;

Each patient is under the care of a clinic physician; and

The nonphysician services are under direct medical supervision.

In physician directed clinics or groups, direct personal physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In

this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by nonphysician personnel are covered even though they are performed in another department of the clinic as long as there is direct physician supervision in that department.

Page 27

HCPCS Codes

1999 Pricing for Radionuclide Material

The following list provides the procedure code, descriptor, and Medicare Part B allowance for radionuclide materials for 1999. Note that "IC" means individual consideration.

Code: A4641
Allowance: \$26.57
Radionuclide Materials: ACD Solution, per 10 ml. vial

Code: A4641
Allowance: \$203.63
Radionuclide Materials: Co-57/Co-58, Cobalt Cyanocobalamin, combined study, Phase 1-AND-2 (SCHILLING TEST KIT, DICOPAC)

Code: A4641
Allowance: \$2.02
Radionuclide Materials: Cr-51, Sodium Chromate, per uCi

Code: A4641
Allowance: IC
Radionuclide Materials: I-125 Iodine Human Serum Albumin for Plasma Volume, up to 10 uCi dose (I-125 HSA)

Code: A4641
Allowance: \$5.45
Radionuclide Materials: I-131 Sodium Iodine solution (therapeutic), each additional mCi (IODOTOPE, Therapeutic solution)

Code: A4641
Allowance: IC
Radionuclide Materials: In-111 Indium Oxyquinoline abeled Platelets, per study, up to 500 uCi (In-111 OXINE)

Code: A4641

Allowance: \$385.00

Radionuclide Materials: In-111 Indium Oxyquinoline Labeled WBCs,
per study, up to 550 uCi (OXINE LABELED LEUKOCYTES)

Code: A4641

Allowance: \$354.76

Radionuclide Materials: In-111 Indium Pentetate, per study, up to
1.5 mCi (DTPA)

Code: A4641

Allowance: IC

Radionuclide Materials: In-111 Indium Pentetreotide, up to 6 mCi
(Octreoscan)

Code: A4641

Allowance: \$401.50

Radionuclide Materials: Tc-99m Technetium, Exametazime Labeled
WBCs, per study, up to 20 mCi (HMPAO)

Code: A4641

Allowance: IC

Radionuclide Materials: Tc-99m Technetium Bicisate, per 10 mCi
(NEUROLITE)

Code: A4641

Allowance: IC

Radionuclide Materials: Tc-99m Technetium Succimer, up to 10 mCi
(DMSA)

Code: A4641

Allowance: IC

Radionuclide Materials: Tc-99m Technetium Teboroxime, up to 40
mCi (CARDIOTEC)

Code: A4641

Allowance: IC

Radionuclide Materials: Tc-99m Technetium, Albumin Colloid
labeled WBC's, per study, up to 10 uCi does (I-125 HSA)

Code: A4641

Allowance: IC

Radionuclide Materials: Tc-99m Technetium, Albumin Colloid, up to
10 mCi

Code: A4641

Allowance: \$45.54

Radionuclide Materials: Tc-99m Technetium, Human Serum Albumin,
up to 30 mCi (HSA)

Code: A4641
Allowance: \$13.81
Radionuclide Materials: Tc-99m Technetium, Oxidronate, up to 30 mCi (HDP)

Code: A4641
Allowance: \$30.25
Radionuclide Materials: Tc-99m Technetium, Pentetate, Aerosol, up to 50 mCi (DTPA)

Code: A4642
Allowance: \$1,003.75
Radionuclide Materials: Supply of Satumomab Pendetide, radiopharmaceutical diagnostic imaging agent, per dose [In-111 Indium Satumomab Pendetide, per study, up to 5 mCi (In-111 ONCOSCINT, ONCOSCINT CR/OV)

Code: A9500
Allowance: \$88.00
Radionuclide Materials: Supply of Technetium Tc Sestamibi, radiopharmaceutical diagnostic imaging agent, per dose (CARDIOLITE, MIBI)

Code: A9502
Allowance: \$88.00
Radionuclide Materials: Supply of radiopharmaceutical diagnostic imaging agent, technetium TC 99M tetrofosmin, per unit dose

Code: A9505
Allowance: \$27.50
Radionuclide Materials: Supply of Thallous Chloride TI201, radiopharmaceutical diagnostic imaging agent, per mCi (THALLIUM TI-201)

Code: A9507
Allowance: IC
Radionuclide Materials: Supply of Radiopharmaceutical diagnostic imaging agent, indium in 11 capromab pendetide, per dose

Code: A9600
Allowance: \$706.80
Radionuclide Materials: Injection, Strontium-89 Chloride, per 10 ml. [In-89 Strontium Chloride (therapeutic), 10 ml. vial-4 mCi (METASTRON)]

Code: A9605
Allowance: IC

Radionuclide Materials: supply of therapeutic
radiopharmaceutical, samarium SM 153 Lexidronamn, 50 mCi

Code: W4125
Allowance: \$26.53
Radionuclide Materials: Tc-99m Technetium, Per technetate, up to
30 mCi

Code: W4128
Allowance: \$0.33
Radionuclide Materials: I-131 Iodohippurate Sodium, per uCi
(HIP PURAN)

Code: W4130
Allowance: \$29.85
Radionuclide Materials: Tc-99m Technetium, Mebrofenin, up to 10
mCi (CHOLETEC)

Code: W4131
Allowance: \$107.25
Radionuclide Materials: Tc-99m Technetium, Mertiatide, up to 20
mCi (MAG 3, TECHNESCAN MAG 3)

Code: W4132
Allowance: \$63.87
Radionuclide Materials: Tc-99m Technetium, Labeled Red Blood
Cells (RBCs), up to 30 mCi (LABELED RBCs)

Code: W4133
Allowance: \$121.69
Radionuclide Materials: Co-57 Cobalt Cyanocobalamin, Phase 1-OR-2
(SHILLING TEST KIT, COBATOPE-57, RUBRATOPE-57)

Code: W4134
Allowance: \$22.57
Radionuclide Materials: Tc-99m Technetium, Pyrophosphate, up
to 30 mCi (PYP, PHOSPHOTEC, PYROLITE, SODIUM PYROPHOSPHATE)

Code: W4136
Allowance: \$13.97
Radionuclide Materials: Xe-133, Xenon, per 10 mCi

Code: W4139
Allowance: \$19.80
Radionuclide Materials: Tc-99m Technetium Pentetate, up to 30 mCi
(PENTETATE DTPA, AN-DTPA, TECHNPLEX, DTPA, TECHNESCAN DTPA)

Code: W4140
Allowance: \$21.81
Radionuclide Materials: I-123 Sodium Iodide capsule, per 100 uCi
(SODIUM IODINE capsules)

Code: W4141
Allowance: \$12.90
Radionuclide Materials: I-131 Sodium Iodide capsule (diagnostic),
up to 100 uCi (IODOTOPE, Diagnostic)

Code: W4142
Allowance: \$121.44
Radionuclide Materials: I-131 Sodium Iodine capsule
(therapeutic), up to 6 mCi (IODOTOPETherapeutic)

Code: W4143
Allowance: \$17.86
Radionuclide Materials: I-131 Sodium Iodide capsule
(therapeutic), each additional mCi (IODOTOPE, Therapeutic)

Code: W4144
Allowance: \$13.75
Radionuclide Materials: GA-67, Gallium Citrate, per NCI (NEOSCAN)

Code: W4147
Allowance: \$115.56
Radionuclide Materials: I-131 Sodium Iodide solution
(therapeutic), up to 6 mCi (IODOTOPETherapeutic solution)

Code: W4149
Allowance: \$13.86
Radionuclide Materials: Tc-99m Technetium, Gluceptate, up to 30
mCi (GLUCO, GLUCOSCAN)

Code: W4150
Allowance: \$19.80
Radionuclide Materials: Tc-99m Technetium, Macroaggregated
Albumin, up to 10 mCi (PULMONITE, MAA)

Code: W4151
Allowance: \$18.15
Radionuclide Materials: Tc-99m Technetium, Medronate, up to 30
mCi (AN-MDP, OSTEOLITEMDPTECHNESCAN MDP)

Code: W4153
Allowance: \$20.35
Radionuclide Materials: Tc-99m Technetium, Sulfur Colloid, up to
10 mCi (AN-SULFUR COLLOID, SC, TESULOID)

Code: W4156

Allowance: \$28.60

Radionuclide Materials: Tc-99m Technetium, Disofenin, up to 10 mCi (HEPATOLITEHIDA)

Code: W4158

Allowance: \$275.00

Radionuclide Materials: Tc-99m Technetium, Sulfur Colloid, up to 10 mCi (an-sulfur colloid, SC, Tesuloid)

Code: 79900

Allowance: \$1,430.06

Radionuclide Materials: P-32 Chromic Phosphate (therapeutic), per 15 mCi(P-32 COLLOID)

Code: 79900

Allowance: \$370.65

Radionuclide Materials: P-32 Chromic Phosphate (therapeutic), per 5 mCi(P-32 SODIUM)

Page 28

G0001, P9603, P9604: Collection of Specimens and Travel Allowance Information concerning per mileage and flat rate per trip fees for collection of specimens (P9603, P9604) and travel allowance and routine venipuncture for collection of specimens (G0001) was provided in the September/October 1998 Medicare Part B Update! (pg. 27) and in the January/February 1999 Update! (pg. 9). As a further explanation regarding national coverage policies, venipuncture/travel is covered by Medicare only when: the laboratory test is a covered service. the venipuncture/travel is by the phlebotomist or technician who drew the blood (courier services are not covered), and specimen collection and travel are only paid for medically necessary venipuncture or catheterization. Medicare will conduct post-payment reviews of venipuncture/travel allowance claims to ensure that no inappropriate payments have been made.

Q0163-Q0181 - Oral Anti-Emetic Drugs
As part of the Balanced Budget Act of 1997, Medicare provides coverage for oral anti-emetic (anti-nausea) drugs when used as a full therapeutic replacement for intravenous anti-emetic drugs as part of a cancer chemotherapeutic regimen. The oral anti-emetic drugs must be administered either by a physician or under the orders of a physician. Suppliers can dispense these oral anti-emetic drugs through a physician's prescription. Refer to pages 34 and 35 of the May/June 1998 Medicare B Update! for the established claim submission and billing guidelines.

J1260: Dolasetron Mesylate

The above referenced code is new for date of services on or after January 1, 1999. The code descriptor is "injection, dolasetron mesylate, 1 mg." When this drug is used for the prevention of nausea and vomiting associated with cancer chemotherapy, it is dispensed in 100 mg vials. These are single-use vials; thus, the number billed field on the claim should reflect the total number of mgs based on the number of vials used. For example, if the provider is using two vials, 200 should be billed.

Additional Changes to Injectable Drugs Fees

The table on the following two pages provides the procedure codes, descriptors, and associated fees for injectable drugs that have had recent pricing changes. These fees supersede those provided in the 1999 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule (pg. 2-11), the 1999 HCPCS Special Issue Update! (pg. 89), and the January/February Medicare Part B Update! (pg.6).

The table containing changes to injectable drugs fees can be found on the following two pages.

Page 29

Injectable Drugs Fees:

CODE: J0530

DESCRIPTION: Injection, penicillin G benzathine and penicillin G procaine up to 600,000 units

PAR ALLOWANCE: \$6.12

NON-PAR ALLOWANCE: \$5.81

LIMITING CHARGE: \$6.69

CODE: J0540

DESCRIPTION: Injection, penicillin G benzathine and penicillin G procaine, up to 1, 200,000 units

PAR ALLOWANCE: \$12.24

NON-PAR ALLOWANCE: \$11.63

LIMITING CHARGE: \$13.37

CODE: J0550

DESCRIPTION: Injection, penicillin G benzathine and penicillin G procaine, up to 2, 400, 000 units

PAR ALLOWANCE: \$25.31

NON-PAR ALLOWANCE: \$24.04

LIMITING CHARGE: \$27.65

CODE: J0635

DESCRIPTION: Injection, calcitriol, 1 mcg ample

PAR ALLOWANCE: \$12.57

NON-PAR ALLOWANCE: \$11.94

LIMITING CHARGE: \$13.73

CODE: J0670

DESCRIPTION: Injection, mepivacaine HCL, per 10 ml

PAR ALLOWANCE: \$44.25

NON-PAR ALLOWANCE: \$42.04

LIMITING CHARGE: \$48.34

CODE: J1055

DESCRIPTION: Injection, medroxyprogesterone acetate for
contraceptive use, 150 mg

PAR ALLOWANCE: \$42.13

NON-PAR ALLOWANCE: \$40.02

LIMITING CHARGE: \$46.03

CODE: J1200

DESCRIPTION: Injection, diphenhydramine HCL, up to 50 mg

PAR ALLOWANCE: \$0.89

NON-PAR ALLOWANCE: \$0.85

LIMITING CHARGE: \$0.97

CODE: J1650

DESCRIPTION: Injection, enoxaparin sodium, 30 mg

PAR ALLOWANCE: \$16.77

NON-PAR ALLOWANCE: \$15.93

LIMITING CHARGE: \$18.32

CODE: J1885

DESCRIPTION: Injection, ketorolac tromethamine, per 15 mg

PAR ALLOWANCE: \$7.51

NON-PAR ALLOWANCE: \$7.13

LIMITING CHARGE: \$8.20

CODE: J1950

DESCRIPTION: Injection, leuprolide acetate (for depot
suspension) per 3.75 mg

PAR ALLOWANCE: \$460.90

NON-PAR ALLOWANCE: \$437.86

LIMITING CHARGE: \$503.53

CODE: J2210

DESCRIPTION: Injection, methylergonovine maleate, up to 0.2 mg

PAR ALLOWANCE: \$3.22

NON-PAR ALLOWANCE: \$3.06

LIMITING CHARGE: \$3.52

CODE: J2550

DESCRIPTION: Injection, promethazine HCL, up to 50 mg

PAR ALLOWANCE: \$0.99

NON-PAR ALLOWANCE: \$0.94
LIMITING CHARGE: \$1.08

CODE: J2597
DESCRIPTION: Injection, desmopressin acetate, per 1 mcg
PAR ALLOWANCE: \$6.30
NON-PAR ALLOWANCE: \$5.99
LIMITING CHARGE: \$6.88

CODE: J2700
DESCRIPTION: Injection, ocacillin sodium, up to 250 mg
PAR ALLOWANCE: \$2.70
NON-PAR ALLOWANCE: \$2.57
LIMITING CHARGE: \$2.95

CODE: J3120
DESCRIPTION: Injection, testosterone enanthate, up to 100 mg
PAR ALLOWANCE: \$1.23
NON-PAR ALLOWANCE: \$1.17
LIMITING CHARGE: \$1.34

CODE: J3130
DESCRIPTION: Injection, testosterone enanthate, up to 200 mg
PAR ALLOWANCE: \$2.47
NON-PAR ALLOWANCE: \$2.35
LIMITING CHARGE: \$2.70

CODE: J3150
DESCRIPTION: Injection, testosterone propionate, up to 100 mg
PAR ALLOWANCE: \$1.65
NON-PAR ALLOWANCE: \$1.57
LIMITING CHARGE: \$1.80

CODE: J3250
DESCRIPTION: Injection, trimethobenzamide HCL, up to 200 mg
PAR ALLOWANCE: \$1.29
NON-PAR ALLOWANCE: \$1.23
LIMITING CHARGE: \$1.41

CODE: J3305
DESCRIPTION: Injection, trimetrexate glucuronate, per 25 mg eff
09/08/98
PAR ALLOWANCE: \$62.70
NON-PAR ALLOWANCE: \$59.57
LIMITING CHARGE: \$68.50

CODE: J7315
DESCRIPTION: Sodium Hyaluronate, 20 mg, for intra articulator
injection

PAR ALLOWANCE: \$120.76
NON-PAR ALLOWANCE: \$114.72
LIMITING CHARGE: \$131.93

CODE: J7320
DESCRIPTION: Hylan G-F 20, 16 mg, for intra articulator injection
PAR ALLOWANCE: \$196.23
NON-PAR ALLOWANCE: \$186.42
LIMITING CHARGE: \$214.38

CODE: J7513
DESCRIPTION: Daclizumab, parenteral, 25 mg
PAR ALLOWANCE: \$397.29
NON-PAR ALLOWANCE: \$377.43
LIMITING CHARGE: \$434.04

CODE: J9190
DESCRIPTION: Fluorouracil, 500 mg
PAR ALLOWANCE: \$2.52
NON-PAR ALLOWANCE: \$2.39
LIMITING CHARGE: \$2.75

CODE: J9206
DESCRIPTION: Irinotecan 20 mg
PAR ALLOWANCE: \$104.86
NON-PAR ALLOWANCE: \$99.62
LIMITING CHARGE: \$114.56

CODE: J9209
DESCRIPTION: Mesna, 200 mg
PAR ALLOWANCE: \$33.11
NON-PAR ALLOWANCE: \$31.45
LIMITING CHARGE: \$36.17

CODE: J9211
DESCRIPTION: Idarubicin HCL, 5 mg
PAR ALLOWANCE: \$276.41
NON-PAR ALLOWANCE: \$262.59
LIMITING CHARGE: \$301.98

CODE: J9213
DESCRIPTION: Interferon alfa-2A, recombinant, 3 million units
PAR ALLOWANCE: \$33.05
NON-PAR ALLOWANCE: \$31.40
LIMITING CHARGE: \$36.11

CODE: Q0136
DESCRIPTION: Injection Epoetin Alpha, (for non ESRD use), per
1000 units

PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9920
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 20 or less
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9921
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 21
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9922
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 22
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9923
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 23
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9924
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 24
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9925
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 25
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9926
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 26
PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9927
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
27
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9928
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
28
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9929
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
29
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9930
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
30
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9931
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
31
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9932
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
32
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83
LIMITING CHARGE: \$12.45

CODE: Q9933
DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of
33
PAR ALLOWANCE: \$11.40
NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9934

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 34

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9935

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 35

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9936

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 36

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9937

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 37

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9938

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 38

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9939

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 39

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: Q9940

DESCRIPTION: Injection of EPO, per 1,000 units, at patient HCT of 40 and/or above

PAR ALLOWANCE: \$11.40

NON-PAR ALLOWANCE: \$10.83

LIMITING CHARGE: \$12.45

CODE: 90724
DESCRIPTION: Immunization, Active, Influenza Virus Vaccine - will
be deleted 04/01/99
PAR ALLOWANCE: \$4.74
NON-PAR ALLOWANCE: \$4.50
LIMITING CHARGE: \$5.18

CODE: 90726
DESCRIPTION: Immunization, Active, Rabies Vaccine - will be
deleted 04/01/99
PAR ALLOWANCE: \$121.93
NON-PAR ALLOWANCE: \$115.83
LIMITING CHARGE: \$133.21

Page 30

First Quarter Changes to the Medicare Physician Fee Schedule
The following revisions have been made to the Medicare Physician
Fee Schedule (MPFS), effective for 1999 services processed on or
after March 29, 1999.

Procedure Code: 31623, 31624, 31643
Change: The multiple surgery status has been revised. These codes
were listed in the December 1998 Medicare Part B Special Issue
HCPCS Update! on Appendix V (page 50). Appendix V indicates
procedures that are subject to "standard" multiple surgery
guidelines. These codes should be moved to Appendix XV - Base
Endoscopies and Related Procedures (page 68). All three should be
listed as related procedures to the base procedure 31622.

Procedure Code: 38724
Change: The bilateral surgery status has been revised. This code
was not listed in the HCPCS Update!, since the bilateral status
at that time was that the concept of bilateral surgery was not
applicable. Procedure code 38724 should now be added to Appendix
XIII - Procedures Which Are Allowed at 150 Percent When Performed
Bilaterally (page 68).

Procedure Code: 77600-77620
Change: The global surgery period has been revised. This code
range was listed in the HCPCS Update! on Appendix 1 - Procedures
With 90 Follow-Up Days (page 42). This has been changed to zero
follow-up days, therefore, these procedures should be added to
Appendix III (page 46).

45305, 45385 - Endoscopic Biopsy, Polyp and Tumor Removals
Endoscopic procedure codes involving multiple biopsies and or
removal of multiple polyps or tumors must be billed as a single
procedure since payment cannot be made for each biopsy or lesion,
or for each polyp and tumor removal. There are many of these

procedure codes under the HCFA common procedure coding system that this guideline applies. One example of this procedure is:

45305

Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) with biopsy, single or multiple

Medicare will allow this procedure code only once on a given day, regardless how many biopsies were performed. If this procedure code is billed with modifier 51, the service will be denied as a bundled service.

Page 31

Revision to UPIN Requirements when Billing for a Diagnostic Mammography Converted from a Screening Mammography

An article on page 28 of the September/October 1998 edition of the Medicare B Update! discussed guidelines for billing claims for diagnostic mammographies converted from screening mammographies. This situation occurs when a radiologist orders additional films based on the findings of the screening mammography.

The UPIN information previously published is no longer correct. When a radiologist orders additional films based on the findings of the screening mammography, the radiologist should enter the treating (or referring) physician's UPIN on the claim. If the UPIN is not included on the claim, the claim will be returned as unprocessable.

The radiologist is expected to report the patient's condition back to the treating physician. This could occur at the same time that the radiologist obtains the treating physician's UPIN.

Contractor Review of E&M Services Begins March 1999

Beginning in March 1999, this Medicare Part B carrier will conduct prepayment reviews on certain Evaluation and Management (E&M) services. This corresponds with the conclusion of the Health Care Financing Administration's random audit of evaluation and management services. The purpose of these pre-payment reviews will be to ensure the correct use of E&M procedure codes among all providers who bill for those services and to ensure services rendered are medically necessary. Medicare Part B cannot release to any provider the codes that will be affected by the review. When a provider's service or services are selected for prepayment review, Medicare Part B will send a letter to the provider to request supporting documentation. Please be sure to send this supporting documentation immediately; as usual, claims will be denied if documentation is not received in a timely manner. At this time, do not send documentation for E&M claims unless it is requested.

E&M documentation guidelines were published in the September 1997 Medicare B Update Special Issue: Documentation Guidelines for Evaluation and Management Services.

Advance Notice Information

Advance notice and waiver of liability are applicable to E&M services. See "Advance Notice Requirement" on page 4 for complete information about advance notice and waiver of liability.

Page 32

Medicare Physician Fee Schedule (MPFS): Facility Pricing Rule
The December 1998 HCPCS Special Issue Update! provided information concerning the changes effective January 1, 1999, for the site of service reduction (SOS) rule (page 41). For 1999, SOS is replaced with a new "facility pricing" rule. The affected procedure codes are in Appendix XXIII of that publication. Since that article was provided, some confusion has been noted regarding facility pricing on many of the applicable services. Some providers have pointed out that the fees are not reduced, however, their remittance advice has a message that indicates a reduction in the fee schedule amount has taken place. The number of procedure codes subject to the new rule has been greatly expanded, but the fees are not necessarily reduced.

Amendments to the Social Security Act required the Health Care Financing Administration (HCFA) to develop a new methodology for determining a specific component used in calculating the Medicare Physician Fee Schedule (MPFS). This component is known as the resource-based practice expense relative value unit. HCFA was directed to change its reimbursement calculation method from its previous charge-based practice expense system to a resource-based method. In developing the new RVUs data set, HCFA was required to consider staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically directed that implementation of the new system be done in a budget neutral manner.

As part of the resource based practice expense initiative, HCFA discontinued the site of service policy and replaced it with a new method of calculating reimbursement rates for certain procedures. The old policy systematically reduced the physician services' practice expense RVU by fifty percent (50%) for every applicable procedure. The new resource based calculation policy also provides two different levels of practice expense RVUs for each applicable procedure code. However, under the new policy, the difference between the non-facility and facility RVUs may be greater or lesser than 50%, and in some cases there is no difference at all.

The higher non-facility practice expense RVUs are generally used to calculate payments for services performed in a physician's office and for services furnished in the patient's home, a facility, or an institution (other than a hospital, skilled nursing facility, and ambulatory surgical center). For these services the physician typically bears the cost of all resources, such as labor, medical supplies and medical equipment associated with the procedure performed. Hence the higher RVU is designed to reflect the practice expense incurred by the physician.

The lower facility practice expense RVUs generally are used to calculate payments for services furnished to patients in a hospital, SNF, or ambulatory surgical center. For these services the physician typically does not bear the cost of the many

resources associated with the procedure performed, so the physician's practice expense level is lower. It was foreseen that the change in calculation methodology would significantly impact MPFS reimbursement rates. In response, the Balanced Budget Act (BBA) of 1997 authorized phasing in the new payment methodology over a four year period, starting January 1, 1999. Each year an additional 25% of the RVU will be calculated using the resource based data set. By the year 2002, 100% of the RVU value will be based upon the new methodology. Because of this phasing in, for a substantial number of procedure codes, there is no difference in the fee schedule amounts for facility and non-facility settings. Thus, when a provider receives the message that indicates a reduction in the fee schedule amount was applied, it sometimes means simply that facility pricing applies; it does not always mean less money. For some procedures, a reduction was applied, just as it previously was for SOS. Facility pricing was initiated so that Medicare can ensure that overhead expenses associated with mainly office settings are not included in payments made when services are performed in certain facilities (referenced in the December HCPCS Special Update!). In cases where it is inappropriate for these services to be performed in an office at all, no monetary reduction has taken place.

If providers have questions regarding whether specific procedure codes listed on Appendix XXIII in the HCPCS Update! have had a pricing reduction applied, they should refer to the 1999 Medicare Fee Schedule for Physicians and Non-Physician Practitioners booklet that was sent out in November. Procedures subject to facility pricing have two sets of fees - one for facility and one for non-facility, but in many cases the fees are the same.

Information concerning the methodology for developing resource-based practice expense RVUs was published as a proposed rule in May of 1998 and was open for comments for 90 days. The final rule was published in the November 2, 1998 Federal Register, on pages 58816-58849.

Page 33

Local and Focused Medical Review Policies

Table Of Contents

| | |
|--|----|
| Correction to Independent Physiological Laboratory (IPL) Policy | 33 |
| Billing for Optison | 33 |
| Viscosupplementation of the Knee | 34 |
| A9270: Noncoverage | 34 |
| E0782, E0783: Implantable Infusion Pumps | 38 |
| J0001: Self-Administered Drugs | 43 |
| J1950, J9217, J9218: Leuprolide Acetate | 44 |
| J9999: Antineoplastic Drugs (Formerly Off-Label Use of Chemotherapy Drugs) | 45 |
| Independent Diagnostic Testing Facility (IDTF) | 48 |
| 51725 Urodynamic Testing | 56 |
| 70450: Computerized Tomography | 57 |
| 90780-90799: Therapeutic Or Diagnostic | |

| | | |
|---|----|----|
| Injections/Infusions - Correction | 58 | |
| 90999: ESRD Laboratory Services and Diagnostic Services | | 59 |
| 93268: Billing of Patient Demand Single or Multiple | | |
| Event Recorder | 60 | |
| 93965, 93970, 93971: Non-Invasive Evaluation of | | |
| Extremity Veins - Correction | 60 | |
| 95860-95864: Needle Electromyography | 60 | |
| 99183: Hyperbaric Oxygen Therapy - Clarification | | 62 |
| Evaluation and Management Codes 99301-99303 | 6 | |

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 in bold type.

Sources of Information

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

***** Billing for Optison

Many providers have inquired as to the appropriate way to bill for Optison, a new cardiac ultrasound contrast agent, in addition to billing a cardiac ultrasound procedure. The reimbursement for Optison is already included in the reimbursement for cardiac ultrasound procedures. Therefore, Optison and/or the intravenous access for the administration of this drug is not to be separately billed.

Correction to Independent Physiological Laboratory (IPL) Policy
As a result of changes required by the 1999 HCPCS update, the policy for Independent Physiological Laboratory (IPL) was provided in the January/February 1999 issue of the Medicare Part B Update! (pages 65 - 66). The following is a correction to the "Documentation Requirements" section of the policy. The statement "The provider number of the physician interpreting a test performed by an Independent/Physiological Laboratory must be provided on the claim" was removed. Additionally, questions have been noted concerning an advance notice statement for this policy. The IPL policy itself does not have advance notice requirements, however, procedure codes that may be performed in an IPL may have such requirements in their individual policies. Providers should refer to the specific Local Medical Review Policy for specific procedure code requirements.

Viscosupplementation of the Knee

A Local Medical Review Policy article concerning viscosupplementation of the knee was published in the May/June 1998 Medicare Part B Update! (page 44). However, the descriptor for the covered diagnosis code should read: "715.96 Osteoarthritis, whether generalized or localized, lower leg." This is the only covered diagnosis for viscosupplementation of the knee.

A9270: Noncoverage

The purpose of these coding guidelines is to create a working list of medical services and procedures that are never covered by the Medicare program. Such services and procedures are always denied either because:

a national decision to noncover the service/procedure exists, or the service/procedure is included on the list of services determined by this contractor to be excluded from coverage.

The coding guidelines are developed under an iterative process and will be updated as national and local coverage decisions change.

Indications and Limitations of Coverage and/or Medical Necessity
A service or procedure on the "national noncoverage list" may be noncovered for a variety of reasons. It may be noncovered based on a specific exclusion contained in the Medicare law; for example, acupuncture; it may be viewed as not yet proven safe and effective and, therefore, not medically reasonable and necessary; or it may be a procedure that is always considered cosmetic in nature and is denied on that basis. The precise basis for a national decision to noncover a procedure may be found in references cited in this policy.

A service or procedure on the "local" list is always denied on the basis that we do not believe it is "medically reasonable and necessary." Our list of local medical review policy exclusions contains procedures that, for example, are:

experimental
not yet proven safe and effective
not yet approved by the FDA

It is important to note that the fact that a new service or procedure has been issued a CPT code or is FDA approved does not, in itself, make the procedure "medically reasonable and necessary." It is our policy that new services, procedures, drugs, or technology must be evaluated and approved either nationally or by our local medical review policy process before they are considered Medicare covered services.

Note: those procedures identified in bold type are effective for services processed on and after April 19, 1999.

HCPCS Codes

Local Noncoverage Decisions

Laboratory Procedures

82172:Apolipoprotein, each
86910:Blood typing, for paternity testing, per individual; ABO, Rh, and MN
86911:each additional antigen system
A9270*:BRCA1 and BRCA2
82523*:Collagen cross links, any method (Urinary Biochemical Assays for Bone Resorption)
89250-89261
Culture and fertilization of oocyte(s) and other artificial insemination procedures
88349:Electron microscopy: scanning
84999*:Lymphocyte mitogen response assays used to monitor the treatment of cancer
88000-88099:Necropsy (autopsy)
A9270*:Neuronal Thread Protein (NTP)
A9270*:In Vitro Chemosensitivity Assays
87270:Infectious agent antigen detection by direct fluorescent antibody technique; Chlamydia trachomatis
87470:Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique
87471:Bartonella henselae and Bartonella quintana, amplified probe technique
87472:Bartonella henselae and Bartonella quintana, quantification
87475:Borrelia burgdorferi, direct probe technique
87477:Borrelia burgdorferi, quantification
86618:Antibody; Borrelia burgdorferi (Lyme disease)
87480:Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87482:Candida species, quantification
86628:Antibody; Candida
87485:Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique
87487:Chlamydia pneumoniae, quantification
87492:Chlamydia trachomatis, quantification
86631:Antibody; Chlamydia

Page 35

87320:Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative multiple step method; Chlamydia trachomatis
87510:Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique
87511:Gardnerella vaginalis, amplified probe technique
87512:Gardnerella vaginalis, quantification
87515:hepatitis B virus, direct probe technique
87520:hepatitis C, direct probe technique
87522*:hepatitis C, quantification
87525:hepatitis G, direct probe technique
87526:hepatitis G, amplified probe technique
87527:hepatitis G, quantification
87531:Herpes virus-6, direct probe technique
87532:Herpes virus-6, amplified probe technique

87533:Herpes virus-6, quantification
87534:HIV-1, direct probe technique
87537:HIV-2, direct probe technique
87538:HIV-2, amplified probe technique
87539:HIV-2, quantification
87540:Legionella pneumophila, direct probe technique
87541:Legionella pneumophila, amplified probe technique
87542:Legionella pneumophila, quantification
87557:Mycobacteria tuberculosis, quantification
87562:Mycobacteria avium-intracellulare, quantification
87580:Mycoplasma pneumoniae, direct probe technique
87581:Mycoplasma pneumoniae, amplified probe technique
87582:Mycoplasma pneumoniae, quantification
87592:Neisseria gonorrhoeae, quantification
87620:papillomavirus, human, direct probe technique
87621:papillomavirus, human, amplified probe technique
87622:papillomavirus, human, quantification

Drugs and Biologicals

A9270*:Becaplermin (Regranex)
J3520:Edetate disodium, per 150 mg (chemical endarterectomy)
A9270:Muse
J3530:Nasal vaccine inhalation

Procedures

01990:Physiological support for harvesting of organs from brain-dead patients
01995:Regional I.V. administration of local anesthetic agent or other medication (upper or lower extremity)
11975:Insertion, implantable contraceptive capsules
11977:Removal with reinsertion, implantable contraceptive capsules
15820-15821:Blepharoplasty, lower lid
15824-15829:Rhytidectomy
15831-15839:Excision, excessive skin and subcutaneous tissue (including lipectomy)
15876-15879:Suction assisted lipectomy
17380:Electrolysis epilation, each 2 hour
43999^*:Gastric Electrical Stimulation
58321:Artificial insemination; intra-cervical
58322:Artificial insemination; intra-uterine
58323:Sperm washing for artificial insemination
58970:Follicle puncture for oocyte retrieval, any method
58974:Embryo transfer, intrauterine
58976:Gamete, zygote, or embryo intrafallopian transfer, any method
58999^*:Pap plus speculoscopy (PPS)
59012:Cordocentesis (intrauterine), any method
76499^*:MRI for use in measuring the blood flow, spectroscopy imaging of cortical bone and calcification, and procedures involving resolution of bone or calcification
92548*:Computerized dynamic posturography
92970*:Cardioassist-method of circulatory assist; internal
92997-92998:Percutaneous transluminal pulmonary artery balloon angioplasty

93720-93722*:Plethysmography, total body
93799*:Metaidobenzylguanidine (MIBG) imaging
95831:Muscle testing, manual (separate procedure); extremity
(excluding hand) or trunk, with report
95832:hand, with or without comparison with normal side
95833:total evaluation of body, excluding hands
95834:total evaluation of body, including hands
95999*:Biothesiometry
95999*:Current Perception Threshold Testing (CPT)
97799*:Low vision rehabilitation
99360:Stand-by anesthesia
A9270*:Autologous Chondrocyte Transplantation
A9270*:Meniscal Allograft Transplantation
A9270*:Cellular Therapy
A9270:High Voltage Pulsed Current (HVPC) Therapy
A9270*:Light reflecting rheography
A9270:Politzer Procedure
95806:Sleep Study unattended by a technologist
95999*:Surface electromyography
27599*:Tidal knee irrigation
A9270*:Epiluminescence microscopy
A9270*
Large and Small Bowel Transplants

Page 36

A9270*:Fiberoptic Endoscopy Evaluation of swallowing with sensory
testing (FEEST)
A9270*:ZStat flu Influenza Test Kits
A9270*:Matrix Pro Elect/Matrix Elect DT
A9270*:Epiduroscopy/Myeloscopy
A9270*:Insertable Loop Recorder
A9270*:Ultrasound Guided Sclerotherapy
A9270*:Gamma Knife for lesions outside the head
A9270*:OssaTron treatment
A9270*:The Canalith Repositioning Procedure
A9270*:Balloon Lacrimoplasty
A9270*:Shark Cartilage Injections
A9270*:Interstim Sacral Nerve Stimulation system (SNS)

National Noncoverage Decisions

Devices

33999*:Artificial hearts and related devices
A9270*:Intrapulmonary percussive ventilator for home use

Laboratory Procedures

80050:General Health Panel
86999*:Cytotoxic leukocyte tests for food allergies
88399*:Human tumor stem cell drug sensitivity assays

Drugs and Biologicals

J3570*:Laetrile (Amygdalin, Vit B17)

A4260*:Levonorgestral (contraceptive) implants system, including implants and supplies
J7140-J7180:Oral Medication
A9270:Oral Medication
J8499^:Oral Medication
J8499*^:Sublingually administered antigens

Procedures

97780-97781*:Acupuncture
93784-93790*:Ambulatory blood pressure monitoring
59899*^:Ambulatory home monitoring of uterine contractions
90908 (prior to 1/1/97): Biofeedback (psychiatric only)
53899*^:Bladder Stimulator
A9270*:Pelvic floor stimulator
A9270:Carbon Dioxide Therapy
A9270*:Cardiac output monitoring by electrical bioimpedance
A9270*:Cardiointegram (CIG) as an alternative to stress test or thallium stress test
A9270*:Carotid body resection to relieve pulmonary symptoms, including asthma
A9270*:Carotid sinus nerve stimulator for treatment of paroxysmal supraventricular tachycardia
A9270*:Chelation Therapy (EDTA) for treatment of arteriosclerosis
56805:Clitoroplasty for intersex state
69949*^:Cochleostomy with neurovascular transplant for Meniere's Disease
A9270*:Colonic irrigation
G0121:Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122:Colorectal cancer screening; barium enema
A9270:Cosmetic surgery
A9270*:Cryosurgery of the prostate
A9270*:Diathermy or ultrasound treatments performed for respiratory conditions or diseases
48550*:Donor pancreatectomy
78351*:Dual Photon Absorptiometry, one or more sites
A9270*:Ear/carbon therapy
A9270*:Electrical aversion therapy for treatment of alcoholism
A9270*:Electrical continence
95999*^:EEG monitoring during open heart surgery and in immediate post-op period
A9270*:Electrosleep therapy
A9270:Electrotherapy for the treatment of facial nerve paralysis (Bell's Palsy)
92971*:Enhanced External Counterpulsation (EECP)
A9270:Eye exam, routine
A9270*:Fabric wrapping of abdominal aneurysms
A9270*:Gastric balloon for treatment of obesity
M0100*:Gastric freezing
A9270*:Hair analysis
V5010:Hearing exam for the purpose of a hearing aid
A9270*:Hemodialysis for treatment of schizophrenia
A9270*:Indirect Calorimetry used to assess nutritional status as a respiratory therapy
90875-90876:Individual psychophysiological therapy incorporating biofeedback

55970-55980*:Intersex surgery
A9270:Intestinal bypass for obesity
A9270*:Intravenous histamine therapy
A9270*:Investigational IOLS in FDA Core Study or Modified Core Study
32491*^:Lung volume reduction surgery
71555*:Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72159*:Magnetic resonance angiography, spine canal and contents, with or without contrast material(s)
72198*:Magnetic resonance angiography, pelvis, with or without contrast material(s)
73225*:Magnetic resonance angiography, upper extremity, with or without contrast material(s)
74185*:Magnetic resonance angiography, abdomen, with or without contrast material(s)
A9170:Noncovered service by chiropractor
A9160:Noncovered service by podiatrist
A9270:Osteopathic cranial manipulation
A9270:Osteopathic pulmonary manipulation
48160*:Pancreatectomy, total, with transplantation

Page 37

A9270*:Partial ventriculectomy (also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery)
92310:Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92314:Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia
A9270*:Platelet-derived wound healing formula (Procuren)
A9270*:Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents
15775-15776:Punch graft for hair transplant
65760-65767,65771*:Refractive keratoplasty to correct refractive error
32491:Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous), for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure (prior to 1/1/97 HCPCS code G0061)
95199^:Repository antigen
90760:Routine physical exam
A9270:Speech therapy by pathologist/speech therapist
64999*^:Stereotactic cingulotomy as a means of psychosurgery
A9270*:Sweat test as predictor of efficacy of sympathectomy in PVD
11920-11922:Tattooing
A9270*:Thermogenic therapy
A9270*:Tinnitus masking
90899*^:Transcendental meditation
A9270*:Transfer factor for treatment of multiple sclerosis

A9270*:Transilluminator light scanning or diaphanography
35452*:Transluminal balloon angioplasty (PTA) in treatment of
obstructive lesions of aortic arch
A9270*:Transmyocardial Revascularization (TMR)
48554*:Transplantation of pancreatic allograft
A9270*:Transvenous (catheter) pulmonary embolectomy
A9270*:Treatment of decubitus ulcers by ultraviolet light, low
intensity direct current, topical application of oxygen and
topical dressings with balsam of Peru in castor oil
A9270*:Treatment of motor function disorders with electrical
nerve stimulation
78810*:Tumor Imaging, Positron Emission Tomography (PET),
metabolic evaluation
A9270*:Ultrafiltration independent of conventional dialysis
57335:Vaginoplasty for intersex state
A9270*:Vertebral Axial Decompression (VAX-D)
A9270:Vitamin B12 injections to strengthen tendons, ligaments of
the foot

* Services which are noncovered due to their being
investigational/experimental

^ Claims for these services will always be reviewed, as they must
currently be billed with an unlisted procedure code.

These lists of noncovered services are not all inclusive.

ICD-9 Codes That Support Medical Necessity
N/A

Reasons for Denial
See criteria for noncoverage.

Noncovered ICD-9 Code(s)
N/A

Coding Guidelines
N/A

Documentation Requirements
National noncovered services may not be covered by the local
carrier.
In order for local noncovered services to be evaluated for
coverage, the following documentation must be submitted to the
local carrier:

Peer reviewed articles from appropriate medical journals
Statements from authorities within the field
FDA approval
Appropriate CPT/HCPCS code

Advance Notice Statement
An advance notice of Medicare's denial of payment must be
provided to the patient when the provider does not want to accept
financial responsibility for a service that is considered
investigational/experimental, or is not approved by the FDA, or

because there is a lack of scientific and clinical evidence to support the procedure's safety and efficacy.

Page 38

E0782, E0783: Implantable Infusion Pumps

Information regarding coverage for implantable infusion pumps was published in the September/October 1997 Medicare Part B Update! (page 23), and is based on the information contained in the Coverage Issues Manual (CIM). The local medical review policy was reviewed as part of the Carrier's process of periodically evaluating all finalized policies. The review concluded that additions to the diagnosis section and HCPCS section were needed to identify appropriate conditions and medications for the covered indications. This revision is effective for claims processed on or after April 19, 1999, regardless of a previously submitted Certificate of Medical Necessity (CMN). Refer to the "billing requirements" section of this policy for more information.

The implantable pump is a sealed, self-powered system that contains a self-regenerating power supply, which is inserted under the skin by a physician. It provides a continuous controlled infusion of a drug to a select body site and can be refilled by percutaneous injection. Two separate ports are available, one for bolus injections and one for continuous infusion. Both may be used for blood or cerebrospinal fluid (CSF) withdrawals.

An implantable infusion pump is used to administer many types of medications through the intra-arterial, intrathecal, or epidural route.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider Implantable Infusion Pumps and the associated services medically reasonable and necessary for the conditions listed below:

Chemotherapy for Liver Cancer

The implantable infusion pump is covered for intra-arterial infusion of 5FUdR(Floxuridine) for the treatment of liver cancer for patients with primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in whom the metastases are limited to the liver, and where (1) the disease is unresectable or (2) where the patient refuses surgical excision of the tumor.

HCPCS Codes

J9200:Floxuridine, 500 mg.

E0782:Infusion pump, implantable, non-programmable

E0783:Infusion pump, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)

ICD-9 Codes that Support Medical Necessity (not an all inclusive list)

155.0

197.7

230.8

Duke's class D colorectal cancer (no ICD-9)

Anti-Spasmodic Drugs for Severe Spasticity

An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

The patient has undergone a previous 6-week trial of non-invasive methods of spasm control, such as oral anti-spasmodic drugs, physical therapy modalities, injections, etc. and cannot be maintained, either because these methods produce intolerable side effects, or fail to control adequately the spasticity.

In addition to the above criteria, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug before pump implantation.

The trial or screening phase involves a test dose of 1cc of a 50 mcg/ml dilution administered into the intrathecal space by barbotage over one minute or more. Significantly decreased severity or frequency of muscle spasm or reduced muscle tone should appear within four to eight hours. If the response is inadequate, a second test dose of 75mcg/1.5cc is given 24 hours after the first. If response is still inadequate, a final test dose of 100 mcg/2cc is given 24 hours later. Patients unresponsive to the 100-mcg dose should not be considered candidates for the implantable pump.

HCPCS Codes

J0475:Injection, baclofen, 10 mg

J0476:Injection, baclofen, 50 mcg for intrathecal trial

E0782:Infusion pump, implantable, non-programmable

E0783:Infusion pump, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)

ICD-9 Codes that Support Medical Necessity (not an all inclusive list)

323.9

333.7

334.1

336.9

340

342.10-342.12

343.0-343.9

344.00-344.09

344.1

344.2

344.30-344.32

344.40-344.42

344.5

344.81

344.89

344.9

437.8

721.0

721.1

721.2
721.3
721.41-721.42
907.2

Opioid Drugs for Treatment of Chronic Intractable Pain
An implantable infusion pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for treatment of severe chronic intractable pain of malignant or nonmalignant origin in patients who have a life expectancy of

Page 39

at least 3 months and who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

The patient's history must indicate that he/she had not responded adequately to non-invasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain); and

In addition to the above criteria, a preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and lack of side effects (including effects on the activities of daily living) and patient acceptance.

HCPCS Codes

J1170:Injection, hydromorphone, up to 4 mg
J2270:Injection, morphine sulfate, up to 10 mg
J2271:Injection, morphine sulfate, 100 mg
J2275:Injection, morphine sulfate, per 10 mg
J3010:Injection, fentanyl citrate, up to 2 ml
E0782:Infusion pump, implantable, non-programmable
E0783:Infusion pump, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)

ICD-9 Codes that Support Medical Necessity (not an all inclusive list)

053.13
140.0-239.9
322.9
336.9
337.20-337.29
354.4
355.71
356.9
719.40-719.49
720.0-721.91
722.0-722.93
723.0-723.9
724.00-724.9
733.90

953.0

Coverage of Other Uses of Implanted Infusion Pumps

Determinations may be made on coverage of other uses of implanted infusion pumps if the contractor's medical staff verifies that:

The drug is reasonable and necessary for the treatment of the individual patient;

It is medically necessary that the drug be administered by an implanted infusion pump; and

The FDA-approved labeling for the pump must specify that the drug being administered and the purpose for which it is administered is an indicated use for the pump.

This determination will be made on an individual basis.

HCPCS Codes

E0782L Infusion pump, implantable, non-programmable

E0783L Infusion pump, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)

"J" codes

All other medications not covered in the above indications which can be used with an implantable infusion pump

ICD-9 Codes that Support Medical Necessity

N/A

Contraindications

The implantation of an infusion pump is contraindicated in the following patients:

Patients with a known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.);

Patients who have an infection;

Patients whose body size is insufficient to support the weight and bulk of the device; and

Patients with other implanted programmable devices since crosstalk between devices may inadvertently change the prescription.

Note: Payment may also be made for drugs necessary for the effective use of an implantable infusion pump as long as the drug being used with the pump is itself reasonable and necessary for the patient's treatment.

Reasons for Denial

According to the Public Health Service, there is insufficient published clinical data to support the safety and effectiveness of the heparin implantable pump. Therefore, the use of an implantable infusion pump for infusion of heparin in the treatment of recurrent thromboembolic disease is not covered. The insulin delivery infusion pump has not been demonstrated to effectively administer insulin. Therefore, the use of an insulin delivery infusion pump is not a covered service.

Based on information from HCFA, the Pfizer Infusaid Model 1000 pump is not covered for intrathecal administration of baclofen.

Coding Guidelines

Insertion, revision and removal of implantable intra-arterial infusion pumps (36260, 36261, and 36262) only are to be used in conjunction with infusion therapy for intra-arterial chemotherapy.

Refilling and maintenance of implantable pump or reservoir (96530) should be billed with the appropriate "J" code to reflect physician services for drug administration (POS 11). Access of a pump port is included in the filling of an implantable pump. In addition to the applicable J codes and Implantable Infusion Pump code, one or more of the following HCPCS codes may be billed during the patient's course of treatment:

A4220

Refill kit for implantable infusion pump

E0785

Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump replacement

Page 40

36260: Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)

36261: Revision of implanted intra-arterial infusion pump

36262: Removal of implanted intra-arterial infusion pump

62350: Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy

62351: with laminectomy

62355: Removal of previously implanted intrathecal or epidural catheter

62361: Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump

62362: programmable pump, including preparation of pump, with or without programming

62365: Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

62367: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming

62368: with reprogramming

96530: Refilling and maintenance of implantable pump or reservoir

If the refill kit (A4220) is covered as incident to a physician service and is provided on the same day as a physician service, then the payment for the refill kit is bundled into the payment for the physician service.

Billing Requirements

Supplies and drugs that are furnished by a supplier for use with an implantable infusion pump must be prescribed by the patient's physician and documented with the initial claim for these items. Claims for these items (for services furnished in Florida) may be submitted either electronically or on the HCFA-1500 claim form to Medicare Part B of Florida. However, claims must be submitted on

the HCFA-1500 for the initial claim/prescription, when there is a prescription change, or a prescription renewal. In order to document the need for the supplies and drugs, in 1995 Medicare Part B of Florida created a "Certificate of Medical Necessity" (CMN) form. The CMN form can be found on page 45. It may be copied for immediate use.

The CMN must be completed in its entirety and signed by the prescribing physician (a facsimile of the physician's signature is not acceptable).

The period of medical necessity should be no longer than six (6) months; that is, the CMN is valid only for periods of up to six months. The period of medical necessity is limited so the physician can ensure the medical effectiveness of the therapy period. If the period of medical necessity is longer than six months, the CMN must be renewed by the sixth month.

The CMN must be submitted with the claim for the supplies/drugs in the following instances:

with the initial claim for the supplies/drugs,
when there is a revision to the patient's prescription, or
when the prescription is renewed.

Subsequent claims do not require the submission of a CMN unless the CMN is revised or renewed.

If a copy of the initial CMN is revised the physician must attest to the revisions by initialling the revisions.

Section B of the CMN (medical information) may be completed only by the physician or the physician's employee; it may not be completed by the supplier.

Suppliers may complete only section A of the CMN.

Claims submitted on the HCFA-1500 claim form should be sent to:

Medicare Part B
PO Box 44225
Jacksonville, FL 32231-4225

Documentation Requirements

Medical record documentation maintained in the patient's file should support the indications as stated in the applicable section of the policy. This information is normally found in the office records, history and physical and/or CMN.

If the indication for the Implantable Infusion Pump is for reasons other than chemotherapy for liver cancer, anti-spasmodic drugs for severe spasticity, or opioid drugs for treatment of chronic intractable pain, the diagnosis is not indicated in the applicable covered indication, documentation supporting medical necessity for the pump and/or medication must be submitted with the claim.

Advance Notice Statement

Applies to medical necessity (see page 4).

Page 41

Certificate Of Medical Necessity: Infusion Pumps

(front of form)

NOT AVAILABLE IN THIS FORMAT

Page 42

Certificate Of Medical Necessity: Infusion Pumps
(back of form)

NOT AVAILABLE IN THIS FORMAT

Page 43

J0001: Self-Administered Drugs

The Health Care Financing Administration (HCFA) receives numerous inquiries about the coverage of self-administered drugs, as well as requests to add more self-administrable drugs to the list of covered benefits.

The Medicare statute does not provide for an overall outpatient drug benefit. As a result, self-administered drugs and biologicals (pill form) or those used for self injection are generally not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage. Currently, Medicare allows for the coverage of the following self-administered drugs:

Blood clotting factors;

Drugs used in immunosuppressive therapy;

Erythropoietin (EPO);

Osteoporosis drugs for certain homebound patients;

Certain oral anti-cancer drugs; and

Certain oral anti-nausea drugs given in conjunction with oral or IV chemotherapy.

Whether a drug or biological is of a type that cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished by the physician. Thus, where a physician gives a patient pills or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a physician gives a patient an injection that is usually self-injected (e.g., insulin or calcitonin), this drug is excluded from coverage, unless it is administered to the patient in an emergency situation (e.g., diabetic coma). However, when a physician injects a drug that is not usually self-administered, this drug is not subject to the self-administrable drug exclusion (regardless of whether the drug may also be available in oral form) since it is not self-administrable in the form in which it was furnished to the patient.

There are times when a drug that is considered to be self-administered may be covered under certain limited circumstances. Coverage for these limited situations is at the discretion of the Carrier. Therefore, this policy was developed to clarify when coverage would be extended to allow payment for certain self-administered drugs. Additionally, this policy will be updated as additional self-administered drugs are added or national coverage decisions change.

Indications and Limitations of Coverage and/or Medical Necessity
Based on national coverage guidelines, drugs and biologicals that are self-administered by the patient are not a benefit of Medicare. However, certain drugs that are generally self-administered may be covered under the "incident to" provision when administered under one or more of the following circumstances:

The initiation of the therapy requires dose titration under the supervision of a physician to test the patient's responsiveness and appropriate dosage; and

Prior to self-administration of a drug, the patient/caregiver must be instructed by a medical professional on the administration and proper technique for the drug that is determined to be medically necessary for the patient's condition.

Under these limited circumstances, Medicare Part B of Florida will allow payment only one time for certain self-administered drugs (See "HCPCS Codes" section).

Note: The individual patient's mental or physical ability to administer any drug may not be a factor in the consideration for this purpose. Decisions regarding coverage are made on an appropriate medical protocol that would apply to any patient with an illness or injury that is being treated by the drug in question.

HCPCS Codes

J1825:Injection, interferon beta-1a, 33 mcg (Avonex)
J1830:Injection, interferon beta-1B, per 0.25 mg (Betaseron)
Q0182:Alprostadil, urethral suppository, administered under direct supervision, excludes self administration

ICD-9 Codes That Support Medical Necessity

N/A

Reasons for Denial

Drugs and biologicals that can be self-administered are not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage.

Oral drugs are not covered under the "incident to a physician's service" provision.

Coding Guidelines

When billing for the initial drug (listed in this policy), the applicable J or Q code should be billed.

For subsequent billing of these drugs, code A9270 should be used.

Documentation Requirements

In the event documentation is required, the provider has the responsibility to ensure that the initial injection/suppository was medically necessary. This information can generally be found in a history and physical and/or office/progress notes.

Page 44

J1950, J9217, J9218: Leuprolide Acetate

Leuprolide Acetate injection is a synthetic analog of the naturally occurring gonadotropin-releasing hormone (GnRH or LH-RH). The analog possesses greater potency than the natural hormone. Gonadotropin-releasing hormone is produced in the arcuate nucleus of the hypothalamus and controls release of the gonadotropins, follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Note that this policy is effective for services processed on and after April 19, 1999.

The administration of leuprolide acetate results in an initial increase in circulating levels of LH and FSH, leading to a transient increase in levels of the gonadal steroids (testosterone and dihydrotestosterone in males, and estrone and estradiol in premenopausal females). However, continuous administration of leuprolide acetate results in decreased levels of LH and FSH. In males, testosterone is reduced to castrate levels. In premenopausal females, estrogens are reduced to postmenopausal levels. These decreases occur within two to four weeks after initiation of treatment.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare of Florida will consider leuprolide acetate medically reasonable and necessary for the following FDA approved indications:

Endometriosis (treatment): for management of endometriosis, including pain relief and reduction of endometriotic lesions.
Leiomyomata: in conjunction with iron supplement therapy, is indicated for the preoperative hematologic improvement of patients with anemia caused by uterine leiomyomata (fibroids).
Carcinoma, prostatic (treatment): for the palliative treatment of advanced prostatic cancer, especially as an alternative to orchiectomy or estrogen administration.

According to the medical literature, there is no demonstrable difference in clinical efficacy between J9217 leuprolide acetate (for depot suspension) and J9202 goserelin acetate implant (Zoladex) in the treatment of malignant neoplasm of the prostate (ICD-9 code 185).

If two services are clinically comparable, Medicare does not cover the additional expense of the more costly one, because this additional expense is not attributable to an item or service that is medically reasonable and necessary. J9217 leuprolide acetate is currently more costly than J9202 goserelin acetate implant. Therefore, if there are no medical indications requiring the use of J9217 instead J9202 for the treatment of malignant neoplasm of the prostate, J9217 will be reimbursed at the J9202 cost.

If there are medical indications requiring the use of J9217 leuprolide acetate instead of J9202 goserelin acetate implant for malignant neoplasm of the prostate such as cachexia, infection or allergy to goserelin acetate, Medicare will consider payment for the difference in cost if the documentation demonstrating medical necessity accompanies the claim.

Dosage and Frequency

Endometriosis: Intramuscular, 3.75 mg depot suspension, (J1950) is administered once a month, or 11.25 mg every three months for a maximum duration of six months.

Uterine leiomyomata: Intramuscular, 3.75 mg depot suspension, (J1950) is administered once a month for a maximum duration of three months or one 11.25 mg injection.

Prostatic carcinoma: Intramuscular, 7.5 mg, (J9217) is administered once a month, 22.5 mg once every three months, or 30 mg dose every four months.

Prostatic carcinoma: Subcutaneous, 1.0 mg (J9218) is administered on a daily basis by the patient in the home setting.

Leuprolide Acetate (J9218), when administered subcutaneously is generally self-administered. Based on national coverage guidelines, drugs and biologicals that are self-administered by the patient are not a benefit of Medicare. However, certain drugs that are generally self-administered may be covered under the "incident to" provision when administered under one or more of the following circumstances:

The initiation of the therapy requires dose titration under the supervision of a physician to test the patient's responsiveness and appropriate dosage; and

Prior to self-administration of a drug, the patient/caregiver must be instructed by a medical professional on the administration and proper technique for the drug that is determined to be medically necessary for the patient's condition.

Under these limited circumstances, Medicare of Florida will allow payment only one time for the self-administration of Leuprolide Acetate (J9218).

HCPCS Codes

J1950:Injection, leuprolide acetate (for depot suspension), per 3.75 mg

J9217:Leuprolide acetate (for depot suspension), 7.5 mg

J9218:Leuprolide acetate, per 1 mg

ICD-9 Codes That Support Medical Necessity

185

280.0

285.1

617.0-617.9

Reasons for Denial

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

Medicare of Florida will deny payment for the additional expense of J9217 as not medically reasonable and necessary if the claim is submitted with ICD-9 code 185 and no supporting documentation of medical need (cachexia, infection, or allergy to goserelin acetate).

Drugs and biologicals that can be self-administered are not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage. The statute does not currently include a benefit for the self-administration of Leuprolide Acetate. Therefore, self/caregiver administration of Leuprolide Acetate (J9218) is non-covered.

Noncovered ICD-9 Code(s)

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

Coding Guidelines

When J9217 leuprolide acetate (for depot suspension) is billed with ICD-9 code 185 and no supporting documentation of medical need (cachexia, infection, or allergy to goserelin acetate), an acceptable advance notice of Medicare's possible denial of payment for the additional expense of J9217 must be given to the patient if the provider does not want to accept financial responsibility for each injection. The beneficiary's liability, however, must not exceed the difference in the Medicare allowance between the two medications (J9217 and J9202). Use the GA modifier to indicate that the "Advance Notice to Beneficiary" statement is on file for the difference in cost of the two drugs. When leuprolide acetate is self-administered, the patient/caregiver must be instructed by a medical professional on the administration and proper technique for the usage of this drug. Therefore, the physician will be reimbursed one time only (per beneficiary) for the subcutaneous administration of leuprolide acetate (J9218) to allow for patient teaching.

Documentation Requirements

Medical record documentation maintained by the physician must indicate the medical necessity for using this drug. Documentation of the symptoms, the administration and dosage of the leuprolide acetate would be expected to be found in the patient's medical record. This information is usually found in the history and physical and/or office/progress notes.

In addition, if Lupron Depot 3.75 mg is given for the indication of anemia, the provider must indicate in the medical record that the patient's anemia was caused by uterine leiomyomata.

Additional documentation must be submitted when billing for J9217 with the diagnosis of malignant neoplasm of the prostate (ICD-9 code 185). The medical record must document the medical necessity for using leuprolide acetate instead of the less costly treatment with goserelin acetate implant (Zoladex). The documentation could include a history and physical, office/progress notes, or a letter of medical necessity from the physician.

J9999: Antineoplastic Drugs (Formerly Off-Label Use of Chemotherapy Drugs)

According to Medicare guidelines, certain medical services that are deemed reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered services. FDA approval is often one of the main criteria of Medicare's coverage guidelines for drugs and biologicals. However, in the case of chemotherapeutic agents, FDA approval does not always keep pace with clinically indicated efficacy. Therefore, the need exists to address off-label chemotherapy drug uses which have been validated by clinical trials.

The purpose of this policy is to establish the FDA approved indications of antineoplastic drugs and to indicate the circumstances under which Medicare will consider off-label uses for chemotherapy drugs to be medically reasonable and necessary, and to specify those drugs and their FDA approved and off-label uses as they become available. This policy does not restrict what providers can provide nor what beneficiaries receive. It simply defines what can be covered by Medicare in order to avoid or reduce denials for unapproved treatment. This policy is effective for services processed on and after April 19, 1999.

Indications and Limitations of Coverage and/or Medical Necessity For off-label use:

Effective January 1, 1994, unlabeled uses of FDA approved drugs and biologicals used singly or in an anti-cancer regimen for a medically accepted indication are evaluated under the conditions described in the following paragraphs. A regimen is a combination of anti-cancer agents that have been clinically recognized for the treatment of a specific type of cancer. An example of a drug regimen is: Cyclophosphamide + vincristine + prednisone (CPV) for non-Hodgkin's lymphoma. There may be different regimens or combinations that are used at different phases of the cancer's history (induction, prophylaxis of CNS involvement, post remission, and relapsed or refractory disease). A protocol may specify the combination of drugs, doses, and schedules for administration of the drugs. For purposes of this provision, a cancer treatment regimen includes drugs used to treat toxicities or side effects of the treatment regimen when the drugs are administered incident to a chemotherapy treatment.

Page 46

To evaluate the off-label uses of chemotherapeutic agents for coverage, the uses must not be listed as "not indicated" by HCFA, the FDA, or the compendia. Justification for approval of off-label uses must be based upon data from clinical trials in which there was a defined combination and dosage schedule, an appropriate study design, an adequate number of trial subjects, and evidence of significant increase in survival rate or life expectancy or an objective and significant decrease in tumor size or reduction in tumor-related symptoms. (Stabilization is not considered a response to therapy.) The unlabeled uses of a chemotherapy drug must be supported by one of the following:

The compendia. (If an unlabeled use does not appear in the compendia or is listed there as insufficient data or investigational, the compendia will be contacted to determine whether a report is forthcoming. If a report is forthcoming, the information in that report will be used as a basis for decision making. The compendium process for making decisions regarding unlabeled uses is very thorough and continually updated.)

Phase III clinical trials.

Clinical research that appears in peer reviewed medical literature. This includes scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This does not include in-house publications of pharmaceutical manufacturing companies or abstracts (including meeting abstracts).

Peer-reviewed medical literature appearing in the following publications:

American Journal of Medicine;
Annals of Internal Medicine;
The Journal of the American Medical Association;
Journal of Clinical Oncology;
Blood;
Journal of the National Cancer Institute;
The New England Journal of Medicine;
British Journal of Cancer;
British Journal of Hematology;
British Medical Journal;
Cancer;
Drugs;
European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);
Lancet; or
Leukemia.

The carrier is not required to maintain copies of these publications.

Physicians seeking to establish Medicare coverage for specific off-label uses of chemotherapeutic drugs must submit documentation from any of the above publications supporting the efficacy of each of the off-label uses to the Medicare Medical Policy and Procedures Department.

Following are chemotherapy drugs and their FDA approved and off-label uses for which Medicare of Florida considers coverage to be medically reasonable and necessary:

Doxorubicin HCL 10mg (Adriamycin PFS; Adriamycin RDF; Rubex)
Doxorubicin is an anthracycline glycoside; it is classified as an antibiotic but is not used as an antimicrobial agent. It selectively kills malignant cells and produces tumor regression in a variety of human neoplasms.

A variety of dosage schedules of Doxorubicin, alone or in combination with other antitumor agents, are used. The prescriber may consult the medical literature, as well as the manufacturer's literature, in choosing a specific dose.

Doxorubicin may be administered intravenously, intra-arterially, and as a topical bladder installation.

Doxorubicin is FDA approved for treatment of the following medical conditions:

Acute lymphocytic (lymphoblastic) leukemia, acute nonlymphocytic (myeloblastic) leukemia, bladder carcinoma, breast carcinoma, gastric carcinoma, small cell lung carcinoma, epithelial ovarian carcinoma, thyroid carcinoma, neuroblastoma, Wilm's tumor, Hodgkin's lymphoma, non-Hodgkin's lymphoma, soft tissue sarcoma, and osteosarcoma.

Clinical trials have also demonstrated the efficacy of Doxorubicin in the treatment of additional carcinomas. Medicare of Florida will cover Doxorubicin for its FDA approved uses, as well as for treatment of the following neoplasms:

Cervical carcinoma
Endometrial carcinoma
Head and neck carcinoma
Non-small cell lung carcinoma
Pancreatic carcinoma
Prostatic carcinoma
Endometrial carcinoma
Ovarian germ cell tumors
Ewing's sarcoma
Multiple myeloma
Chronic lymphocytic leukemia
Primary hepatocellular carcinoma
Hepatoblastoma
Thymoma

Gestational trophoblastic tumors
AIDS-related Kaposi's sarcoma

Page 47

HCPCS Codes
J9000:Doxorubicin HCl, 10 mg

150-0-150.9
151.0-151.9
155.0
157.0-157.9
160.0-160.9
162.2-162.9
164.0
170.0-170.9
171.0-171.9
174.0-174.9
175.0-175.9
176.0-176.9
180.0-180.9
182.0

183.0
185
186.0-186.9
188.0-188.9
189.0
193
195.0
200.00-200.88
201.00-201.98
202.00-202.08
203.00-203.01
204.00-204.01
204.10-204.11
205.00-205.91

ICD-9 Codes That Support Medical Necessity

Doxorubicin, Liposomal (Doxil)

Doxorubicin is an anthracycline cytostatic antibiotic. Liposomal Doxorubicin is Doxorubicin encapsulated in long-circulating liposomes. Liposomes are microscopic vesicles composed of a phospholipid bilayer that are capable of encapsulating active drugs. Once within the tumor, the active ingredient Doxorubicin is presumably available to be released locally as the liposomes degrade and become permeable in situ.

Liposomal Doxorubicin is FDA approved for treatment of patients with AIDS-related Kaposi's sarcoma disease that has progressed in spite of prior combination chemotherapy or patients who are intolerant of such therapy. Clinical trials have also demonstrated the efficacy of Liposomal Doxorubicin in the treatment of an additional carcinoma. Medicare of Florida will now cover Liposomal Doxorubicin for its FDA approved use, as well as for the treatment of the following neoplasm:

Ovarian carcinoma

HCPCS Codes

J9999:Not otherwise classified, antineoplastic drugs

176.0-176.9
183.0

ICD-9 Codes That Support Medical Necessity

Gemcitabine (Gemzar(r))

Gemcitabine is a deoxycytidine analogue antimetabolite that is structurally related to cytarabine. In contrast to cytarabine it has greater membrane permeability and enzyme affinity, as well as prolonged intracellular retention. The compound acts as an inhibitor of DNA synthesis, and its mechanism of action appears to be cell-cycle specific.

Gemzar is for intravenous use only. It is supplied as 200mg of powder to be reconstituted, and should be administered by intravenous infusion at a dose of 1000mg/m² over 30 minutes once weekly for up to 7 weeks, (or until toxicity necessitates reducing or holding a dose), followed by a week of rest from treatment. Subsequent cycles should consist of infusions once weekly for 3 consecutive weeks out of every 4 weeks. Dosage adjustment is based upon the degree of hematologic toxicity experienced by the patient.

Gemzar is FDA approved for first-line treatment of patients with advanced or metastatic adenocarcinoma of the pancreas or non-small cell lung cancer. Clinical trials have also demonstrated the efficacy of Gemzar in the treatment of an additional carcinoma. Medicare of Florida will now cover Gemzar for its FDA approved uses, as well as for treatment of the following neoplasm:

Bladder carcinoma

HCPCS Codes

J9201:Gemcitabine HCl, 200 mg

ICD-9 Codes That Support Medical Necessity

157.0-157.9

162.2-162.9

188.0-188.9

Docetaxel (Taxotere(r))

Docetaxel, an antineoplastic agent belonging to the taxoid family, acts by disrupting cell replication. It is a derivative of 10-deacetylbaaccatin 111, a compound extracted from the needles of the European yew tree. Docetaxel acts by disrupting the microtubular network in cells, an essential component of vital mitotic and interphase cellular functions.

Taxotere is supplied as either 20 mg or 80 mg Concentrate for Infusion. The recommended dose is 60-100 mg/m² administered intravenously over one hour every three weeks.

Taxotere is FDA approved as a frontline agent in the treatment of metastatic breast cancer when anthracycline-based therapy and other agents have failed. It is also FDA approved as a second-line treatment of AIDS-related Kaposi's sarcoma. Clinical trials have demonstrated the efficacy of Taxotere in the treatment of several additional carcinomas, as well. Medicare of Florida will now cover Taxotere for its FDA approved uses, as well as for the treatment of the following neoplasms:

Non-small cell and small cell carcinoma of the lung

Squamous cell carcinoma of the head and neck

Ovarian carcinoma

Gastric carcinoma

Melanoma

HCPCS Codes
J9170:Docetaxel, 20 mg

ICD-9 Codes That Support Medical Necessity

151.0-151.9
162.2-162.9
172.0-172.9
174.0-174.9
175.0-175.9
176.0-176.9
183.0
195.0

Topotecan Hydrochloride (Hycamtin(r))

Page 48

Topotecan Hydrochloride is a semi-synthetic derivative of camptothecin and is an anti-tumor drug with topoisomerase I-inhibitory activity. Hycamtin for injection is supplied in a single dose vial containing topotecan hydrochloride equivalent to 4mg of topotecan as free base. The reconstituted solution is intended for administration by intravenous infusion. The cytotoxicity of topotecan is thought to be due to double strand DNA damage produced during DNA synthesis when replication enzymes interact with the ternary complex formed by topotecan, topoisomerase I, and DNA. Mammalian cells cannot efficiently repair these double strand breaks. Hycamtin is FDA approved for treatment of metastatic carcinoma of the ovary. Clinical trials have also demonstrated the efficacy of Hycamtin in the treatment of additional carcinomas. Medicare of Florida will now cover Hycamtin for its FDA approved use, as well as for treatment of the following neoplasms:

Non-small cell and small cell carcinoma of the lung
Myelodysplastic syndrome (MDS)
Chronic myelomonocytic leukemia (CMML)

HCPCS Codes
J9350:Topotecan, 4 mg

ICD-9 Codes That Support Medical Necessity

162.2-162.9
183.0
205.10
205.11
238.7

Reasons for Denial

The use of Adriamycin, Doxil, Gemzar, Taxotere or Hycamtin for any clinical indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9 Code(s)

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

Coding Guidelines

When billing for Doxorubicin HCL 10mg, use HCPCS code J9000 and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated.

When billing for Liposomal Doxorubicin, use HCPCS code J9999 and include the name of the drug and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated.

When billing for Gemcitabine 200mg, use HCPCS code J9201 and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated.

When billing for either Taxotere 80mg or Taxotere 20mg, use HCPCS code J9170 and include both the drug strength and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated.

When billing for Topotecan 4mg, use HCPCS code J9350 and the appropriate ICD-9 diagnosis code that indicates the medical condition being treated.

Documentation Requirements

Medical record documentation maintained by the performing physician must substantiate the medical necessity for the use of these chemotherapy drugs by clearly indicating the condition for which these drugs are being used. This documentation is usually found in the history and physical or in the office/progress notes.

Independent Diagnostic Testing Facility (IDTF)

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

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

Note: IPLs who are converting from IPL to IDTF status are required to submit a new EDI enrollment form for the IDTF before they can bill electronically (see page 67 for more information).

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

Supervising physician

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

Page 49

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

Nonphysician personnel

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

Ordering of tests

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

Multi-state entities

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

Applicability of State law

An IDTF must comply with applicable laws of any State in which it operates.

The nonphysician personnel credentialing requirements listed below are divided into the following sections: Diagnostic Ultrasound, Cardiology, Echocardiography, Non-invasive Vascular Diagnostic Studies, Pulmonary, and Neurology and Neuromuscular. It is required that the nonphysician personnel performing the diagnostic tests, be credentialed as evidenced by State licensure and/or national board certification. The Carrier is cognizant that all IDTF applicants may not currently meet the credentialing criteria as outlined in this policy. So therefore, the Carrier will allow up to one year from the date the applicant enrolled as an IDTF for the applicable certification/licensure to be obtained. It is expected that once licensure and/or credentialing has been obtained, that documentation is submitted verifying that credentialing requirements have been met. In addition, the credentialed and/or licensed nonphysician personnel must maintain an active licensure and/or credential status in order for the diagnostic tests to be covered.

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

Diagnostic Ultrasound

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

The American Registry of Diagnostic Medical Sonographers (ARDMS) offers the following credentials:

Registered Diagnostic Medical Sonographer (RDMS);
Registered Diagnostic Cardiac Sonographer (RDCS);
Registered Vascular Technologist (RVT);
Registered Ophthalmic Ultrasound Biometrist (ROUB).

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

The Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) offers the following credentials:

Certified Ophthalmic Assistant (COA);
Certified Ophthalmic Technician (COT);

Certified Ophthalmic Medical Technologist (COMT).

CPT-4 CODE(S): 76506
CERTIFICATION: ARDMS: RDMS-Neurosonology

CPT-4 CODE(S): 76511-76529
CERTIFICATION: ROUBJCAHPO: COA,COT,COMT

CPT-4 CODE(S): 73536
CERTIFICATION: ARDMS: RDMS-Abdomen

CPT-4 CODE(S): 76604-76778
CERTIFICATION: ARDMS: RDMS-Abdomen

CPT-4 CODE(S): 76800
CERTIFICATION: ARDMS: RDMS-Neurosonology

CPT-4 CODE(S): 76805-76818
CERTIFICATION: ARDMS: RDMS-Obstetrics & Gynecology

CPT-4 CODE(S): 76825-76828
CERTIFICATION: ARDMS: RDMS-Obstetrics & Gynecology

CPT-4 CODE(S): 76830-76831
CERTIFICATION: ARDMS: RDMS-Obstetrics & Gynecology

CPT-4 CODE(S): 76856-76857
CERTIFICATION: ARDMS: RDMS-Obstetrics & Gynecology

CPT-4 CODE(S): 76870
CERTIFICATION: ARDMS: RDMS-Abdomen

CPT-4 CODE(S): 76872
CERTIFICATION: ARDMS: RDMS-Abdomen

CPT-4 CODE(S): 76880
CERTIFICATION: ARDMS: RDMS-Abdomen

CPT-4 CODE(S): 76885-76886
CERTIFICATION: ARDMS- RDM

CPT-4 CODE(S): 76977
CERTIFICATION: Demonstrates proficiency

CPT-4 CODE(S): 76999

CERTIFICATION: ARDMS: RDMS-Appropriate credentialing based on
body area examining

CPT-4 CODE(S): G0050

CERTIFICATION: ARDMS: RDMS-Abdomen

Page 50

HCPCS Codes

76506:Echoencephalography, B-scan and/or real time with image documentation (gray scale)(for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated

76511:Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification

76512:contact B-scan (with or without simultaneous A-scan)

76513:immersion (water bath) B-scan

76516:Ophthalmic biometry by ultrasound echography, A-scan;

76519:with intraocular lens power calculation

76529:Ophthalmic ultrasonic foreign body localization

76536:Echography, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), B-scan and/or real time with image documentation

76604:Echography, chest, B-scan (includes mediastinum) and/or real time with image documentation

76645:Echography, breast(s)(unilateral or bilateral), B-scan and/or real time with image documentation

76700:Echography, abdominal, B-scan and/or real time with image documentation; complete

76705:limited (e.g., single organ, quadrant, follow-up)

76770:Echography, retroperitoneal (e.g., renal, aorta, nodes), B-scan and/or real time with image documentation; complete

76775:limited

76778:Echography of transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler studies

76800:Echography, spinal canal and contents

76805:Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)

76810:complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester

76815:limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)

76816:follow-up or repeat

76818:Fetal biophysical profile

76825:Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;

76826:follow-up or repeat study

76827:Doppler echocardiography, fetal, cardiovascular system,
pulsed wave and/or continuous wave with spectral display;
complete
76828:follow-up or repeat study
76830:Echography, transvaginal
76831:Hysterosonography, with or without color flow Doppler
76856:Echography, pelvic (nonobstetric), B-scan and/or real time
with image documentation; complete
76857:limited or follow-up (e.g., for follicles)
76870:Echography, scrotum and contents
76872:Echography, transrectal
76880:Echography, extremity, non-vascular, B-Scan and/or real
time with image documentation
76885:Echography of infant hips, real time with imaging
documentation; dynamic (e.g., requiring manipulation)
76886:limited, static (e.g., not requiring manipulation)
76977:Ultrasound bone density measurement and interpretation,
peripheral site(s), any method
76999:Unlisted ultrasound procedure

G0050:Measurement of post-voiding residual urine and/or bladder
capacity by ultrasound

Page 51

ICD-9 Codes That Support Medical Necessity
For covered ICD-9 codes for an individual CPT code, refer to the
specific Local Medical Review Policy for that code.

Cardiology

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

Cardiovascular Credentialing International (CCI) offers the
following credentials:

Certified Cardiographic Technician (CCT);
Registered Cardiac Sonographer (RCS);
Registered Cardiovascular Invasive Specialist (RCIS);
Registered Vascular Specialist (RVS).

CPT-4 CODE(S): 93000-93278, G0004-G0015, Q0035
CERTIFICATION: CCI: CCTRegistered Nurse (RN)

HCPCS Codes

93000:Electrocardiogram, routine ECG with at least 12 leads; with
interpretation and report
93005:tracing only, without interpretation and report
93012:Telephonic transmission of post-symptom electrocardiogram
rhythm strip(s), per 30 day period of time; tracing only
93015:Cardiovascular stress test using maximal or submaximal
treadmill or bicycle exercise, continuous electrocardiographic
monitoring, and/or pharmacological stress; with physician
supervision, with interpretation and report
93017:tracing only, without interpretation and report

93024:Ergonovine provocation test
 93040:Rhythm ECG, one to three leads; with interpretation and report
 93041:tracing only without interpretation and report
 93224:Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation
 93225:recording (includes hook-up, recording, and disconnection)
 93226:scanning analysis with report
 93230:Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation
 93231:recording (includes hook-up, recording, and disconnection)
 93232:microprocessor-based analysis with report
 93235:Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; includes monitoring and real-time data analysis with report, physician review and interpretation
 93236:monitoring and real-time data analysis with report
 93268:Patient demand single or multiple event recording with presymptom memory loop, per 30 day period of time; includes transmission, physician review and interpretation
 93270:recording (includes hook-up, recording, and disconnection)
 93271:monitoring, receipt of transmissions, and analysis
 93278:Signal-averaged electrocardiography (SAECG), with or without ECG
 G0004:Patient demand single or multiple event recording with presymptom memory loop and 24 hour attended monitoring, per 30 day period; includes transmission, physician review and interpretation
 G0005:Patient demand single or multiple event recording with presymptom memory loop and 24 hour attended monitoring, per 30 day period; recording (includes hook-up, recording and disconnection)
 G0006:Patient demand single or multiple event recording with presymptom memory loop and 24 hour attended monitoring, per 30 day period; 24 hour attended monitoring, receipt of transmissions, and analysis
 G0015:Postsymptom telephonic transmission of electrocardiogram rhythm strip(s) and 24 hour attended monitoring, per 30 day period; tracing only
 Q0035:Cardiokymography

ICD-9 Codes That Support Medical Necessity

For covered ICD-9 codes for an individual CPT code, refer to the specific Local Medical Review Policy for that code.

Echocardiography

The personnel performing the tests identified under the HCPCS Codes section must have the applicable certification as listed on the following page:

The American Registry of Diagnostic Medical Sonographers (ARDMS) offers the following credentials:

Registered Diagnostic Medical Sonographer (RDMS);
Registered Diagnostic Cardiac Sonographer (RDCS);
Registered Vascular Technologist (RVT);
Registered Ophthalmic Ultrasound Biometrist (ROUB).

Cardiovascular Credentialing International (CCI) offers the following credentials:

Certified Cardiographic Technician (CCT);
Registered Cardiac Sonographer (RCS);
Registered Cardiovascular Invasive Specialist (RCIS);
Registered Vascular Specialist (RVS).
CPT-4 CODE (S): 93303-93308
CERTIFICATION: ARDMS: RDCSCCI: RCS

CPT-4 CODE (S): 93312
CERTIFICATION: ARDMS: RDCSCCI: RCS

CPT-4 CODE (S): 93315
CERTIFICATION: ARDMS: RDCSCCI: RCS

CPT-4 CODE (S): 93320-93325
CERTIFICATION: ARDMS: RDCSCCI: RCS

CPT-4 CODE (S): 93350
CERTIFICATION: ARDMS: RDCSCCI: RCS, CCT for stress portion

HCPCS Codes

93303: Transthoracic echocardiography for congenital cardiac anomalies; complete
93304: follow-up or limited study
93307: Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete
93308: follow-up or limited study
93312: Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93315: Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93320: Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete
93321: follow-up or limited study (List separately in addition to codes for echocardiographic imaging)
93325: Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)
93350: Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise

and/or pharmacologically induced stress, with interpretation and report

ICD-9 Codes That Support Medical Necessity

For covered ICD-9 codes for an individual CPT code, refer to the specific Local Medical Review Policy for that code.

Non-invasive Vascular Diagnostic Studies

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

The American Registry of Diagnostic Medical Sonographers (ARDMS) offers the following credentials:

Registered Diagnostic Medical Sonographer (RDMS);
Registered Diagnostic Cardiac Sonographer (RDCS);
Registered Vascular Technologist (RVT);
Registered Ophthalmic Ultrasound Biometrist (ROUB).

Cardiovascular Credentialing International (CCI) offers the following credentials:

Certified Cardiographic Technician (CCT);
Registered Cardiac Sonographer (RCS);
Registered Cardiovascular Invasive Specialist (RCIS);
Registered Vascular Specialist (RVS).

CPT- 4 CODE(S): 54240, 93875-93990

CERTIFICATION: ARDMS: RVTCCI: RVS

HCPCS Codes

54240:Penile plethysmography

93875:Non-invasive physiologic studies of extracranial arteries, complete bilateral study (e.g., periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)

93880:Duplex scan of extracranial arteries; complete bilateral study

93882:unilateral or limited study

93886:Transcranial Doppler study of the intracranial arteries; complete study

93888:limited study

93922:Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)

Page 53

93923:Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen

tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924:Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925:Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926:unilateral or limited study
93930:Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931:unilateral or limited study
93965:Non-invasive physiologic studies of extremity veins, complete bilateral study (e.g., Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970:Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971:unilateral or limited study
93975:Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976:limited study
93978:Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979:unilateral or limited study
93980:Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981:follow-up or limited study
93990:Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

ICD-9 Codes That Support Medical Necessity

For covered ICD-9 codes for an individual CPT code, refer to the specific Local Medical Review Policy for that code.

Pulmonary

The personnel performing the tests identified under the HCPCS Codes section must have the applicable certification as follows.

The National Board for Respiratory Care (NBRC) offers the following credentials:

Certified Pulmonary Function Tech (CPFT);
Registered Pulmonary Function Tech (RPFT);
Certified Respiratory Therapy Tech (CRTT);
Registered Respiratory Therapist (RRT);
Perinatal/Pediatric Care Specialist.

Once credentialing is obtained then a State license is obtained from the Florida state board. A person holding a license may have one or more of the above certifications.

CPT-4 CODES(S): 94010, 94060-94070
CERTIFICATION: Registered Nurse (RN)

CPT-4 CODES(S): 94200-94450
CERTIFICATION: State license: RPFT, RRT, CPFT, CRT

CPT-4 CODES(S): 94620-94621
CERTIFICATION: State license: RPFT, RRTRegistered Nurse (RN)

CPT-4 CODES(S): 94664-94665
CERTIFICATION: State license: CPFT, RPFT, CRTT, RRTRegistered Nurse (RN)

CPT-4 CODES(S): 94680-94750
CERTIFICATION: State license: RPFT, RRT

CPT-4 CODES(S): 94760-94762
CERTIFICATION: State license: CPFT, RPFT, CRTT, RRTRegistered Nurse (RN)

CPT-4 CODES(S): 94770
CERTIFICATION: State license: RPFT, RRT

CPT-4 CODES(S): 94799
CERTIFICATION: State license: Appropriate credentialing based on service performing

HCPCS Codes

94010:Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

94060:Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)

94070:Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent, with subsequent spirometrics

94200:Maximum breathing capacity, maximal voluntary ventilation

94240:Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method

94250:Expired gas collection, quantitative, single procedure (separate procedure)

94260:Thoracic gas volume

94350:Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time

94360:Determination of resistance to airflow, oscillatory or plethysmographic methods

94370:Determination of airway closing volume, single breath tests

94375:Respiratory flow volume loop

94400:Breathing response to CO₂ (CO₂ response curve)
94450:Breathing response to hypoxia (hypoxia response curve)
94620:Pulmonary stress testing; simple (e.g., prolonged exercise test for bronchospasm with pre- and post- spirometry)
94621:complex (including measurements of CO₂ production, O₂ uptake, and electrocardiographic recordings)
94664:Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665:subsequent
94680:Oxygen uptake, expired gas analysis; rest and exercise, direct, simple
94681:including CO₂ output, percentage oxygen extracted
94690:rest, indirect (separate procedure)
94720:Carbon monoxide diffusing capacity, any method
94725:Membrane diffusion capacity
94750:Pulmonary compliance study, any method
94760:Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761:multiple determination (e.g., during exercise)
94762:by continuous overnight monitoring (separate procedure)
94770:Carbon dioxide, expired gas determination by infrared analyzer
94779:Unlisted pulmonary service or procedure

Neurology and Neuromuscular

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

The American Association of Electrodiagnostic Technologists (AAET) offers the following credentials:

Registered Electrodiagnostic Technologist (R. EDT.)

The American Board of Registration of Electroencephalographic and Evoked Potential Technologists, Inc. (ABRET) offers the following credentials:

Registered Electroencephalographic Technologist (R. EEG T.);
Registered Evoked Potential Technologist (R. EP T.);
Certified Neurophysiologic Interoperative Monitoring Technologist (CNIM).

The National Board for Respiratory Care (NBRC) offers the following credentials:

Certified Pulmonary Function Tech (CPFT);
Registered Pulmonary Function Tech (RPFT);
Certified Respiratory Therapy Tech (CRTT);

Registered Respiratory Therapist (RRT);
Perinatal/Pediatric Care Specialist.

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

Registered Polysomnographic Technologist (RPSGT)

CPT-4 CODES(S): 92585
CERTIFICATION: ABRET: R. EP T., R. EEG T. Audiologist

CPT-4 CODES(S): 95805, 95807-95811
CERTIFICATION: ABRET: R. EEG T. BRPT: RPSGT State license: CPFT, RPFT, CRTT, RRT

CPT-4 CODES(S): 95812-95822, 95827
CERTIFICATION: ABRET: R. EEG T.

CPT-4 CODES(S): 95860-95870
CERTIFICATION: Physician service or qualified Physical Therapist who is permitted to perform service under state law

CPT-4 CODES(S): 95900-95904
CERTIFICATION: AAET: R. EDT. ABRET: R. EP T, Qualified Physical Therapist permitted to perform service under state law

CPT-4 CODES(S): 95921-95923
CERTIFICATION: AAET: R. EDT.

CPT-4 CODES(S): 95925-95930
CERTIFICATION: ABRET: R. EP T., R. EEG T.

CPT-4 CODES(S): 95933-95937
CERTIFICATION: AAET: R. EDT. Qualified Physical Therapist who is permitted to perform service under state law

CPT-4 CODES(S): 95950-95953
CERTIFICATION: ABRET: R. EEG T.

CPT-4 CODES(S): 95954
CERTIFICATION: ABRET: R. EEG T

CPT-4 CODES(S): 95956-95957
CERTIFICATION: ABRET: R. EEG T.

CPT-4 CODES(S): 95958
CERTIFICATION: ABRET: R. EEG T.

CPT-4 CODES(S): 95999
CERTIFICATION: Appropriate credentialing based on service performing

HCPCS Codes

92585: Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system.

95805:Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95807:Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808:Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist

95810:sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811:sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

Page 55

95812: Electroencephalogram (EEG) extended monitoring; up to one hour
95813:greater than one hour
95816:Electroencephalogram (EEG) including recording awake and drowsy, with hyperventilation and/or photic stimulation
95819:Electroencephalogram (EEG) including recording awake and asleep, with hyperventilation and/or photic stimulation
95822:Electroencephalogram (EEG); sleep only
95827:all night sleep only
95860:Needle electromyography, one extremity with or without related paraspinal areas
95861:Needle electromyography, two extremities with or without related paraspinal areas
95863:Needle electromyography, three extremities with or without related paraspinal areas
95864:Needle electromyography, four extremities with or without related paraspinal areas
95867:Needle electromyography, cranial nerve supplied muscles, unilateral
95868:Needle electromyography, cranial nerve supplied muscles, bilateral
95869:Needle electromyography, thoracic paraspinal muscles
95870:other than paraspinal (e.g., abdomen, thorax)
95900:Nerve conduction, amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; motor, without F-wave study
95903:motor, with F-wave study
95904:sensory
95921:Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio
95922:vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt
95923:sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat

imprint, thermoregulatory sweat test, and changes in sympathetic skin potential

95925:Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs

95926:in lower limbs

95927:in the trunk or head

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

95933:Orbicularis oculi (blink) reflex, by electrodiagnostic testing

95934:H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle

95936:record muscle other than gastrocnemius/soleus muscle

95937:Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

95950:Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (e.g., 8 channel EEG) recording and interpretation, each 24 hours

95951:Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for presurgical localization), each 24 hours

95953:Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours

95954:Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (e.g., thiopental activation test)

95956:Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours

95957:Digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis)

95958:Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring

95999:Unlisted neurological or neuromuscular diagnostic procedure

ICD-9 Codes That Support Medical Necessity

For covered ICD-9 codes for an individual CPT code, refer to the specific Local Medical Review Policy for that code.

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 and applicable Local Medical Review Policies.

When the services are performed for screening purposes.

When the medical record does not verify that the service described by the HCPCS code was provided.

Noncovered ICD-9 Code(s)

Any diagnosis codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of the applicable Local Medical Review Policy.

Coding Guidelines

The performing provider must have on-site 24 hour availability when the HCPCS code(s) identifies the services as one performed for 24 hours. The use of an answering service or machine for review at a later time to meet the 24 hour requirement, is not appropriate.

Documentation Requirements

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

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

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

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

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

51725 Urodynamic Testing

Urodynamic tests are designed to determine the anatomic and functional status of the urinary bladder and urethra.

Indications and Limitations of Coverage and/or Medical Necessity
Conditions acquired through disease or trauma and some conditions of congenital origin, which interfere with the sensory or motor innervation of the urinary bladder and/or the urethral sphincter constitute indications for urodynamic studies.

Conditions that interfere with urinary flow on the basis of obstruction or psychiatric conditions are not indications for urodynamic studies.

Uroflometric evaluations (also referred to as urodynamic voiding or urodynamic flow studies) are covered under Medicare for diagnosing various urological dysfunctions, including bladder outlet obstructions.

HCPCS Codes

51725:Simple cystometrogram (CMG) (e.g., spinal manometer)
51726:Complex cystometrogram (e.g., calibrated electronic equipment)
51736:Simple uroflowmetry (UFR) (e.g., stop-watch flow rate, mechanical uroflowmeter)
51741:Complex uroflowmetry (e.g., calibrated electronic equipment)
51772:Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique
51792:Stimulus evoked response (e.g., measurement of bulbocavernosus reflex latency time)
51795:Voiding pressure studies (VP); bladder voiding pressure, any technique
51797:intra-abdominal pressure (AP) (rectal, gastric, intraperitoneal)

ICD-9 Codes That Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9 Code(s)

N/A

Coding Guidelines

Reimbursement for cystometrograms (51725-26, 51726-26), uroflowmetry (51736-26, 51741-26), pressure studies (51772-26, 51795-26, 51797-26), and stimulus evoked response (51792-26) when billed on the same day by the same physician will be based on multiple surgery guidelines. These services are not payable as repeat procedures.

Documentation Requirements

Documentation to support the medical necessity for urodynamic testing such as office notes, test results, progress notes, history and physical should be maintained on file in the event of a postpayment audit.

Advance Notice Statement

Applies to medical necessity (see page 4).

Page 57

70450: Computerized Tomography:Tomography is the recording of internal body images at a pre-determined plane by x-ray. Computerized axial tomography, or CT scans, involve the measurement of the emergent x-ray beam by a scintillation counter. The electronic pulses are recorded on a magnetic disk and then processed by a minicomputer for reconstruction display of the body in cross-section on a cathode ray tube.

Indications and Limitations of Coverage and/or Medical Necessity

Computerized Tomography Scans:

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

HCPCS Codes

70480:Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481:with contrast material(s)
70482:without contrast material, followed by contrast material(s) and further sections
70486:Computerized axial tomography, maxillofacial area; without contrast material
70487:with contrast material(s)
70488:without contrast material, followed by contrast material(s) and further sections
70490:Computerized axial tomography, soft tissue neck; without contrast material
70491:with contrast material(s)
70492:without contrast material, followed by contrast material(s) and further sections
71250:Computerized axial tomography, thorax; without contrast material
71260:with contrast material(s)
71270:without contrast material, followed by contrast material(s) and further sections
72125:Computerized axial tomography, cervical spine; without contrast material
72126:with contrast material
72127:without contrast material, followed by contrast material(s) and further sections
72128:Computerized axial tomography, thoracic spine; without contrast material
72129:with contrast material
72130:without contrast material, followed by contrast material(s) and further sections
72131:Computerized axial tomography, lumbar spine; without contrast material
72132:with contrast material
72133:without contrast material, followed by contrast material(s) and further sections
73200:Computerized axial tomography, upper extremity; without contrast material
73201:with contrast material(s)
73202:without contrast material, followed by contrast material(s) and further sections
73700:Computerized axial tomography, lower extremity; without contrast material
73701:with contrast material(s)
73702:without contrast material, followed by contrast material(s) and further sections
74150:Computerized axial tomography, abdomen; without contrast material
74160:with contrast material(s)
74170:without contrast material, followed by contrast material(s) and further sections

ICD-9 Codes That Support Medical Necessity
N/A

Computerized Tomography Scans - Head:

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

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

Coverage for headache should only be for the following situation:

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

HCPCS Codes

70450:Computerized axial tomography, head or brain; without contrast material

70460:with contrast material(s)

70470:without contrast material, followed by contrast material(s) and further sections

Page 58

ICD-9 Codes That Support Medical Necessity

006.5
013.00-013.36
013.60-013.96
036.0-036.2
042
046.0-046.9
047.0-047.9
049.0-049.9
052.0
053.0
054.3
054.72
055.0
056.01
062.0-062.9
063.0-063.9
064
072.1-072.2

090.40-090.49
094.0-094.9
112.83
114.2
115.01
115.11
115.91
130.0
162.0-162.9*
170.0
191.0-191.9
192.0.192.1
194.3-194.4
195.0
196.0
198.3-198.5
199.0-199.1
200.11
200.21
201.11
201.21
201.41
201.51
201.61
201.71
201.91
213.0
225.0-225.2
225.8
227.3-227.4
237.0-237.1
237.5-237.9
239.6-239.7
250.20-250.23
250.30-250.33
253.0-253.9
255.0-255.9
290.0-290.9
293.0-293.83
294.0-294.9
298.9
310.0-310.9
320.0-326
330.0-334.9
341.0-341.9
342.00-342.92
343.0-343.9
344.00-344.9
345.00-345.91
348.0-348.9
349.1-349.9
350.1-350.9
351.0-351.9
352.0-352.9
368.11
368.12
368.2

368.40
368.8
368.9
374.31
377.00-377.01
377.51-377.52
377.61
377.71
378.51-378.56
386.2
388.2
388.5
430-438.9
572.2
674.00-674.04
738.10-738.19
740.0-740.2
742.0-742.4
742.8
742.9
747.81
756.0
759.2-759.9
765.0-765.1
767.0
767.1
767.3
768.5
768.6
768.9
770.8
772.1-772.2
779.0-779.2
780.01-780.09
780.1
780.2
780.31-780.39
780.4
780.6
780.9
781.0-781.9
784.2
784.3
784.5
784.60-784.69
793.0
794.00-794.09
800.00-804.99
850.0-854.19
873.0-873.1
873.9
950.0-950.9
951.0-951.9
996.2
997.00-997.09
V10.85
V10.86

V10.88
V45.2
V67.1
V67.2

* Note: ICD9 code range 162.0-162.9 is added effective for services processed on and after February 22, 1999

Reasons for Denial

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

Noncovered ICD-9 Code(s)

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

Coding Guidelines

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

Documentation Requirements

Documentation should be maintained in the patient's medical record that supports the need for services. Documentation including office/progress notes and/or history and physical and a copy of the CT report should be maintained in the patient's medical record.

90780-90799: Therapeutic Or Diagnostic Injections/Infusions - Correction

The medical policy for these procedure codes was provided in the January/February 1999 Medicare Part B Update! (page 48). An error has been noted in the second paragraph under the "Indications and Limitations of Coverage and/or Medical Necessity" heading. The article referenced use of procedure code modifier -GB, however, the correct modifier should be -59. The corrected paragraph appears below.

"Reimbursement for infusion injection codes (90780-90781) are allowed in addition to the evaluation and management visit, and chemotherapy administration (96410, 96412, 96414) and the cost of the drug(s) when billed on the same date of service using the -59 modifier."

The remainder of the policy is correct as published in the January/February 1999 Update!

Page 59

90999: ESRD Laboratory Services and Diagnostic Services

The Health Care Finance Administration (HCFA) has designated services that are included in the composite rate and those services that are separately billable to the Carrier. The Local

Medical Review Policy (LMRP) for ESRD Laboratory Services and Diagnostic Services (90999) reflects the national coverage of laboratory and diagnostic services that are included in the composite rate and the services that are separately billable to the Carrier. The LMRP has been revised to reflect the current national coverage for separately billable tests that are covered routinely without documentation of medical necessity.

Indications and Limitations of Coverage and/or Medical Necessity
The following lab tests for Hemodialysis, Peritoneal Dialysis, and CCPD are included in the composite rate:

(1)

Per treatment

All Hematocrit (85013)

All Hemoglobin (85018)

All Clotting Time Tests (85345)

(2)

Weekly

Prothrombin Time (85610)

Serum Creatinine (82565)

BUN (84520)

(3)

Monthly

Serum Albumin (82040)

Serum Chloride (82435)

Serum Calcium (82310)

Serum Bicarbonate (82374)

CBC (85031)

Serum Phosphorous (84100)

Serum Potassium (84132)

Alkaline Phosphatase (84075)

Total Protein (84155)

SGOT (84450)

LDH (83615)

The following laboratory tests for CAPD are included in the composite rate:

Monthly

BUN (84520)

Creatinine (82565)

Sodium (84295)

CO2 (82374)

Calcium (82310)

Magnesium (83735)

Phosphate (84100)

Potassium (84132)

Total Protein (84155)

Albumin (82040)

Dialysate Protein (84165)

Alkaline Phosphatase (84075)

Hct (85014)

Hgb (85018)

HCPCS Codes

See HCPCS codes included in this policy

ICD-9 Codes That Support Medical Necessity

N/A

Reasons for Denial

N/A

Noncovered ICD-9 Code(s)

N/A

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.

Documentation Requirements

Diagnosis, complaint, or symptom other than renal disease should be present on the claim for tests in excess of the frequency, as described for various tests. Documentation to support medical necessity of additional tests should be maintained on file in the event of postpayment audit.

Advance Notice Statement

Applies to medical necessity (see page 4).

Page 60

93268: Billing of Patient Demand Single or Multiple Event Recorder

The Local Medical Review Policy (LMRP) for Patient Demand Single or Multiple Event Recorder was published on pages 35-37 of the November/December 1998 Medicare B Update!. We have received inquiries regarding a statement in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy that reads, "The recording device and transmission equipment must be verifiably in the patient's possession for the entire thirty day period of submission." The inquiries were regarding the proper billing of these services when, under rare circumstances, the patient has the recording device or transmission equipment in his/her possession for less than thirty days.

We are aware that there may be rare circumstances in which the patient may not have the recording device and transmission

equipment in his/her possession for the entire thirty days (e.g., the patient expires before the thirty days of monitoring is completed, the patient experiences cardiovascular symptomatology which is correlated with an abnormal rate and rhythm [which the device records] that enables the physician to determine the precise mechanism of the arrhythmia and medically manage the patient before the thirty days of monitoring are completed, etc.). Under these rare circumstances, providers must bill the service with the appropriate procedure code and a -52 modifier.

93965, 93970, 93971: Non-Invasive Evaluation of Extremity Veins - Correction

This policy revision was originally published in the November/December 1998 Medicare Part B Update! (page 38). Procedure codes 93970 and 93971 were inadvertently omitted, however, these procedures should also be included in the revision. The corrected policy revision is as follows.
"The Local Medical Review Policy (LMRP) for procedure codes 93965, 93970 and 93971 has been revised. An additional indication for coverage has been approved. Non-invasive evaluation of extremity veins will be considered medically necessary when the patient presents with signs and symptoms of pulmonary embolism. The more common symptoms include: acute onset of dyspnea, chest pain, apprehension, hemoptysis or syncope. ICD-9 codes that support this medical indication are 786.00-786.59 (Symptoms involving respiratory system and other chest symptoms). For additional information regarding the LMRP for these procedure codes, see page 64 of the March/April 1997, Medicare Part B Update!"

Advance Notice Statement
Applies to medical necessity (see page 4).

95860-95864: Needle Electromyography
This is a clarification regarding the proper reporting of needle electromyography services. The descriptors for the following procedure codes specifically indicate the number of extremities. Therefore, the number billed for these codes should never exceed one.

95860: Needle electromyography, one extremity with or without related paraspinal areas
95861: Needle electromyography, two extremities with or without related paraspinal areas
95863: Needle electromyography, three extremities with or without related paraspinal areas
95864: Needle electromyography, four extremities with or without related paraspinal areas

Page 61

95937: Neuromuscular Junction Testing
Neuromuscular junction testing involves the stimulation of an individual motor nerve by means of repetitive electrical impulses

with measurement of muscle electrical activity. Supramaximal electrical stimuli are delivered to the skin overlying a motor nerve. A percutaneous electrode placed over the corresponding muscle records the evoked muscle action potentials using standard EMG technique. This procedure is unique in that the electrical stimuli are delivered in a repetitive train (1-4 Hz). In diseases of the neuromuscular junction, characteristic changes in the compound action potential may be seen upon repetitive stimulation.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare Part B will consider Neuromuscular Junction Testing medically necessary and reasonable when performed for the following circumstances:

Evaluation of the patient with a disorder of the neuromuscular junction suspected on clinical grounds. This includes both postsynaptic disorders such as myasthenia gravis and presynaptic disorders such as Eaton-Lambert syndrome (myasthenic paraneoplastic syndrome associated with small cell carcinoma of the lung), botulism and disorders associated with use of aminoglycosides.

Myasthenia gravis usually affects the muscles to the eyes, face, jaws, throat, and neck first; however, as the disease advances it often spreads to other muscles. Signs and symptoms may include, but are not limited to, the following: ptosis, diplopia, difficulty in chewing and swallowing, dysarthria, respiratory difficulties, limb weakness, or some combination of these problems. Weakness may remain localized to a few muscle groups, especially the ocular muscles, or may become generalized. Sensory modalities and deep tendon reflexes are normal. Symptoms often fluctuate in intensity during the day. Muscle weakness tends to increase with continued activity and rest restores strength at least partially.

Myasthenic syndrome (Eaton-Lambert Syndrome) usually affects muscles of the trunk, shoulder girdle, pelvic girdle, and lower extremities. Often the first symptoms are difficulty in arising from a chair, climbing stairs, and walking; the shoulder muscles are usually affected later. Other signs and symptoms may include ptosis, diplopia, dysarthria, and dysphagia. Tendon reflexes are often diminished. There may be a temporary increase in muscle power with sustained contractions.

Botulism results from ingestion of toxin and symptoms usually begin within 72 hours and may progress for several days. Typically, there is diplopia, ptosis, facial weakness, dysphagia, and nasal speech, followed by respiratory difficulty, and finally weakness in the limbs. Other signs and symptoms may include blurring of vision (with unreactive dilated pupils), dryness of the mouth, constipation, and postural hypotension. Sensory modalities and deep tendon reflexes are normal.

Aminoglycoside antibiotics may produce clinical disturbance similar to botulism, but symptoms subside rapidly as the responsible drug is eliminated from the body. These antibiotics

are particularly dangerous in patients with pre-existing disturbances of neuromuscular transmission and are therefore best avoided in patients with myasthenia gravis. You would not expect to see this procedure performed for this reason due to the fact that the symptomatology subsides with removal of the drug. If signs and symptoms persist after removal of the medication, then this should be billed per signs and symptoms that exist.

HCPCS Codes

95937:Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

ICD-9 Codes That Support Medical Necessity

199.1
358.0
358.1
368.2
368.8
374.30
378.73
723.1
728.9
780.79
781.2
781.9
784.5
786.03-786.09
787.2

Reasons for Denial

All except those listed above.

Noncovered ICD-9 Code(s)

N/A

Rationale For Creating Policy

Analysis of Medicare claims data for Florida indicates that the carrier has allowed significantly more reimbursement, per 1,000 Medicare beneficiaries, than Medicare has paid nationally for procedure code 95937.

Coding Guidelines

Based on review of this service, it has been determined that this service should be carried out in a fully equipped electrodiagnostic testing room. Therefore, this service should not be performed in the home (POS 12) or in a custodial care facility (POS 33).

Page 62

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Medical record documentation in support of medical necessity could include:

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

Office/progress notes

Repetitive neuromuscular junction test(s) results

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

Advance Notice Statement

Applies to medical necessity (see page 4).

99183: Hyperbaric Oxygen Therapy - Clarification
On pages 54-57 of the March/April 1998 Medicare B Update!, the coverage criteria for hyperbaric oxygen therapy were published. Since the publication of that article, the following language has been modified: The physician must be personally in attendance in the hyperbaric department (unit) when the patient is receiving hyperbaric oxygen therapy (this does not imply that the physician must be in the chamber with the patient).

Codes 99301-99303
The above range of procedure codes involve evaluation and management of a new or established patient in a nursing facility. While these codes describe different levels of care, it is apparent that these nursing facility visit codes should not be billed by the following provider specialties: Oral Surgery, Dentists, Optometry, and Podiatry. Claims for procedure codes 99301-99303 rendered by these specialties will be denied.

Page 63

PC-ACE(tm) Customer Support Needs Your Help!
The Customer Support staff understands how valuable your time is, and would like to assist you in reducing the amount of time you spend on the phone with us. In order to accomplish this, please have the following information available when you contact our office:

Sender number (located in your Submitter file)

Mailbox ID (provided on the introduction letter received with your initial software)

Release number (located in the top right hand corner of Main Menu screen)

Backup diskette (you have the opportunity to create a backup each time you exit the software or transmit claims)

Error message (if received)

Additionally, if you are experiencing transmission problems, please contact us on a phone line other than the one you transmit on.

EDI Enrollment Form

The following information is being provided primarily to Independent Physiological Laboratories (IPLs) who are being re-certified as Independent Diagnostic Testing Facilities (IDTFs). IDTFs should refer to page 48 for more information on credentialing requirements. A new EDI enrollment agreement is necessary for the new entity to bill electronic media claims to Medicare of Florida. This enrollment form is not limited in use to IDTFs; it is applicable to any provider is interested in billing electronically

General Completion Instructions For "EDI Enrollment Form"

Page 1-2 of 3

Section A-B:

Each provider, supplier or PA group who is applying to submit electronic claims or replacing existing forms should ensure they read and agree to the provisions in this section of the document prior to signing.

Page 3 of 3

Section C:

THIS SECTION MUST BE COMPLETED (each field is listed in the order as it appears on the form)

PROVIDER NAME: Name of provider, supplier or PA group should be listed (enrollment forms for PA groups should always have the PA group name listed in the Provider's Name section).

TITLE: Indicate the title of the provider, supplier or PA group listed in the Provider's Name section.

ADDRESS: The physical address where services are performed must be listed. If you recently changed your address, do not submit your enrollment form until the change has been made with Medicare B Registration.

CITY/STATE/ZIP: Indicate the city/state/zip for the provider, supplier or PA group.

BY: The signature of the person completing the enrollment form should be listed.

TITLE: Title of person completing enrollment form (e.g. Office Manager, MD, Billing Coordinator, etc.).

DATE: Date enrollment form was completed.

PHYSICIAN/SUPPLIER/PA GROUP/HOSPITAL ADMINISTRATOR SIGNATURE: Provider signature, owner of supplier site (e.g., IPL, ACS, etc.) signature of president or office manager signature for PA groups is required.

BILLING SERVICE: Name of company. If you are using a billing service to submit your claims electronically, indicate the name of the company.

CLEARINGHOUSE: Name of company. If you are using a clearinghouse to submit your claims electronically, indicate the name of the company.

SENDER NUMBER: Indicate the sender number you currently use to bill electronically to Medicare if already established. If you are adding a provider to your existing EMC sender location indicate your sender number. If you currently bill paper claims this field should be left blank.

CONTACT PERSON: Name of the person in the provider's office to speak with regarding application or claims inquiries.

TELEPHONE NUMBER: Telephone number (with area code) of the contact person.

MEDICARE B PHYSICIAN/SUPPLIER/PA GROUP PROVIDER NUMBER: Provider number used to bill Medicare B; if provider is a PA group or facility list the group or facility number.

MEDICARE A PROVIDER NUMBER: This is for Medicare Part A provider's only (hospitals, CORF, etc.) Hospitals billing for Medicare Part B services to Blue Cross Blue Shield of Florida (in Jacksonville) need to indicate the provider number in the Medicare B Provider Number section.

Page 64 - 66

EDI Enrollment Form

FORM NOT AVAILABLE IN THIS FORMAT

Please contact the Medicare EDI Marketing Area at (904)791-8767 for support in getting started with EMC and copies of this and other forms required for EDI.

Page 67

The Medicare Fraud and Abuse Incentive Reward Program
One of the provisions outlined in the Health Insurance Portability and Accountability Act of 1996 instruct the Department of Health and Human Services to establish a program to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of sanctions as specified under the Social Security Act or who have otherwise engaged in sanctionable fraud and abuse against the Medicare program.

Recently, a program was established which allows payment to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. The following information outlines the Medicare Fraud and Abuse Incentive Reward Program: The Medicare program will make a monetary reward only for information that leads to a minimum recovery of \$100 of Medicare funds from individuals and entities determined to have committed sanctionable offenses.

The information must relate to a specific situation, individual, or entity, and must specify the time period of the alleged activities. It must be relevant material to impose a sanction, and non-frivolous.

The Health Care Financing Administration (HCFA) does not give a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a review or investigation by HCFA, its contractors, the OIG, the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), or any other Federal, State or local law enforcement agency.

Any person is eligible to receive a reward if the person submits the information described previously. The following individuals are not eligible to receive a reward:

An individual who was, or is an immediate family member of, an officer or employee of the Department of Health and Human Services (DHHS), its contractors or subcontractors, the Social Security Administration (SSA), the OIG, a State Medicaid Agency, the DOJ, the FBI, or any other Federal, State, or local law enforcement agency at the time he or she came into possession of, or divulged information leading to a recovery of Medicare funds;

Any other Federal or State employee, contractor or subcontractor, or a DHHS grantee, if the information submitted came to his/her knowledge during the course of his/her official duties;

An individual who illegally obtained the information he/she submitted; or

An individual who participated in the sanctionable offense with respect to which payment would be made.

The amount of the reward will not exceed 10 percent of the amounts recovered in the case, or \$1000, whichever is less. Individuals who contact the Medicare contractor to report Medicare fraud and abuse are automatically considered for the reward program. Individuals must note that the process may take a significant amount of time because the scope of an investigation could take months or years to complete. However, once an investigation is completed which results in a recovery of \$100 or more, the individual who qualifies for the reward will be notified by letter.

Page 68

Compliance Programs Guidance Issued by the Office of the Inspector General

In an effort to engage the health care community in combatting fraud, waste, and abuse, the Department of Health and Human Services, Office of the Inspector General (OIG) issues guidance on compliance programs. Specifically, the OIG has issued guidance on compliance programs for the hospital industry, home health agencies, and clinical laboratories - each were published in the Federal Register on February 23, 1998, August 7, 1998, and August 24, 1998, respectively. More recently, the OIG issued guidance in the December 21, 1998, Federal Register for third-party medical billing companies and the health care providers they serve. In formulating the guidance, the OIG worked closely with the Health Care Financing Administration (HCFA), the Department of

Justice (DOJ), and various sectors of the health care industry. Based on their work, the OIG has identified seven fundamental elements to an effective compliance program:

Implementing written policies, procedures, and standards of conduct;

Designating a compliance officer and compliance committee;

Conducting effective training and education;

Developing effective lines of communication;

Enforcing standards through well-publicized disciplinary guidelines;

Conducting internal monitoring and auditing; and

Responding promptly to detected offenses and developing corrective action.

Although compliance programs are strictly voluntary, adopting one could be beneficial to a health care provider or any entity involved in the health care industry. Implementing a compliance program could assist them in establishing a culture within their organization that promotes prevention, detection, and resolution of behaviours or practices that do not conform to Federal or State law, and Federal, State, or private payor health care program requirements, as well as ethical business practices. Those interested in implementing a compliance program based on the OIG's published guidance must understand that although there is basic procedural and structural guidance for designing and implementing a compliance program, the guidance in itself is NOT a compliance program. Rather, it is a set of guidelines for consideration in implementing such a program. The compliance program should effectively articulate and demonstrate the provider's or entity's commitment to legal and ethical conduct. Eventually, a compliance program should become part of the provider's or entity's routine operations. Furthermore, having a compliance program in place does not provide the health care provider or other organization with immunity from scrutiny and/or corrective action by the government or any Federal, State, or private payor health care program.

Compliance Programs for Third-Party Billing Companies

As previously mentioned, the OIG issued guidance on compliance programs for third-party billing companies. Because third-party billing companies may support a variety of providers who may rely on them to provide advice with regard to coverage and reimbursement matters, as well as overall business decision-making, third-party billing companies are in a unique position to implement compliance programs not only for themselves, but for their clients, which may effectively detect and prevent fraud and abuse.

Using the basic elements of an effective compliance program, the
OIG identified specific areas of third-party medical billing
company operations that may be vulnerable to fraud and abuse:

Unbundling;

Upcoding;

Inappropriate balance billing;

Inadequate resolution of overpayments;

Lack of integrity in computer systems;

Failure to maintain the confidentiality of information/records;

Knowing misuse of provider identification numbers, which results
in improper billing;

Outpatient services rendered in connection with inpatient stays;

Duplicate billing in an attempt to gain duplicate payment;

Billing for discharge in lieu of transfer;

Failure to properly use modifiers;

Billing company incentives that violate the anti-kickback statute
or other similar Federal or State statute or regulation;

Joint ventures;

Routine waiver of copayments and billing third-party insurance
only; and

Discounts and professional courtesy.

Page 69

Although this may not be a comprehensive list, it provides a
basis for consideration in formulating a compliance program.
Also, because third-party billing companies can offer an array of
services to their clients which may vary in size, type, and/or
specialty, the applicability of compliance program guidelines and
recommendations may depend on the circumstances of each
particular billing company and their clients. However, regardless
of a third-party billing company's size and structure, every
company can accomplish the objectives and principles underlying
the compliance policies and procedures recommended.
For a comprehensive explanation of compliance program guidance
for third-party billing companies, refer to the December 21, 1998
Federal Register. In addition, the document issued by the OIG on
compliance programs are on the Internet at:

<http://www.dhhs.gov/progorg/oig>.

Heart, Liver, and Lung Transplant Centers in Florida
Below is a list of Medicare-approved heart transplant centers,
heart-lung transplant centers, and liver transplant centers in
Florida.

Medicare Heart Transplant Centers

Name and Address: Tampa General Hospital, Davis Islands, P. O.
Box 1289 Tampa, Florida 33601
Effective Date: August 19, 1988

Name and Address: Shands Hospital(University of Florida)Box J-
286, JHMH, Gainesville, Florida 32610
Effective Date: January 19, 1990

Name and Address: Jackson Memorial Hospital1611 NW. Twelfth
Avenue, Miami, Florida 33136
Effective Date: September 29, 1995

Medicare Heart-Lung Transplant Centers

Name and Address: University of Florida - Shands Transplant
Center, P.O. Box 100251Gainesville, Florida 32610-0251
Effective Date: April7, 1997

Medicare Liver Transplant Centers

Name and Address: Jackson Memorial Hospital1611 NW Twelfth
Avenue, Miami, Florida 33136
Effective Date: February 15, 1995

Name and Address: Shands Hospital at University of Florida, P.O.
Box 100251Gainesville, Florida 32610-0251
Effective Date: June 2, 1995

Enforcement of Child Support Provisions of the Debt Collection
Act of 1996
The Debt Collection Act of 1996 and Executive Order 13019 allow
delinquent child support payments to be offset from Federal
payments. The Health Care Financing Administration (HCFA) is
working with the Administration for Children and Families to
identify individuals delinquent in their child support
obligations who receive Federal payments and to consider
withholding Federal payments, if appropriate. HCFA also plans to
coordinate its efforts with the States, which have authority
under recent welfare reform legislation to revoke licenses of
health professionals who are delinquent in child support
payments.

Ending Suppression of Medicare Summary Notices

Effective April 1, 1999, Medicare is ending the current guidelines requiring the suppression of Medicare Summary Notices (MSNs), when certain criteria were met, in all instances except for the following claim types: Laboratory, Demonstrations, Exact Duplicates, and Statistical Adjustments. These four types of claims still require suppression of notices. Additionally, to comply with Section 4311 of the Balanced Budget Act of 1997, Medicare will include the following message on all Medicare Summary Notices: "You have the right to request 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 if you would like an itemized statement." As a result of this implementation, providers' offices that are not currently providing the patients with an itemized statement of the services rendered/supplied, may experience an increase in requests for these statements.

Sanctioned Provider Information Available on the Internet
The Office of the Inspector General (OIG) keeps public records of individuals/entities that are excluded from reimbursement under Medicare (Title XVIII of the Social Security Act). This information is available on the Internet. Visit www.arnet.gov/epl/ for the list of debarred, excluded, and suspended providers and entities.

Page 70

Medicare Enrollment of PTs and OTs in Private Practice
Effective on or after January 1, 1999, physical therapists (PTs) and occupational therapists (OTs) desiring to engage in "a private practice" are allowed to use the Medicare Carrier enrollment process and no longer are required to be certified by the Agency for Health Care Administration (AHCA). Therefore, these type of applications do not have to be submitted to the AHCA. This requirement replaces the current requirement in which the term "independent practice" is dropped and replaced by "private practice".

Private vs. Independent Practice
"Independently practicing" was defined as services rendered free of administrative and professional control of an employer such as a physician, institution, or agency. The "private practice" definition differs as it includes an "individual" whose practice is in an unincorporated solo practice or unincorporated partnership. Private practice also includes an "individual" who is practicing therapy as an employee of an unincorporated practice, a professional corporation, or other incorporated therapy practice. Private practice does not include individuals working as employees of a hospital, skilled nursing facility (SNF), critical access hospital (CAH), home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF), community mental health center (CMHC), hospice, clinic, rehabilitation agency, or public health agency.

Requirements for Establishing a Private Practice

A physical or occupational therapist in private practice must maintain a private office space, even if services are always furnished in the patients' homes. The space must be owned, leased, or rented by the independently practicing therapist or the therapist's practice and used for the exclusive purpose of operating the practice.

Qualified physical and occupational therapists must enroll as individuals by completing the HCFA-855 enrollment application. All information submitted on the application will be verified to ensure the qualifications and requirements for a PT/OT in private practice are met. To validate the enrollment information provided in the HCFA-855 form, an on site visit may be conducted.

Physical therapists and occupational therapists may form a professional association (P.A.) group. The P.A. group must consist only of physical and/or occupational therapists. A HCFA-855 general enrollment application must be submitted for the group and for each PT/OT not previously enrolled with Medicare. PT/OT with a Medicare number must submit a HCFA-855R for reassignment of benefits. Privately practicing therapists cannot join an existing group of physicians or any other non- PT or OT practitioners.

The applicant must indicate on the HCFA-855 general enrollment application whether he or she intends to bill the Medicare fiscal intermediary, the carrier or both. If the intention is to bill the fiscal intermediary, then the individual or group is applying for a Medicare Part A provider number which requires submission of an annual cost report and state certification by the AHCA. In this case the enrollment application must be submitted to:

The Agency For Health Care Administration
Hospital and Outpatient Section
2727 Mahan Drive
Tallahassee, FL 32308

HCFA-855 general enrollment applications submitted to the Medicare carrier indicating the intention of billing for a fiscal intermediary number will be forwarded to the AHCA to undergo survey and certification.

Physical/occupational therapist applicants choosing to become Medicare Part B providers in private practice setting must submit the HCFA-855 general enrollment application form to:

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

For transition purposes, independent therapists who are currently certified and enrolled will be "grandfathered" in at this time and would be subject to the new enrollment rules and procedures if they are required to reenroll in the future.

Overpayment Interest Rate

Medicare Part B assesses interest on overpaid amounts which are not refunded in a timely manner. Interest will be assessed if the overpaid amount is not refunded within 30 days from the

overpayment demand letter date. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate. Effective February 1, 1999, the interest rate applied to Medicare overpayments is 13.75 percent based on the new revised PCR rate. The following table lists interest rates:

Period: October 23, 1998 - January 31, 1999
Interest Rate: 13.50%

Period: July 31, 1998 - October 22, 1998
Interest Rate: 13.75%

Period: May 13, 1998 - July 30, 1998
Interest Rate: 14.00%

Period: January 28, 1998 - May 12, 1998
Interest Rate: 14.50%

Period: October 24, 1997 - January 27, 1998
Interest Rate: 13.875%

Page 71

Medicare Payment for Teleconsultation in Rural HPSAs
HCFA provides Medicare payment for a teleconsultation in Rural Health Professional Shortage Areas. Payment for teleconsultations represents a departure from traditional Medicare policy by allowing payment for a service which has historically required a face-to-face, "hands on" encounter. A summary of the provisions is outlined below.

Eligibility for Teleconsultation
Medicare beneficiaries residing in rural HPSAs (health professional shortage area) are eligible to receive teleconsultation services. The site of presentation is a proxy for beneficiary residence. Teleconsultation may be provided in full and partial county HPSAs designated by section 332(a) (1)(A) of the Public Health Service Act.

Scope of Coverage
Covered services include initial, follow-up, or confirming consultations in hospitals, outpatient facilities, or medical offices delivered via interactive audio and video telecommunications systems (CPT codes 99241-99245, 99251-99255, 99261-99263, and 99271-99275).

Practitioners Eligible to be Consulting and Referring
Practitioners
Clinical psychologists, clinical social workers, certified registered nurse anesthetists, and anesthesiologist assistants do not provide consultation services payable under Medicare and therefore cannot provide a teleconsultation under this provision. Additionally, certified nurse anesthetists and anesthesiologist assistants are not eligible to be referring practitioners for a teleconsultation. Practitioners who may provide teleconsultations

include the following: physicians*, physician assistants, nurse practitioners, clinical nurse specialists, and nurse-midwives. Practitioners who may refer patients for teleconsultation include the following: physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse-midwives, clinical psychologists, and clinical social workers.

*Note that "physician" means a doctor of medicine or osteopathy, a doctor of dental surgery or of dental medicine acting within the scope of his license, a doctor of podiatric medicine with respect to functions which he is legally authorized to perform, a doctor of optometry with respect to the provision of items or services which he is legally authorized to perform, or a chiropractor with respect to treatment by means of manual manipulation of the spine.

Conditions of Payment

The patient must be present at the time of consultation, the medical examination of the patient must be under the control of the consulting practitioner, and the consultation must take place via an interactive audio and video telecommunications system. Interactive telecommunications systems must be multi-media communications that, at a minimum, include audio and video equipment permitting real-time consultation among the patient, consulting practitioner, and referring practitioner (as appropriate). Telephones, facsimile machines, and electronic mail systems do not meet the requirements of interactive telecommunications systems.

The teleconsultation involves the participation of the referring practitioner or a practitioner eligible to be a referring practitioner who is an employee of the actual referring practitioner as appropriate to the medical needs of the beneficiary and to provide information to and at the direction of the consultant.

If the medical needs of the beneficiary do not necessitate the participation of a referring or presenting practitioner for all or a portion of a teleconsultation, we would not require a referring or presenting practitioner as a condition of payment. However, we believe that the number of teleconsultations in which a referring or presenting practitioner would not be medically appropriate for at least a portion of the teleconsultation should be few. As noted above, the participation of a referring or presenting practitioner, use of interactive audio and video technology and the patient's real time presence are required as conditions of payment. These requirements are intended to serve as a reasonable substitute for a face-to-face examination which is a requirement for consultation under Medicare. The absence of a referring or presenting practitioner for the entire teleconsultation is subject to review.

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

Medicare Payment Policy

A single payment will be made to the consulting practitioner. The amount will equal the consultant's current fee schedule payment for a face-to-face consultation. The statute requires that the

fee be shared by the referring and consulting practitioners. The consulting practitioner receives 75 percent, and the referring practitioner 25 percent, of the consulting practitioner's Medicare fee. The patient continues to be responsible for the 20 percent Medicare coinsurance.

Billing for Teleconsultation

The consulting practitioner will submit one claim for the consultation service and will provide the referring practitioner with 25 percent of any payment, including any deductible or coinsurance received for the consultation. A modifier will be used to identify the claim as a teleconsultation. Providers must submit the claim with the modifier "GT - via interactive audio and video telecommunication systems." The referring practitioner cannot submit a Medicare claim for the teleconsultation. Additionally, by using the modifier to bill for the consultation, the consulting practitioner has authenticated that an eligible practitioner has served as the referring practitioner.

Page 72

Important Information From Medicare Registration

The Medicare Registration department continues to experience a substantial return rate in applications requesting general enrollment and or changes to the information maintained on the provider file. The most important reasons for the return of improper applications are:

the signature is not that of an authorized representative, and

failure to submit a reassignment of benefits for individuals organized as professional associations.

The Health Care Financing Administration has defined an authorized representative as the individual or appointed official (e.g. officer, chief executive officer, general partner, etc.) who has the authority to enroll the entity in Medicare or other federal health care programs and to financially commit the corporation to Medicare or other federal health care program laws and regulations.

Acceptable authorized representatives include president, vice-president, secretary, treasurer, or owner. If the applicant is a not-for-profit organization, a member of the board of directors must sign the certification statement indicating ("BOD") as his/her title.

Unacceptable authorized representatives include titles such as office manager, medical director, enrollment specialist, agent, manager, credential specialist, insurance specialist, consultant, receptionist, administrator, etc.

Individuals organized as professional associations must include a reassignment of benefits form (HCFA-855R) if reimbursement is issued in the business name. For example, John Doe, M.D. is organized as John Doe, M.D., P.A. as indicated on the IRS CP-575. A HCFA-855R must be included for payment to be issued to John Doe, M.D., P.A. Otherwise, payment must be issued to John Doe, M.D. under his social security number.

As a reminder, the Health Care Financing Administration has concurred that it is permissible to copy the HCFA-855 forms and attachments as long as there is an original signature for each application submitted.

1999 Customer Service Hours of Operation

The normal hours of operation for the Medicare Part B of Florida Provider Telephone Customer Service area are from 9 a.m. until 4:30 p.m., Monday through Thursday, and from 8 a.m. until noon on Friday. The Automated Response Unit (ARU) system is available from 7:30 a.m. until 5:30 p.m. on Mondays and Fridays, and 7:30 a.m. until 6:30 p.m. Tuesday through Thursday.

Holiday dates and hours of operation for the first six months of 1999 are:

Thursday, April 1, 1999
Closed at 2 p.m.

Friday, April 2, 1999
Good Friday Observed

Monday, May 31, 1999
Memorial Day Observed

The schedule for the remainder of the year will be published in a later Medicare B Update!

Nurse Practitioner/Physician Assistant Guidelines

An article was provided on page 74 of the January/February 1999 Medicare Part B Update! concerning the above topic. An error has been noted that changes the meaning of the entire paragraph. Specifically, the word "not" was omitted in error. The offending paragraph is reprinted below in its entirety, with the correction made.

"Page 21 of the March/April 1998 and page 16 of the July/August 1998 Medicare Part B Update! contains information regarding nurse practitioner and physician assistant services. These articles reference that these practitioners may obtain Medicare Part B provider numbers for billing the Medicare Part B Program directly. If nurse practitioners and physician assistants are rendering services incident to a physicians service, services should be billed under the physicians provider number. In this instance, a provider number for the nurse practitioner and/or physician assistant is not needed. When nurse practitioners and/or physician assistants render services which are incident to a physicians service, a provider number is NOT needed."

UPIN Directory Available

The Health Care Financing Administration (HCFA) has recently shipped copies of the Unique Provider Identification Number (UPIN) Directory to each Medicare carrier. The directory is a supplement and contains UPINs added to the UPIN Registry from August 1996 to August 1998. Due to the Balanced Budget Act of 1997, the UPIN Directory has been expanded to include non-physician practitioners (Clinical Nurse Specialists, Nurse Practitioners and Physician Assistants). To obtain a copy of this

supplement, contact the Medicare Part B Provider Customer Service Department at (904) 634-4994.

Page 73 - 74

Medicare Part B Financial Services
Physicians/Supplier Service Request Form

NOT AVAILABLE IN THIS FORMAT

Please contact the Customer Service Area at (904)634-4994.

Page 75

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019
Participating Providers
Medicare Part B
Participating Providers
P.O. Box 44117
Jacksonville, FL 32231-4117
Chiropractic Claims
Medicare Part B
Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067
Ambulance Claims
Medicare Part B
Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099
Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078
ESRD Claims
Medicare Part B ESRD Claims
P.O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Review Requests
Medicare Part B
Claims Review
P. O. Box 2360 Jacksonville, FL 32231-0018
Fair Hearing Requests
Medicare Part B Fair Hearings

P. O. Box 45156
Jacksonville, FL 32232-5156
Administrative Law Judge Hearing
Administrative Law Judge Hearing
P.O. Box 45001 Jacksonville, FL 32231-5001

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018
Overpayments
Medicare Part B
Financial Services
P.O. Box 44141
Jacksonville, FL 32231-0048

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Palmetto GBA
Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-2537

Over 40 days of initial request:
Submit the charge(s) in question, including information
requested, as you would a new claim to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Fraud and Abuse
Medicare Fraud Branch
P.O. Box 45087
Jacksonville, FL 32231
Medicare Claims for Railroad Retirees:
MetraHealthRRB Medicare

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

Provider Change of Address:
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109
and
Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider Education:
For Educational Purposes and Review of Customary/Prevailing
Charges or Fee Schedule:
Medicare Part B
Provider Education Department
P. O. Box 2078Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Provider Education Department
P. O. Box 45157
Jacksonville, FL 32231

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P.O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P.O. Box 2078
Jacksonville, FL 32231-0048

Provider Participation and Group Membership Issues;
Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P.O. Box 44021
Jacksonville, FL 32231

Page 76

Medicare Online BBS flyer

NOT AVAILABLE IN THIS FORMAT

Page 77

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

NOT AVAILABLE IN THIS FORMAT

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.

Page 79

Order Form - 1999 Part B Materials

NOT AVAILABLE IN THIS FORMAT

Page 80

Order Form - 1999 Medifest and Specialty Seminar Books

NOT AVAILABLE IN THIS FORMAT

Page 81 - 83

Index

NOT AVAILABLE IN THIS FORMAT

Page 84

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

Electronic Funds Transfer (EFT):
904-791-8016

PC-ACE Support:
904-355-0313

Testing:
904-354-5977

Help Desk (Confirmation/Transmission):
904-791-9880

OCR
Printer Specifications/Test Claims:
904-791-8132

INSERT - Page 1

Medicare Part B Financial Services Department

The Financial Services Department assists physicians/suppliers and beneficiaries with the following Medicare Part B correspondence:

Overpayments: Medicare Part B funds received in excess of amounts due and payable.

Refunds: Medicare Part B funds returned due to an overpayment.

Forgeries: Alleged fraudulent endorsement of a Medicare Part B check.

Garnishments: A court order which allows creditors of the person in question (known as the debtor) to identify and collect funds owed to the debtor by a third party (known as the garnishee).

Tax Levies: A notification received from the Department of Treasury, Internal Revenue Service (IRS) requesting Medicare Part B to withhold payments toward recovery of a debt owed to the IRS.

Bankruptcies: A court document informing the creditors a certain party has filed for protection under various chapters of bankruptcy.

Written Inquiries: Questions related to overpayments and other debt collections.

Medicare Part B Financial Services Physician/Supplier Service Request Form

The Financial Services Department Physician/Supplier Service Request Form (enclosed) will ensure financial related correspondence and/or refunds are forwarded to the appropriate area for timely resolution. This form may be photocopied, or additional copies may be requested by calling the Provider Customer Service Department. The form should be completed and submitted with any financial related correspondence and/or refund. Mail to:

Medicare Part B
Financial Services Department
P.O. Box 44141
Jacksonville, FL 32231

This pamphlet provides detailed information about the notification and collection of overpayments which are monies owed to Medicare Part B.

NOTE: Physician/suppliers who relocate must timely notify the Medicare Registration Department by using HCFA-855C, Change of Information form (a copy of the occupational license must be included) to ensure Medicare checks and correspondence are mailed to the correct address the first time. The form must be mailed to:

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

For general questions and other information, physicians/suppliers can call Provider Customer Service at (904) 634-4994 (specialty issues) or the Automated Response Unit (ARU) at (904) 353-3205. Or may write to the Customer Services Department at the address below:

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

What is an Overpayment?

Overpayments are Medicare funds a physician/supplier or a beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined an overpayment has been made, the amount of the

overpayment is a debt owed to the United States government. The following are some examples of overpayments:

Payment based on a charge that exceeds the fee schedule or reasonable charge (e.g., services which are processed with an incorrect procedure code; thus, the Medicare approved amount is incorrect).

INSERT - Page 2

Medicare Part B Financial Services Department

Duplicate processing of the same charges/claims (e.g., duplicate billing).

Payment made to incorrect payee.

Payment for non-covered items/services or medically unnecessary services.

Incorrect application of the deductible or co-insurance.

Payment for items/services provided during a period of patient non-entitlement.

Claims processed incorrectly by Medicare Part B as the primary payer.

How are Overpayments Detected?
Overpayments are detected in many ways:

Overpayments can be identified by physicians/suppliers and beneficiaries.

Overpayments can be identified through the review or hearing process.

Overpayments can be identified as the result of an investigation of customer complaints or a random sample of physician/supplier billing practices.

Overpayments can be identified by Federal agencies (e.g., Health Care Financing Administration, Office of Inspector General, etc.) conducting audits of physician/supplier claims, which may result in the identification of overpayments.

Regardless of how these overpayments are detected, they are referred to the Financial Services Department for collection or resolution.

How to Refund Overpayments

Physician/suppliers and beneficiaries occasionally determine overpayments exist before refunds are requested by Medicare Part B. In these instances, voluntary refunds should be made without written overpayment requests.

If a physician/supplier finds that an overpayment exists on all claims associated with their Medicare check, the company check and all Provider Remittance Notices associated with the check should be returned with the Financial Services Physician/Supplier Service Request Form to the Financial Services Department.

If an overpayment exists on only one or some of the claims, the physician/supplier should cash the Medicare check and issue a personal check to Medicare for the overpaid amount. Complete the Financial Services Physician/Supplier Service Request Form and send a complete explanation of the reason for the overpaid amount and a copy of the Provider Remittance Notice or a detailed listing, that includes the health insurance claim number, date of service and amount of refund, explaining the claims in which the overpayment applies.

All physician/supplier and beneficiary overpayments should be refunded to the Financial Services Department. A check in the amount of the overpayment should be made payable to Medicare Part B and forwarded to:

Medicare Part B
Financial Services Department
P.O. Box 44141
Jacksonville, FL 32231

Beneficiaries may follow the same instructions. The beneficiary should include the original Medicare check and a copy of the Medicare Summary Notice.

If you receive an overpayment letter:
The overpayment amount should be refunded to Medicare Part B within 30 days from the date of the refund request letter.

If you do not make a timely refund:
If you do not refund the overpaid amount within 30 days from the date of the initial refund request letter, we will take the following steps:

A follow-up letter is sent advising the balance due, interest begins accruing, and offset is initiated.

Interest will accrue at an annual rate specified by law on the outstanding balance. In accordance with the provisions of Section 1833 (j) of the Tax Equity and Fiscal Responsibility Act and 42 CFR 405.376. First Coast Service Options, Inc., is required to charge interest on this account. You will not be assessed any interest if payment is received within 30 days. After this 30 day period, interest will be assessed for the first 30 day period and an additional 30 day period. This will continue for each 30 day period or portion thereof for which no payment is received. When money is offset (withheld) from your paid claims, it is applied to the accrued interest first and then to the principal.

Medicare Part B Financial Services Department

NOTE: The follow-up letter does not imply that the debtor has another 30- day period to refund the amount due and it does not prevent the withholding of future claim payments after the 30-day period has elapsed

Disagreements with Overpayment Refund Requests

In some cases, a physician/supplier or beneficiary may disagree with the overpayment request (e.g., they do not believe an overpayment exists). In these instances, they should follow the steps for requesting an appeal as outlined in the overpayment refund request letter. Listed below are the general appeal rights:

If the amount of the refund request is under \$100 a review may be requested stating the reason for the disagreement. Send the review request to the address referenced in the appeals section of the refund request letter. If the Financial Services Department is referenced, please use the Financial Services Physician/Supplier Service Request form.

If the amount of the refund is \$100 or more, a hearing may be requested. You may combine other refund request to meet the \$100 or more limit. The address for requesting a hearing is:

Medicare Hearings

P.O. Box 45156
Jacksonville, FL 32232-5156

How to Track Offset Claims

The refund request letters contain a Financial Control Number (FCN). The FCN is used to account for and track monies offset (withheld) from paid claims. The FCN will appear on the Provider Remittance Notice or the Medicare Summary Notice on which the offset (money withheld) was applied. The FCN can then be used to cross-reference the offset claim to the overpayment refund request letter.

Extended Repayment Schedules for Overpayments

The Health Care Financing Administration (HCFA) has established repayment options for debts in excess of \$1000.00 for physician/supplier who find it difficult to repay debts to the Medicare program. Requests for extended repayment schedules must be documented in writing to Medicare Part B.

Repayment Schedules for 12 Months or Less

Medicare Part B may approve repayment schedules up to a period of 12 months.

Documentation for this repayment schedule includes:

A detailed explanation of the problems preventing a lump sum repayment.

A statement of how much the physician/supplier can pay for each installment and the number of months.

A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 form must be completed or must indicate "N/A" (not applicable).

A copy of the physician/supplier's most recent federal income tax return.

Requests for extended repayment schedules should be sent to the Financial Services Department.
Within 10 to 15 days of the receipt of the request, we will document to the physician/supplier an approval or renegotiate the payment amount. Once the extended repayment schedule is established, the Financial Services Department will provide an amortization schedule based on the approved amount (principal balance and any accrued interest). An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

Repayment Schedules for Longer Than 12 Months

Requests for extended repayment schedules for longer than 12 months are referred to HCFA for approval.

The requests must include extensive and specific financial documentation from the physician/supplier to support the request. HCFA will make a decision to grant, modify or reject the extended repayment schedule based on the financial documentation submitted with the request.

The documentation required to support a request for an extended repayment schedule for more than 12 months varies. This depends on the debtor's legal identity (as explained below) at the time the overpayment case was established. The forms for the documentation are provided upon request by the Financial Services Department.

Sole Proprietors: Sole proprietors (i.e., an individual physician who is not part of a group or individual owner), must complete and submit the following documentation to the Financial Services Department:

INSERT - Page 4

Medicare Part B Financial Services Department

A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 form must be completed or must indicate "N/A" (not applicable).

A copy of the physician/supplier's most recent federal income tax return.

Entities: Entities (i.e., partnership, group or corporation), must complete and submit the following documentation to the Financial Services department:

A copy of the federal income tax return for the most recent tax year for both the partnership, group or corporation and the individual debtor or principal owner of the group or corporation.

A Financial Statement of Debtor form (HCFA-379).

The most current balance sheet and the balance sheet for the last complete fiscal year.

The most current income statement and the income statement for the last complete fiscal year.

A statement of source and application of funds for the period covered by the submitted income statements.

Cash flow statements for the periods covered by the submitted balance sheets. If the date of request for an extended repayment schedule is more than three months after the date of the most recent balance sheet, a cash flow statement for all months between that date and the date of the request is required.

A projected cash flow statement covering the remainder of the fiscal year. If fewer than six months remain in the fiscal year, a projected cash flow statement for the following year is required.

A list of restricted cash funds, by amount, as of the date of the request and the purpose of each.

A list of investments, by type (stock, bond, etc.), amount and current market value as of the date of the request.

A list of notes and mortgages payable by amount as reflected in the balance sheet and their due dates.

An extended repayment period of 12 months or more, the debtor must include at least two letters from separate financial institutions denying the debtor's loan request for the amount of the overpayment. A copy of the loan application(s) is also required.

The financial statements should be completed by the debtor's accountant. The balance sheets and income statements should include the following statements:

Misrepresentation or falsification of any information contained in this balance sheet or income statement may be punishable by fine and/or imprisonment under federal law.

Once the Financial Service Department receives all documentation along with requests for extended repayment schedules for longer than 12 months, we prepare the documentation and send our recommendations to HCFA. The requested repayment schedule is either approved by HCFA or the Financial Services Department is advised of the suggested repayment schedule. When the repayment schedule is established, the Financial Services Department notifies the debtor of the results and sends an amortization schedule based on the approved amount. An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

If the monthly payments are not received in our by the due date each month, we will be forced to cancel the extended repayment schedule and begin to withhold your Medicare payments to satisfy the overpayment balance.

Certification by Officer/Owner of Debtor(s):

I hereby certify I have examined the balance sheet and income
statement prepared by

and to the best of my knowledge and belief, it is true, correct
and the complete statement from the books and records of debtor.

Signed

Officer or Owner of Debtor(s)

Title

Date

(end of file)