Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

Features

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

Routing Suggestions:

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

Health Care Financing Administration

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

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The *Medicare B Update!* is published bimonthly by the Medicare Publications Department, to provide timely and useful information to Medicare Part B providers in Florida.

Questions concerning this publication or its contents may be directed in writing to:

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

A PHYSICIAN'S FOCUS

"The Value of Surfing"

The Health Care Financing Administration (HCFA) has recently implemented new procedures to allow public access to medical coverage policies that are under review by Medicare. The Internet address for this information is ***www.hcfa.gov***. The site also has links to various government publications, including the Federal Register. If you click on "Medicare Coverage Process," you will find information on the Medicare Coverage Advisory Committee (MCAC), town hall meetings, and the review process for coverage issues. You will also find information on several new services that HCFA has approved or is considering for coverage. Among them are:

- Autologous Stem Cell Transplantation
- Electrical Stimulation for Fracture Healing
- Ferrlecit (Sodium Ferric Gluconate Complex in Sucrose Injection)
- Human Tumor Assay Systems
- Intestinal and Multivisceral Transplants
- Pressure Reducing Therapy (Support Surfaces)
- Cryosurgery of the Prostate
- Helicobactor Pylori Testing
- Transmyocardial Revascularization for Severe Angina

Please note that these policies are in various stages of development and are not effective until finalized and published. These details are included in the material available on the Web site.

There are several other Web sites that will provide you with Medicare and other medical information. One of them is ***www.medicaretraining.com***. First Coast Service Options, Inc. (Florida Medicare contractor) created this new site for HCFA to provide a multi-state educational resource. There are several computer-based training courses available. All are free. Y2K readiness information, the schedule for future satellite broadcasts for various Medicare educational topics, and several related links are available to expand your exploration of Medicare related subjects.

Another site you might want to check out is ***www.quackwatch.com***. There you will find articles on several procedures, tests, equipment and treatments that have been found to be lacking scientific evidence to support their use.

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

Sincerely,

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

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

Advance Notice Requirement

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

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

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

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

- The notice must be given in writing, in advance of furnishing the service or item.
- The notice must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., the service is not covered based on the diagnosis of the patient, the frequency of the service was furnished in excess of the utilization screen, etc.).
- The notice must be signed and dated by the patient indicating that the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for the reason(s) indicated on the advance notice. The signature of the provider of service is not required.

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

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

General Information About the *Medicare B Update!*

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

Distribution of the *Update!* is limited to individual providers and professional association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers meeting this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit distributing a copy to all of a provider's practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. For additional copies, providers may purchase a separate annual subscription for $75 (see order form on page 70), or download the text version from our on-line service, the Medicare Online BBS (see page 69 for information about the BBS).

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

About the Format

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

Notification of Millennium Rollover Year-End Claims Processing

Our goal for the year 2000 rollover is to ensure a smooth and risk free transition to the new millennium. To accomplish it, there are certain steps we must take which are outside of our normal processing routine. We are providing you with this information as early as possible so you may take the necessary action to adjust your processing and cash flow needs. With appropriate preparation, you will not be adversely impacted.

Year-End Claims Processing Schedule

The time frame of December 29, through December 31, 1999 will be used to perform comprehensive system back-ups and to complete month-end, quarter-end, and year-end processing. This will begin at 4:30 a.m. (EST) December 29, 1999 and end at 8:00 a.m. on January 1, 2000. This means that for this period of time, you will not have electronic access to the system. Claim processing cycles will also not run and provider payments will not be generated on December 29, 1999 through December 31, 1999. The first claims processing cycle will be Saturday, January 1, 2000. Provider payments will be mailed on (Monday) January 3, 2000 in accordance with the normal payment disbursement schedule. The chart below delineates these activities on a day by day basis.

Date	Claims Processing Impact
Wednesday, Dec. 29	• This is the last day to do any type of claims processing activity. • No claims processing activity after December 28, 1999 • System cycles will run as normal. • Provider payments disbursed as usual. • Electronic Providers can submit claims.
Thursday, Dec. 30 - Friday, Dec. 31	• No access to the System • No claims processing cycles will run. • No provider payments disbursed. • Electronic Providers can submit claims through 10:00 AM on Dec. 30, 1999.
Saturday, Jan. 1	• System available for access • System cycle will run. • Electronic Providers can submit claims.
Sunday, Jan. 2	• System available for access. • System cycle will run. • Electronic Providers can submit claims.
Monday, Jan. 3 & beyond	• Business as usual • System available for access • Provider payments disbursed • Electronic Providers can submit claims.

Provider Preparation

Providers must prepare for this period. Proper preparation should minimize any impact to your claims processing functions and financial management responsibilities.

All Providers
All providers will experience a short period of time where no Medicare payments will be disbursed December 29, 1999 through January 2, 2000. Providers should plan accordingly, as advance payments will not be available for this period. In addition the system unavailability will impact our ability to respond to provider inquiries during this period.

Electronic Claim Providers
Electronic providers should access the system before 10:00 a.m. on December 30th. Electronic providers who submit claims via file transfer can continue to submit claims until 10:00 a.m. on December 30, 1999; however, claims received after 6:00 p.m. on December 28, 1999, will not be read into the system until January 1, 2000. Claims received on December 30, 1999, prior to the 10:00 a.m. cutoff, will be processed on January 1, 2000. Claims cannot be received after 10:00 a.m. on December 30, 1999 through 8:00 a.m. on January 1, 2000.

Paper Claim Providers
Paper providers may continue to send paper claims to the carrier during this period. However, the carrier will not be able to enter claims into the system between December 29,1999 and December 31, 1999.

Return to Normal Claims Processing Activities

On January 3, all claims processing activities will return to the normal schedule and payments will be disbursed as usual.

Reminder on Claims with Year 2000 Dates of Service

Beginning January 1, 2000, you may file claims as usual, but Medicare contractors will hold all claims with dates of service of January 1 or later until January 17 in order to correctly apply the year 2000 payment and other annual updates, including any changes in beneficiary coinsurance and deductibles. You will not need to take any action, other than submitting a millennium compliant claim, to receive the correct payment amount.

By law, electronic clean claims must be held for at least 14 calendar days but no longer than 30 calendar days before payment can be made. The period of time from receipt of year 2000 claims will count toward these requirements. Beginning on January 17, all claims for services in the year 2000 will be released for processing, and claims are expected to be finalized for payment very quickly. Therefore, holding claims with year 2000 service dates until January 17 should only minimally affect their date of payment, if at all (because of the statutory requirement to hold claims payment for at least 14 calendar days).

Claims with Service Dates Prior to Year 2000
From January 1 until 17, claims having dates of service only occurring during the calendar year 1999 or a previous year will continue to be processed and paid using the appropriate payment rates. However, because of the way our system functions, any claims received from January 1 until January 17, 2000, that includes services occurring during calendar year 2000 and previous years will be held in its entirety until January 17. If you have a claim with dates of service occurring both in 2000 and in a previous year, and you do not wish the entire claim held until January 17, you should send in two separate claims: one for year 1999 (or earlier) services, and one for year 2000 services. In this way, the processing of your claims for year 1999 (or earlier) services will not be held.

If you have questions about this article, please contact your carrier at (904) 634-4994.

This document is a Year 2000 disclosure made pursuant to the Year 2000 Information and Readiness Disclosure Act (U.S Public Law 105-271). Your legal rights regarding the use of the statements made herein may be substantially limited as provided in the Act.

CLAIMS

Correct Coding Initiative

"Claim/service denied/reduced because this service is not paid separately."

Sound familiar? Sometimes two or more procedure codes comprise or describe a service provided to a beneficiary. However, it may not always be appropriate to bill for each component of the service, according to Medicare's Correct Coding Initiative (CCI).

When two or more billed procedures are subject to a CCI edit, Medicare will allow the code identified by CCI as the primary procedure, and deny the remaining code(s). This is done to alert the provider that the procedures are considered one service. Generally, it is best to bill only for the highest value procedure code and omit the lesser value code(s). Medicare may then process the claim for the service rendered.

When a provider frequently receives the above denial message, it may be useful to obtain a current set of the CCI edits. This is a listing of procedure codes that are "bundled" together. The information is ordered by code ranges that parallel the American Medical Association's *Current Procedural Terminology* (CPT) book.

How to Obtain the CCI Edits

Although Medicare carriers are prohibited from publishing specific CCI edits, this information may be obtained by ordering the *National Correct Coding Policy Manual* from the National Technical Information Service (NTIS).

- To request a single issue of the *National Correct Coding Policy Manual,* call (703) 605-6000.
- For a subscription to the *National Correct Coding Policy Manual*, call (703) 605-6060 or (800) 363-2068.
- To receive information from NTIS by mail, call (800) 553-6847.

For additional information on claim denials, contact Provider Customer Service at (904) 634-4994.

Guidelines for Purchased Diagnostic Tests: Clarification

An article published in the November/December 1999 *Medicare B Update!* (page 12) included the statement: "When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form. In the case of repeat procedures on the same day, modifier 76 (repeat procedure by same physician) must also be submitted. Supporting documentation for the use of modifier 76 must be provided."

Prior to publication of this statement, providers were not requested to submit documentation for the **second** test if modifier 76 was submitted with the procedure code. Because this instruction could cause providers to send paper claims with documentation when purchasing more than one diagnostic test, it has been revised. Providers will be requested to submit documentation only when **more than two** diagnostic tests are purchased for the same beneficiary on the same day.

When multiple purchased diagnostic tests are submitted, providers are instructed to submit the first claim with modifiers 26 and WU. All subsequent claims should be submitted with modifier 76.

EXAMPLE:

CLAIM #1:	88305-26 (professional component) 88305-WU (purchased technical component)
CLAIM #2:	88305-2676 (purchased professional component) 88305-WU76 (purchased technical component)
CLAIM #3:	88305-2676 (purchased professional component) 88305-WU76 (purchased technical component)

Providers should submit their claims as illustrated and *should not submit documentation unless requested by Medicare.* Using this billing method, Medicare will allow the initial claim and a second purchased test with modifier 76 (if applicable coverage criteria are met). All additional tests (e.g., claim #3, above) will be denied as duplicate services. In these situations, providers may request a written or telephone review.

Health Professional Shortage Area (HPSA) Designations

Physicians are eligible for a ten percent bonus when they render service(s) in certain medically underserved areas. These areas, known as Health Professional Shortage Areas (HPSAs), may cover an entire county, or a portion of a county or city, and are designated as either rural or urban HPSAs. The HPSA designated areas are determined by the Health and Human Services Division (HHSD) for the state of Florida.

The incentive payments are based on ten percent of the paid amount for both assigned and nonassigned claims for services performed by the physician. The incentive payment is not made on a claim-by-claim basis. Rather, payments are issued on a quarterly basis.

Eligibility

A physician is eligible for the HPSA incentive payment *when services are furnished in an area designated as a HPSA*, regardless of where the physician's office is located. For example, a physician's office may be located in an area not designated as a HPSA; however, the physician may treat a patient in a nursing facility that is located in a HPSA. In this instance, the physician would be eligible for the HPSA incentive payment. Likewise, the physician's office may be in a HPSA; however, the physician may treat a patient in his/her home that is not located in a HPSA. In this case, the physician is *not* eligible for the HPSA incentive payment.

Only physicians are eligible for the HPSA incentive payments. The following degrees/credentials are considered physicians eligible for the incentive payments:

M.D., D.O., D.C., D.P.M., D.D.S., and O.D.

Claims Filing Requirements

To report services furnished in a HPSA, one of the following procedure code modifiers should be reported with the service:

QB	Physician service rendered in a rural HPSA
QU	Physician service rendered in an urban HPSA

In addition, Item 32 of the HCFA-1500 claim form (or electronic equivalent) must be completed when either the QB or QU modifiers is billed. The physical location where the service was furnished must be indicated, if it is other than the patient's home. However, if the address is the same as the billing provider's address (in Item 33), the word "SAME" may be indicated in Item 32.

Appeal of HPSA Incentive Payments

The incentive payments do not include Explanation of Benefits (EOB) for nonassigned claims or Provider Remittance Notices (PRN) for assigned claims. Only a list of the claims to which the incentive payment applies is attached to the payment. As a result, physicians have not been provided with an opportunity to challenge the amounts of their HPSA incentive payments on nonassigned claims or to challenge nonassigned claims where incentive has not been paid.

The Health Care Financing Administration has provided clarification of these issues:

- In cases where a physician is not satisfied with the amount of the incentive payment on either assigned or nonassigned claims, he or she may request a review of the incentive payment. The review request must be made within sixty (60) days of the date when the incentive payment was issued.
- In cases where an incentive payment was not made on a claim (assigned or nonassigned), but the physician believes that one should have been made, he or she may request a reopening of that particular claim. The request must be within one year of the claim payment.

NOTE: If the physician is unsure of the date a nonassigned claim was processed, the request for reopening may be made within one year of the date the claim was submitted, to ensure the request for the reopening is made within the one-year time limit.)

Clarification

An article published in the July/August 1999 *Medicare B Update!* (page 7) indicated that specific census tracts in Dade county had changed, effective July 1, 1999. That information is incorrect. The following comprehensive table lists the current HPSAs in the entire state of Florida.

HPSA designations are subject to change.

Incentive payments are available for services rendered in **any** portion of the following counties:

County	Type	Effective Date	Termination Date
Bradford	Urban	01/01/1991	
Calhoun	Rural	10/31/1988	10/01/1997
Dixie	Rural	01/01/1990	
Gadsden	Urban	01/01/1991	01/01/1998
Gadsden	Urban	01/01/1998	
Gilchrist	Rural	10/31/1988	10/01/1997
Glades	Rural	01/01/1991	
Hamilton	Rural	06/01/1993	
Hardee	Rural	10/31/1988	03/01/1998
Hardee	Rural	05/01/1999	
Holmes	Rural	10/31/1988	10/01/1997
Holmes	Rural	02/01/1998	
Jefferson	Rural	10/31/1988	05/01/1997
Lafayette	Rural	10/31/1988	
Levy	Rural	09/01/1993	03/01/1998
Liberty	Rural	10/31/1988	03/01/1996
Madison	Rural	10/31/1988	05/01/1998
Madison	Rural	08/01/1999	
Osceola	Urban	01/01/1991	03/01/1996
Putnam	Rural	04/01/1992	08/01/1997
Sumter	Rural	10/31/1988	05/01/1997
Suwannee	Rural	10/31/1988	
Taylor	Rural	05/01/1993	
Union	Rural	10/31/1988	12/01/1999
Wakulla	Rural	10/31/1988	
Walton	Rural	10/31/1988	10/01/1997
Washington	Rural	12/01/1997	

Incentive payments will be made for services rendered in portions of the following *urban* HPSAs (defined by census tracts):

County	Effective Date	Termination Date
Clay		
Keystone Heights	06/01/1993	
Keystone Heights CCD	06/01/1993	
Collier		
Everglades		
Census Tract 111.01	06/01/1993	
Census Tract 111.02	06/01/1993	
Imokalee		
Census Tract 112.01	06/01/1993	
Census Tract 112.02	06/01/1993	
Census Tract 112.03	06/01/1993	
Census Tract 113	01/01/1991	
Census Tract 114	01/01/1991	
Dade		
Southern Dade (Homestead)		
Census Tract 103	01/01/1991	03/31/1999
Census Tract 104	01/01/1991	03/31/1999
Census Tract 105	01/01/1991	03/31/1999
Census Tract 106.02	01/01/1991	03/31/1999
Census Tract 107.01	01/01/1991	03/31/1999
Census Tract 108	01/01/1991	03/31/1999
Census Tract 109	01/01/1991	03/31/1999
Census Tract 110.01	07/01/1994	03/31/1999
Census Tract 110.02	07/01/1994	03/31/1999
Census Tract 111	01/01/1991	03/31/1999
Census Tract 112.01	07/01/1994	03/31/1999
Census Tract 112.02	07/01/1994	03/31/1999
Census Tract 113	01/01/1991	03/31/1999
Census Tract 114.98	07/01/1994	03/31/1999
Wynwood		
Census Tract 14.01	06/01/1993	
Census Tract 14.02	06/01/1993	
Census Tract 20.01	06/01/1993	
Census Tract 20.03	06/01/1993	
Census Tract 20.04	06/01/1993	
Census Tract 21	06/01/1993	
Census Tract 22.01	06/01/1993	
Census Tract 22.02	06/01/1993	
Census Tract 25	06/01/1993	
Census Tract 26	01/01/1991	
Census Tract 27.01	01/01/1991	
Census Tract 27.02	01/01/1991	
Census Tract 28	01/01/1991	
Census Tract 29	06/01/1993	
Model Cities		
Census Tract 4.08	03/01/1993	
Census Tract 8.01	03/01/1993	
Census Tract 8.02	03/01/1993	

County	Effective Date	Termination Date
Census Tract 9.01	03/01/1993	
Census Tract 9.02	03/01/1993	
Census Tract 9.03	01/01/1991	
Census Tract 10.01	01/01/1991	
Census Tract 10.02	01/01/1991	
Census Tract 10.03	01/01/1991	
Census Tract 10.04	01/01/1991	
Census Tract 11.03	03/01/1993	
Census Tract 15.01	01/01/1991	
Census Tract 15.02	01/01/1991	
Census Tract 16.01	03/01/1993	
Census Tract 16.02	03/01/1993	
Census Tract 17.01	01/01/1991	
Census Tract 17.02	01/01/1991	
Census Tract 18.01	01/01/1991	
Census Tract 18.02	01/01/1991	
Census Tract 18.03	01/01/1991	
Census Tract 19.01	01/01/1991	
Census Tract 19.03	03/01/1993	
Census Tract 19.04	03/01/1993	
Census Tract 23	01/01/1991	
Escambia		
Atmore/Century (AL/FL)		
Census Tract 38	09/01/1994	
Census Tract 39	09/01/1994	
Census Tract 40	09/01/1994	
Hendry		
Labelle		
Census Tract 9603	10/01/1997	
Census Tract 9604	10/01/1997	
Hillsborough		
East Tampa/Ybor City		
Census Tract 10	01/01/1991	05/01/1998
Census Tract 17	06/01/1993	05/01/1998
Census Tract 18	01/01/1991	05/01/1998
Census Tract 19	01/01/1991	05/01/1998
Census Tract 30	01/01/1991	05/01/1998
Census Tract 31	01/01/1991	05/01/1998
Census Tract 32	01/01/1991	05/01/1998
Census Tract 33	01/01/1991	05/01/1998
Census Tract 34	01/01/1991	05/01/1998
Census Tract 35	01/01/1991	05/01/1998
Census Tract 36	01/01/1991	05/01/1998
Census Tract 37	01/01/1991	05/01/1998
Census Tract 38	01/01/1991	05/01/1998
Census Tract 39	01/01/1991	05/01/1998
Census Tract 40	01/01/1991	05/01/1998
Census Tract 41	01/01/1991	05/01/1998

County	Effective Date	Termination Date
Census Tract 42	01/01/1991	05/01/1998
Census Tract 43	01/01/1991	05/01/1998
Census Tract 44	01/01/1991	05/01/1998
Census Tract 49	01/01/1991	05/01/1998
Census Tract 50	01/01/1991	05/01/1998
Census Tract 51	01/01/1991	05/01/1998
Lee		
Dunbar		
Census Tract 5.01	06/01/1997	
Census Tract 5.02	06/01/1997	
Census Tract 6.00	06/01/1997	
Martin		
Indiantown	01/01/1991	
Indiantown CCD	01/01/1991	
Nassau		
Callahan/Hilliard		
Census Tract 504	01/01/1991	04/01/1997
Reinstated	12/01/1998	
Census Tract 505	01/01/1991	04/01/1997
Reinstated	12/01/1998	
Palm Beach		
West Palm Beach		
Census Tract 20	06/01/1993	
Census Tract 21	01/01/1991	
Census Tract 22	01/01/1991	
Census Tract 23	01/01/1991	
Census Tract 24	01/01/1991	
Census Tract 25	01/01/1991	
Census Tract 26	01/01/1991	
Polk		
Polk City/Eva		
Census Tract 116	08/01/1993	
Census Tract 123	08/01/1993	
Census Tract 124	08/01/1993	
Frost Proof/ Lake Wales		
Census Tract 142	06/01/1993	
Census Tract 143	06/01/1993	
Census Tract 144	06/01/1993	
Census Tract 154	06/01/1993	
Census Tract 155	06/01/1993	
Census Tract 156	06/01/1993	
Census Tract 157	06/01/1993	
Census Tract 158	06/01/1993	
Census Tract 160	06/01/1993	
Census Tract 161.98	06/01/1993	
Volusia		
Pierson/Seville/ DeLeon Springs		
Census Tract 0901.00	03/01/1998	

COVERAGE/REIMBURSEMENT

AMBULANCE

Ambulance Services—Questions & Answers

The following question and answer article has been developed by the Health Care Financing Administration (HCFA) to clarify issues related to the ambulance coverage regulation changes.

Physician Certification

Q1 Assuming the physician certification cannot be obtained in the required time period, when appropriate, we assume there is no prohibition against billing the patient. Is that correct?

A1 Because it is unclear what is meant by "when appropriate," the answer is based on a general response. No, the assumption that a patient can be billed directly for ambulance transportation services when the physician certification cannot be obtained in the required time period is incorrect.

42 CFR 410.40(d)(2), "Special Rule for Nonemergency, Scheduled Ambulance Services," states that nonemergency ambulance services are covered "if the ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity criteria of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished." Additionally, 42 CFR 410.40(d)(3), *"Special Rule for Nonemergency, Unscheduled Ambulance Services,"* specifies the circumstances under which Medicare will cover nonemergency, unscheduled ambulance services. For residents in facilities where they are under the direct care of a physician, ambulance suppliers can obtain written orders from the beneficiary's attending physician, certifying that the medical necessity requirements have been met, "within 48 hours after the transport." For beneficiaries residing at home or in a facility where they are not under the direct care of a physician, a physician certification is not required.

The physician certification statement is not required in cases that meet the definition of an emergency: "An emergency service is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part." Any ambulance service that does not meet these criteria would be a "nonemergency service" and would require a physician certification statement.

In response to comments submitted by ambulance industry representatives, we agreed that to avoid unnecessary delays, it would be appropriate for ambulance suppliers to obtain physician certification statements within 48 hours after the ambulance service was furnished. While the 48-hour time frame is the standard required by regulation, we acknowledge that there may be instances when meeting this requirement may not be possible. Therefore, if the physician cannot be reached within the 48-hour time period it is acceptable for the ambulance supplier to obtain the physician's signature before a bill may be submitted for the service. (For further clarification of the claims submission requirement, please refer to 42 CFR 424.44, *Time Limits for Filing Claims*.)

It is also important to be aware that the limitation of liability provisions (see Medicare Carriers Manual (MCM) section 7300) must also be taken into consideration. For situations involving noncovered services, please refer to MCM section 3043.

Q2 Our understanding is that the certificate of medical necessity (CMN) is not needed for **any** unscheduled transports of patients residing in their home or in an extended care/assisted living facility. Is that correct?

A2 This is not correct. 42 CFR 410.40(d)(2) specifically addresses the "*Special Rule for Nonemergency, Scheduled Ambulance Services*." 42 CFR 410.40(d)(3) addresses the rules for nonemergency, unscheduled ambulance services. 42 CFR 410.40(d)(3)(ii) indicates that "For a beneficiary residing at home or in a facility *who is not under the direct care of a physician*, a physician certification is not required."

Q3 Is a CMN needed for emergencies by hospital based ambulances since it is currently required by sections 3322 and 3660 of the Medicare Intermediaries Manual and section 279 of the Hospital Manual or does this regulation overrule these sections?

A3 The requirements of the Medicare Intermediaries Manual sections 3322 and 3660 and section 279 of the Hospital Manual are **not** superseded by the final rule.

Q4 If a registered nurse (RN) orders the ambulance, **on behalf of the physician,** can the RN sign the CMN, on behalf of the physician? Please advise.

A4 An RN who is employed by the attending physician or who is an employee of the hospital or facility where the patient is being treated may sign a physician certification statement on oral orders from the physician. The RN's signature is acceptable in instances where nonemergency, unscheduled ambulance transportation is required and the attending physician is not physically present in the facility, but is in consultation with the RN, at the time the medically necessary transport is required. The physician must later countersign the physician certification statement.

The ambulance supplier is responsible for obtaining the physician certification statement with the appropriate signatures as quickly as possible.

Q5 Since physicians are generally unavailable or working reduced hours during weekends and holidays, can the 48-hour rule for unscheduled transports be interpreted to mean 48 business hours?

A5 No, the 48-hour rule should be interpreted as calendar days.

Scheduled/Unscheduled Nonemergency Ambulance Transportation

Q6 Is it correct to assume that the new dialysis coverage, as specified in 410.40(e)(4), includes transport from an extended care/assisted living facility to a freestanding dialysis facility?

A6 Yes. Medicare guidelines indicate that "**A patient's residence** is the place where he/she makes his/her home and dwells permanently, or for an extended period of time. A **skilled nursing facility** is one which is listed in the Directory of Medical Facilities as a participating SNF or as an institution which meets section 1819(a)(1) of the law."

Miscellaneous

Q7 Does this regulation apply for hospital-based ambulance services?

A7 Where applicable various provisions of this regulation do apply to hospital-based ambulance services.

Q8 The final rule clarifies the circumstances under which an ambulance trip is a patient transport under Medicare Part A as opposed to an ambulance service under Medicare Part B, and also allows for scheduled round-trip transportation of a beneficiary with end-stage renal disease from home to the nearest appropriate dialysis facility, whether freestanding or hospital-based. Please provide further background clarification as it relates to this issue.

A8 The final rule clarifies that the Part A inpatient hospital and skilled nursing facility (SNF) benefits historically have recognized and included payment for the cost of patient transportation services, such as ambulance trips, that the institution furnishes to its inpatients during the course of a covered stay. However, unlike transportation via ambulance (which involves a service that is specifically delineated in terms of vehicle type, appropriate destinations, etc.), the concept of non-ambulance transportation is a more generalized one that denotes the basic function of transporting an individual from one place to another, rather than a particular mode of transport.

For example, under the long term care facility requirements for participation at 42 CFR 483.25, an SNF's essential obligation is to provide each resident with those services that are necessary, "...to attain or maintain the [resident's] highest practicable physical, mental, and psychosocial well being..." In fulfilling this basic obligation, however, a SNF may utilize a wide variety of means either to send its residents to the offsite location of the services or, alternatively, to bring the services themselves onsite to its residents.

Moreover, in contrast to ambulance trips (for which a specific Part B benefit exists), there is no Part B benefit that provides for non-ambulance forms of transportation. Historically, SNFs themselves were under no obligation to undertake providing non-ambulance forms of transportation directly to their residents as a part of a covered Part A stay, and in actual practice, they rarely, if ever, did so. Rather, the responsibility for providing such transportation for SNF residents has generally been assumed instead by other sources, such as the Medicaid program, local community service organizations, or the resident's own family.

In this context, the preamble to the final rule on the prospective payment system (PPS)for SNFs (64 FR 41674-75, July 30, 1999) explains that it is not HCFA's intent to include within the scope of the current SNF PPS bundle any types of transportation services for which the Medicare program did not previously assume financial responsibility under either Part A or Part B. Accordingly, the final rule clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of medically necessary transportation via ambulance, rather than more general coverage of other forms of transportation.

CARDIOLOGY

Free-Standing Cardiac Catheterization Facilities

The Health Care Financing Administration (HCFA) recently advised Medicare carriers to discontinue on-site visits to free-standing cardiac catheterization facilities (FSCCFs) for survey and certification of applicable requirements. FSCCFs will now be treated the same as a physician with regards to enrollment procedures.

Medicare of Florida last published billing instructions for FSCCFs in the November/December 1994 *Medicare B Update!* The following article is reprinted from that publication:

How to Bill

There are two ways to file claims for cardiac catheterization (procedure codes 93501 and 93510 - 93556) performed in an approved FSCCF. These categories are based on whether or not the facility is a physician group practice.

- Category I: FSCCF Group Practice
  If the cardiac catheterization takes place in a FSCCF that is part of a physician group practice, and a member of the group performs the procedure, file the claim for the global procedure (no modifier) using place of service 99.
- Category II: FSCCF Non-Group Practice
  If the cardiac catheterization takes place in a FSCCF that is not part of a physician group practice, the *facility* would file for the technical component only (TC modifier) using place of service 99. The *physician* would file for the professional component only (26 modifier) using place of service 99.

Other Services

Providers who use an office within the FSCCF to provide services other than heart catheterization, or services not related to heart catheterization, should use place of service 11 (*not* 99) when billing for those services. Remember to include the facility number, name, and address in blocks 32 *and* 33 of the HCFA-1500 claim form (or electronic equivalent).

Commonly Asked Questions About Heart Catheterizations

Q Is there a technical component for procedure codes 93539 - 93545?

A No, these codes are injection procedures, and there is no technical component. Do not file with a TC modifier.

Q Is procedure code modifier 26 required with procedure codes 93539 - 93545?

A No, 93539 - 93545 are injection procedures, and the 26 modifier is not required.

Q Should blocks 32 and 33 of the HCFA-1500 form always be the same?

A Yes, *unless* filing for the professional component only. If filing for the professional component only (26 modifier), the facility number must be in block 32.

Q If multiple injection procedures (procedure codes 93539 - 93545) are performed, can each procedure be reported separately?

A Yes. If the injection procedures are performed individually, procedure codes 93539 - 93545 may be reported separately.

Q If multiple injection procedures are performed (procedure codes 93539 - 93545), how should I file for the supervision and interpretation (procedure codes 93555 - 93556)?

A Each supervision and interpretation procedure (procedure codes 93555 and 93556) may be billed *once* to identify the imaging supervision of all necessary views and written report of all these views of the overall intervention.

If you have questions or concerns about filing FSCCF claims, contact Provider Customer Service at (904) 634-4994.

CHIROPRACTIC

Changes to Medicare Coverage of Chiropractic Services

Effective for claims with dates of service on or after January 1, 2000, an X-ray is not required to demonstrate the subluxation. However, an X-ray may be used for this purpose if the chiropractor so chooses. An X-ray is still required to demonstrate subluxation for services rendered prior to January 1, 2000.

In accordance with the Balanced Budget Act of 1997 (BBA), Medicare has revised policy and documentation requirements for chiropractic services, ***effective April 1, 2000.*** These changes are as follows:

Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the

device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device; nor does Medicare recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered. *This means that if a chiropractor orders, takes, or interprets an X-ray or any other diagnostic test, the X-ray or other diagnostic test may be used for claims processing purposes, but Medicare coverage and payment are not available for those services.* This does not affect the coverage of X-rays or other diagnostic tests furnished by other practitioners under the program. For example, an X-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine is a covered diagnostic test if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy.

The word "correction" may be used in lieu of "treatment." Also, a number of different terms composed of the following words may be used to describe manual manipulation as defined above:

- Spine or spinal adjustment by manual means;
- Spine or spinal manipulation;
- Manual adjustment; and
- Vertebral manipulation or adjustment.

Documentation of Subluxation

Subluxation is defined as a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered, although contact between joint surfaces remains intact. A subluxation may be demonstrated by an X-ray or by physical examination, as described below:

Demonstrated by X-ray. Although no longer required for Medicare coverage (for services rendered on or after January 1, 2000), an X-ray may be used to document subluxation. The X-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific X-ray evidence is warranted, an X-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older X-ray may be accepted, provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence, if a subluxation of the spine is demonstrated.

Demonstrated by Physical Examination. Evaluation of musculoskeletal/ nervous system to identify:

- Pain/tenderness evaluated in terms of location, quality, and intensity;
- Asymmetry/misalignment identified on a sectional or segmental level;
- Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and
- Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under "physical examination" are required, one of which must be asymmetry/misalignment or range of motion abnormality.

A patient's history, as recorded in the medical record, should include the following:

- Symptoms causing patient to seek treatment;
- Family history if relevant;
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location and radiation of symptoms;
- Aggravating or relieving factors; and
- Prior interventions, treatments, medications, secondary complaints.

Documentation Requirements: Initial Visit. The following documentation requirements apply, whether the subluxation is demonstrated by X-ray or by physical examination:

1. History as stated above.
2. Description of the present illness including:
   - Mechanism of trauma;
   - Quality and character of symptoms/problem;
   - Onset, duration, intensity, frequency, location, and radiation of symptoms;
   - Aggravating or relieving factors;
   - Prior interventions, treatments, medications, secondary complaints; and
   - Symptoms causing patient to seek treatment.

   These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal), and joint (arthro), and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, and/or arm, shoulder, and hand problems, as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.
3. Evaluation of musculoskeletal/nervous system through physical examination.
4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

5. Treatment Plan: The treatment plan should include the following:
   - Recommended level of care (duration and frequency of visits);
   - Specific treatment goals; and
   - Objective measures to evaluate treatment effectiveness.
6. Date of the initial treatment.

Documentation Requirements: Subsequent Visits. The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

1. History
   - Review of chief complaint;
   - Changes since last visit;
   - System review if relevant.
2. Physical exam
   - Exam of area of spine involved in diagnosis;
   - Assessment of change in patient condition since last visit;
   - Evaluation of treatment effectiveness.
3. Documentation of treatment given on day of visit.

Necessity for Treatment

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by X-ray or physical exam, as described above.

Most spinal joint problems may be categorized as follows:

- **Acute subluxation**: A patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical exam, as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest or retardation of the patient's condition.
- **Chronic subluxation**: A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered.

Maintenance Therapy. A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition is not a Medicare benefit. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary under the Medicare program.

Contraindications. Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out the use of dynamic thrust. The doctor should discuss this risk with the patient and record this in the chart. The following are **relative contraindications** to dynamic thrust:

- Articular hypermobility and circumstances where the stability of the joint is uncertain;
- Severe demineralization of bone;
- Benign bone tumors (spine);
- Bleeding disorders and anticoagulant therapy; and
- Radiculopathy with progressive neurological signs.

Dynamic thrust is **absolutely contraindicated** near the site of demonstrated subluxation and proposed manipulation in the following:

- Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation; including acute rheumatoid arthritis and ankylosing spondylitis;
- Acute fractures and dislocations or healed fractures and dislocations with signs of instability;
- An unstable os odontoideum;
- Malignancies that involve the vertebral column;
- Infection of bones or joints of the vertebral column;
- Signs and symptoms of myelopathy or cauda equina syndrome;
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; and
- A significant major artery aneurysm near the proposed manipulation.

Location of Subluxation

The *precise* level of the subluxation must be specified to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified.

There are two ways in which the level of the subluxation may be specified.

- The exact bones may be listed, for example: C5, 6, etc.
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and Cl [atlas]), lumbo-sacral (L5 and sacrum) sacro-iliac (sacrum and ilium).

Treatment Guidelines

Medicare affords chiropractors the opportunity to effect improvement or arrest or retard deterioration of subluxation within a reasonable and generally predictable period of time.

Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition (e.g., loss of joint mobility or other joint problems) implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

It has come to Medicare's attention that some chiropractors have been using an "intensive care" concept of treatment. Under this approach, multiple daily visits (as many as four or five in a single day) are given in the office or clinic, and so-called room or ward fees are

charged since the patient is confined to bed usually for the day. The room or ward fees are not covered, and reimbursement under Medicare will be limited to not more than one treatment per day unless documentation of the reasonableness and necessity for additional treatment is submitted.

X-ray Review

As noted above, effective for claims with dates of service on and after January 1, 2000, the X-ray is no longer required. Therefore, the X-ray review process is no longer required for claims with those dates of service. For claims with dates of service *prior to* January 1, 2000, however, the following instructions still apply:

- It is the responsibility of the treating chiropractor to make the documenting X-ray(s) available to Medicare's review staff.
- The X-ray film(s) must have been taken at a time reasonably proximate to the initiation of the course of treatment and must demonstrate a subluxation at the level of the spine specified by the treating chiropractor on the claim.
- An X-ray obtained by the chiropractor for his own diagnostic purposes before commencing treatment generally should suffice for claims documentation purposes. However, when subluxation was for treatment purposes diagnosed by some other means and X-rays are taken to satisfy Medicare's documentation requirement, chiropractors should cone in on the site of the subluxation in producing X-rays. Such a practice not only minimizes the exposure of the patient but also should result in a film more clearly portraying the subluxation.
- Medicare will consider an X-ray to be of acceptable technical quality if any individual trained in the reading of X-rays could recognize a subluxation if present.
- If the beneficiary refuses to have the X-ray, the chiropractor must submit one of the appropriate HCPCS codes for chiropractic manipulation in addition to modifier GX (Service not covered by Medicare), and the claim will be denied as a technical denial.

Note: Although an X-ray is no longer required for services rendered on or after January 1, 2000, use of modifier GX will still result in a technical denial.

DRUGS & BIOLOGICALS

Changes to Drug Allowances

Medicare Part B allowances for certain anti-cancer drugs have been updated, effective for services processed on or after November 29, 1999.

In addition, the allowances for Depo-Medrol injections were updated effective for services processed on or after December 6, 1999.

Finally, the January 1, 2000 pricing update has been applied to the entire list of injectable drugs, as appropriate. The new allowances for all of these are on the following pages.

IC = Allowance is determined on an individual consideration basis
NA = Concept does not apply
NC = Noncovered by Medicare

FEE SCHEDULE CHANGES

Additional Fees for 2000

The Year 2000 allowances for carrier-priced Medicare Physician and Non-Physician Practitioner Fee Schedule services were published in the *2000 Medicare B Update! Special Issue HCPCS and MPFSDB Update* (December 1999) on pages 79 - 80. The Clinical Laboratory Fee Schedule for calendar year 2000 was provided on pages 84 - 87 of that issue. Since that publication was released, additional fees have been determined.

Carrier-Priced Codes

	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
G0159	404.29	431.00	458.37	384.08	409.45	435.45	441.69	470.87	500.77
38120	1085.27	1148.06	1206.95	1031.01	1090.66	1146.60	1185.66	1254.26	1318.59
44201	858.89	916.15	970.26	815.95	870.34	921.75	938.34	1000.89	1060.01
60650	1085.27	1148.06	1206.95	1031.01	1090.66	1146.60	1185.66	1254.26	1318.59

Clinical Laboratory Fee Schedule

CODE	FEE
87338	26.45

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J0120	Injection, tetracycline, up to 250 mg	$11.56	$10.98	$12.63
J0130	Injection, abciximab, 10 mg	$513.01	$487.36	$560.46
J0150	Injection, adenosine, 6 mg	$26.45	$25.13	$28.90
J0151	Injection, adenosine, 90 mg	$212.56	$201.93	$232.22
J0170	Injection, adrenalin, epinephrine, up to 1 ml ampule	$1.00	$0.95	$1.09
J0190	Biperiden, 5 mg - lactate	$3.16	$3.00	$3.45
J0200	Injection, alatrofloxacin mesylate, 100 mg	$17.51	$16.63	$19.13
J0205	Alglucerase, per 10 units	$37.52	$35.64	$40.99
J0207	Injection, amifostine, 500 mg	$350.31	$332.79	$382.71
J0210	Methyldopate HCL, up to 250 mg	$8.97	$8.52	$9.80
J0256	Injection, alpha 1 - proteinase inhibitor, human, 10 mg	$2.09	$1.99	$2.28
J0270	Injection, alprostadil, per 1.25 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$0.51	$0.48	$0.56
J0275	Injection, alprostadil, urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$18.76	$17.82	$20.49
J0280	Injection, aminophyllin, up to 250 mg	$1.30	$1.24	$1.43
J0285	Injection, amphotericin B, 50 mg	$15.77	$14.98	$17.23
J0286	Injection, amphotericin B, any lipid formulation 50 mg	$95.00	$90.25	$103.79
J0290	Injection, ampicillin sodium, up to 500 mg	$1.06	$1.01	$1.16
J0295	Injection, ampicillin sodium/sulbactam sodium, 1.5 gm	$13.73	$13.04	$15.00
J0300	Injection, amobarbital, up to 125 mg	$2.02	$1.92	$2.21
J0330	Injection, succinylocholine chloride, up to 20mg	$0.08	$0.08	$0.09
J0340	Injection, nandrolone phenpropionate, up to 50 mg	$7.87	$7.48	$8.60
J0350	Injection, anistreplase, per 30 units	$2,517.57	$2,391.69	$2,750.44
J0360	Injection, hydralazine HCL, up to 20 mg	$7.62	$7.24	$8.33
J0380	Injection, metaraminol bitartrate, per 10 mg	$1.12	$1.06	$1.22
J0390	Injection, chloroquine HCL, up to 250 mg	$16.20	$15.39	$17.70
J0395	Injection, arbutaime HCL, 1 mg	$182.40	$173.28	$199.27
J0400	Injection, trimethaphan camsylate, up to 500 mg	$27.17	$25.81	$29.68
J0456	Injection, azithromycin, 500 mg	$22.52	$21.39	$24.60
J0460	Injection, atropine sulfate, up to 0.3 mg	$1.98	$1.88	$2.16
J0470	Injection, dimercaprol, per 100 mg	$23.67	$22.49	$25.86
J0475	Injection, baclofen, 10 mg	$215.65	$204.87	$235.60
J0476	Injection, baclofen, 50 mcg for intrathecal trial	$74.10	$70.40	$80.96
J0500	Injection, dicylomine HCL, up to 20 mg	$1.66	$1.58	$1.82
J0510	Injection, benzquinamide HCL, up to 50 mg	$5.47	$5.20	$5.98
J0515	Injection, benztropine mesylate, per 1 mg	$3.46	$3.29	$3.78
J0520	Injection, bethanechol chloride, mytonachol or urecholine up to 5 mg	$5.16	$4.90	$5.64
J0530	Injection, penicillin G benzathine and penicillin G procaine up to 600,000 units	$6.32	$6.00	$6.68
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1, 200,000 units	$12.65	$12.02	$13.82
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2, 400, 000 units	$25.30	$24.04	$26.75
J0560	Injection, penicillin G benzathine, up to 600,000 units	$7.50	$7.13	$8.20
J0570	Injection, penicillin G benzathine, up to 1200,000 units	$12.24	$11.63	$13.37
J0580	Injection, penicillin G benzathine, up to 2400,000 units	$24.48	$23.26	$26.75
J0585	Botulinum toxin type A, per unit	$4.38	$4.16	$4.78
J0590	Injection, ethylnorepinephrine HCL, 1 ml	$4.17	$3.96	$4.55
J0600	Injection, edetate calcium disodium, up to 1000 mg	$36.44	$34.62	$39.81
J0610	Injection, calcuuium gluconate, per 10 ml	$1.01	$0.96	$1.10
J0620	Injection, calcium glycerophosphate and calcium lactate, per 10 ml	$0.34	$0.32	$0.37
J0635	Injection, calcitriol, 1 mcg ample	$12.82	$12.18	$14.01
J0640	Injection, leucovorin calcium, per 50 mg	$35.47	$33.70	$38.76
J0690	Injection, cefazolin sodium, 500 mg	$1.96	$1.86	$2.14
J0694	Injection, cefozitin sodium, 1 g	$10.83	$10.29	$11.83
J0695	Injection, cefonicid sodium, 1 mg	$24.79	$23.55	$27.08
J0696	Injection, ceftriaxone sodium, per 250 mg	$13.78	$13.09	$15.05
J0697	Injection, sterile cefuroxime sodium, per 750 mg	$6.09	$5.79	$6.66
J0698	Injection, cefotaxime sodium, per g	$12.12	$11.51	$13.24
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg	$4.39	$4.17	$4.80
J0704	Injection, betamethasone sodium phosphate, per 4 mg	$3.21	$3.05	$3.51
J0710	Injection, cephapirin sodium, up to 1 g	$1.55	$1.47	$1.69
J0713	Injection, ceftazidime, per 500 mg	$9.67	$9.19	$10.57
J0715	Injection, ceftizoxime sodium, per 500 mg	$6.15	$5.84	$6.72
J0720	Injection, chloramphenicol sodium succinate, up to 1 g	$6.18	$5.87	$6.75
J0725	Injection, chorionic gonadotropin, 1000 USP units	$1.62	$1.54	$1.77
J0730	Injection, chlorpheniramine maleate, per 10 mg	$0.33	$0.31	$0.36
J0735	Injection, clonidine hydrochloride, 1 mg	$48.45	$46.03	$52.93
J0740	Injection, cidofavir, 375 mg	$723.90	$687.71	$790.87

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J0743	Injection, cilastatin sodium imipenem, per 250 mg	$13.67	$12.99	$14.94
J0745	Injection, codeine phosphate, per 30 mg	$0.86	$0.82	$0.94
J0760	Injection, colchicine, per 1 mg	$4.78	$4.54	$5.22
J0770	Injection, colistimethate sodium, up to 150 m	$39.03	$37.08	$42.64
J0780	Injection, procholrperazine, up to 10 mg	$2.62	$2.49	$2.86
J0800	Injection, corticotropin, up to 40 units	$4.55	$4.32	$4.97
J0810	Injection, cortisone, up to 50 mg	$2.76	$2.62	$3.01
J0835	Injection, cosyntropin, per 0.25 mg	$12.44	$11.82	$13.59
J0850	Injection, cytomegalovirus immune globulin intravenous (human) per vial	$612.18	$581.57	$530.81
J0895	Injection, deferoxamine mesylate, 500 mg, per 5 cc	$11.46	$10.89	$12.52
J0900	Injection, testosterone enanthate and estradiol valerate, up to 1 cc	$1.51	$1.43	$1.64
J0945	Injection, brompheniramine maleate, per 10 mg	$0.52	$0.49	$0.56
J0970	Injection, estrodiol valerate, up to 40 mg	$1.61	$1.53	$1.76
J1000	Injection, depo-estradiol cypionate, up to 5 mg	$0.80	$0.76	$0.87
J1020	Injection, methylprednisolone acetate, 20 mg	$2.37	$2.25	$2.59
J1030	Injection, methylprednisolone acetate, 40 mg	$2.84	$2.70	$3.10
J1040	Injection, methylprednisolone acetate, 80 mg	$7.66	$7.28	$8.37
J1050	Injection, medroxyprogesterone acetate, 100 mg	$13.10	$12.45	$14.32
J1060	Injection, testosterone cypionate and estradiol cypionate up to 1 ml	$1.03	$0.98	$1.13
J1070	Injection, testosterone cypionate, up to 100 mg	$1.21	$1.15	$1.32
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	$2.25	$2.14	$2.46
J1090	Injection, testosterone cypionate, 1 cc, 50 mg	$0.60	$0.57	$0.66
J1095	Injection, dexamethasone acetate, per 8 mg	$4.45	$4.23	$4.86
J1100	Injection, dexamethasone sodium phosphate, up to 4mg/ml	$0.59	$0.56	$0.52
J1110	Injection, dihydroergotamine mesylate, per 1 mg	$12.52	$11.89	$13.67
J1120	Injection, acetazolamide sodium, up to 500 mg	$29.64	$28.16	$32.38
J1160	Injection, digoxin, up to 0.5 mg	$1.86	$1.77	$2.03
J1165	Injection, phenytoin sodium, per 50 mg	$0.80	$0.76	$0.87
J1170	Injection, hydromorphone, up to 4 mg	$1.18	$1.12	$1.29
J1180	Injection, dyphylline, up to 500 mg	$5.28	$5.02	$5.77
J1190	Injection, dexrazoxane hydrochloride, per 250 mg	$150.56	$143.03	$164.48
J1200	Injection, diphenhydramine HCL, up to 50 mg	$3.90	$3.71	$4.26
J1205	Injection, chlorothiazide sodium, per 500 mg	$9.31	$8.84	$10.17
J1212	Injection, DMSO, Dimethyl Sulfoxide, 50%, 50ml	$34.67	$32.94	$37.88
J1230	Injection, methodene HCL, up to 10 mg	$0.71	$0.67	$0.77
J1240	Injection, dimenhydrinate, up to 50 mg	$0.69	$0.66	$0.76
J1245	Injection, dipridamole, per 10 mg	$21.34	$20.27	$23.31
J1250	Injection, dobutamine HCL, per 250 mg	$11.40	$10.83	$12.45
J1260	Injection, dolasetron mesylate, 10 mg	$14.80	$14.06	$16.17
J1320	Injection, amitriptyline HCL, up to 20 mg	$0.85	$0.81	$0.93
J1325	Injection, epoprostenol, 0.5 mg	$16.53	$15.70	$18.06
J1327	Injection, eptifibatide, 5 mg	$12.56	$11.93	$13.72
J1330	Injection, ergonovine maleate, up to 0.2 mg	$4.50	$4.28	$4.92
J1362	Injection, erthromycin gluceptate, per 250 mg	$5.95	$5.65	$6.50
J1364	Injection, erthromycin lactobionate, per 500 mg	$11.07	$10.52	$12.10
J1380	Injection,estradiol valerate, up to 10 mg	$0.70	$0.67	$0.77
J1390	Injection,estradiol valerate, up to 20 mg	$1.25	$1.19	$1.37
J1410	Injection, estrogen conjugated, per 25 mg	$46.20	$43.89	$50.47
J1435	Injection, estrone, per 1 mg	$0.19	$0.18	$0.21
J1436	Injection, etidronate disodium, per 300 mg	$63.64	$60.46	$69.53
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$130.62	$124.09	$142.70
J1440	Injection, filgrastim (G-CSF), 300 mcg	$163.85	$155.66	$179.01
J1441	Injection, filgrastim (G-CSF), 480 mcg	$260.68	$247.65	$284.80
J1450	Injection, fluconazole, 200 mg	$81.33	$77.26	$88.85
J1455	Injection, foscarnet sodium, per 1, 000 mg	$11.60	$11.02	$12.67
J1460	Injection, gamma globulin, intramuscular, 1 cc	IC	IC	IC
J1470	Injection, gamma globulin, intramuscular, 2 cc	IC	IC	IC
J1480	Injection, gamma globulin, intramuscular, 3 cc	IC	IC	IC
J1490	Injection, gamma globulin, intramuscular, 3 cc	IC	IC	IC
J1500	Injection, gamma globulin, intramuscular, 5 cc	IC	IC	IC
J1510	Injection, gamma globulin, intramuscular, 6 cc	IC	IC	IC
J1520	Injection, gamma globulin, intramuscular, 7 cc	IC	IC	IC
J1530	Injection, gamma globulin, intramuscular, 8 cc	IC	IC	IC
J1540	Injection, gamma globulin, intramuscular, 9 cc	IC	IC	IC
J1550	Injection, gamma globulin, intramuscular, 10 cc	IC	IC	IC
J1560	Injection, gamma globulin, intramuscular, over 10 cc	IC	IC	IC
J1561	Injection, immune globulin, intravenous 500 mg	$61.56	$58.48	$67.25

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J1562	Injection, immune globulin, intravenous 5 gms	$380.00	$361.00	$415.15
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg	$717.39	$681.52	$783.75
J1570	Injection, ganciclovier sodium, 500 mg	$33.88	$32.19	$37.02
J1580	Injection, garamycin, gentamicin,up to 80 mg	$2.16	$2.05	$2.36
J1600	Injection, gold sodium thiomalate, up to 50 mg	$11.22	$10.66	$12.26
J1610	Injection, glucagon hydrochloride, per 1 mg	$36.52	$34.69	$39.89
J1620	Injection, gonadorelin hydrochloride, per 100 mcg	$61.95	$58.85	$67.68
J1626	Injection, granisetron hydrochloride, 100 mcg	$18.54	$17.61	$19.31
J1630	Injection, haloperidol, up to 5 mg	$7.19	$6.83	$7.54
J1631	Injection, haloperidol decanoate, per 50 mg	$29.94	$28.44	$32.71
J1642	Injection, heparin sodium, (Heparin Lock Flush) per 10 units	$0.26	$0.25	$0.29
J1644	Injection, heparin sodium, per 1,000 units	$0.37	$0.35	$0.40
J1645	Injection, dalteparin sodium, per 2500 IU	$13.25	$12.59	$14.48
J1650	Injection, enoxaparin sodium, 10 mg	$5.32	$5.05	$5.81
J1670	Injection, tetanus immune globulin, human up to 250 units	$95.00	$90.25	$103.79
J1690	Injection, prednisolone tebutate, up to 20 mg	$3.89	$3.70	$4.26
J1700	Injection, hydrocortisone acetate, up to 25 mg	$0.83	$0.79	$0.91
J1710	Injection, hydrocortisone sodium phosphate, up to 50 mg	$4.94	$4.69	$5.39
J1720	Injection, hydrocostisone sodium succinate, up to 100 mg	$2.80	$2.66	$3.06
J1730	Injection, diazoxide, up to 300 mg	$93.00	$88.35	$101.60
J1739	Injection, hydroxyprogesterone caproate, 125 mg/ml	$1.29	$1.23	$1.41
J1741	Injection, hydroxyprogesterone caproate, 250 mg/ml	$2.71	$2.57	$2.96
J1742	Injection, ibutilide fumarate, 1 mg	$210.27	$199.76	$214.68
J1745	Injection, infliximab, 10 mg	$58.07	$55.17	$63.44
J1750	Injection, iron dextran, 50 mg	$17.91	$17.01	$19.57
J1785	Injection, imiglucerase, per unit	$3.75	$3.56	$4.09
J1790	Injection, droperidol, up to 5 mg	$3.65	$3.47	$3.99
J1800	Injection, propranolol HCL, up to 1 mg	$5.93	$5.63	$6.48
J1810	Injection, droperidol and fentanyl citrate, up to 2 ml ampule	$7.02	$6.67	$7.67
J1820	Injection, insulin, up to 100 units	$1.97	$1.87	$2.15
J1825	Injection, interferon BETA - 1A, per 33 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$202.35	$192.23	$221.06
J1830	Injection, interferon BETA - 1B, per 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$68.40	$64.98	$74.73
J1840	Injection, kanamycin sulfate, up to 500 mg	$3.19	$3.03	$3.48
J1850	Injection, kanamycin sulfate, up to 75 mg	$2.88	$2.74	$3.15
J1885	Injection, ketorolac tromethamine, per 15 mg (depends upon mgs)	IC	IC	IC
J1890	Injection, cephalothin sodium, up to 1 g	$10.26	$9.75	$11.21
J1910	Injection, kutapressin, up to 2 ml	$12.04	$11.44	$13.15
J1930	Injection, propiomazine HCL, up to 20 mg	$3.93	$3.73	$4.29
J1940	Injection, furosemide, up to 20 mg	$0.93	$0.88	$1.02
J1950	Injection, leuprolide acetate (for depot suspension) per 3.75 mg	$454.10	$431.40	$496.10
J1955	Injection, levocarnitine, per 1 gm	$34.20	$32.49	$37.36
J1956	Injection, levofloxacin, 250 mg	$18.81	$17.87	$20.55
J1960	Injection, levorphanol tartrate, up to 2 mg	$3.69	$3.51	$4.03
J1970	Injection, methotrimepraxine, up to 20 mg	$21.55	$20.47	$23.54
J1980	Injection, hyoscyamine sulfate, up to 0.25 mg	$5.32	$5.05	$5.81
J1990	Injection, chlordiazepoxide HCL, up to 100 mg	$24.99	$23.74	$27.30
J2000	Injection, lidocaine HCL, up to 50 cc	NC	NC	NC
J2010	Injection, lincomycin HCL, up to 300 mg	$0.95	$0.90	$1.04
J2060	Injection, lorazepam, 2 mg	$8.33	$7.91	$9.10
J2150	Injection, mannitol, 25% in 50 ml	$3.26	$3.10	$3.57
J2175	Injection, meperidine HCL, per 100 mg.	$0.57	$0.54	$0.62
J2180	Injection, meperidine and promethazine, HCL, up to 50 mg	$3.69	$3.51	$4.04
J2210	Injection, methylergonovine maleate, up to 0.2 mg	$3.22	$3.06	$3.52
J2240	Injection, metovurine iodide, up to 2 mg	$1.28	$1.22	$1.40
J2250	Injection, midazolam HCL, per 1 mg	$2.07	$1.97	$2.27
J2260	Injection, milrinone lactate, per 5 ml	$37.43	$35.56	$40.89
J2270	Injection, morphine sulfate, up to 10 mg	$0.97	$0.92	$1.06
J2271	Injection, morphine Sulfate, 100 mg	$13.18	$12.52	$14.40
J2275	Injection, morphine sulfate (preservative-free sterile solution per 10 mg	$7.41	$7.04	$8.10
J2300	Injection, nalbuphine HCL, per 10 mg	$1.44	$1.37	$1.58
J2310	Injection, naloxone HCL, per 1 mg	$2.03	$1.93	$2.22
J2320	Injection, nandrolone decanoate HCL, up to 50 mg	$5.20	$4.94	$5.68
J2321	Injection, nandrolone decanoate HCL, up to 100 mg	$4.94	$4.69	$5.39
J2322	Injection, nandrolone decanoate HCL, up to 200 mg	$12.64	$12.01	$13.81
J2330	Injection, thiothixene, up to 4 mg	$1.84	$1.75	$2.01

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J2350	Injection, niacinamide, niacin, up to 100 mg	$0.11	$0.10	$0.12
J2352	Injection, octreotide acetate, 1 mg	$115.33	$109.56	$126.00
J2355	Injection, oprelvekin, 5 mg	$236.31	$224.49	$258.16
J2360	Injection, orphenadrine citrate, up to 60 mg	$2.26	$2.15	$2.47
J2370	Injection, phenylephrine HCL, up to 1 ml	$2.37	$2.25	$2.59
J2405	Injection, ondansetron HCL, per 1 mg	$6.08	$5.78	$6.64
J2410	Injection, oxymorphoine HCL, up to 1 mg	$2.64	$2.51	$2.89
J2430	Injection, pamidronate disodium, per 30 mg	$232.51	$220.88	$254.02
J2440	Injection, papaverine HCL, up to 60 mg	$3.56	$3.38	$3.89
J2460	Injection, oxytetracycline HCL, up to 50 mg	$0.89	$0.85	$0.98
J2480	Injection, hydrochlorides of opium alkaloids, up to 20 mg	$3.24	$3.08	$3.54
J2500	Injection, paricalcitol, 5 mcg	$25.15	$23.89	$27.48
J2510	Injection, penicillin G procaine, aqueous, up to 600,000 units	$3.13	$2.97	$3.42
J2512	Injection, pentagastrin, per 2 ml	$35.48	$33.71	$38.77
J2515	Injection, pentobarbital sodium, per 50 mg	$0.88	$0.84	$0.97
J2540	Injection, penicillin G potassium, up to 600,000 units	$0.39	$0.37	$0.43
J2543	Injection, piperacillin sodium/tazobactam sodium, 1 gram 0.125 grams (1.125 grams)	$10.26	$9.75	$11.21
J2545	Pentamidine isethionate, inhalation solution, per 300 mg through a DME	$92.62	$87.99	$101.19
J2550	Injection, promethazine HCL, up to 50 mg	$0.24	$0.23	$0.26
J2560	Injection, phenbarbital sodium, up to 120 mg	$2.26	$2.15	$2.47
J2590	Injection, oxtocin, up to 10 units,	$0.56	$0.53	$0.61
J2597	Injection, desmopressin acetate, per 1 mcg	$4.67	$4.44	$5.11
J2640	Injection, prednisolone sodium phosphate, up to 20 mg	$0.66	$0.63	$0.72
J2650	Injection, predinosolone acetate, up to 1 ml	$0.34	$0.32	$0.37
J2670	Injection, tolazoline HCL, up to 25 mg	NC	NC	NC
J2675	Injection, progesterone, (Gesterol 50, Progestaject) per 50 mg	$0.96	$0.91	$1.05
J2680	Injection, fluphenzaine decanoate, up to 25 g	$15.20	$14.44	$16.61
J2690	Injection, procainamide HCL, up to 1 g	$11.02	$10.47	$12.04
J2700	Injection, ocacillin sodium, up to 250 mg	$2.00	$1.90	$2.19
J2710	Injection, neostrigmine methylsulfate, up to 0.5 mg	$0.70	$0.67	$0.77
J2720	Injection, protamine sulfate, per 10 mg	$0.77	$0.73	$0.84
J2725	Injection, protirelin, per 250 mg	$23.45	$22.28	$25.62
J2730	Injection, pralidoxime chloride, up to 1 g	$60.92	$57.87	$66.55
J2760	Injection, phentolamine mesylate, up to 5 mg	$28.91	$27.46	$31.58
J2765	Injection, metoclopramine HCL, up to 10 mg	$1.90	$1.81	$2.08
J2780	Injection, ranitidine hydrochloride, 25 mg	$1.46	$1.39	$1.60
J2790	Injection, Rho (D) immune globulin, human, one dose package	$41.32	$39.25	$45.14
J2792	Injection, Rho D Immune Globulin, Intravenous, Human, Solvent Detergent, 100 IU	$20.54	$19.51	$22.44
J2800	Injection, methocarbamol, up to 10 ml	$11.52	$10.94	$12.59
J2810	Injection, theophylline, per 40 mg	$1.44	$1.37	$1.58
J2820	Injection, sargramostim (GM-CSF) 50 mcg	$27.41	$26.04	$29.95
J2860	Injection, secobarbital sodium, up to 250 mg	$8.21	$7.80	$8.97
J2910	Injection, aurothioglucose, up to 50 mg	$13.14	$12.48	$14.35
J2912	Injection, sodium chloride, 0.9%, per 2 ml	$1.10	$1.05	$1.21
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	$2.01	$1.91	$2.20
J2930	Injection, methlprednosolone sodium sucdinate, up to 125 mg	$3.54	$3.36	$3.86
J2950	Injection, promazine HCL, up to 25 mg	$0.45	$0.43	$0.49
J2970	Injection, methicillin sodium, up to 1 g	$5.57	$5.29	$6.08
J2994	Injection, reteplase, 37.6 mg (two single vials)	$2,612.50	$2,481.88	$2,854.16
J2995	Injection, streptokinase, per 250,000 IU	NC	NC	NC
J2996	Injection, alteplase recombinant, per 10 mg	$261.25	$248.19	$285.42
J3000	Injection, streptomycin, up to 1 g	$5.65	$5.37	$6.18
J3010	Injection, fentanyl citrate, up to 2 ml	$1.49	$1.42	$1.63
J3030	Injection, sumatriptan succinate, 6 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	$42.78	$40.64	$46.74
J3070	Injection, pentazocine HCL, up to 30 mg	$3.17	$3.01	$3.46
J3080	Injection, chlorprothixene, up to 50 mg	$9.73	$9.24	$10.63
J3105	Injection, terbutaline sulfate, up to 1 mg	$2.34	$2.22	$2.33
J3120	Injection, testosterone enanthate, up to 100 mg	$0.57	$0.54	$0.62
J3130	Injection, testosterone enanthate, up to 200 mg	$1.14	$1.08	$1.24
J3140	Injection, testosterone suspension, up to 50 mg	$0.39	$0.37	$0.43
J3150	Injection, testosterone propionate, up to 100 mg	$0.95	$0.90	$1.04
J3230	Injection, chlorpromazine HCL, up to 50 mg	$1.90	$1.81	$2.08
J3240	Injection, thyrotropin alfa, 0.9 mg	$897.75	$852.86	$980.79
J3245	Injection, tirofiban hydrochloride, 12.5 mg	$399.00	$379.05	$435.91
J3250	Injection, trimethobenzamide HCL, up to 200 mg	$2.39	$2.27	$2.61

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J3260	Injection, tobramycin sulfate, up to 80 mg	$10.80	$10.26	$11.80
J3265	Injection, torsemide, 10 mg/ml	$1.89	$1.80	$2.07
J3270	Injection, imipramine HCL, up to 25 mg	$2.21	$2.10	$2.42
J3280	Injection, thiethylperazine maleate, up to 10 mg	$5.01	$4.76	$5.47
J3301	Injection, triamcinolone acetonide, per 10 mg	$1.48	$1.41	$1.62
J3302	Injection, triamcinolone diacetate, per 5 mg	$0.81	$0.77	$0.88
J3303	Injection, traimcinolone hexacetonide, per 5 mg	$2.26	$2.15	$2.47
J3305	Injection, trimetrexate glucoronate, per 25 mg	$69.83	$66.34	$76.29
J3310	Injection, perphenazine, up to 5 mg	$6.30	$5.99	$6.89
J3320	Injection, spectinomycin dihydrochloride, up to 2 g	$22.12	$21.01	$24.16
J3350	Injection, urea, up to 40 g	$80.20	$76.19	$87.62
J3360	Injection, diazepam, up to 5 mg	$1.37	$1.30	$1.86
J3364	Injection, urokinase, 5,000 IU vial	$56.61	$53.78	$61.85
J3365	Injection, IV, irokinase, 250,000 IU vial	$466.16	$442.85	$509.28
J3370	Injection, vancomycin HCL, up to 500 mg	$5.19	$4.93	$5.67
J3390	Injection, methoxamine HCL, up to 20 mg	$23.20	$22.04	$25.35
J3400	Injection, triflupromazine HCL, up to 20 mg	$11.85	$11.26	$12.95
J3410	Injection, hydrixyzine HCL, up to 25 mg	$0.62	$0.59	$0.68
J3420	Injection, vitamin B-12 cyanocobalamin, up to 1,000 mg	$0.05	$0.05	$0.06
J3430	Injection, phytonadione (vitamin K) per mg1	$2.24	$2.13	$2.45
J3450	Injection, mephentermine sulfate, up to 30 mg	$2.00	$1.90	$2.19
J3470	Injection, hyaluronidase, up to 150 units	$8.48	$8.06	$9.27
J3475	Injection, magnestium sulfate, per 500 mg	$0.28	$0.27	$0.31
J3480	Injection, potassium chloride, per 2 mEq	$0.10	$0.10	$0.12
J3490	Unclassified drugs	IC	IC	IC
J3520	Edetate disodium	NC	NC	NC
J3530	Nasal vaccine inhalation	NC	NC	NC
J3535	Drug administered through a metered dose inhaler	NC	NC	NC
J3570	Laetrile, amygdalin, vitamin B-17	NC	NC	NC
J6015	Typhus	NC	NC	NC
J7030	Infusion , normal saline solution, 1, 000 cc	NC	NC	NC
J7040	Infusion, normal saline solution, sterile (500 ml = 1unit)	$10.30	$9.79	$11.26
J7042	5% dextrose/normal saline (500 ml + 1 unit)	$10.73	$10.19	$11.72
J7050	Infusion, normal saline solution, 250 cc	$10.90	$10.36	$11.91
J7051	Sterile saline or water, up to 5cc	$0.55	$0.52	$0.60
J7060	5% dextrose/water (500 ml + 1 unit)	$9.56	$9.08	$10.44
J7070	Infusion D-5-W, 1,000 cc	$10.85	$10.31	$11.86
J7100	Infusion, dextran 40, 500 ml	$27.01	$25.66	$29.51
J7110	Infusion, dextran 75, 500 ml	$107.52	$102.14	$117.47
J7120	Ringer's lactate infusion, upto 1,000 cc	$12.67	$12.04	$13.84
J7130	Hypertonic saline solution, 50 or 100 meq. 20 cc vial	$6.79	$6.45	$7.42
J7190	Factor VIII (anti-hemophilic factor)(Human) per IU	$0.85	$0.81	$0.93
J7191	Factor VIII (anti-hemophilic factor)(porcine) per IU	$2.09	$1.99	$2.28
J7192	Factor VIII (anti-hemophilic factor)(recombinant) per IU	$1.12	$1.06	$1.22
J7194	Factor IX complex, per IU	$0.31	$0.29	$0.34
J7197	Antithrombin III (human) per IU	$0.81	$0.77	$0.88
J7198	Anti-inhibitor, per I.U.	$1.42	$1.35	$1.55
J7199	Hemophilia clotting factor, not otherwise classified	I.C.	I.C.	I.C.
J7300	Intrauterine copper contraceptive	NC	NC	NC
J7310	Ganciclovir, 4.5 mg long-acting implant	$3,800.00	$3,610.00	$4,151.50
J7315	Sodium Hyaluronate, 20 mg, for intra articulator injection	$125.59	$119.31	$137.21
J7320	Hylan G-F 20, 16 mg, for intra articular injection	$204.86	$194.62	$223.81
J7500	Azathioprine, oral, tab, 50 mg 100's ea	$110.79	$105.25	$121.04
J7501	Azathioprine, parenteral, vial, 100 mg 20 ml ea.	$77.52	$73.64	$84.69
J7502	Cyclosporine, oral, per 100 mg	$5.63	$5.35	$6.15
J7504	Lymphocyte immune globulin, antithymocyte globulin, parenteral, amp, 250mg	$249.16	$236.70	$272.21
J7505	Monoclonal antibodies - parenteral, 5 mg	$684.00	$649.80	$747.27
J7506	Prednisione, oral, per 5 mg	$0.12	$0.11	$0.13
J7507	Tacrolimus, oral, per 1 mg	IC	IC	IC
J7508	Tacrolimus, oral, per 5 mg	IC	IC	IC
J7509	Methylprednosolone, oral, per 4mg	IC	IC	IC
J7510	Prednisolone, oral per 5 mg	IC	IC	IC
J7513	Daclizumab, parenteral, 25 mg	$397.29	$377.43	$434.04
J7515	Cyclosporine, oral, 25 mg	$1.41	$1.34	$1.54
J7516	Cyclosporin, parenteral, 250 mg	$27.69	$26.31	$30.25
J7517	Mycophenolate mofetil, oral, 250 mg	$2.13	$2.02	$2.33
J7599	Immunosuppressive drug, not otherwise classified	IC	IC	IC
J7608	Acetylcysteine, inhalation solution administered through DME, unit dose form per gram	IC	IC	IC

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J7610	Acetylcysteine, 10% per ml, inhalation solution adm thru DME	$1.29	$1.23	$1.41
J7615	Acetylcysteine, 20% per ml, inhalation solution adm thru DME	$1.54	$1.46	$1.68
J7618	Albuterol, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7619	Albuterol, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7620	Albuterol sulfate, 0.083% per ml, inhalation solution adm. DME	$0.38	$0.36	$0.42
J7625	Albuterol sulfate, 0.5% per ml, inhalation solution adm. DME	$0.67	$0.64	$0.73
J7627	Bitolterol mesylate, 0.2% per 10 ml, inhalation solution adm DME	$4.98	$4.73	$5.44
J7628	Bitolterol mesylate, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7629	Bitolterol mesylate, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7630	Cromolyn sodium per 20 mg inhalation solution adm thru DME	$0.66	$0.63	$0.72
J7631	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligram	IC	IC	IC
J7635	Atropine, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7636	Atropine, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7637	Dexamethasone, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7638	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7639	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7640	Epinephrine 2.25% per ml, inhalation solution adm.thru DME	$0.77	$0.73	$0.84
J7642	Glycopyrrolate, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7643	Glycopyrrolate, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7644	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7645	Ipratropium bromide 0.02% per ml, inhalation sol. adm thru DME	IC	IC	IC
J7648	Isoetharine HCL, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7649	Isoetharine HCL, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7650	Isoetharine HCL, 0.1% per ml, inhalation solution adm thru DME	$0.37	$0.35	$0.40
J7651	Isoetharine HCL, 0.125% per ml, inhalation solution adm thru DME	$0.23	$0.22	$0.25
J7652	Isoetharine HCL, 0.167% per ml, inhalation solution adm thru DME	$0.31	$0.29	$0.34
J7653	Isoetharine HCL, 0.2% per ml, inhalation solution adm thru DME	$0.37	$0.35	$0.40
J7654	Isoetharine HCL, 0.25% per ml, inhalation solution adm thru DME	$0.47	$0.45	$0.51
J7655	Isoetharine HCL, 1.0% per ml, inhalation solution adm thru DME	$1.73	$1.64	$1.89
J7658	Isoproterenol HCL, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7659	Isoproterenol HCL, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7660	Isoproterenol HCL, 0.5 % per ml inhalation solution adm/DME	$2.35	$2.23	$2.57
J7665	Isoproterenol HCL, 1.0% per ml. inhalation solution adm thru DME	$2.56	$2.43	$2.80
J7668	Metaproternol sulfate, inhalation solution administered through DME, concentrated form, per 10 milligrams	IC	IC	IC
J7669	Metaproternol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams	IC	IC	IC
J7670	Metaproternol sulfate, 0.4% per 2.5 mo inhalation solution adm/DME	$1.30	$1.24	$1.42
J7672	Metaproternol sulfate, 0.6% per 2.5 mo inhalation solution adm/DME	$1.05	$1.00	$1.15
J7675	Metaproternol sulfate, 5.0% per 2.5 mo inhalation solution adm/DME	$1.30	$1.24	$1.42
J7680	Terbutaline sulfate, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7681	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7682	Tobramycin, unit dose form, per 300 mg, inhalation solution, administered through DME	IC	IC	IC
J7683	Triamcinolone, inhalation solution administered through DME, concentrated form, per milligram	IC	IC	IC
J7684	Triamcinolone, inhalation solution administered through DME, unit dose form, per milligram	IC	IC	IC
J7699	NOC drugs, inhalation solution administered thru DME	IC	IC	IC
J7799	NOC drugs, other than inhalation drugs, adm thru DME	IC	IC	IC

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J8499	Prescription drug, oral, nonchemotherapeutic, not otherwise specified	NC	NC	NC
J8510	Busulfan, oral, 2 mg	$1.65	$1.57	$1.80
J8520	Capecitabine, oral, 150 mg	$1.93	$1.83	$2.11
J8521	Capecitabine, oral, 500 mg	$6.45	$6.13	$7.05
J8530	Cyclophosphamide, oral, 25 mg	$1.84	$1.75	$2.01
J8560	Etoposide, oral, 50 mg	$38.42	$36.50	$41.97
J8600	Melphalan, oral 2 mg	$2.07	$1.97	$2.26
J8610	Methotrexate, oral 2.5 mg	$3.22	$3.06	$3.52
J8999	Prescription drug, oral, chemotherapeutics, not otherwise specified	IC	IC	IC
J9000	Doxorubicin HCL, 10 mg	$42.81	$40.67	$46.77
J9001	Doxorubicin hydrochloride, all lipid formualtions, 10 mg	$311.71	$296.12	$340.54
J9015	Aldesleukin, per single use vial	$569.76	$541.27	$622.46
J9020	Asparaginase, 10,000 units	$51.94	$49.34	$56.74
J9031	BCG live (intravesical) per installation	$140.12	$133.11	$153.08
J9040	Bleomycin sulfate, 15 units	$289.37	$274.90	$316.14
J9045	Carboplatin, 50 mg	$91.44	$86.87	$99.90
J9050	Carmustine, 100 mg	$103.27	$98.11	$112.82
J9060	Cisplatin, powder or solution, per 10 mg	$40.06	$38.06	$43.77
J9062	Cisplatin, 50 mg	$200.34	$190.32	$218.87
J9065	Injection, cladribine, per 1 mg	$53.46	$50.79	$58.41
J9070	Cyclophosphamide 100 mg	$5.97	$5.67	$6.52
J9080	Cyclophosphamide 200 mg	$11.34	$10.77	$12.39
J9090	Cyclophosphamide 500 mg	$23.80	$22.61	$26.00
J9091	Cyclophosphamide, 1 g	$47.64	$45.26	$52.05
J9092	Cyclophosphamide, 2 g	$95.26	$90.50	$104.07
J9093	Cyclophosphamide, lyophilized, 100 mg	$6.12	$5.81	$6.69
J9094	Cyclophosphamide, lyophilized, 200 mg	$11.63	$11.05	$12.71
J9095	Cyclophosphamide, lyophilized, 500 mg	$24.42	$23.20	$26.68
J9096	Cyclophosphamide, lyophilized, 1 g	$48.85	$46.41	$53.37
J9097	Cyclophosphamide, lyophilized, 2 g	$97.74	$92.85	$106.78
J9100	Cytarabine, 100 mg	$6.27	$5.96	$6.85
J9110	Cytarabine, 500 mg	$27.29	$25.93	$29.81
J9120	Dactinomycin, 0.5 mg	$12.73	$12.09	$13.91
J9130	Dacarbazine, 100 mg	$12.66	$12.03	$13.83
J9140	Dacarbazine, 200 mg	$25.32	$24.05	$27.66
J9150	Daunorubicin HCL, 10 mg	$80.03	$76.03	$87.43
J9151	Daunorubicin Citrate, Liposomal formulation, 10 mg	$64.60	$61.37	$70.58
J9165	Diethylstilbestrol diphosphate, 250 mg	$2.69	$2.56	$2.94
J9170	Docetaxel, 20 mg	$270.14	$256.63	$295.13
J9181	Etoposide, 10 mg	$12.37	$11.75	$13.51
J9182	Etoposide, 100 mg	$104.50	$99.28	$114.17
J9185	Fludarabine phosphate, 50 mg	$230.13	$218.62	$251.42
J9190	Fluorouracil, 500 mg	$2.52	$2.39	$2.75
J9200	Floxuridine, 500 mg	$129.56	$123.08	$141.54
J9201	Gemcitabine HCL, 200 mg / Gemzar 200 mg	$88.46	$84.04	$96.64
J9202	Goserelin acetate implant, per 3.6 mg	$446.49	$424.17	$487.79
J9206	Irinotecan 20 mg	$117.81	$111.92	$128.71
J9208	Ifosfamide, per 1 gm	$141.40	$134.33	$154.48
J9209	Mesna, 200 mg	$36.51	$34.68	$39.89
J9211	Idarubicin HCL, 5 mg	$241.44	$229.37	$263.77
J9212	Injection, Interferon Alfacon-1, recombinant, 1 mcg	$35.15	$33.39	$38.40
J9213	Interferon alfa-2A, recombinant, 3 million units	$33.22	$31.56	$36.29
J9214	Interferon alfa-2B, recombinant, 1 million units	$11.28	$10.72	$12.32
J9215	Interferon alfa-N3, (human keukocyte derived) 250,000 IU	$7.55	$7.17	$8.25
J9216	Interferon gamma-1B, 3 million units	$133.00	$126.35	$145.30
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	$564.91	$536.66	$617.16
J9218	Leuprolide acetate, per 1 mg	$77.54	$73.66	$84.71
J9230	Mcechlorethamine HCL, (nitrogen mustard) , 10 mg	$11.00	$10.45	$12.02
J9245	Injection, melphalan HCL, 50 mg	$363.47	$345.30	$397.09
J9250	Methotrexate sodium, 5 mg	$0.45	$0.43	$0.49
J9260	Methotrexate sodium, 50 mg	$4.51	$4.28	$4.93
J9265	Paclitaxel, 30 mg	$173.49	$164.82	$189.54
J9266	Pegaspargase, per single dose vial	$1,321.64	$1,255.56	$1,443.89
J9268	Pentostatin, per 10 mg	$1,562.75	$1,484.61	$1,707.30
J9270	Plicamycin, 2,500 mg	$84.29	$80.08	$92.09
J9280	Mitomycin 5 mg	$121.64	$115.56	$132.89
J9290	Mitomycin 20 mg	$413.71	$393.02	$451.98
J9291	Mitomycin 40 mg	$869.33	$825.86	$949.74
J9293	Injection, mitoxantrone HCL, per 5 mg	$223.02	$211.87	$243.65

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J9310	Rituximab, 100 mg	$420.28	$399.27	$459.16
J9320	Stretozocin, 1 gm	$100.85	$95.81	$110.18
J9340	Thiotepa, 15 mg	$100.30	$95.29	$109.58
J9350	Topotecan, 4 mg (Hycamtin)	$573.75	$545.06	$626.82
J9355	Trastuzumab, 10 mg	$4.88	$4.64	$5.33
J9357	Valrubicin, intravesical, 200 mg	$423.22	$402.06	$462.37
J9360	Vinblastine sulfate, 1 mg	$4.10	$3.90	$4.48
J9370	Vincristine sulfate, 1 mg	$30.16	$28.65	$32.95
J9375	Vincristine sulfate, 2 mg	$36.33	$34.51	$39.69
J9380	Vincristine sulfate, 5 mg	$154.57	$146.84	$168.87
J9390	Vinorelbine tartrate, per 10 mg	$75.50	$71.73	$82.48
J9600	Porfimer sodium 75 mg	$2,444.75	$2,322.51	$2,670.89
J9999	Not otherwise classified, antineoplastic drug	IC	IC	IC
Q0136	Injection Epoetin Alpha, (for non ESRD use), per 1000 units	$11.40	$10.83	$12.45
Q0144	Azithromycin Dihydrate, Oral, Capsules/Powder, 1 gram	NC	NC	NC
Q0156	Infusion, Albumin (Human), 5%, 500 ml.	$166.25	$157.94	$181.63
Q0157	Infusion, Albumin (Human), 25%, 50 ml.	$71.25	$67.69	$77.84
Q0160	Factor IX (antihemophilic factor, purified, non recombinant) per IU	$0.85	$0.81	$0.93
Q0163	Factor IX (antihemophilic factor, recombinant) per IU	$0.06	$0.06	$0.07
Q0164	Diphenhydramine hydrochloride, 5 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment not to exceed a 48 hour dosage regimen	$0.52	$0.49	$0.57
Q0165	Prochloperazine maleate, 5 mg oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment not to exceed a 48 hour dosage regimen	$0.76	$0.72	$0.83
Q0166	Granisetron hydrochloride 1 mg, oral FDA approved prescription anti-emetic, for use as complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$44.69	$42.46	$48.82
Q0167	Dronabinol 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$3.37	$3.20	$3.68
Q0168	Dronabinol 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$6.73	$6.39	$7.35
Q0169	Promethazine hydrochloride, 12.5 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.06	$0.06	$0.07
Q0170	Promethazine hydrochloride, 25 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.01	$0.01	$0.01
Q0171	Chlorpromazine hydrochloride, 10 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.25	$0.24	$0.27
Q0172	Chlorpromazine hydrochloride, 25mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.57	$0.54	$0.62
Q0173	Thiethylperazine hydrochloride, 250mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.36	$0.34	$0.39
Q0174	Thiethylperazine maleate, 10mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.03	$0.03	$0.03
Q0175	Perphenzaine, 4mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.61	$0.58	$0.67
Q0176	Perphenzaine, 8mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.74	$0.70	$0.81
Q0177	Hydroxyzine pamoate, 25 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.19	$0.18	$0.21
Q0178	Hydroxyzine pamoate, 50 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.20	$0.19	$0.22
Q0179	Ondansetron hydrochloride 8 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$25.15	$23.89	$27.48

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
Q0180	Dolassetron mesylate, 100 mg, oral FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$65.20	$61.94	$71.23
Q0181	Unspeeified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitue for and IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	IC	IC	IC
Q0187	Factor VIIA (coagulation factor, recombinant) per 1.2 mg	$1,596.00	$1,516.20	$1,743.63
Q9920	Injection of EPO, per 1,000 units, at patient HCT of 20 or less	$11.40	$10.83	$12.45
Q9921	Injection of EPO, per 1,000 units, at patient HCT of 21	$11.40	$10.83	$12.45
Q9922	Injection of EPO, per 1,000 units, at patient HCT of 22	$11.40	$10.83	$12.45
Q9923	Injection of EPO, per 1,000 units, at patient HCT of 23	$11.40	$10.83	$12.45
Q9924	Injection of EPO, per 1,000 units, at patient HCT of 24	$11.40	$10.83	$12.45
Q9925	Injection of EPO, per 1,000 units, at patient HCT of 25	$11.40	$10.83	$12.45
Q9926	Injection of EPO, per 1,000 units, at patient HCT of 26	$11.40	$10.83	$12.45
Q9927	Injection of EPO, per 1,000 units, at patient HCT of 27	$11.40	$10.83	$12.45
Q9928	Injection of EPO, per 1,000 units, at patient HCT of 28	$11.40	$10.83	$12.45
Q9929	Injection of EPO, per 1,000 units, at patient HCT of 29	$11.40	$10.83	$12.45
Q9930	Injection of EPO, per 1,000 units, at patient HCT of 30	$11.40	$10.83	$12.45
Q9931	Injection of EPO, per 1,000 units, at patient HCT of 31	$11.40	$10.83	$12.45
Q9932	Injection of EPO, per 1,000 units, at patient HCT of 32	$11.40	$10.83	$12.45
Q9933	Injection of EPO, per 1,000 units, at patient HCT of 33	$11.40	$10.83	$12.45
Q9934	Injection of EPO, per 1,000 units, at patient HCT of 34	$11.40	$10.83	$12.45
Q9935	Injection of EPO, per 1,000 units, at patient HCT of 35	$11.40	$10.83	$12.45
Q9936	Injection of EPO, per 1,000 units, at patient HCT of 36	$11.40	$10.83	$12.45
Q9937	Injection of EPO, per 1,000 units, at patient HCT of 37	$11.40	$10.83	$12.45
Q9938	Injection of EPO, per 1,000 units, at patient HCT of 38	$11.40	$10.83	$12.45
Q9939	Injection of EPO, per 1,000 units, at patient HCT of 39	$11.40	$10.83	$12.45
Q9940	Injection of EPO, per 1,000 units, at patient HCT of 40 and/or above	$11.40	$10.83	$12.45
90281	Immune Globulin (IG), Human for Intramuscular Use	NC	NC	NC
90283	Immune Globulin (IGIV), Human for Intravenous Use	NC	NC	NC
90287	Botulinum Antitoxin, Equine, any route	NC	NC	NC
90288	Botulinum Immune globulin Human, for intravenous use	NC	NC	NC
90291	Cytomegalovirus Immune globulin (cmv-igiv) Human, for intravenous use	NC	NC	NC
90296	Diphtheria Antitoxin, Equine, any route {replaces 90711}	NC	NC	NC
90371	Hepatitis B immune globulin (HBIG), Human, for intramuscular use	IC	IC	IC
90375	Rabies Immune globulin (RIG), human , for intramuscular use {replaces 90726}	NC	NC	NC
90376	Rabies Immune globulin, Heat-trated (RIG-HT), human for intramuscular use { replaces 90726}	NC	NC	NC
90378	Respiratory syncytial virus immune globulin (RSV-IGIM), for intramuscular use	$1,216.99	$1,156.14	$1,329.56
90379	Respiratory Syncytial Virus Immune globulin (RSV-IGIV), human, for intravenous	IC	IC	IC
90384	RHO (D) immune globulin (RHIG), human, for intramuscular use, Full-Dose {replaces 90742}	NC	NC	NC
90385	RHO (D) immune globulin (RHIG), human, for intramuscular use, Mini-Dose {replaces 90742}	NC	NC	NC
90386	RHO (D) immune globulin (RHIGIV), human, for intravenous use {replaces 90742}	NC	NC	NC
90389	Tetanus Immune globulin (TIG), human, for intramuscular use { replaces 90742}	NC	NC	NC
90393	Vaccinia Immune globulin, human, for intramuscular use {replaces 90742}	NC	NC	NC
90396	Varicella-Zoster Immune globulin, Human, for intramuscular use {replaces 90742}	NC	NC	NC
90399	unlisted immune globulin	NC	NC	NC
90476	Adenovirus vaccine, type 4, LIVE, for oral use	NC	NC	NC
90477	Adenovirus vaccine, type 7, LIVE, for oral use	NC	NC	NC
90581	Anthrax vaccine, for subcutaneous use	NC	NC	NC
90586	Bacillus Calmette-Guerin Vaccine (BCG) for bladder cancer, LIVE, for intravesical use { replaces 90728}	NC	NC	NC
90592	Cholera vaccine, LIVE, for oral use	IC	IC	IC
90632	Hepatitis A vaccine, Adult Dosage, for intramuscular use { replaces 90730}	NC	NC	NC
90633	Hepatitis A vaccine, Pediatric/Adolescent Dosage-2 dose schedule, for intramuscular use {replaces 90730}	NC	NC	NC
90634	Hepatitis A vaccine, Pediatric/Adolescent Dosage-3 dose schedule, for intramuscular use{ replaces 90730}	NC	NC	NC
90636	Hepatitis A and Hepatitis B vaccine (Hepa-Hepb), adult dosage, for Intramuscular use {replaces 90730 }	NC	NC	NC
90645	Hemophilus Influenza B vaccine (HIB), HBOC conjugate (4 dose schedule), for intramuscular use {replaces 90737}	NC	NC	NC
90646	Hemophilus Influenza B vaccine (HIB),PRP-D conjugate for booster use only, for intramuscular use {replaces 90737}	NC	NC	NC
90647	Hemophilus Influenza B vaccine (HIB),PRP-OMD conjugate (3 dose schedule), for intramuscular use{replaces 90737}	NC	NC	NC

CODE	NAME OF DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
90648	Hemophilus Influenza B vaccine (HIB),PRP-Tconjugate (4 dose schedule), for intramuscular use{ replaces 90737}	NC	NC	NC
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use {replaces 90724}	$2.18	NA	NA
90658	Influenza virus vaccine, split virus, 3 years and above, for intramuscular or jet injection use {replaces 90724}	$5.03	NA	NA
90659	Influenza virus vaccine, split virus,whole virus, for intramuscular or jet injection use {replaces 90724}	$6.65	NA	NA
90660	Influenza virus vaccine, LIVE, for intranasal use	NC	NC	NC
90665	LYME disease vaccine, adult dosage, for intramuscular use	NC	NC	NC
90669	Pneumococcal conjugate vaccine, polyvalent, for intramuscular use	NC	NC	NC
90675	Rabies vaccine, for intramuscular use {replaces 90726}	NC	NC	NC
90676	Rabies vaccine, for intradermal use (replaces 90726}	NC	NC	NC
90680	Rotavirus vaccine, tetravalent, Live, for oral use	NC	NC	NC
90690	Typhoid vaccine, LIVE, oral {replaces 90714}	NC	NC	NC
90691	Typhoid vaccine, VI capsular polysaccharide (VICPS), for intramuscular use {replaces 90714}	NC	NC	NC
90692	Typhoid vaccine,Heat - and phenol-inactivated(H-P), for subcutaneous or intradmermal use {replaces 90714}	NC	NC	NC
90693	Typhoid vaccine, acetone-killed, dried, (AKD), for subscutanwous or jet injection use (US military){replaces 90714}	NC	NC	NC
90700	Immunization, Active; Diphtheria, Tetanus, Toxoids, and Acellular Pertussis Vaccine(DTaP)	NC	NC	NC
90701	Immunization, Active, Diphtheria and Tetanus Toxoids and Pertussis Vaccine (DTP)	NC	NC	NC
90702	Immunization, Active, Diphtheria and Tetanus Toxoids (DT)	NC	NC	NC
90703	Immunization, Active Tetanus Toxoid	$2.90	$2.76	$3.17
90704	Immunization, Active, Mumps Virus Vaccine, Live	NC	NC	NC
90705	Immunization, Active, Measles Virus Vaccine, Live, Attenuated	NC	NC	NC
90706	Immunization, Active, Rubella Virus Vaccine, Live	NC	NC	NC
90707	Immunization, Active, Measles, Mumps, and Rubella Virus Vaccine, Live	NC	NC	NC
90708	Immunization, Active, Measles and Rubella Virus Vaccine, Live	NC	NC	NC
90709	Immunization, Active, Rubella and Mumps Virus Vaccine, Live	NC	NC	NC
90710	Immunization, Active; Measles, Mumps, Rubella and Varicella Vaccine	NC	NC	NC
90712	Immunization, Active, Poliovirus Vaccine, Live, Oral (any Type) Vaccine	NC	NC	NC
90713	Immunization, Active, Poliomyelitis Vaccine	NC	NC	NC
90716	Immunization, Active; Varicella (Chicken Pox) Vaccine	NC	NC	NC
90717	Immunization, Active, Yellow Fever Vaccine	NC	NC	NC
90718	Immunization, Active, Tetanus and Diphtheria, Toxioids Aborbed, for Adult Use (TD)	NC	NC	NC
90719	Immunization, Active, Diphtheria Toxoid	NC	NC	NC
90720	Immunization, Active; Diphtheria, Tetanus Toxoids,and Pertussis (DTP) and Hemophilus Influenza B (Hib) Vaccine	NC	NC	NC
90721	Immunization, Active; Diphtheria, Tetanus, Toxoids, and Acellular Pertussis Vaccine DTat and Hemophilus Influenza B (Hib) Vaccine	NC	NC	NC
90725	Immunization, Active, Cholera Vaccine	NC	NC	NC
90727	Immunization, Active, Plague Vaccine	NC	NC	NC
90732	Immunization, Active, pneumococcal vaccine, polyvalent	$10.83	$10.29	$11.83
90733	Immunization, Active, Meningococcal Polysaccharide Vaccine [any group(s)]	NC	NC	NC
90735	Immunization, Active, Encephalitis Virus Vaccine	NC	NC	NC
90744	Immunization, Active, Hepatitis B Vaccine; pediatric or pediatric/adolescent dosage for intramuscular use	$13.36	$12.69	$14.60
90745	Immunization, Active, Hepatitis B Vaccine; adolescent/high risk infant dosage, for intramuscular use	$14.06	$13.36	$15.36
90746	Immunization, Active, Hepatitis B Vaccine; adult dosage, for intramuscular use	$52.70	$50.07	$57.57
90747	Immunization, Active, Hepatitis B Vaccine; Dialysis or Immunosupressed patient dosage for Intramuscular use	$172.23	$163.62	$188.16
90748	Immunization, active, Hepatitis B and Hemophilus influenza B vaccine (HepB-HIB) for intramuscular use	NC	NC	NC
90749	Unlisted Immunization Procedure	IC	IC	IC
A9504	Supply of radiopharmaceutical diagnostic imaging agent, technetium TC 99m Apcitide	$522.50	$496.38	$570.83
A9600	Injection, Strontium-89 Chloride, per MCI	$862.12	$819.01	$941.87

GENERAL SURGERY

G0160, G0161: Cryosurgery of the Prostate Gland

The national medical policy for cryosurgery of the prostate was published in the July/August 1999 *Medicare B Update!* (page 22). The following information provides clarification for a specific billing scenario, but the coverage requirements of the policy have not been changed.

As noted in the "Coding Guidelines" section of the policy, procedure code G0161 (Ultrasonic guidance for interstitial cryosurgical probe placement) is payable only when procedure code G0160 [Cryosurgical ablation of localized prostate cancer, primary treatment only (postoperative irrigations and aspiration of sloughing tissue included)] has already been paid for the same beneficiary for the same date of service. However, because two different providers may perform these services for a given beneficiary, Medicare may receive a claim for G0161 before receiving the corresponding claim for G0160. Providers should coordinate claims submission to eliminate delays in payment.

A new line-level remark code (M121) will be implemented on April 1, 2000, for use when G0161 is denied because there is no allowed G0160 on file.

M121 We pay for this service only when performed with a covered cryosurgical ablation.

HEMATOLOGY/ONCOLOGY

Adult Liver Transplantation: Change in Coverage

Adult liver transplantation, when performed on beneficiaries with end stage liver disease other than hepatitis B or malignancies, is a covered service under Medicare (effective July 15, 1996), when performed in a facility approved by HCFA as meeting institutional coverage criteria.

Effective December 10, 1999, HCFA national coverage policy is revised to remove hepatitis B as a noncovered condition. The ICD-9-CM codes for hepatitis B are:

070.20 070.21 070.22 070.23 070.30 070.31 070.32 070.33

Because this change is being be implemented off the regular quarterly update cycle, Medicare carriers will reopen and reprocess all claims for liver transplants with dates of service on or after December 10, 1999, in accordance with the revised policy.

A list of approved liver transplant centers in Florida was published in the March/April 1999 *Medicare B Update!* (page 69). An additional approved facility was identified in the November/December *Update!* (page 43).

INFLUENZA , PPV & HEPATITIS B

Allowances for Influenza Virus, Pneumococcal Virus and Hepatitis B Vaccines

The *2000 Medicare B Update! Special Issue HCPCS and MPFSDB Update* (December 1999) provided updated fees for the administration of influenza virus, pneumococcal pneumococcal virus and hepatitis B vaccines (page 6). That article indicated that the allowances for these vaccines for calendar year 2000 were contained in the *Year 2000 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule*. This is not accurate; the allowances are not in that publication. The 2000 allowances for these codes are as follows:

Procedure Code	2000 Allowance
90657	$2.18
90658	$5.03
90659	$6.65

Correction to 1999 Allowances

In addition, the allowances Medicare of Florida used for most of 1999 were incorrect for procedure codes 90657, 90658 and 90659. The table below illustrates the incorrect allowances and allowances fees that Medicare is now using.

Procedure Code	Incorrect 1999 Allowance	Correct 1999 Allowance
90657	$1.66	$3.32
90658	$3.32	$6.65
90659	$3.32	$6.65

Because the higher allowance should have been in effect for all of 1999, Medicare will *automatically* adjust claims for services where the billed amount was greater than or equal to the correct allowances indicated above.

Providers with questions should contact customer service at (904) 634-4994.

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

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

Effective Dates

The effective dates are provided in each policy, near the end of the article. Effective dates are based on the date claims are *processed,* not the date of service (unless otherwise noted in the policy).

Sources of Information

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

Table of Contents—Medical Review Policies

Policy Changes Related to the 2000 HCPCS Update

HCFA's Common Procedure Coding System (HCPCS) update for 2000 is effective for services furnished January 1, 2000, and after. Lists of procedure codes added, revised, or discontinued as part of the update were published in the December 1999 *Medicare B Update! Special Issue: 2000 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update*. While there is a grace period during which deleted or invalid procedure codes may still be used for 2000 service dates (received before April 1, 2000), we encourage all providers to complete the transition to the new 2000 codes as soon as possible to prevent possible delays in claim payment.

The coverage for the following procedures that have been either added or revised for 2000 have been incorporated into existing policies that are not being provided in this issue since the policy requirements have not changed, only the procedure code(s). To assist providers in adjusting to the new coding structure, a reference to previous publications is outlined:

Policy	Changes	Publication
00103 Anesthesia Services	Descriptor change for codes 00103, 00142, 00144, 00145, 00147, & 67220 Descriptor change for modifier QY	Mar/Apr 1998, p.44
20974 Osteogenic Stimulation	Statement of noncoverage added for code 20979	Sep/Oct 1998, p.25
33216 Implantation of Automatic Defibrillator	Added codes 33216, 33217, 33218, & 33220 Deleted codes 33242 & 33247 Descriptor changes for codes 33223, 33240, 33241, 33243, 33244, 33245, 33246, & 33249	Jul/Aug 1999, p.26
36430 Transfusion Medicine	Added code P9023 Descriptor change for code 86915	May/Jun 1997, p.20 Jan/Feb 1999, p.18
54235 Injection of Corpora Cavernosa	Descriptor change for code J0270	Mar/Apr 1997, p.42
61862 Deep Brain Stimulation	Added codes 61862 & 61886 Deleted code 61855 Descriptor change for codes 61885, 95970, & 95971	Mar/Apr 1998, p.49 Jan/Feb 1999, p.22

Policy	Changes	Publication
64573 Vagus Nerve Stimulation	Added code 61886 Descriptor change for codes 61885, 95970, & 95971	Nov/Dec 1998, p.25 Jan/Feb 1999, p.24 Jul/Aug 1999, p.28
80049 Automated Multichannel Tests	Added codes 80048, 80053, 80069, & 80076 Deleted codes 80049, 80054, & 80058	Mar/Apr 1998, p.35 May/Jun 1998, p.35 Jan/Feb 1999, p.10
82947 Blood Glucose Testing	Added codes 80048 & 80053 Deleted codes 80049 & 80054	Jul/Aug 1999, p.32
84436 Thyroid Function Tests	Deleted codes 80091 & 80092 Descriptor change for codes 84479 & 84480	Jul/Aug 1998, p.53
88141 Pap Smears	Descriptor change for codes 88148, G0147, & G0148	Jan/Feb 1998, p.25 Jan/Feb 1998, p.26 Jan/Feb 1999, p.42
90744 Hepatitis B Vaccine	Deleted code 90745 Descriptor change for code 90744	Nov/Dec 1996, p.19 Mar/Apr 1998, p.38 Jan/Feb 1999, p.42
90780 Therapeutic or Diagnostic Infusion/Injection	Descriptor change for codes 90782 & 90799	Jan/Feb 1999, p.48 Mar/Apr 1999, p.58
92980 Interventional Cardiology	Descriptor change for codes 92975, 92978, 92980, 92982, & 92995	Jan/Feb 1999, p.52
93619 Intracardiac Electrophysiological Evaluation	Descriptor change for codes 93640, 93641, & 93642	Jan/Feb 1999, p.54 Sep/Oct 1999, p.36
95816 Electroencephalography (EEG)	Descriptor change for codes 95816 & 95819	May/Jun 1996, p.46 Sep/Oct 1996, p.51
95900 Nerve Conduction Studies	Descriptors change for codes 95900, 95903, & 95904	May/Jun 1997, p.30 May/Jun 1998, p.49 Sep/Oct 1998, p.41
99183 Hyperbaric Oxygen Therapy	Statement of noncoverage added for code G0167	October 1996, p.46 Jan/Feb 1997, p.38 Mar/Apr 1997, p.64 Sep/Oct 1997, p.40 Mar/Apr 1998, p.54 May/Jun 1998, p.51 Mar/Apr 1999, p.62 May/Jun 1999, p.28 Sep/Oct 1999, p.39
A4300 Implantable Vascular Access Devices	Descriptor change for code 36533	Sep/Oct 1997, p.23
D0110 Dental Services	Replaced code 77419 with code range 77427-77432 Descriptor change for codes D2662, D2664, D4266, & D4267	Jan/Feb 1996, p.5 Mar/Apr 1996, p.16
E0782 Implantable Infusion Pump	Descriptor change for code 62350	Sep/Oct 1997, p.23 Mar./Apr 1999, p.38
J0001 Self-Administered Drugs	J3490 (Enbrel) changed to code J1438 Q0182 changed to code J0275 Descriptor change for codes J1825 & J1830	Mar/Apr 1999, p.43 May/Jun 1999, p.24 Nov/Dec 1999, p.21
J1750 Iron Dextran	Added code J1750 Deleted codes J1760, J1770, & J1780	Jan/Feb 1996, p.53
J7190 Hemophilia Clotting Factors	Added codes J7198, J7199, & Q0187 Deleted code J7196	Jan/Feb 1998, p.52 May/Jun 1998, p.45
J9999 Antineoplastic Drugs	Changed J9999 (Doxil®) to code J9001 Changed J9999 (Herceptin®) to code J9355	Jul/Aug 1998, p.46 Sep/Oct 1998, p.32 Mar/Apr 1999, p.45 Sep/Oct 1999, p.30 Nov/Dec 1999, p.27

The List of Medicare Noncovered Services

Medicare of Florida's noncoverage guidelines were published in their entirety in the March/April 1999 *Medicare B Update!* (page 34). On page 17 of the July/August 1999 *Update!* and page 28 of the September/October 1999 *Update!,* additional changes (additions and deletions) were published. Since that time, the title of these guidelines has been changed to "The List of Medicare Noncovered Services," and further additions and deletions have occurred. Listed below are the changes to this policy and their effective dates. These lists incorporate the 2000 update to HFCA's Common Procedure Coding System (HCPCS).

Additions to Local Noncoverage

11980 (eff. 1/1/2000)	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
20979* (eff. 1/1/2000)	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
58670 (eff. 1/1/2000)	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671 (eff. 1/1/2000)	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
D9248 (eff. 1/1/2000)	Non-intravenous conscious sedation
G0167 (eff. 1/1/2000)	Hyperbaric oxygen treatment not requiring physician attendance, per treatment session

Addition to National Noncoverage

90669 (eff. 1/1/2000)	Pneumococcal conjugate vaccine, polyvalent, for intramuscular use

Deletions to Local Noncoverage

87480 (eff. 1/1/2000)	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87510 (eff. 1/1/2000)	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis; direct probe technique
87621 (eff. 1/1/2000)	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human amplified probe technique
90669 (eff. 1/1/2000)	Pneumococcal conjugate vaccine, polyvalent, for intramuscular use
A9270* (eff. 12/6/99)	Autologous Chondrocyte Transplantation
A9270* (eff. 12/6/99)	Interstim Sacral Nerve Stimulation (SNS) system
A9270* (eff. 12/6/99)	Percutaneous Polymethymethacrylate (PMMA) Vertebroplasty
A9270* (eff. 2/21/2000)	Insertable Loop Recorder

Other Changes to Local Noncoverage

- Procedure code 77380* (Proton beam delivery to a single treatment area, single port, custom block, with or without conpensation, with treatment set-up and verification images) was changed to 77520 (eff. 1/1/2000)
- Procedure code 77381* (Proton beam delivery to one or two treatment areas, two or more ports, two or more custom blocks, and two or more conpensators, with treatment set-up and verification images) was changed to 77523 (eff. 1/1/2000)
- The descriptor for procedure code 95831 was changed to read, "Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk" (eff. 1/1/2000)

*** Denotes services that are noncovered due to their being investigational or experimental.**

Independent Diagnostic Testing Facility

The local medical review policy (LMRP) Independent Diagnostic Testing Facilities (IDTF) was published in its entirety in the July/August 1999 *Medicare Part B Update!* (page 13). Based on the 2000 HCPCS changes, the following revisions have been made:

- The following statement was added under the "Coding Guidelines" section of the LMRP, "Effective 1/1/2000, procedure codes 94760, 94761, and 93770 are considered bundled services, and, therefore are not separately reimbursable."
- The descriptors were changed for procedure codes 76513, 78457, 93640, 93641, 93642, 93737, 95816, 95819, 95900, and 95904.
- Procedure codes 76005, 76873, 78456, 93727, and 93741-93744 were added to the credentialing chart and to the listed HCPCS Codes. The credentialing requirements for the added procedure codes are as follows:

CPT-4 CODE(S)	CERTIFICATION
76005	State license: CRT-R (General Radiographer)
76873	ARDMS: RDMS-Abdomen
78456	State license: CRT-N, CNMT
93727	CCI: CCT; Registered Nurse; Paramedic
93741-93744	CCI: CCT; Registered Nurse; Paramedic

Effective Date

This revisions are effective for services processed on or after January 1, 2000.

A4644: Low Osmolar Contrast Media (LOCM)—Revision to Policy

The final version of the local medical review policy for LOCM (A4644) was published in the July/August 1998 *Medicare B Update!* (page 44). Since that time, the policy has been revised to include the following indication:

Medicare of Florida may make separate payment for Low Osmolar Contrast Media (LOCM) under the following circumstance:

For all medically necessary intrathecal radiological procedures furnished to non-hospital patients. The applicable procedure codes for such injections are: 70010, 70015, 72240, 72255, 72265, 72270, 72285, and 72295.

Effective Date

This change is effective for services rendered on or after November 29, 1999.

Advance Notice Statement

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

G0166, 93799: Enhanced External Counterpulsation

In the July/August 1999 and September/October 1999 issues of the Medicare B Update!, *coverage information was published on enhanced external counterpulsation. Since that time a local medical review policy (LMRP) was developed reflecting national coverage requirements and additional information such as diagnosis and documentation requirements. This article reflects that LMRP.*

Enhanced external counterpulsation (EECP) is a non-invasive method of treatment for coronary artery disease refractory to medical and/or surgical therapy. EECP uses sequential diastolic inflation of lower extremity pneumatic cuffs to augment aortic diastolic pressure, increase venous return to the heart and decrease left ventricular afterload. Augmenting aortic diastolic pressure increases the coronary artery perfusion pressure and transmyocardial pressure gradient, possibly enhancing coronary collateral development.

A full course of treatment usually consists of thirty-five (35) one-hour sessions, which may be offered once or twice daily, and covers a period of four to seven weeks.

During treatment, the patient lies on a padded table that contains electronically controlled inflation and deflation valves. These valves are connected to three compressive air cuffs that are wrapped around the patient's lower extremities (usually around the calves and lower and upper thighs). The cuffs inflate and deflate in synchronization with the patient's cardiac cycle.

During diastole, the three sets of air cuffs are inflated sequentially (distal to proximal) compressing the vascular beds within the muscles of the calves, lower thighs and upper thighs. This action results in an increase in diastolic pressure, generation of retrograde arterial blood flow, and an increase in venous return. The cuffs are deflated simultaneously just prior to systole, which produces a rapid drop in vascular impedance, a decrease in ventricular workload, and an increase in cardiac output.

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

Indications and Limitations of Coverage and/or Medical Necessity

Medicare considers EECP (procedure code G0166) medically reasonable and necessary when performed for dates of service on or after July 1, 1999 for patients with disabling stable angina that meet ***all*** the following criteria:

- Class III or Class IV angina based on the Canadian Cardiovascular Society Classification scale or an equivalent classification scale.
- A cardiologist or cardiothoracic surgeon must indicate that the patient is not amenable to surgical intervention, such as percutaneous transluminal coronary angioplasty (PTCA) or cardiac bypass because: their condition is inoperable, or there is a high risk of operative complications or post-operative failure; their coronary anatomy is not readily amenable to such procedures, or; they have co-morbid states which create excessive risk.

This procedure must be performed under direct supervision of a physician. The physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the personnel is performing the service.

Coverage is further limited to those enhanced counterpulsation systems that have sufficiently demonstrated their medical effectiveness in treating patients with severe angina in well-designed trials.

ICD-9-CM Codes That Support Medical Necessity

413.9

Reasons for Denial

Medicare coverage is limited to its use in patients with disabling stable angina pectoris, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Other uses of this device or similar devices, i.e., for conditions such as unstable angina, acute myocardial infarction, and cardiogenic shock, remain non-covered.

Hydraulic versions of these devices are non-covered.

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

Coding Guidelines

Procedure codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761) and plethysmography (93922 or 93923) are not medically necessary with EECP and should not be paid on the same day, unless they occur in a clinical setting not connected with the delivery of the EECP. In addition, these services must meet the medical necessity identified in the applicable local medical review policy.

Daily evaluation and management codes (99211-99215) cannot be billed with the EECP treatments. Any evaluation and management service must be justified with adequate documentation of the medical necessity of the visit.

Note: As indicated in the List of Medicare Noncovered Services, procedure code 92971 is locally non-covered.

For dates of service July 1 through December 31, 1999, procedure code 93799 should be billed. Effective for services rendered on or after January 1, 2000, use procedure code G0166.

Documentation Requirements

The medical record documentation submitted with the claim must support that the service was ordered by the physician for a patient with Class III or Class IV angina not amenable to surgical intervention. In addition, the documentation must support that the service was performed. This information is usually found in the history and physical, progress notes, and/or hospital/office notes.

Effective Date

This local medical review policy is effective for services processed on or after February 21, 2000.

Advance Notice Requirement

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

J0207: Amifostine

Amifostine (Ethyol®) is categorized as an antineoplastic adjunct and cytoprotective agent. Each single-use 10ml vial contains 500mg of amifostine.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider Amifostine (Ethyol®- procedure code J0207) medically reasonable and necessary under any of the following conditions:

- Nephrotoxicity, Cisplatin-induced (prophylaxis)- to reduce cumulative nephrotoxicity associated with Cisplatin therapy in patients with advanced ovarian carcinoma, non-small cell lung carcinoma (NSCLC), or advanced solid tumors of non-germ cell origin.
- Moderate to severe xerostomia, radiation induced- to reduce the incidence of moderate to severe xerostomia in patients undergoing radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid gland.

Clinical trials have also demonstrated the efficacy of amifostine in the reduction of additional complications related to antineoplastic administration. Medicare of Florida will cover Amifostine for its FDA approved uses as well as for treatment of the following conditions:

- Bone marrow toxicity, antineoplastic agent-induced (prophylaxis)- to reduce acute and cumulative hematologic toxicities associated with a Cisplatin and cyclophosphamide (CP) regimen in patients with advanced solid tumors of non-germ cell origin. Amifostine is also indicated to decrease bone marrow toxicity during treatment with high dose Cisplatin alone for head and neck carcinoma, cyclophosphamide alone for malignant lymphoma, carboplatin for NSCLC, and carboplatin plus radiation therapy for head and neck carcinoma.
- Neurotoxicity, Cisplatin-induced (prophylaxis)- to decrease the frequency or severity of Cisplatin-induced peripheral neuropathy and ototoxicity.

Coding Guidelines

Chemotherapy Administration Coding: Use only 90780, as the Ethyol® infusion is only 15 minutes long.

Documentation Requirements

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

Effective Date

This local medical review policy is effective for services processed on or after November 8, 1999.

Advance Notice Statement

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

J0585: BOTOX - Correction to Policy

The local medical review policy (LMRP) for BOTOX was published in the November/December 1999 *Medicare B Update!* (pages 22-24). Since that publication, a revision has been made to the third paragraph under the "Coding Guidelines" section on page 23. The corrected paragraph is as follows:

> Due to the short life of the Botulinum toxin, Medicare will reimburse the unused portion of this drug. However, documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

Effective Date

This revision is effective for services processed on or after December 15, 1999.

J8500: Oral Anti-Cancer Drugs

Oral anti-cancer drugs approved by the Food and Drug Administration (FDA) are covered services. When prescribed as anti-cancer chemotherapeutic agents with the same active ingredients as the injectable form, the substitution of an oral form of an anti-neoplastic drug requires that the drug be retained for absorption. Self-administered antiemetic drugs prescribed for use with a covered anti-neoplastic drug plus drugs used to treat toxicities or side effects of the cancer regimen are considered reasonable and necessary and are also covered services.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will cover anti-neoplastic chemotherapeutic agents, the primary drugs which directly fight the cancer, and the self-administered antiemetic and drugs used to treat toxicities or side effects necessary for the administration and absorption of the oral anti-neoplastic drug.

For an oral anti-cancer drug to be covered under Part B, it must:

- Be prescribed by a physician or other practitioner licensed under State law to prescribe such drugs as anti-cancer chemotherapeutic agents;
- Be a drug or biological that has been approved by the Food and Drug Administration (FDA);
- Have the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic drug or biological that is covered when furnished incident to a physician's service. The oral anti-cancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium;
- Be a Prodrug, an oral drug ingested into the body which metabolizes into the same active ingredient, as is found in the non-self administrable form of the drug;
- Be used for the same indications, including unlabeled uses, as the non-self-administrable version of the drug; and
- Be reasonable and necessary for the individual patient.

HCPCS Codes

J8510	Busulfan; oral, 2 mg
J8520	Capecitabine, oral, 150 mg
J8521	Capecitabine, oral, 500 mg
J8530	Cyclophosphamide; oral 25 mg
J8560	Etoposide; oral 50 mg
J8600	Melphalan; oral 2 mg
J8610	Methotrexate, oral 2.5 mg
J8999	Prescription drug, oral, chemotherapeutic, NOS

ICD-9-CM Codes That Support Medical Necessity

N/A

Reasons for Denial

If 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-CM Code(s)

N/A

Coding Guidelines

When billing for oral anti-cancer drugs, use the specific codes. Do not bill for oral anti-cancer drugs using **J9000** series of codes.

When billing for FDA approved oral anti-cancer Prodrugs, use code J8999.

Oral anti-cancer drugs and Prodrugs are processed by the DMERC. However, if the oral anti-cancer drug or Prodrug is submitted on the same claim as anti-emetic drug, then the following instructions apply:

- When an oral anti-cancer drug or Prodrug (J code) is submitted on the same claim with an oral anti-emetic (K code), the claim will be processed by the DMERC.
- When an oral anti-cancer drug or Prodrug (J code) is submitted on the same claim with an oral anti-emetic (Q code) and is provided in the physician's office, the claim will be processed by the Carrier.
- When an oral anti-cancer drug or Prodrug (J code) is submitted on the same claim with an oral anti-emetic (Q code) and is supplied by a pharmacy, the claim will be processed by the DMERC.
- When an oral anti-cancer drug or Prodrug (J code) is submitted on the same claim with a rectal anti-emetic (K code), the claim will be processed by the DMERC.
- When an oral anti-cancer drug or Prodrug (J code) is submitted on the same claim with an intravenous anti-emetic (J code), the DMERC processes the oral anti-cancer agent (J code) and the Carrier processes the intravenous anti-emetic (J code).

Documentation Requirements

The patient's medical record (i.e., history and physical, office/progress notes) must document the medical necessity for treatment using these medications, such as the name of the drug, number of units given, and a diagnosis of cancer.

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

Billing Clarification for Trastuzumab (Herceptinâ) and Denileukin diftitox (Ontakâ)

The coverage criteria and documentation requirements regarding Herceptinâ and Ontakâ were published on pages 30-31 of the September/October 1999 *Medicare B Update!* A number of providers have voiced concern that these drugs must be submitted on paper claims; however, claims for these drugs may be submitted electronically.

Claims for Herceptinâ with a date of service prior to January 1, 2000 must be billed using the unlisted procedure code J9999. When submitting a claim for Herceptinâ electronically prior to January 1, indicate the name of the drug, its strength, the dosage administered, the patient's weight, and a statement regarding the patient's overexpression of HER 2 in the appropriate narrative record.

A new procedure code (J9355) is effective for Herceptinâ for services rendered on or after January 1, 2000. Claims for Herceptinâ submitted on or after January 1 will be processed based on the dual diagnosis requirement. Documentation (whether it be submitted via paper claim or electronically) will no longer be required on a prepayment basis.

Ontakâ is to be billed using the unlisted procedure code J9999 prior to and after January 1, 2000, as this drug has not received its own "J" code. Therefore, providers may submit the claim electronically and indicate the name of the drug, its strength, the dosage administered, and a statement in the narrative record indicating that the patient's malignant cells express CD25.

33140: Transmyocardial Revascularization

On pages 8-9 of the July/August 1999 Medicare B Update! *the coverage criteria for transmyocardial revascularization was published. Since that time a local medical review policy (LMRP) was developed reflecting national coverage and additional information such as applicable diagnoses and documentation requirements. This article reflects that LMRP.*

Transmyocardial revascularization (TMR) is a surgical technique that uses a laser to bore holes through the myocardium of the heart to the ventricular cavity in an attempt to restore perfusion to areas of the heart not being reached by diseased or clogged arteries. The precise workings of this technique are not clear. Several theories have been proposed, including partial denervation of the myocardium, or the triggering of the cascade of biological reactions that encourage increased development of blood vessels.

The procedure is normally performed through an incision either through the chest wall or the sternum, exposing the left ventricle. The surgeon uses a laser to create typically 15-40 one-millimeter transmural channels. The technique varies somewhat depending on the type of laser used.

The high-powered carbon dioxide (CO_2) laser delivers approximately 40 joules of energy with each burst. The burst is timed to coincide with the beginning of ventricular systole. At this point, the ventricles are full of blood, all valves are closed, and intraventricular pressure is high. When the laser beam passes through the heart wall into the ventricular chamber, the blood in the cavity absorbs the remaining energy. This prevents the beam from passing through the other side of the heart and entering tissues. In addition, penetrating the myocardium at this point in the cardiac cycle also reduces the likelihood of ventricular arrhythmias.

The holmium: YAG laser delivers short bursts of low energy into the myocardium. Because the energy does not penetrate beyond the myocardial tissue that is in direct contact with the laser, there is no need to have blood in the ventricular chamber to act as a backstop for the beam.

To determine when the laser beam has penetrated the myocardium, the physician uses transesophageal echocardiography. A burst of bubbles in the left ventricle appears on the screen when the laser beam has penetrated the myocardium.

The surgeon stops the bleeding from each newly-created channel by applying pressure to the site with his fingers until the blood clots.

Since TMR is performed on the beating heart, a cardiopulmonary machine is not utilized during the procedure. Consequently, the risks of decreased cardiac output, extravascular volume changes, renal and central nervous system alterations, and other complications normally associated with bypass are minimized.

TMR does not provide increased life expectancy, nor is it proven to affect the underlying cause of angina. However, it appears effective in treating the symptoms of angina, reducing hospitalizations, and allowing patients to resume some of their normal activities of daily living.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare will consider TMR (procedure code 33140) medically reasonable and necessary when performed for dates of service on or after July 1, 1999 as a last resort for patients with severe angina (stable or unstable) who meet ***all*** of the following criteria:

- Class III or Class IV angina based on the Canadian Cardiovascular Society Classification scale or an equivalent classification scale. Patients in Class III experience a marked limitation of ordinary physical activity, whereas those in Class IV are unable to carry out any physical activity without discomfort.
- The patient has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages.
- The angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty (PTCA), stenting, coronary atherectomy, or coronary bypass.
- Have an ejection fraction of 25% or greater.

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

Coverage is further limited to those uses of the laser (used in performing the procedure) that have been approved by the Food and Drug Administration for the purpose for which they are being used.

In addition, the following coverage requirements apply:

- The physician must be properly trained in this procedure.
- The provider of this service must document that all ancillary personnel, including physicians, nurses, operating room personnel and technicians, are trained in the procedure and the proper use of the equipment involved.
- The facility must have dedicated cardiac care units, including the diagnostic and support services necessary for care of patients undergoing this therapy.
- The providers must conform to the standards for laser safety set by the American National Standards Institute, ANSI Z1363.

ICD-9-CM Codes That Support Medical Necessity

411.1 413.9

Reasons for Denial

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

TMR performed in conjunction with coronary artery bypass grafting (CABGs) is not covered.

Coding Guidelines

TMR performed from 7/1/99 through 12/31/99 should be billed with procedure code 33999. For dates of service on or after 1/1/2000, procedure code 33140 should be billed.

Documentation Requirements

The medical record documentation must support that the patient meets all of the criteria contained in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. In addition, the documentation must support that the service was performed. This information is usually found in the history and physical, progress note, operative note, diagnostic test results, and/or discharge summary.

Documentation verifying the laser's FDA approval, appropriate training of the physician and all ancillary personnel, facility requirements, and that the laser safety standards are being followed must be available at the facility.

Effective Date

This local medical review policy is effective for services processed on or after February 21, 2000.

Advance Notice Statement

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

33282: Insertable Loop Recorder (ILR)

A 510 (k) approval (substantially equivalent device) was granted for the Medtronic Reveal® ILR on January 16, 1998, for use as "an implantable patient-activated monitoring system that records subcutaneous electrocardiogram and is indicated for patients who experience transient symptoms that may suggest a cardiac arrhythmia."

The Reveal® ILR device is implanted subcutaneously in a single incision procedure in the left pectoral or mammary location. It measures 61mm x 19mm x 8mm and weighs 17 grams. Its projected longevity is 14 months, due to a low battery condition. The manufacturer recommends that the device be removed when it is no longer clinically necessary or when the battery is depleted.

SYSTEM	
Reveal® ILR	Subcutaneously placed, programmable cardiac event recorder with looping memory
Reveal® Activator	Hand-held, telemetry unit used by the patient to activate ECG storage
9790 Programmer	Used to program Reveal® ILR and retrieve, display, and print stored data

Indications and Limitations of Coverage and/or Medical Necessity

An insertable loop recorder (ILR) is indicated in patients with syncope or presyncope who have had recurrent but infrequent syncopal or presyncopal episodes that have defied diagnosis by conventional means. These patients will frequently have a history of injury or even hospitalization directly attributed to prior syncopal or presyncopal events. Syncope, for the purpose of this policy, is defined as a sudden but transient total loss of consciousness with spontaneous resolution.

Medicare of Florida will consider an ILR medically reasonable and necessary only if a definitive diagnosis has not been made after *all* of the following conditions have been met:

- Complete history and physical examination;
- An appropriate selective diagnostic work-up;
- Electrocardiogram; and
- A 2 to 4 week period of long-term electrocardiographic monitoring with an external loop recorder that fails to determine whether cardiac arrhythmia is the cause of recurrent syncope or presyncope.

HCPCS Codes

33282 Implantation of patient-activated cardiac event recorder (Initial implantation includes programming. For subsequent electronic analysis and/or reprogramming, use 93727)

33284 Removal of an implantable, patient-activated cardiac event recorder
93727 Electronic analysis of implantable loop recorder (ILR) system (Includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)
E0616 Implantable cardiac event recorder with memory, activator and programmer

ICD-9-CM Codes That Support Medical Necessity
780.2

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.

The insertion of the ILR device for patients in whom the prerequisite studies have not been completed due to patient noncompliance.

Noncovered ICD-9-CM Code(s)
Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Coding Guidelines
The ILR device itself should be coded as E0616. E0616 should be billed to the carrier on a HCFA-1500 form (or electronic equivalent) if the ILR insertion is performed in a physician's office. Otherwise, claims for E0616 performed in a hospital setting should be submitted to the fiscal intermediary on a UB-92 form.

The ILR device insertion procedure is considered to be a physician service. This major global surgery has a postoperative period of 90 days. The procedure does not require an assistant surgeon.

Electrocardiogram analyses obtained during device insertion for signal quality and amplification purposes are considered part of the implant procedure and should not be separately billed.

Removal of an ILR device on the same day as the insertion of a cardiac pacemaker in any given patient is considered to be part of the pacemaker insertion procedure and will not be reimbursed separately. This limitation applies whether or not the ILR implantation site is used for the pacemaker pocket.

Documentation Requirements
Medical record documentation (e.g., office/progress notes) must be maintained by the ordering/referring physician and must support that all of the conditions for ILR coverage as set forth under the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met (e.g., the prior testing performed and the results, the patient history of the syncopal or presyncopal incident and symptomatology). Additionally, documentation must also support that the service billed was actually performed (e.g., an operative note/report).

Effective Date
This local medical review policy is effective for services processed on or after February 21, 2000.

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

36521: Extracorporeal Plasmapheresis

Extracorporeal plasmapheresis-immunoadsorption with staphylococcal protein A columns (ECI) is the technique of involving pumping the patient's anticoagulated venous blood through a cell separator from which 1-3 liters of plasma rejoins the separated, unprocessed cells and is retransfused to the patient.

Indications and Limitations of Coverage and/or Medical Necessity
Extracorporeal Immunoadsorption (ECI):

The above process, using Protein A columns, has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases.

HCPCS Codes
36521 Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion

ICD-9-CM Codes That Support Medical Necessity
287.3

Reasons for Denial
Any ICD-9-CM code other than listed.

Noncovered ICD-9-CM Code(s)
N/A

Coding Guidelines
The use of protein A columns is covered by Medicare only for the treatment of Idiopathic thrombocytopenia purpura (ITP) failing other treatments. Other uses of these columns are currently considered to be investigational and, therefore, not reasonable and necessary.

Documentation Requirements
N/A

Effective Date
This local medical review policy is effective for services processed on or after January 1, 2000.

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

40000: Digestive System

This policy lays out coding and payment guidelines for procedures performed on the digestive system.

Indications and Limitations of Coverage and/or Medical Necessity

Digestive System:

Any conditions that warrant surgical intervention.

HCPCS Codes

40490-49999

ICD-9-CM Codes That Support Medical Necessity

N/A

Esophagus Acid Reflex Tests:

Esophagus acid reflex tests (91032-91033) are covered services for certain conditions.

HCPCS Codes

91032-91033

ICD-9-CM Codes That Support Medical Necessity

530.0	530.7	531.10	531.51
530.10	530.81	531.11	531.60
530.11	530.82	531.20	531.61
530.19	530.83	531.21	531.70
530.2	530.84	531.30	531.71
530.3	530.89	531.31	531.90
530.4	530.9	531.40	531.91
530.5	531.00	531.41	
530.6	531.01	531.50	

Reasons for Denial

Colonic irrigation (A9270) is not medically indicated for any condition and has no evidence of therapeutic value.

Intestinal by-pass surgery (A9270) is not considered a safe procedure for treatment of obesity.

Fabric wrapping of abdominal aneurysms (M0301) is not considered reasonable and necessary. This procedure has not been proven to prevent eventual rupture.

Gastric freezing (M0100) was a nonsurgical treatment used nearly twenty years ago. Today, it is considered an obsolete problem.

Diagnostic breath analysis (A9270) are performed to diagnose certain gastrointestinal diseases. At this time, the lactose breath hydrogen test for diagnosing small bowel bacterial overgrowth and measuring small bowel transit time is excluded from coverage.

Excision, fatty apron panniculus adiposus (15831) for treatment of obesity is noncovered under the Medicare program.

Gastric balloon (A9270) for treatment of obesity is noncovered under the Medicare program.

Implantation of mesh or other prosthesis for incisional or ventral hernia repair (49568) is covered when billed separately with incisional or ventral hernia repairs (49560-49566). The use of mesh or other prosthetic devices are not reported separately with codes 49495-49557; 49570-49587.

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

CPT code 43259 upper gastrointestinal endoscopy including endoscopic ultrasound (EUS)

If the person doing the original endoscopy has access to the EUS and if the clinical situation is appropriate, the EUS may be done at the same time. The procedure, diagnostic and EUS, would be reported under the same code because the code, CPT code 43259, includes diagnostic endoscopy.

Therefore, when a diagnostic examination of the upper gastrointestinal tract "including esophagus, stomach, and either the duodenum or jejunum as appropriate", includes the use of endoscopic ultrasonography, the service should be reported by a single code, namely CPT code 43259. Interpretation, whether by a radiologist of endoscopist, is reported under CPT code 76975-26. These codes may both be reported on the same day.

Procedures for morbid obesity which include gastric bypass (43846, 43847, 43848) gastroplasty, (43842, 43843) and/or revision of gastric partition or other type of gastroplasty (43850, 43860, 43865, 43999) must be reviewed for medical necessity. The following information is required for medical review:

- operative report
- history and physical
- Attachment A, (Letter No. 415-416 or comparable information)

Implantation of an anti-gastroesophageal reflux device (43499) may be considered reasonable and necessary when a conventional valvuloplasty procedure is contraindicated.

The device is covered only for patients with documented severe or life-threatening gastroesophageal reflux disease whose conditions have been resistant to medical treatment. The following information is required for medical review:

- history and physical
- operative report

Twenty-four (24) hour esophageal PH monitoring (91033) is a covered service.

Reimbursement for removal of transplanted pancreatic allograft (48556) will be allowed on an individual consideration (I.C.) basis only.

Medical Documentation Required:

- operative report
- history and physical

Laparoscopic cholecystectomy is a surgical procedure in which a diseased gall bladder is removed through the use of instruments introduced via cannulae, with vision of the operative field maintained by use of a high-resolution television camera-monitor system (video laparoscope).

For all other claims use CPT codes 47562 for laparoscopy, surgical; cholecystectomy 47563 for laparoscopy, surgical; cholecystectomy with cholangiography, and 47564 for laparoscopy, surgical; cholecystectomy with exploration of common duct.

Omental flap (e.g., for reconstruction of sternal and chest wall defects) (list separately in addition to code for primary procedure) (49905) is a covered service.

Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor (47134), liver allotransplantation; orthoptic, partial or whole, from cadaver or living donor, any age (47135) and liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age (47136) are covered services when determined to be medically reasonable and necessary. Certain conditions and diagnosis criteria must be met before payment can be extended. In addition, the service must be furnished in a Medicare-approved facility. This procedure will be reviewed and reimbursed on an individual basis by the physician consultant.

The reimbursement for donor hepatectomy, with preparation and maintenance of allograft from cadaver donor **(47133)** is included in the organ acquisition charge of the Certified Transplant Center or the Independent Organ Procurement Organization which is covered under the Medicare Part A payment.

Documentation Requirements

Should a medical review be necessary the physician would be expected to maintain specific patient information in the medical record to justify the need for services, i.e., history, physical, offices notes, and photographs, if necessary.

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

ATTACHMENT A

MEDICARE PART B
P.O. BOX 2525
JACKSONVILLE, FL 32231-0019

Letter No. 415-416

Date of Service: _____
Reference: _____

Dear Doctor:

Benefits for the treatment of "obesity" are provided by Medicare B only under limited conditions. To assist us in evaluating the above beneficiary's claim, we require the following information for review:

1. Have the pressures of excess weight resulted in any physical trauma or disability:
   Yes ( ) No ( ) If yes, please describe in detail:
   _____
2. Are either pulmonary or circulatory insufficiencies present?
   _____
   Have pulmonary function studies been done? If so, submit documented report.
   _____
3. Is arteriosclerosis, diabetes, coronary disease or endocrine disease present? If so, indicate current status and extent of condition(s). If condition(s) is under current treatment, please describe:
   _____
4. Have electrocardiograms or similar evaluations been performed? If so, submit copy of tracing and/or documented report.
   _____
5. Have any specific blood chemistries been done? If so, submit documented report.
   _____
6. Is the patient able to function normally in his/her work and/or home environment?
   Comments:
   _____
7. Patient's Height ___, Weight ___, Age ___, Body Build (circle one): Small Frame ( ) Medium Frame ( ) Heavy Frame ( )
8. How long has present level of obesity been present?
   _____ (years)
9. Has the patient attempted weight control through diet under the supervision of a physician? Yes ( ) No ( ). If yes, please indicate data and results obtained. (If another attending physician, please give name.)
   _____
10. If surgery has been (or is to be) performed in an attempt to relieve the obesity, please describe the indications for surgical intervention:
    _____
11. General Comments:
    _____

PREPARED BY: DATE:

Thank you for prompt attention to this matter.

Sincerely,
Special Claims

WEIGHT IN POUNDS ACCORDING TO FRAME
MEN - AGES 25 AND OVER
(With shoes on - 1 inch heels)

HEIGHT	**SMALL FRAME**	**MEDIUM FRAME**	**LARGE FRAME**
5 ft. 2"	112-120	118-129	126-141
5 ft. 3"	115-123	121-133	129-144
5 ft. 4"	118-126	124-136	132-148
5 ft. 5"	121-129	126-139	135-152
5 ft. 6"	124-133	130-143	138-156
5 ft. 7"	128-137	134-147	142-161
5 ft. 8"	132-141	138-152	147-166
5 ft. 9"	136-145	142-156	151-170
5 ft. 10"	140-150	146-160	155-174
5 ft. 11"	144-154	150-165	159-170
6 ft. 0"	148-158	154-170	164-184
6 ft. 1"	152-162	158-175	168-189
6 ft. 2"	156-167	162-180	173-194
6 ft. 3"	160-171	167-185	178-199
6 ft. 4"	164-175	172-190	182-204

WEIGHT IN POUNDS ACCORDING TO FRAME
WOMEN AGES 25 AND OVER
(Girls between 18 & 25 subtract one pound for each year under 25)

HEIGHT	SMALL FRAME	MEDIUM FRAME	LARGE FRAME
4 ft. 10"	92-98	96-107	104-119
4 ft. 11"	94-101	98-110	106-122
5 ft. 0"	96-104	101-113	109-125
5 ft. 1"	98-107	104-116	112-128
5 ft. 2"	102-110	107-119	115-131
5 ft. 3"	105-113	110-122	118-134
5 ft. 4"	108-116	113-126	121-138
5 ft. 5"	111-119	116-130	125-142
5 ft. 6"	114-123	120-135	129-146
5 ft. 7"	118-127	124-139	133-150
5 ft. 8"	122-131	128-143	137-154
5 ft. 9"	126-135	132-147	141-158
5 ft. 10"	130-140	136-151	145-163
5 ft. 11"	134-144	140-155	149-168
6 ft. 0"	138-148	144-159	153-173

Excerpt from "Four Steps to Weight Control", © Metropolitan Life Insurance Company (06/72)

55250: Sterilization

Sterilization is used as a means of preventing pregnancy.

Indications and Limitations of Coverage and/or Medical Necessity

Covered Conditions

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

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

Noncovered Conditions

- Elective hysterectomy, tubal ligation, and vasectomy, if the stated reason for these procedures is sterilization;
- A sterilization that is performed because a physician believes another pregnancy would endanger the overall general health or the woman is not considered to be reasonable and necessary for the diagnosis or treatment of illness or injury. The same conclusion would apply where the sterilization is performed only as a measure to prevent the possible development of, or effect on, a mental condition should the individual become pregnant; and
- Sterilization of a mentally retarded person where the purpose is to prevent conception, rather than the treatment of an illness or injury.
- Insertion of an IUD (intrauterine device) (58300) is not a benefit of Medicare.
- Removal of an IUD (intrauterine device) (58301) for birth control purposes is not a covered service, however, removal of an IUD (58301) for medical necessity such as infection, would be a covered service.
- Insertion, implantable contraceptive capsules (11975) and removal with reinsertion (11977) are not covered services.
- Removal, implantable contraceptive capsules (11976) is not a covered service unless it is done for a medical reason, such as the site has become infected.
- Laparoscopy, surgical; with fulguration of oviducts (with or without transection) (58670) is not a covered service.
- Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring) (58671) is not a covered service.

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

HCPCS Codes

55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55400	Vasovasostomy, vasovasorrhaphy
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	with occlusion of oviducts by device (eg, band, clip, or Falope ring)
11975	Insertion, implantable contraceptive capsules
11976	Removal, implantable contraceptive capsules
11977	Removal with reinsertion, implantable contraceptive capsules

Reasons for Denial

Not medically necessary

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

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

Documentation Requirements

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

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

70541: Magnetic Resonance Angiography (MRA)

The complete local medical review policy (LMRP) for MRA was published in the July/August 1999 *Medicare B Update!* to reflect national coverage changes for services performed on or after July 1, 1999. Additional ICD-9-CM codes were added and published in the September/October 1999 *Medicare B Update!*. The following additional ICD-9-CM diagnosis codes have been added to the LMRP for procedure code 70541 and ICD-9-CM diagnosis codes have been developed for procedure codes 71555, 73725, and 74185:

HCPCS Code

70541 Magnetic resonance angiography, head and/or neck, with or without contrast material(s)

ICD-9-CM Codes That Support Medical Necessity

325
437.4
437.6

HCPCS Code

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

ICD-9-CM Codes That Support Medical Necessity

415.0	441.01	786.05
415.11-415.19	441.03	786.06
416.0	441.2	786.3
416.8	441.7	
416.9	786.00	

HCPCS Code

73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)

ICD-9-CM Codes That Support Medical Necessity

250.70-250.73	442.3	443.89
440.20-440.29	443.1	443.9
440.30-440.32	443.81	444.22

HCPCS Code

74185 Magnetic resonance angiography, abdomen, with or without contrast material(s)

ICD-9-CM Codes That Support Medical Necessity

441.02
441.03
441.4
441.7
441.9

Effective Date

The above ICD-9-CM diagnosis code lists have an effective date of February 21, 2000.

Advance Notice Statement

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

76512: B-Scan

B-scan implies a two-dimensional ultrasonic scanning procedure with two-dimensional display.

Indications and Limitations of Coverage and/or Medical Necessity

A B-scan is done for the purpose of evaluating the interior of the eye. Medicare payment will be allowed only for services that are medially reasonable and necessary for the patient's condition.

HCPCS Codes

76512 Ophthalmic ultrasound, echography, diagnostic; contact B-scan (with or without simultaneous A-scan)

76513 Ophthalmic ultrasound, echography, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy

ICD-9-CM Codes That Support Medical Necessity

190.0	282.60	360.61	361.81	371.01
190.1	282.61	360.62	361.89	371.02
190.2	282.62	360.63	361.9	371.03
190.3	282.63	360.64	362.01-362.89	371.04
190.4	282.69	360.65	363.00-363.9	371.05
190.5	360.00	360.69	364.41	371.10
190.6	360.01	360.81	364.42	371.11
190.7	360.02	360.89	364.51	371.12
190.8	360.03	360.9	364.52	371.20
190.9	360.04	361.00	364.53	371.21
198.4	360.11	361.01	364.54	371.22
224.0	360.12	361.02	364.55	371.23
224.1	360.13	361.03	364.56	371.50
224.2	360.14	361.04	364.57	371.51
224.3	360.19	361.05	364.59	371.52
224.4	360.40	361.06	364.60-364.64	371.53
224.5	360.41	361.07	364.74	371.54
224.6	360.42	361.10	366.17	371.55
224.7	360.43	361.11	366.18	371.56
224.8	360.44	361.12	366.20	371.57
224.9	360.50	361.13	366.21	371.58
228.03	360.51	361.14	366.22	371.70
228.09	360.52	361.19	366.23	371.71
234.0	360.53	361.2	366.50	371.72
238.8	360.54	361.30	366.51	371.73
239.8	360.55	361.31	366.52	376.00
277.3	360.59	361.32	366.53	376.01
	360.60	361.33	371.00	376.02

376.03	376.89	377.16	379.05	379.22	743.42	743.55	871.6
376.04	377.00	377.21	379.06	379.23	743.43	743.56	871.7
376.10	377.01	377.22	379.07	379.24	743.44	743.57	871.9
376.11	377.02	377.23	379.09	379.25	743.45	743.58	921.2
376.12	377.03	377.24	379.11	379.26	743.46	743.59	921.3
376.13	377.04	377.32	379.12	379.29	743.47	743.66	930.0
376.21	377.10	377.42	379.13	379.32	743.48	871.0	996.51
376.22	377.11	379.00	379.14	379.33	743.49	871.1	
376.30-376.36	377.12	379.01	379.15	379.34	743.51	871.2	
376.6	377.13	379.02	379.16	379.42	743.52	871.3	
376.81	377.14	379.03	379.19	379.92	743.53	871.4	
376.82	377.15	379.04	379.21	743.41	743.54	871.5	

Reasons for Denial

N/A

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

Bill for services using the CPT code which describes the services and the ICD-9-CM code which shows the symptom or condition being evaluated.

Documentation Requirements

Medical records must contain sufficient information to show medical necessity of the service. If requesting a review following a medical necessity denial, submit the following:

- History and physical
- Progress notes
- Radiology report

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

77427: Weekly Radiation Therapy Management

Weekly radiation therapy management represents the professional services of the physician managing a course of radiation therapy. The professional services furnished during treatment management typically consists of: reviewing port films; reviewing dosimetry, dose delivery and treatment parameters; reviewing the patient's treatment set-up and examining the patient for medical evaluation and management. In most instances this involves daily administration of clinical radiation therapy, usually five days a week. In some situations, a patient may be treated on other schedules such as every other day, three days a week, once a week, hyperfractionation (two times a day) or other individualized treatment plans. The physician's management involves a continual assessment of how the treatment is being delivered as well as the patient's response to the treatment.

Indications and Limitations of Coverage and/or Medical Necessity

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

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

HCPCS Codes

77427	Radiation treatment management, five treatments
77431	Radiation therapy management with complete course of therapy consisting of one or two fractions only

ICD-9-CM Codes That Support Medical Necessity

N/A

Reasons for Denial

N/A

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

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

- One fraction equals one "session" of radiation therapy
- Five fractions equal one weekly radiation therapy management service
- One weekly radiation therapy management code can be reimbursed for each "set" of five fractions. Therefore, if a patient receives treatments twice a day for five days, two weekly radiation therapy management services will be reimbursed for that calendar week.
- If at the end of a treatment course, three or four fractions remain, then one unit of weekly radiation therapy management will be reimbursed.
- If at the end of a treatment course, only one or two fractions remain, then no reimbursement will be made.
- If a patient's entire treatment course consists of only one or two fractions, the physician should bill CPT code 77431 (radiation therapy management with complete course of therapy consisting of one or two fractions only). This code should *not* be used to fill in the last week of a long course of therapy.

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

- For each weekly radiation therapy management code billed, the actual number of radiation treatments the patient received must be indicated in the "days or units" field on the claim.
- Each weekly radiation therapy management service should be billed on a separate detail line.
- The date of service should be the beginning date for each treatment week.
- Payment should only be made after the fifth treatment has been delivered, not before. However, payment will be made for one weekly radiation therapy management service if the entire treatment course consists of only three or four fractions.

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

11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; including micropigmentation 6.0 sq. cm or less
11921	6.1 to 20.0 sq. cm
11922	each additional 20.0 sq. cm (List separately in addition to code for primary procedure)
16000	Initial treatment, first degree burn, when no more than local treatment is required
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small
16015	under anesthesia, medium or large, or with major debridement
16020	without anesthesia, office or hospital, small
16025	without anesthesia, medium (e.g., whole face or whole extremity)
16030	without anesthesia, large (e.g., more than one extremity)
36425	Venipuncture, cut down age 1 or over
53670	Catheterization, urethra; simple
53675	complicated (may include difficult removal of balloon catheter)
90780	IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
90781	each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to face with the patient;
90805	with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to face with the patient;
90807	with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to face with the patient;
90809	with medical evaluation and management services
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to face with the patient;
90817	with medical evaluation and management services
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to face with the patient;
90819	with medical evaluation and management services
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to face with the patient;
90822	with medical evaluation and management services
90847	Family psychotherapy (conjoint psychotherapy) with patient present
99050	Services requested after office hours in addition to basic service
99052	Services requested between 10:00 pm and 8:00 am in addition to basic service
99054	Services requested on Sundays and holidays in addition to basic service
99058	Office services provided on an emergency basis
99071	Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician
99090	Analysis of information data stored in computers (e.g., ECG, blood pressures, hematologic data)
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session
99185	Hypothermia; regional
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity.

99238 Hospital discharge day management; 30 minutes or less

99281 Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making.

99282 Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity.

99283 Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity.

99284 Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity.

99285 Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history, a comprehensive examination; and medical decision making of high complexity.

99354 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

99355 each additional 30 minutes (List separately in addition to code for prolonged physician service)

99356 Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour (List separately in addition to code for inpatient Evaluation and Management service)

99357 each additional 30 minutes (List separately in addition to code for prolonged physician service)

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

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

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

Anesthesia (whatever code billed)
Care of infected skin (whatever code billed)
Checking of treatment charts
Verification of dosage, as needed (whatever code billed)
Continued patient evaluation, examination,
Written progress notes, as needed (whatever code billed)
Final physical examination (whatever code billed)
Medical prescription writing (whatever code billed)
Nutritional counseling (whatever code billed)
Pain management (whatever code billed)
Review and revision of treatment plan (whatever code billed)
Routine medical management of unrelated problem (whatever code billed)
Special care of ostomy (whatever code billed)
Written reports, progress note (whatever code billed)
Follow-up examination and care for 90 days after last treatment (whatever code billed)

These procedures can be performed at the following places of service:

11 FRTC
11 Office
21 Inpatient Hospital
22 Outpatient Hospital

Documentation Requirements

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

- radiation therapy treatment plan
- record of radiation treatments delivered
- physician's documentation of weekly management

Other Comments

One would expect to see the following specialty performing these services.

92 Radiation Oncologist

Terms Defined:

Port Film: A radiograph taken with the patient interposed between the treatment machine portal and an X-ray film. The purpose of this film is to radiographically demonstrate that the treatment port as externally set on the patient adequately encompasses the treatment volume and at the same time avoids adjacent critical structures.

Hyperfractionation: Radiation therapy delivered more than once a day.

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

77750: Clinical Brachytherapy

Brachytherapy, or internal radiation therapy is the method by which a radioactive substance is placed in, on or around a tumor. This can be interstitial, intracavitary, or on the surface with the radioactive substance enclosed in tubes, needles, wires, or seeds. The insertion of the radionuclide may be temporary or permanent and may be used in conjunction with external beam, or radiation therapy.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare Part B will consider brachytherapy to be medically necessary in documented cases of neoplasm in a patient for whom the need for a course of treatment has been established.

- Brachytherapy is used to improve control of local disease, treat areas at high risk for recurrence of malignancy, preserve vital organ function and minimize normal surrounding tissue damage.
- Transperitoneal ultrasound guided implantation of radioactive seeds is indicated in organ-confined prostate cancer, Stage A and B. In general neoplasms exhibiting endoscopic evidence of extension distally beyond the verumontanum or proximately into the bladder neck or trigone are considered unsuitable. This is a permanent implant.

HCPCS Codes

77750	Infusion or instillation of radioelement solution
77761	Intracavitary radioelement application; simple
77762	intermediate
77763	complex
77776	Interstitial radioelement application; simple
77777	intermediate
77778	complex
77781	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters
77782	5-8 source positions or catheters
77783	9-12 source positions or catheters
77784	over 12 source positions or catheters
77789	Surface application of radioelement
77790	Supervision, handling, loading of radioelement
77799	Unlisted procedure, clinical brachytherapy

ICD-9-CM Codes That Support Medical Necessity

N/A

Reasons for Denial

Radiofrequency hyperthermia (A9270) not performed in conjunction with radiation therapy is a noncovered service.

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

The interstitial radioelement application (77776-77778) for cancer, e.g., Palladium 103, Iodine 125, is normally performed by a radiation oncologist and a urologist in inpatient or outpatient hospital. For services up to and including 12/31/95, co-surgery guidelines will apply when physicians bill for the professional component of the radioelement applications (77776-77778) with the 26 modifier. The 62 modifier must be used to denote that both physicians provided the same service.

Example:

Interstitial radioelement application; simple
77776-26-62 Radiation Oncologist
77776-26-62 Urologist

In the event the procedure is performed in a free-standing radiation treatment center, *two* professional components may be billed with the 62 modifier and a *single* technical component would be billed by the appropriate entity.

Example:

Interstitial radioelement application; simple
77776-26-62 Radiation Oncologist
77776-26-62 Urologist
77776-TC Facility

Separate reimbursement would be made for the ultrasound services associated with the procedure through the appropriate ultrasonic guidance procedure code. The most appropriate procedure code for prostatic volume study would be:

76873 Echography, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)

This study should not be billed as an unlisted procedure and changing the procedure code to 77262 (therapeutic radiology treatment planning; simple) is inappropriate.

As of 1/1/96, these code combinations will no longer be appropriate.

For services on or after 1/1/96, the following codes should be used to bill for transperineal ultrasound guided seed implantation.

Urologist

55859 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

76965-26 Ultrasonic guidance for interstitial radioelement application

Radiologist

77776-26 Interstitial radioelement application; simple
77777-26 Interstitial radioelement application; intermediate
77778-26 Interstitial radioelement application; complex

Separate reimbursement may still be made for any other ultrasound services as well as radiology services such as treatment planning and radiation physics that would normally be associated with this procedure.

The admission to the hospital and the normal follow-up care during and after the course of treatment for a period of 90 days will be included in the reimbursement for primary procedures codes 77777-26, and 77778-26.

Separate reimbursement will be made for other radiology services, such as, treatment planning and radiation physics procedure codes.

Medical Documentation Required:

- Operative Report/Procedure Report
- History and Physical
- Pathology Report

Separate reimbursement will be made for the radioelement (Iodine 125, Palladium 103) when provided in a free-standing radiation treatment center in conjunction with transperitoneal ultrasound guided seed implantation of the prostate. The appropriate procedure code is as follows:

79900 Provision of therapeutic radionuclide

Medical Documentation Required:

- Invoice

Reimbursement for procedure codes 77781-77784 remote afterloading high intensity brachytherapy) includes the cost of the expendable source used during these procedures, specifically Iridium 192 (79900). Separate reimbursement will not be made.

Radiation treatment delivery can be billed using a date range if the treatments are performed on consecutive days and each treatment is the same dosage, the total number being indicated in the days or units field.

Radiation treatment management (77427) may be reported every fifth treatment with remote afterloading brachytherapy (HDR). It may also be billed after every fifth treatment of combination therapy, e.g., three HDR and two external beams.

Radiation therapy management (77431) should be used if the complete course of therapy consists of one or two sessions.

The code selected for billing should reflect the number of ribbons or sources used.

If the dates of service are not consecutive or the dosage is not the same, each date of service must be billed in a separate detail line.

When one or more treatments are performed on the same day, e.g., hyperfractionization, each treatment should be billed on a separate detail line.

Multiple treatment sessions on the same day are payable as long as there has been a distinct break in therapy services and the individual sessions are of the character usually furnished on different days.

This procedure can be billed in the following places of service:

- 11 FRTC
- 21 Inpatient Hospital
- 22 Outpatient Hospital

Documentation Requirements

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

- medical necessity for administering more than one radiation treatment delivery on the same day.

Other Comments

The most common specialty one would expect to see performing these services are:

92 Radiation Oncology

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

78267: Breath Test for Helicobacter Pylori (H. Pylori)

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

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

The carbon-13 breath test (not radioactive) consists of analysis of breath samples before and after ingestion of 13C-urea. 13C-urea will decompose to form 13CO2 and NH4 in the presence of urease, which is produced by H. pylori in the stomach. The 13CO2 is absorbed in the blood, then exhaled in the breath. The exhaled breath sample is then analyzed and compared with the baseline breath sample which was obtained before the ingestion of the 13C-urea.

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

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

Indications and Limitations of Coverage and/or Medical Necessity

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

- A patient has uncomplicated symptoms of peptic ulcer disease (i.e., epigastric pain, dyspepsia, nausea, and anorexia) and antibiotic therapy is planned if the H. pylori breath test is positive, and no gastrointestinal endoscopy has been done within the preceding six weeks or is planned;
- An upper gastrointestinal contrast series has been done which shows duodenal ulcer or significant gastritis and/or duodenitis, and no endoscopy has been done within the preceding six weeks or is planned; and/or
- There are persistent or recurrent symptoms six weeks after appropriate antibiotic and H3 antagonist treatment for a documented H. pylori infection and no endoscopy has been planned.
- Medicare of Florida will consider the breath test for H. pylori **not** medically necessary in the following situations:
- Patients who are being screened for H. Pylori infection in the absence of documented upper gastrointestinal tract symptoms and/or pathology;
- Patients who have had an upper gastrointestinal endoscopy within the preceding six weeks or for whom an upper gastrointestinal endoscopy is planned;
- Patients who have new onset dyspepsia responsive to conservative treatment (withdrawal of nonsteroidal antiinflammatory drugs and/or use of antisecretory agents);
- Patients who have non-specific dyspeptic symptoms with a negative H. pylori serum antibody test, and/or
- Patients who are asymptomatic after treatment of an H. pylori infection (either proven or suspected). Therefore, repeating the breath test for mere confirmation of treatment success will not be covered.

HCPCS Codes

78267	Urea breath test, C-14; acquisition for analysis; (Note: use this code for 14C Breath Test only)
78268	analysis; (Note: use this code for 14C Breath Test only)
83013	Helicobacter pylori, breath test analysis (mass spectrometry); (Note: use this code for 13C Breath Test only)
83014	drug administration and sample collection (Note: use this code for 13C Breath Test only)

ICD-9-CM Codes That Support Medical Necessity

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

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

Use code 78267 (C-14) or 83013 (C-13) for isotope administration and sample collection only.

Use code 78268 (C-14) or 83013 (C-13) for the actual analysis.

If the physician performs the drug administration, specimen collection and analysis, then both codes (78267 and 78268 or 83013 and 83014) should be reported.

Currently, the kit used by the practitioner performing the acquisition includes the isotope. Therefore, separate reporting for the provision of the radiopharmaceutical (HCPCS A4641 or code 78990) is unnecessary. Also included is a "mailer," which precludes the reporting of code 99000.

Documentation Requirements

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

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

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

84153: Prostate Specific Antigen

Prostate-specific antigen (PSA) is a serum glycoprotein produced by normal prostate tissue, hypertrophic prostate tissue, and malignant prostate tissue. PSA is a serum tumor marker used in early detection, staging, and monitoring of a patient's response to treatment for prostate cancer. PSA can be present in abnormal quantities in both prostate cancer and benign prostatic hypertrophy (BPH). PSA levels are measured by radioimmunoassay or enzyme immunoassay. The normal range for serum PSA is 0 to 4.0 ng/ml.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider a PSA (procedure code 84153) medically reasonable and necessary in the following circumstances:

- Diagnostic tool for patients in whom a digital rectal exam reveals a suspicious abnormal prostate, (e.g., asymmetry of the prostate gland, hard, irregular nodule).
- Monitor patient response to treatment in cases of a known prostate malignancy.
- Detecting metastatic or persistent disease following treatment.
- Prior to initiation of Proscar™ for patients with BPH.
- Monitor patients who are taking Proscar™.

ICD-9-CM Codes That Support Medical Necessity

170.2	196.5	198.82	790.93
185	196.6	233.4	995.2
188.5	196.8	236.5	V10.46
188.8	198.5	239.5	V67.51

Coding Guidelines

The ICD-9-CM diagnosis code for which the service was performed must be submitted with the claim. PSA's performed for evaluation of a nodule on the prostate should be billed with the diagnosis of 236.5 (Neoplasm of uncertain behavior of prostate) or 239.5 (Neoplasm of unspecified nature of other genitourinary organs).

For patients initiating Proscar™ therapy, use diagnosis 995.2 and V67.5 for follow-up monitoring of the drug.

For screening PSAs (dates of service on or after January 1, 2000), refer to the November/December 1999 *Medicare B Update!* (page 20) - "G0102, G0103: Prostate Cancer Screening."

Documentation Requirements

Medical record documentation (office/progress notes and/or hospital notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing a prostate specific antigen.

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

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

86706, 87340: Hepatitis B Surface Antibody and Surface Antigen-Correction

Medicare of Florida's recently implemented local medical review policy (LMRP) was published in the November/December 1999 *Medicare B Update!* (pages 32-34). The title of that article incorrectly identified the Hepatitis B surface antibody as procedure code 87349. The correct code is 87340.

References throughout the body of the policy correctly identified the Hepatitis B surface antibody as 87340.

93304, 93305, 93307, 93308, 93320-93321, 93325: Transthoracic and Doppler Echocardiography, and Doppler Flow Velocity Mapping

Echocardiography is used to image cardiac structures and function and also flow direction and velocities within cardiac chambers and vessels. Usually these images are obtained from several positions on the chest wall and abdomen using a hand-held transducer. The direction of flow of the red blood cells within the heart is displayed with the use of a Doppler transducer. The direction of the flow of the blood is depicted by using color coding of velocity shifts and the red blood cell velocity is measured through the use of Doppler color flow velocity mapping.

Indications and Limitations of Coverage and/or Medical Necessity

Transthoracic Echocardiography for Congenital Cardiac Anomalies:

Medicare of Florida will consider transthoracic echocardiography for congenital cardiac anomalies (CPT codes 93303, 93304) medically necessary when they are specifically performed for congenital cardiac anomalies.

Transthoracic Real time Echocardiography:

Medicare of Florida will consider resting real time echocardiography (CPT code 93307, 93308) medically necessary under any one of the following circumstances:

- The patient has a prosthetic heart valve and echocardiography is needed to monitor response to therapy or investigate a change in the patient's clinical condition.
- The patient has clinical findings which suggest the presence of valvular heart disease, i.e., the patient has a heart murmur which is felt to be clinically significant.
- The patient has proven endocarditis or clinical findings suggestive of endocarditis.
- The patient has clinical findings diagnostic of or suggestive of acute myocardial ischemia or infarction, or the patient has complications of acute myocardial infarction such as valvular incompetency, ventricular septal rupture or aneurysm of heart.
- The patient has documented cardiomyopathy, or the patient has clinical findings which suggest possible cardiomyopathy, or the patient has unexplained cardiomegaly.
- The patient has pericardial disease or the patient has clinical findings suggestive of pericardial disease (e.g., friction rub, pericarditis, pericardial effusion, cardiac tamponade, pericardial tumor or cyst) and echocardiography is necessary for evaluation and/or follow-up.
- The patient has an intracardiac mass (e.g., tumor, thrombus, vegetation).
- The patient has a thoracic aortic aneurysm or dissection, or the patient has clinical findings suggestive of aortic dissection or aneurysm.
- The patient has confirmed or suspected abnormality of the vena cava or other large intrathoracic venous structure.
- The patient has hypertension along with other clinical evidence of heart disease.
- The patient had dyspnea of suspected cardiac origin based on clinical findings.
- The patient has chest pain with clinical findings which suggest a possible cardiac origin for the pain.
- The patient exhibits signs or symptoms of cerebral embolism and a cardiac etiology for the embolus is suspected.
- The patient has syncope and a cardiac etiology is suspected based on clinical findings.
- The patient has experienced peripheral embolism and a cardiac origin of embolus is suspected.
- The patient has documented, clinically significant, arrhythmia (e.g., paroxysmal tachycardia, atrial fibrillation or flutter, or ventricular fibrillation or flutter, sinoatrial node dysfunction) and echocardiography is being done to evaluate the patient for associated heart disease.
- The patient has unexplained edema and a cardiac etiology is suspected.
- The patient has sustained chest trauma and cardiac injury is suspected.
- The patient has undergone heart transplantation.
- The patient has cardiac dysfunction, such as post-cardiology syndrome or congestion failure, following surgery or other procedure.
- The patient is under treatment, or being considered for treatment, with a cardiotoxic medication.
- The patient has suspected or confirmed pulmonary hypertension and/or cor pulmonale and echocardiography is necessary for evaluation and/or follow-up.
- Echocardiography would be considered appropriate as part of the initial evaluation of a patient with suspected or confirmed chronic ischemic heart disease.

ICD-9-CM Codes That Support Medical Necessity

164.1	414.10-414.19	444.81-444.89	746.9
212.7	416.0	453.2	747.0
391.0-391.9	416.8	745.0	747.10-747.11
394.0-394.9	416.9	745.10-745.19	747.3
395.0-395.9	421.0-421.9	745.2	780.2
396.0-396.9	423.0-423.9	745.3	782.3
397.0-397.9	424.0-424.3	745.4	785.2
398.91	424.90-424.99	745.5	785.3
402.00-402.01	425.0-425.9	745.60-745.69	786.02-786.09
402.10-402.11	427.0-427.5	745.7	786.50-786.59
402.90-402.91	427.81	745.8	861.00-861.03
403.00-403.91	428.0-428.9	745.9	861.10-861.13
404.00-404.93	429.3	746.00-746.09	963.1
410.00-410.92	429.4	746.1	996.02
411.0	429.5	746.2	996.03
411.1	429.6	746.3	997.1
411.81	429.71	746.4	997.2
411.89	429.79	746.5	V42.1
412	429.81	746.6	V42.2
413.0-413.9	434.10-434.11	746.7	V43.3
414.00-414.05	444.21-444.22	746.81-746.89	V67.51

Doppler Echocardiography and Doppler Color Flow Velocity Mapping:
Medicare of Florida will consider Doppler echocardiography (CPT code 93320-93321) and Doppler color flow velocity mapping (93325) medically necessary under any one of the following circumstances:

- The patient has valvular heart disease or congenital heart disease and echocardiography is needed to define the condition, monitor response to therapy, or to investigate a change in the patient's clinical condition.
- The patient has a prosthetic heart valve and echocardiography is needed to monitor response to therapy or investigate a change in the patient's clinical condition.
- The patient has clinical findings which suggest the presence of valvular heart disease, i.e., the patient has a heart murmur which is felt to be clinically significant.
- The patient has proven endocarditis or clinical findings suggestive of endocarditis.
- The patient has clinical findings diagnostic of or suggestive of acute myocardial ischemia or infarction, or the patient has complications of acute myocardial infraction such as valvular incompetency, ventricular septal rupture or aneurysm of heart.
- The patient has a thoracic aortic aneurysm or dissection, or the patient has clinical findings suggestive of aortic dissection or aneurysm.
- The patient has undergone heart transplantation.
- The patient has suspected or confirmed pulmonary hypertension and/or cor pulmonale and echocardiography is necessary for evaluation and/or follow-up.
- Routine performance of resting echocardiography, Doppler echocardiography, or Doppler color flow velocity mapping on patients with stable chronic coronary artery disease is not considered medically necessary unless the patient has had a change in clinical status which makes repeat procedures necessary. Also, the performance of procedures on patients with simple hypertension without other evidence of heart disease is considered not medically necessary.

ICD-9-CM Codes That Support Medical Necessity

391.0-391.9	412	429.6	746.4
394.0-394.9	413.0-413.9	429.7	746.5
395.0-395.9	414.00	429.71	746.6
396.0-396.9	414.01	429.79	746.7
397.0-397.9	414.02	429.81	746.81-746.89
398.91	414.03	745.0	746.9
402.01	414.04	745.10-745.19	747.0
402.11	414.05	745.2	747.10-747.11
402.91	414.10-414.19	745.3	747.3
404.01	416.0	745.4	780.2
404.03	416.8	745.5	785.2
404.11	416.9	745.60-745.69	786.50-786.59
404.13	421.0-421.9	745.7	996.02
404.91-404.93	424.0-424.3	745.8	996.03
410.00-410.92	424.90	745.9	V42.1
411.0	424.91	746.00-746.09	V42.2
411.1	424.99	746.1	V43.3
411.81	428.0-428.9	746.2	
411.89	429.5	746.3	

Documentation Requirements

Medical record documentation must indicate the medical necessity of echocardiographic studies covered by the Medicare program. Also, the results of echocardiographic studies covered by the Medicare program must be included in the patient's medical record. This information is usually found in the office/progress notes, and/or tests results.

If the provider of echocardiographic studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. When ordering echocardiographic studies from an independent diagnostic testing facility or other provider, the ordering/referring physician must state the reason for the echocardiographic studies in his order for the test(s).

Effective Date

This local medical review policy is effective for services processed on or after December 20,1999.

Advance Notice Statement

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

94762: Noninvasive Ear or Pulse Oximetry For Oxygen Saturation

Pulse oximetry provides a simple, accurate, and noninvasive technique for the continuous or intermittent monitoring of arterial oxygen saturation. A small lightweight device attaches to the finger or toe and directs through the nailbed two wavelengths of light; a photodetector measures absorption. Arterial pulsation is used to gate the signal to the arterial component of blood contained within the nailbed.

Ear oximetry is a noninvasive method for evaluating arterial oxygenation. Ear oximeters are commonly used in sleep studies.

Indications and Limitations of Coverage and/or Medical Necessity

Continuous Overnight Monitoring:

Medicare Part B in Florida will consider ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (CPT code 94762) to be medically necessary in the following circumstances (see "ICD-9-CM Codes That Support Medical Necessity"):

- The patient must have a condition for which intermittent arterial blood gas sampling is likely to miss important variations ***and***
- The patient must have a condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen.

HCPCS Codes

94762 Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (separate procedure)

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (CPT code 94762) include the following:

162.2-162.9	493.10-493.11	518.5
428.0	493.20-493.21	518.81-518.89
428.9	493.90-493.91	780.51
491.20-491.21	494	780.53
492.0-492.8	496	780.57
493.00-493.01	515	786.03-786.09

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

Effective 1/1/2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician (i.e., office/progress notes) must indicate the medical necessity for performing ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (94762). Additionally, a copy of the study results should be maintained in the medical records.

If the provider of oximetry studies 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 study. The ordering/referring physician must state the clinical indication/medical necessity for the oximetry study in his order for the test.

Effective Date

This local medical review policy is effective for services processed on or after January 1, 2000.

Advance Notice Statement

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

95805-95811, 95822: Coverage for Sleep Testing

One of the coverage requirements for sleep testing is that the patient must have been referred to the sleep disorder clinic by his or her attending physician, and the clinic maintains a record of the attending physician's order. In order to meet this criteria, it is expected that the provider of the service submit with the claim not only the documentation to support the medical necessity of the service, but documentation supporting the patient was referred by his or her attending physician. The attending physician's name must be included in the documentation. This requirement is considered met if this information is provided on the claim or medical record, there is a written order for an evaluation and/or sleep study by the referring physician, or there is a dictated note from the performing provider to the referring provider reflecting the test results. If the documentation submitted with the claim does not provide evidence that the patient was referred by his or her attending physician, the claim will be denied. Further information regarding the coverage of sleep studies can be found on pages 59-61 of the July/August 1998 *Medicare B Update!*

ELECTRONIC MEDIA CLAIMS

Embrace the Millennium with Electronic Media Claims

Start off the new year with an Electronic Media Claims (EMC) bang! There is no better time than right now to begin filing Medicare claims electronically, rather than the cumbersome process of paper filing. EMC filing will benefit your office in many ways. You can experience increased claim control, reduced filing costs, and reduced billing errors; and claims will process in half the time.

If your office is ready for more efficient use of time and money, please contact Provider Electronic Services Marketing at (904) 791-8767. Our friendly staff of experts will be glad to discuss the best ways to help you meet your office needs.

Preventing EMC Rejects

The Provider Electronic Services department is working hard to assist providers and senders in avoiding rejected claims from front-end EMC edit errors. When billing personnel receive an EMC error report, it means the claim was rejected from the Medicare processing system and must be corrected and resubmitted. This leads to **delays and/or no payment on your Medicare claims.** Listed below are the top three reject messages from September 1999 and helpful hints to prevent these rejects from affecting you.

ERROR REPORT MESSAGE	RECORD & FIELD	EXPLANATION	PREVENTIVE ACTION
INV PROV NBR	BA0 02 BA0 09 HCFA 1500: BLOCK 33	The number you have entered as the billing provider is not valid on the Medicare B provider files or it is not in a valid format. Please correct the billing provider number and retransmit.	Verify the number you have entered as the billing provider. Make corrections and retransmit the entire claim. If you are sure you have keyed the correct number, contact Customer Service at (904) 634-4994.
PROV NOT IN GROUP	FA0 23 HCFA 1500: BLOCK 24K	You have entered a performing provider number that is not a member of the PA group billing for the service or it is not in a valid format. Correct the performing provider number (and suffix if applicable) and retransmit your claims.	Verify the suffix of the performing provider you have entered. Make corrections and retransmit the entire claim. If you are sure you have entered the correct provider number with/without suffix, contact Customer Service at (904) 634-4994.
LAB/FAC	EA0 37 EA1 04 EA1 06 EA1 08 EA1 09 EA1 10 HCFA 1500: BLOCK 32	The place of service on this claim indicates that the services were billed by an independent lab . The claim must contain the facility identification number **or** the complete name and address (address, city, state, zip) of the facility where the lab services were rendered. The Facility ID number was not given and at least one of the name/address fields was blank or contained special characters.	Verify the facility number and/or the complete name, address, city, state, and zip of the facility where the lab services were rendered and include the data in the appropriate location of your EMC claim.

Provider Y2K Testing—Myth Versus Reality

The following article has been developed by the Health Care Financing Administration (HCFA) to clarify some of the misunderstandings related to future-date Y2K claims testing offered by Medicare contractors.

This is a HCFA document, which is being published at the recommendation of HCFA.

The Year 2000 statements contained in this document originally made by third parties, including information about third party vendor products are Republications pursuant to the Year 2000 Information and Readiness Disclosure Act. First Coast Service Options, Inc., is not the source of the Republication. Each Republication is based on information supplied by the third party vendor and/or manufacturers.

MYTH	REALITY
1. HCFA's systems are not Y2K ready so there's no reason for me to test systems with HCFA at this time.	All of HCFA's claims processing systems have been fully-tested and certified as compliant as of April 1999, and are processing and paying Medicare claims today. HCFA's independent verification and validation expert, with oversight from the HHS Inspector General and the GAO, has verified the readiness of these claims processing systems. Since HCFA had to make software changes to these systems this summer, HCFA is engaging in a rigorous retesting of the systems to certify that any software changes did not affect the Y2K compliance of those systems. Recertification testing is scheduled to be completed by November 1999.
2. Medicare contractors are not ready to test.	All Medicare contractors are ready and willing to test with their providers/submitters. HCFA is strongly encouraging all claims submitters to test future-dated claims with the contractors' front-end systems. To assist you in your testing process HCFA has developed a "point of contact" list of contractors that you can call when you are ready to do Y2K testing. (see the HCFA website at **www.hcfa.gov/y2k**)
3. If you can send a Y2K compliant claim to your contractor today as HCFA required by April 5, 1999, your systems are millennium ready.	Unfortunately, this is not true. All your systems that interface to produce a compliant claim and other electronic transactions must be renovated and tested.
4. If I can't submit claims on January 1, 2000, HCFA will send me an advance payment	HCFA has clearly stated it will not be making advance payments as part of its contingency plan. HCFA's contingency plan provides mechanisms to make sure that providers that submit valid claims for services rendered will be paid even if parts of HCFA's or its contractors' systems experience unanticipated failure. If a provider cannot submit a bill, that provider is not covered by the HCFA payment contingency plan. Being able to submit a valid claim to HCFA is the minimal requirement health care providers must meet to receive payment from Medicare.
5. My contractor will only test the exchange of data with me. I believe an end to end test from claim submission to payment notice is needed.	Medicare contractors have conducted stringent end-to-end testing in future-dated environments. This testing shows that claims received by the contractors will be accurately processed and paid, including the generation of back-end remittances. The data exchange you test with your contractor will show your claim can get to Medicare. Logistics and time prevent end-to-end testing with the more than 200,000 submitters in Medicare.
6. Testing doesn't uncover any problems.	Significant problems have been found by Medicare contractors in testing with providers/submitters, including dates of 2000 and beyond being read as 1900 in provider/submitter systems. That's why it's critical that submitters test and test early; it allows them time to make necessary corrections in time for the millennium rollover.
7. I made changes and renovations to my systems, so I don't need to do any testing.	Even if you believe your billing systems are compliant, you should test your entire system to make sure you can generate a future-dated claim, and then test with your contractor's front end system. Our experience shows that testing reveals additional renovations that may need to be made to be fully compliant.

8. I can always print paper claims if I can't generate an electronic claim.	If your systems can not produce an electronic submission, they won't likely be able to print paper claims. Also, since the time frame for processing paper claims is about 2 weeks longer than that for electronic claims, your cash flow may suffer. Finally, HCFA's contractors will simply not be able to timely process and pay a significant increase in paper claims. An influx of paper claims may result in payment backlogs.
9. Testing will cause problems for my production system.	It is true that following testing instructions and setting future date clocks on computers requires a level of skill. Following vendor/submitter instructions is essential. There are many products available to help you test. Use your contractor as a resource.
10. If I do future date testing my system will crash and I will not be able to reset my system back to the current date.	Testing does require some level of technical knowledge. It is important to closely follow instructions from your hardware and software vendors. Use your contractors as a resource.
11. If some other provider tests using the same billing software I use, then I don't need to do so.	Yes, you do need to test that same software because that other provider may have a different hardware system than you. Just because one provider's claims went through smoothly does not mean that you won't run into problems when you do your testing.
12. Testing with Medicare means everything will be all right.	Testing with Medicare will improve the odds of your Y2K readiness, but does not assure a smooth millennium rollover with other payers. Providers/submitters should make arrangements to test with other payers as well.
13. Why should I care? Vendors test for me!	Vendors should do the testing with contractors for you, and in many cases should be testing with you as well. The best thing to do is to call your vendor to determine their Y2K readiness program.
14. Everything will be all right if I test.	Not necessarily, but testing is worth the effort. Iron-clad guarantees are difficult in computing where there are literally trillions of variables. But testing with future dated claims (ie., The clock is set for a date in the Year 2000) will help you avoid some of the billing road blocks. And remember, if you change the hardware or software after you have tested--the test results could become invalid. Now might not be a good time to make system changes.
15. I don't need to test my hardware.	Testing Hardware is just as critical as testing software. Computer hardware must be Y2K compliant just like software.
16. If I deal with many contractors, I need to only test with one.	Unfortunately, that is not true. Many contractors use different systems to receive your claims. Testing with each contractor increases your assurance level.
17. I've tested my billing software, my job is done.	Testing assures you that you can successfully submit a claim to your payers. But you need to identify all of your critical business functions and make sure they will operate in the Year 2000. And, we advise that you thoroughly check the Y2K readiness of systems and devices that go to the heart of quality care and patient safety.
18. I've talked with my billing service and have been told that testing is too expensive.	The cost of testing now is a better choice than the real potential of significant cash flow disruption starting in January, 2000. Talk to your billing service to get a clear picture of any cost. If the cost sounds prohibitive, ask why. Also, let your contractor know you would like to test but the billing service charges are too expensive.

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

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FRAUD AND ABUSE

The Wheels of Justice Turn

In government, the wheels of justice turn constantly, though seldom at the desired pace. Many days, it seems that our Medicare work is for naught. Cases we investigate are moved on to other government agencies and years may pass before they are resolved. However, the system does work, and when fraud, waste, or abuse exist, our efforts to eliminate them do pay off.

During this past quarter, several significant cases involving fraud, waste, or abuse were finalized through the courts. Here is an update about some of the cases in which First Coast Service Options, Inc., in concert with the Health Care Financing Administration, the Federal Bureau of Investigations, the Office of Inspector General, the Department of Justice, and the Agency for Health Care Quality, has participated:

- In a large health care corporation case, two of four defendants were found guilty on six counts of Medicare cost report fraud spanning 1987 through 1992 and totaling nearly $3.5 million. Indictments in this case were issued in October 1998, and the trial concluded in August 1999.
- The owner of several mobile diagnostic laboratory companies throughout the Southern and Middle Districts of Florida pled guilty to conspiracy to defraud the United States government by paying kickbacks to clinics and physicians for the referral of Medicare patients (violation of Title 19 USC, Section 371). The individual, sentenced to three years probation and six months home detention, was ordered to make restitution to the government in the amount of $400,000, and was ordered to pay a special assessment of $100.
- A physician was sentenced to 27 months in prison and three years supervised release, and was ordered to pay $200,504 in restitution and a $200 special assessment for conspiracy and filing false claims.
- Two defendants pled guilty to conspiracy and were sentenced to prison time and ordered to pay $444,066 in restitution and a $4,000 fine.
- A physician was ordered to pay $1,384,500 in a settlement agreement for a case which involved filing false claims from 1993 to 1996. In addition, the physician agreed to be excluded from all publicly funded health care programs for five years.
- A "patient broker" pled guilty to violating the Medicare Anti-Kickback statute and was ordered to pay $221,850 in restitution and sentenced to six months home detention and three years probation.
- The owner of an independent laboratory pled guilty to conspiracy to submit false claims and was sentenced to three years probation with four months in a half-way house and eight months of home confinement with electronic monitoring, and ordered to pay a $50 special assessment fee.

Cases may take years to resolve, but the prevention and detection of fraud, waste and abuse in the Medicare program pays off. Each day, when we come to work, we are rewarded by the knowledge that we are protecting and safeguarding the Medicare trust fund, now and for the future.

FINANCIAL

Overpayment Interest Rate

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

Effective October 28, 1999, the interest rate applied to Medicare overpayments is ***13.375*** percent based on the new revised PCR rate. The following table lists *previous* interest rates.

Period	Interest Rate
August 04, 1999 - October 27, 1999	13.25%
May 05, 1999 - August 03, 1999	13.375%
February 01, 1999 - May 04, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%
October 24, 1996 - January 22, 1997	13.375%

MEDICARE REGISTRATION

Site Visits and Enrollment of Independent Diagnostic Testing Facilities

The Health Care Financing Administration (HCFA) has directed all contractors to conduct site visits to all enrolling Independent Diagnostic Testing Facilities (IDTFs). This includes all entities already enrolled as IDTFs, IPLs (Independent Physiological Labs) who intend to convert their enrollment from an IPL to an IDTF, and new entities seeking IDTF enrollment. For IPLs who have already submitted a Form HCFA-855 requesting to become an IDTF, and on that basis have been granted a temporary exemption for IDTF billing (in accordance with B-98-52), a second site visit shall be performed prior to the final determination that the IPL should be enrolled as an IDTF.

Medicare Registration may not conduct a site visit to each location if an IDTF has multiple practice locations. A sampling of practice locations will be visited. However, each IDTF must list each practice location, which will be verified. Mobile units are required to list all sites where they furnish services.

Purpose of Site Visit

The purpose of a site visit is to verify that an IDTF actually exists at the location(s) shown on the Form HCFA-855, that the IDTF meets or exceeds Medicare rules for enrollment, and that the information shown on Attachment 2 of the Form HCFA-855 is correct, verifiable, and in accordance with IDTF requirements. Site visits are normally performed on an unannounced basis. However, enrolling IDTFs may be contacted to request an appointment. All IDTFs are subject to a revisit at any time, and at a minimum must be able to demonstrate that they meet the following:

- The Supervising Physician(s) listed in the enrollment application is aware of his/her responsibilities as a Supervising Physician.
- The technicians and/or physicians who are performing the tests are licensed, registered or certified by an appropriate credentialing agency. They are not required to be employees of the IDTF. They may be contracted by the IDTF. They may even be employees of a hospital, whom the hospital is providing under contract with the IDTF.
- The IDTF must have written procedures in place (protocols), detailing the responsibilities of the Supervising Physician.
- The IDTF must obtain any applicable state or local occupational licenses.

What the Registration Coordinator Will Look For

The Registration Coordinator will:

- Verify that the location address(es) shown on the Form HCFA-855 is the physical address for the IDTF.
- Verify that the test equipment shown in block 3 of Attachment 2 actually exists and is present at the IDTF.
- Observe that diagnostic tests performed by the IDTF are rendered by a state licensed, registered or certified technician shown in block 3 of Attachment 2 of the enrollment application.

Personal and Direct Supervision by a Physician

The Registration Coordinator will check to determine if a Supervising Physician shown in block 2 of Attachment 2 of the HCFA 855 form is actually present with the patient for tests that require personal supervision and that the Supervising Physician is within the required proximity of the patient for tests requiring direct supervision.

General Supervision

In accordance with Code of Federal Regulations (CFR) section 410.32, "General Supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. In applying this definition, a physical distance limit between where the test is performed and where the Supervising Physician is located has not been imposed. However, the Supervising Physician for each test must be licensed in each state where he or she is acting as a Supervising Physician.

Under general supervision, the Supervising Physician for each test must be listed on Attachment 2 of Form HCFA-855. A group practice of physicians cannot be considered a Supervising Physician. Each physician from the group practice who actually provides the supervision must be listed separately as a Supervising Physician on Attachment 2 of Form HCFA-855. If a Supervising Physician has been recently added or changed, a HCFA 855 form must be submitted within 30 days of the change.

The Registration Coordinator will try to determine the following for tests that require general supervision:

- The technician(s) know the name of the Supervising Physician(s) who are supervising the tests. They should be listed in block 2 of Attachment 2, of the enrollment application.
- The technician(s) must know how they can get in contact with the Supervising Physician(s), and have written instructions detailing actions they should take when they encounter problems while performing diagnostic tests.
- The technician(s) will be asked to demonstrate that they are operating under general supervision requirements.

Supervision Requirements

IDTFs must notify Medicare Registration when a Supervising Physician is added or deleted. All listed Supervising Physicians must be aware that they are a Supervising Physician for tests being performed by the IDTF. All Supervising Physician(s) must be enrolled with Medicare. There must be written procedures authored by the Supervising Physician(s) to ensure the following:

- The equipment is properly functioning and calibrated.
- The personnel working as technicians for the IDTF obtain and maintain any applicable state license, credential, certification or registration necessary.
- The actions IDTF personnel should take during emergency situations, or when experiencing problems in the performance of diagnostic testing.

Billing Issues

IDTFs are responsible to make sure the procedure codes they submit to the Registration Area are covered by Medicare. This can be done by contacting the Medicare Provider Customer Service department at (904) 634-4994.

An IDTF is not restricted to billing only the technical component of diagnostic services. In certain situations, an IDTF can bill for both the technical component of the diagnostic test and interpretative services. This is referred to as billing "globally." The interpretative services must be performed by a licensed practitioner who is allowed to perform the service.

If the interpreting practitioner is an employee of the IDTF, the IDTF must submit a Reassignment of Benefits, Form HCFA-855R, which has been signed by the practitioner. This is in accordance with Medicare Carrier Manual (MCM) section 3060.1 If the interpreting practitioner is a contractor performing the interpretation on the premises that the IDTF owns or leases, the IDTF must submit a Reassignment of Benefits, Form HCFA-855R, which has been signed by the practitioner. This is in accordance with MCM 3060.3C. In no instance may a group of physicians reassign their benefits to the IDTF. Only individual practitioners may reassign their benefits.

If an IDTF wants to bill for a professional interpretation performed by an independent practitioner off the premises of the IDTF, the IDTF must meet the conditions shown in MCM 3060.5 concerning purchased interpretations. In this case there is no reassignment of benefits, since the purchaser of the test is considered the supplier of the test. When the technical component of a test is performed by a mobile unit of the IDTF and the interpretative practitioner is the practitioner who ordered the test, the IDTF cannot bill for the interpretation. The interpretative practitioner must bill for the interpretation.

The contractor section of the Form HCFA-855, Section 12, should be completed by the IDTF only for businesses that are contractors and are providing the IDTF $10,000.00 or more per year in medical or diagnostic supplies. Individuals should not be included in Section 12.

Additional services related to, or generally considered required for, performing a diagnostic test are also payable to an IDTF. Examples are the billing for injections used in performance of a diagnostic test. Specifically codes 23350, 64445, 19030, 19110 and 19100 are payable to an IDTF. As noted above, an IDTF can bill practitioner services when they are performed by a qualified practitioner in accordance with the coverage, payment and general billing rules, and in accordance with the reassignment of benefit and purchased test rules. However, an IDTF is not allowed to bill for surgical procedures that are clearly not related to, or required for a diagnostic test. In some cases, an Ambulatory Surgical Center (ASC) may be performing the surgery. The ASC and the IDTF can be owned by a single entity but must have a separate enrollment and billing number for each.

There has been some confusion over applying the term "independent" in permitting IDTF enrollments. All entities requesting to become IDTFs are considered to be independent unless they are designated as provider based. Entities may be owned wholly or in part by other individuals or entities who are providers or suppliers. The term "independent" is used to distinguish an IDTF from entities who can bill for diagnostic tests but do not have to meet IDTF standards. Examples of these are hospitals, individual physicians, and group practices of physicians.

Site Visits for Mobile Units and Electronic Monitoring Services

For mobile units that cross state/carrier lines, an enrollment is required at each carrier where their patients are located. However, only one site visit to the garaging/docking location of the mobile unit is required. Carriers enrolling a mobile unit that does not have the garage/docking location in their area use the findings/decision of the carrier who made the actual site visit (because the garage/docking unit is in that carrier's area).

For electronic cardiac services, the actual service is often performed at a location different than the patient's location. This is the case even when the monitor is placed on the patient. For example, an electronic cardiac services provider in Florida may perform the service for patients in all states via telephone line or mailed computer disks. In this instance, the electronic cardiac service provider needs to be enrolled and site-visited only in Florida.

Submitting Enrollment Applications: Correction

An article in the November/December 1999 *Medicare B Update!* (page 6) provided incorrect information regarding providers wishing to change their tax identification number. The article incorrectly stated that this type of change could be submitted to Medicare Registration using a HCFA form **855C**. When changing a tax identification number, completion of HCFA Form **855** is *always* required.

Availability of MEDPARD Directory

Medicare's directory of participating physicians, the MEDPARD, will again be available only in an electronic format.

The 2000 MEDPARD will not only be available on the Medicare Online Bulletin Board System (BBS), but will also be on our beneficiary Web site, ***www.medicarefla.com***.

It is expected that the new directory will be available by February 15, 2000.

MEDIGAP/CROSSOVER

Crossover Updates

The following updates have been performed to the Medicare Part B of Florida Crossover Insurers list. These changes may be viewed on the Florida Medicare Online Bulletin Board System (BBS) in the Medigap Crossover Listing section.

For additional information concerning Medicare Part B Crossover, please refer to the September/October 1998 *Medicare B Update!* (pages 42-48).

Automatic Crossover

- New Crossover Insurer

  The following private insurer has been added to our list of Automatic Crossover Insurers:
  BCBS of New Hampshire

- Updates to Crossover Insurers

Health Data Management Corporation (HDM)
Added plans administer for:

Aid Association for Lutherans
American General
Continental General
Gulf Life
Life & Casualty of Tennessee
National Life & Accident
Oxford Life Insurance
Savers Life Insurance
State Farm Insurance
State Mutual
Wakely and Associates

Mutual of Omaha
No longer administers plans for:
Aid Association for Lutherans
Continental General
State Mutual
Wakely and Associates

Medigap Crossover

• Name Change

Number	Former Name	New Name
51001	BCBS of S Dakota	Wellmark BCBS of S Dakota
54007	BCBS of Utah	Regence BCBS of Utah
61002	BCBS Natl Capital Area	CareFirst BCBS
50004	Capital Security	Monumental Life Insurance
48043	Conestoga Life Assurance	Erin Group Administrators
17052	CT ST Teachers Ret Board	Stirling & Stirling
62002	Grp Sales & Serv of PR	United HealthCare of PR
25021	Preferred Risk Life	GuideOne Life Insurance
48081	Protected Life Insurance	Protected Home Mutual

• Address Change

Number	Insurer Name/Address
59013	American Family Insurance 6000 American Parkway Madison WI 59013
48135	American Independent PO Box 190240 Atlanta GA 31119
48014	American Integrity 110 West 7th St #300 Ft Worth TX 76102
20002	Atlantic American Life PO Box 190240 Atlanta GA 31119
53008	Bankers Commercial Life 5720 LBJ Freeway #200 Dallas TX 75240
13005	BCBS of Arizona PO Box 2924 Phoenix AZ 85062
18004	BCBS of Delaware PO Box 1991 Wilmington DE 19899
26012	BCBS of Kansas 1133 Topeka Box 2396 Topeka KS 66629
60001	BCBS of Wyoming PO Box 2266 Cheyenne WY 82003
23149	Benicorp Insurance Co 7702 Woodland Dr Indianapolis IN 46278
23177	Country Life Insurance PO Box 2000 Bloomington IL 61702
48037	Life & Health of America 110 West 7th St #300 Ft Worth TX 76102
43001	Mid South Insurance PO Box 40030 Roanoke VA 24011
53131	National Security Life PO Box 149151 Austin TX 78714
23015	Trustmark Insurance PO Box 7931 Lake Forest IL 60045
19795	United General PO Box 10811 Clearwater FL 33757

Exempt Non-Medigap Insurers

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

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

Number	Insurer Name
33051	Allianz Life Insurance
46019	American Fidelity Assurance
34001	American Public Life
15049	Benefits Plan of N California
19392	Dade County Guardianship
50021	Dayco Products
33056	DRIASI
30020	FELRA UFCW
31054	FELRA UFCW
35011	Fidelity Security Life
19822	Florida Insurance Guarantee
47013	Greater Oregon Health Svcs
61062	Insurance Services
45091	Insured Plans Inc.
27012	Investors Heritage
40071	J M Huber Corporation
15138	MCA PMI
34004	MHA Diversified
17012	Mutual Life
33030	Mutual Service
61019	NAGE Health Benefit
42084	NBA National Benefits
32061	Occidental Life
49012	Ocean State Phy Health Plan
23203	Old Republic Company
15039	Pacific Care
15136	Partners Health Plan
19428	Paul Revere Insurance
31024	Paul Revere Insurance
16010	Pera Aurora Health Plan
24060	Physicians' Health Network
19115	Pilot Life Insurance
42212	Priest Medical Plan
40057	Rutgers Community Health
15101	Secure Horizons
57005	Select Care
23139	Share Member Services
19908	Sherwood Medical
37023	The Mutual Life
45116	Toledo Health Plan
15053	United of Omaha
11119	United of Omaha
48121	United Security Assurance

2000 HCPCS Update—Correction

The update to the HCFA Common Procedure Coding System (HCPCS) for the year 2000 was published in the *2000 Medicare B Update! Special Issue HCPCS and MPFSDB Update* (December 1999). The following procedure code was inadvertently omitted from the list of codes *revised* for 2000:

33223 Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator

EDUCATIONAL RESOURCES

MEDICARE AND THE MILLENNIUM - A NEW DAWNING

MEDIFEST 2000
The Cutting Edge Training Conference

Medifest Symposiums are back by popular demand; however, the Medicare Education and Outreach department will only host three– yes, **three, Medifest Symposiums** this year! Don't be left out of this training extravaganza! Register now – Seating is limited!

- Learn how to integrate efficiency techniques into the workplace
- Find out proven ways to resolve Medicare denials
- Receive coding advice from the experts
- Discover new Medicare technologies and different avenues of education
- Become a top Medicare performer
- Obtain a one-of-a-kind resource document
- Leave with a toolbox of strategies based on successful claim processing techniques

Provider Education and Training (PET) Advisory Council Meetings for Medicare Part A and B Providers
Education – A Team Effort

- Effect change by contributing to the development of user-friendly, high-quality curricula and reference materials
- Partner with Medicare to review and create materials that meet your educational needs
- Network with other providers, members of state medical/hospital associations, and Medicare consultants

Let's Talk With Medicare: Part A Sessions
Providers and Medicare – Working Together to Achieve Results

- Receive information about the latest Medicare regulations – Hot Topics
- Have your questions answered by Medicare experts
- Find out proven ways to resolve Medicare denials
- Meet your Medicare representatives
- Discover new Medicare technologies and different avenues of education
- Make contacts and network with other providers who face some of the same challenges you do
- Obtain tips to avoid claim processing denials and/or RTPs

Let's Talk With Medicare: Part B Sessions
Providers and Medicare – Working Together to Achieve Results

- Receive the latest Medicare News – Hot Topics
- Have your questions answered by Medicare experts
- Find out proven ways to resolve Medicare denials
- Meet your Medicare representatives
- Discover new Medicare technologies and different avenues of education
- Make contacts and network with other providers who face some of the same challenges you do
- Obtain tips to avoid electronic rejects, claim filing denials, and unprocessable claims

Additional Medicare Part A and B Educational Events
Coming Soon to a location near You!

- **Focused Viewpoints —** Customized Seminars to Meet Your Educational Needs
- **Medicare 101 for Part A Providers —** The ABCs of Medicare, Your Building Blocks for Success
- **Medicare 101 for Part B Providers —** The ABCs of Medicare, Your Building Blocks for Success
- **Teleconferences/Video Training —** Education at Your Finger Tips
- **Specialty Seminars —** Everything You Need to Know About Your Specialty

HCFA
Health Care Financing Administration

Medifest 2000 Registration

$199
per person

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

Registration

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

Payment

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

Cancellations and Refunds

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

Substitution

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

Confirmation Number

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

For hotel reservations -ask for the Medicare Medifest rate.
Miami - Radisson Mart Plaza Hotel
(305) 261-3800

St. Petersburg - St Petersburg Hilton
(727) 894-5000

Orlando - Omni Rosen Hotel
(407) 996-9840

Complete the Registration Form (one form per person)

Please Print

Registrant's Name _____

Provider's Name _____

Title/Position _____

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

Address _____

City, State, ZIP code _____

Phone ( ) _____ Fax ( ) _____

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

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

Meeting Dates and Locations

☐ **Miami - March 28 & 29, 2000**
(registration & payment must be received by March 20)
Radisson Mart Center
711 NW 72nd Ave. • Miami, FL • 33126

☐ **Tampa/St. Petersburg - July 11 & 12, 2000**
(registration & payment must be received by July 3)
St. Petersburg Hilton
333 1st Street South • St. Petersburg, FL • 33701

☐ **Orlando - August 8 & 9, 2000**
(registration & payment must be received by July 31)
Orange County Convention Center
9800 International Dr. • Orlando, FL • 32819

FOUR IMPORTANT STEPS

Please follow all four

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

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

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

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4 You must bring your confirmation number with you.

Your class schedule must accompany your registration

Medifest Class Schedule 2000

(A) - Part A Class
(B) - Part B Class
(A/B) - Both Parts A & B

Registrant's name: _____

Please register for only one class per time slot.

Day 1

March 28
July 11
August 8

8:30 - 10:00

01 ☐ General Session (A/B)
Participants are encouraged to attend this session.
Topics to be discussed include:
- Medifest registration packet
- Incident to
- Advanced Beneficiary Notice
- ARNP/PA services
- Latest program changes

10:30 - 12:00

02 ☐ E/M Documentation (A/B)
03 ☐ Global Surgery (B)
04 ☐ Primary Care (B)
05 ☐ Medicare Part C (A/B)
06 ☐ Inquiries, Appeals and Overpayment (B)
07 ☐ Partial Hospitalization Program (A)
08 ☐ Reimbursement Efficiency for Part A Providers (A)
09 ☐ PC-ACE™ for HCFA-1500 Claims Filing (B)
10 ☐ Direct Data Entry (A)

1:30 - 3:00

11 ☐ Reimbursement Efficiency for Part B Providers (B)
12 ☐ Fraud and Abuse (A/B)
13 ☐ Medical Review (A/B)
14 ☐ PC-ACE™ for UB-92 Claims Filing (A)
15 ☐ Direct Data Entry (A)

1:30 - 5:00*

16 ☐ HCFA-1500 Claims Filing (B)
17 ☐ E/M Documentation & Coding (B)
18 ☐ CPT Coding for Beginners (B)
19 ☐ ICD-9 for Beginners (B)

3:30 - 5:00

20 ☐ Reimbursement Efficiency for Part B Providers (B)
21 ☐ Fraud and Abuse (A/B)
22 ☐ Inquiries, Appeals and Overpayment (B)
23 ☐ Medicaid (A/B)
24 ☐ Electronic Media Claims (B)

Day 2

March 29
July 12
August 9

8:30 - 10:00

25 ☐ Global Surgery (B)
26 ☐ Primary Care (B)
27 ☐ Reimbursement Efficiency for Part B Providers (B)
28 ☐ Fraud and Abuse (A/B)
29 ☐ Medicaid (A/B)

8:30 - 12:00*

30 ☐ HCFA-1500 Claims Filing (B)
31 ☐ ICD-9-CM for Beginners (A/B)
32 ☐ UB-92 Claims Filing (A)

10:30 - 12:00

33 ☐ Global Surgery (B)
34 ☐ Reimbursement Efficiency for Part B Providers (B)
35 ☐ Medical Review (A/B)
36 ☐ Fraud and Abuse (A/B)
37 ☐ How to Help Your Patients Understand Medicare (A/B)
38 ☐ Electronic Media Claims (B)

1:30 - 3:00

39 ☐ Inquiries, Appeals and Overpayment (B)
40 ☐ Medicare Part C (A/B)
41 ☐ Medicare Secondary Payer (B)
42 ☐ CORF/ORF (A)
43 ☐ Inpatient/Outpatient PPS (A)
44 ☐ Electronic Media Claims (B)

1:30 - 5:00*

45 ☐ E/M Documentation & Coding
46 ☐ CPT Coding for Beginners (B)

3:30 - 5:00

47 ☐ Inquiries, Appeals and Overpayment (B)
48 ☐ Medicare Part C (A/B)
49 ☐ Reimbursement Efficiency for Part A Providers (A)
50 ☐ Skilled Nursing Facilities (A)
51 ☐ How to Help Your Patients Understand Medicare (A/B)

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

Please Note: The Medifest price is not a class or day charge but is $199 per person.
Please see substitution policy if you are unable to attend this event once you have registered.

MEDIFEST COURSE DESCRIPTIONS

Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Facilities (ORF)

Audience: Part A CORF and ORF medical coding and billing personnel, as well as other rehabilitation professionals.

Description: The course considers HCFA and local medical policy guidelines on Medicare benefits relating to CORF/ORF providers and services; reimbursement guidelines and payment limitations; key HCFA-1450 (UB-92) form locators and billing elements; and the Prospective Payment System as it applies to CORF/ORF providers.

CPT-4 Coding

Audience: *New* Part A and Part B medical coding and billing personnel.

Description: This course provides the beginning coder with techniques to perform concise and accurate coding, including (1) a step-by-step review of the format and contents of the CPT book (e.g., overview/ history of CPT, appendixes, alphabetical index, cross reference tools), and (2) practical application relating to identifying additions/deletions/revisions and appropriate procedure codes. Participants must bring the latest edition of the CPT manual to the session.

Direct Data Entry (DDE)

Audience: Part A billing personnel.

Description: This course introduces and demonstrates the First Coast Service Options (FCSO) Medicare Part A Direct Data Entry (DDE) system, including claims entry, claims correction, online adjustments, inquiry functions, and online claims status.

Electronic Media Claims

Audience: New and experienced Part B office staff who send electronic claims.

Description: This course considers reports that providers receive from Medicare Part B (e.g., confirmation messages, front-end edits, and reject letters) that help them monitor the status of claims submitted; the various electronic applications available to help improve office efficiency; requirements for each application; and who to contact to gain access to these applications.

Evaluation and Management (E/M) Coding and Documentation

Audience: Part B physicians, medical coders, and office managers.

Description: This course presents comprehensive instructions based on the latest Medicare guidelines for selecting and documenting the appropriate level of E/M code for office, hospital, home, and nursing home visits; guidelines for concurrent care situations, hospital observations, and care oversight; and practical application of instructions and guidelines, using a sample medical record. Note: A separate session on E/M Documentation *only* will also be offered.

Fraud and Abuse

Audience: New and experienced Part A and Part B office administrators, medical staff and billing/coding personnel.

Description: This course considers government legislation relating to fraud and abuse; what constitutes Medicare fraud and abuse; penalties associated with fraud and abuse; and proactive measures providers can take to protect their organization from possible fraudulent activities.

Global Surgery

Audience: Part B medical coding and billing personnel.

Description: This course considers the Global Surgery concept; the correct use of modifiers for visits and other procedures during the global period; other frequently used common modifiers; and the billing/ reimbursement for specific surgical situations (e.g., multiple surgery, bilateral surgery, secondary procedures, split care, site of service reductions, co-surgery, surgical assistant, surgery team, Physician Assistants that assist at surgery).

HCFA-1500 Claims Filing

Audience: New and experienced Part B billing personnel.

Description: This course provides background of the HCFA-1500 claims form, rules for mandatory claims submission, how to avoid claim denials, how to read the Medicare Summary Notice, and comprehensive instructions for completing the HCFA-1500.

How to Help Your Patients Understand Medicare

Audience: Primarily those who work directly with Medicare patients, but beneficial to any Part A and Part B provider staff.

Description: This course provides information on how to assist people on Medicare to understand fee-for-service and managed care, preventive benefits, eligibility, enrollment/disenrollment, benefit guidelines, agencies/resources available for patient referral, and other current Medicare and health care issues.

ICD-9-CM Coding

Audience: New Part A and Part B medical coding and billing personnel.

Description: This course provides an introduction to the International Classification of Diseases, (9th Revision), Clinical Modification (ICD-9-CM) manual, including a brief overview of Volume III coding for Part A providers; a lengthy discussion of Volumes I and II; practical application of coding to the "highest level of specificity"; claim completion requirements for reporting diagnoses; and the importance of diagnosis coding as it relates to medical documentation. Participants must bring their ICD-9-CM manual.

Inpatient/Outpatient Prospective Payment System

Audience: Part A office managers and medical coding/ billing personnel.

Description: This course presents a review of the Prospective Payment System (PPS); and considers HCFA's implementation of PPS for hospital outpatient services; changes to beneficiary coinsurance determination for services under PPS; and the use of HCFA's Common Procedure Coding System (HCPCS) for reporting outpatient services on the HCFA-1450 (UB-92) claim form.

Inquiries, Appeals, and Overpayments

Audience: New and experienced Part B billing personnel.

Description: This course considers who to contact to resolve issues relating to claims; the steps necessary to request a review; the four levels of the appeals process; and how to detect and refund overpayments.

Medical Review

Audience: Medicare Part A and Part B providers and their office/billing staff.

Description: This course considers the medical review process from both the Carrier and Fiscal Intermediary viewpoints, including the benefits of the review process; how providers participate in the process; and how providers can decrease the level and number of reviews.

Medicare Secondary Payer

Audience: Medicare Part A and Part B providers, billing staff, and suppliers who submit claims to Medicare Secondary Payer.

Description: This course provides an introduction to the many situations where Medicare will pay only as secondary insurer; a review of regulations regarding "no-fault" (or cases where a liability insurer is involved); rules around the working aged and disabled Medicare patients; special processing for End Stage Renal Disease (ESRD); and Medicare's methodology for MSP calculation of payment and proper method for MSP claim filing.

Medicare Part C

Audience: Medicare Part A and B providers and billing staff.

Description: This course (1) provides an overview of new Medicare Part C plan options; coverage election policies; and plan/provider relationship issues (e.g., inclusion in medical policy development); and (2) includes a discussion of provider compensation guidelines for each type of Medicare Part C plan.

Partial Hospitalization Program

Audience: Part A providers and facilities involved in the delivery of Partial Hospitalization services to Medicare beneficiaries, as well as billing personnel for Partial Hospitalization Programs.

Description: This course provides an introduction to the partial hospitalization benefit under Medicare, including coverage and billing issues; information on the history of partial hospitalization; when and for whom this benefit is intended; the difference between appropriate and inappropriate utilization of this benefit; and the Prospective Payment System as it applies to PHP.

PC-ACE® for HCFA-1500 Claim Filing

Audience: Part B individuals who currently use or are considering using Blue Cross and Blue Shield of Florida's software package to submit HCFA-1500 claims.

Description: This course includes an overview of PC-ACE® HCFA-1500 software features; hardware/software requirements; the ease of patient and claim entry; claim flow through PC-ACE® ; recent and future enhancements; a live demonstration; and a question/answer session.

PC-ACE® for UB-92 Claim Filing

Audience: Part A individuals who currently use or are considering using Blue Cross and Blue Shield of Florida's software package to submit HCFA-1450 (UB-92) claims.

Description: This course includes an overview of PC-ACE® HCFA-1450 (UB-92) software features; hardware/software requirements; the ease of patient and claim entry; claim flow through PC-ACE® ; recent and future enhancements; a live demonstration; and a question/answer session.

Primary Care

Audience: Part B physicians, billers, and coders who bill primary care services to the Medicare program.

Description: This course considers procedures applicable to primary care practitioners, with an emphasis on preventive services, laboratory and pathology services, programs changes, and ways to avoid common claim denials.

Reimbursement Efficiency for Part A Providers

Audience: Office personnel responsible for the day-to-day operations of a Medicare Part A facility.

Description: This course presents some of the tools utilized to enhance office efficiency and considers key Medicare Part A reports that can help providers reduce their claim return rate.

Reimbursement Efficiency for Part B Providers

Audience: Part B providers and billing staff.

Description: This course (1) recommends efficient ways to partner with the Medicare Carrier (e.g. send/track/edit/receive payment for claims); (2) considers how to analyze the effectiveness of current billing practice by reviewing practice-specific MED 598 reports (three-month claim submission history); and (3) identifies the most frequent claim filing errors and ways to avoid them. Participants must indicate their provider/group billing number at time of initial registration to ensure availability of MED 598 reports.

Skilled Nursing Facility

Audience: Part A Skilled Nursing Facility providers, as well as vendors providing ancillary services to skilled nursing facility residents.

Description: This course considers the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Final Rules, with an emphasis on Consolidated Billing from both the SNF perspective as well as the outside vendor; clinical criteria required for the Minimum Data Set Assessment (MDS); and key UB-92 form locators and billing elements.

UB-92 Claims Filing

Audience: *New* Part A medical coding and billing personnel.

Description: This course includes a detailed review of the HCFA-1450 (UB-92) claim form; billing requirements; and how to apply the proper codes to the UB-92 claim for specific types of facility and Medicare entry requirements.

MEDICARE EDUCATION AND OUTREACH NEEDS YOUR HELP!!

You are cordially invited to attend a **Medicare Part A and Part B Provider Education and Training (PET) Advisory Meeting**.

PLEASE NOTE: ***THESE SESSIONS ARE NOT TRAINING SEMINARS.***

First Coast Service Options, Inc., is excited about receiving your input. With the help of providers like you, we have proven that partnership works. Providers input and feedback have been very instrumental in helping us make operational improvements.

Some examples:

- Improvements to our *Medicare A Bulletin* or *Medicare B Update!*
- Enhancements to our customer service automated response unit (ARU)
- The development of new Medicare educational courses

HOW TO PREPARE FOR THE MEETING

1. Upon registration you will receive course curriculum to review.
2. Write down three ideas for improving, changing and/or enhancing each of the courses.
3. Write down any general improvements, course additions, or course deletions.
4. Submit a copy of your ideas when you arrive at the meeting.
5. Be prepared to discuss your ideas during the curricula review session.
6. Select one session from the breakout groups listed below that you will attend on the day of the meeting.

To thank you for your participation, three lucky winners will receive a FREE Medifest 2000 tuition voucher. To be eligible for the drawing, bring three ***written*** ideas for any of the courses and submit them upon arrival.

Please select one group of interest from the groups listed below

Group 1: Medicare Part A and B Topics	Group 2: Medicare Part B Topics
Included in this group would be topics such as: • **Inpatient/ Outpatient Prospective Payment System** • **Ambulance** • **Rural Health Clinics** • **Home Health Services** • **End Stage Renal Disease/Nephrology** • **Partial Hospital Programs/Mental Health** • **CORF/ORF Services/ Physical Therapy/Occupational Therapy** • **Federal Register Rules** • **Revenue/Line Item Billing Guidelines**	**Included in this group would be topics such as:** • **Chiropractic Services** • **Radiology** • **Ophthalmology** • **Oncology** • **Pathology** • **ARNP/PA Services** • **Podiatry** • **Federal Register Rules** • **Anesthesia**

Please COME and spend an exciting half-day with us. You will not be disappointed! Your input, feedback, and partnership are vital to the success of this meeting!!

Register TODAY! Seating is limited.

To register, use the registration form on the following page.

FOR MORE INFORMATION CALL (904) 791-8299

REGISTRATION FORM FOR QUARTERLY MEDICARE PART A and PART B PROVIDER EDUCATION AND TRAINING ADVISORY MEETING

(PLEASE NOTE: This event is not a training seminar)

HOW TO PREPARE FOR THE MEETING!

1. Review the Medicare course curriculum.
2. Write down three ideas for improving, changing and/or enhancing each of the courses.
3. Write down any general improvements, course additions, or course deletions.
4. Submit a copy of your ideas when you arrive at the meeting.
5. Be prepared to discuss your ideas during the curricula review session.
6. Select one session from the breakout groups that you will attend on the day of the meeting and write in the space below.

Please complete one form per person

Registrant's Name:_____

Registrant's Title/Position:_____

Provider's Name:_____

Specialty Association Name:_____

Medicare Billing Provider Number:_____

Address:_____

City, State, Zip Code:_____

Phone: ( )_____ Fax: ( )_____

List Choice of one group:
Group 1: Medicare Part A and B Topics ☐ **OR Group 2: Medicare Part B Topics** ☐

Cost: FREE!!

Please fax your registration form to (904) 791-6035

Location: First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, FL 32202

Directions to our building will be faxed with your confirmation

Time: 8:30 a.m. - 12:30 a.m.
✓Check one of the following dates.

- ☐ **February 18, 2000**
- ☐ **June 23, 2000**
- ☐ **September 27, 2000**

Please RSVP 10 days prior to the event

"Let's Talk With Medicare: " Part A Session

MEDICARE PART A PROVIDERS

Would You Like to Discuss Billing and/or Program Issues With Your Medicare Part A Representatives?

First Coast Service Options, Inc., is offering you the opportunity to discuss your questions or concerns (face-to-face) with representatives from the many departments within Medicare. Help us help you! We are excited about the opportunity to meet you and address/resolve your inquiries. Register for one of Medicare's "Let's Talk" Sessions.

To help us address your questions and/or concerns, we need them **ten (10) days prior to the event** . Please complete this survey and fax it to:
Medicare Education and Outreach at (904) 791-6035

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.
Claims Submission *(e.g., claim filing, return to provider reason codes, denial reason codes)*

Direct Data Entry *(e.g., screens, field values, navigation, onilne reports)*

Medicare Part A Reports *(e.g., consolidated provider profile report, 201 report)*

Medical Policy *(e.g., medical review process, additional development correspondence)*

Questions Concerning Your Specialty *(e.g., Skilled Nursing Facility, End Stage Renal Disease, etc.)*

Other

"Let's Talk With Medicare: Part A Session"

FOUR IMPORTANT STEPS

Four Easy Steps to Register:

STEP 1: FAX registration form to (904)791-6035.

STEP 2: Make checks payable to:
First Coast Service Options(FCSO)
Account #756240. $49 per person.

STEP 3: Mail this form and your payment to:
Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4: Directions to the facility and a confirmation number will be faxed within 10 days of receiving your registration.
Please bring this with you the day of the event. If you do not receive a confirmation number, please call (904) 791-8299

All cancellation requests must be received seven days prior to the seminar to be eligible for a refund. *All refunds are subject to a $20.00 administrative fee, per person.*

Only $49.00 per person!

MEDICARE PART A PROVIDER - REGISTRATION FORM

Registrant's Name: _____

Registrant's Title/Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Please select one of the following dates.

Time: 8:30 a.m. - 12:00 p.m.

☐ **March 17, 2000** **$49 per person**
☐ **May 19, 2000**
☐ **July 28, 2000**

Location: FCSO/Blue Cross Blue Shield of FL
532 Riverside Ave.
Jacksonville, FL 32202

"Let's Talk With Medicare: " Part B Session

MEDICARE PART B PROVIDERS

Would You Like to Discuss Billing and/or Program Issues With Your Medicare Part B Representatives?

First Coast Service Options, Inc., is offering you the opportunity to discuss your questions or concerns (face-to-face) with representatives from the many departments within Medicare. Help us help you! We are excited about the opportunity to meet you and address/resolve your inquiries. Register for one of Medicare's "Let's Talk" Sessions.

To help us address your questions and/or concerns, we need them **ten (10) days prior to the event** . Please complete this survey and fax it to:
Medicare Education and Outreach at (904) 791-6035

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.
Claims Submission *(e.g., claim filing questions, unprocessible claims, denials, etc.)*

Electronic Claims Submission *(e.g., electronic funds transfer, mailbox questions, PC-ACE™, etc.)*

Inquiries, Appeals and Overpayments: *(e.g., questions about reviews, customer service, returning money to Medicare, etc.)*

Medical Policy/Review: *(e.g., medical review process, utilization denials, etc.)*

Questions Concerning Your Specialty *(e.g., chiropractic, radiology, pathology, etc.)*

Other

"Let's Talk With Medicare: Part B Session"

FOUR IMPORTANT STEPS	MEDICARE PART B PROVIDER - REGISTRATION FORM

Four Easy Steps to Register:

STEP 1: FAX registration form to (904)791-6035.

STEP 2: Make checks payable to:
First Coast Service Options(FCSO)
Account #756240. $49 per person.

STEP 3: Mail this form and your payment to:
Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 4: Directions to the facility and a confirmation number will be faxed within 10 days of receiving your registration. Please bring this with you the day of the event. If you do not receive a confirmation number, please call (904) 791-8299

All cancellation requests must be received seven days prior to the seminar to be eligible for a refund. *All refunds are subject to a $20.00 administrative fee, per person.*

Only $49.00 per person!

Registrant's Name: _____

Registrant's Title/ Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Please select one of the following dates.

Time: 1:00 p.m. - 4:30 p.m.

☐ March 17, 2000 **$49 per person**
☐ May 19, 2000
☐ July 28, 2000

Location: FCSO/Blue Cross Blue Shield of FL
532 Riverside Ave.
Jacksonville, FL 32202

Medicare Offers FREE National Education Programs

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

Medicare Computer Based Training

Computer Based Training Courses via the Internet

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

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

Here's How it Works:

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

CBT System Requirements:

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

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

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

Courses via Satellite Broadcast

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

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

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

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

The Medicare Resident Training Program
Available on Videotape from the September 1999 National Satellite Broadcast

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

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

Coming Soon - Medicare Provider Web Site

A new Web site for Medicare providers serviced by First Coast Service Options, Inc., will be operational by December 31, 1999. The address for this site is ***www.floridamedicare.com***.

Information will be limited at first, however, FCSO plans to expand the site content to include all information that is currently available on the Medicare Online Bulletin Board System (BBS).

Most of the files on the site will be in PDF (Portable Document Format). Providers who want to view files on the site will need to have Adobe® Systems, Inc., Acrobat® Reader on their PCs. Acrobat® Reader is **free** software that can be downloaded from Adobe's Web site at ***www.adobe.com***.

Look for more information about this site in upcoming issues of the *Update!*

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

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

What is Medicare Online BBS?

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

Using HyperTerminal

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

Step 1: Accessing HyperTerminal

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

Step 2: Setup Wizard

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

Step 3: Connection Description

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

Step 4: Phone Number

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

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

Users within Jacksonville, FL, area
791-6991

Step 5: Dialing Properties

The setup wizard allows you to revise dialing properties to make your connection. Click on Dialing Properties. Revise settings appropriately under "How I dial from this location": how your location accesses an outside line (e.g., "9" for an outside line), long distance access (e.g., "1" for long distance), and disabling call waiting (click on selections available and choose appropriately: e.g., "*70"). When complete, click OK.

Step 6: Connect

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

Step 7: Signing On To Medicare Online BBS

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

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

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

FREE Windows-Based Communications Software

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

ORDER FORM - PART B MATERIALS FOR 2000

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

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Update!*** **Subscription** - For non-provider entities or providers who need additional copies at other office locations, an annual subscription is available. This subscription includes all issues published during calendar year 2000 (back issues sent upon receipt of order).	756245	$75.00
_____	**2000 Fee Schedule** - Contains calendar year 2000 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2000. These items include the payment rates for injectable drugs, but *do not* include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!*	756250	$20.00
_____	**Procedure/Diagnosis Relationship File** - This is a listing of the most current file used during claims processing to determine coverage for procedures subject to specific diagnosis criteria. This document is designed to assist providers by outlining coverage criteria in order to limit their financial liability for these procedures. Available in single issues or an annual subscription that includes quarterly updates.	756245	Annual (4 issues) $60.00 Single Issue $20.00

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 45280
Jacksonville, FL 32232-5280

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please make check/money order payable to: BCBSFL- FCSO Account # (fill in from above)

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID -
DO NOT FAX - PLEASE PRINT

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

G

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M

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

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X

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

Y

Modifiers

Procedure Codes

HCPCS Codes

Anesthesia/Surgery, 00100-69979

Diagnostic Tests, 70010-89399

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

Medicine, 90281-99199

Evaluation and Management, 99201-99499

* Special *Updates!*

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

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

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

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

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

COMMUNICATIONS

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

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

Administrative Law Judge 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

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Education and Outreach
P. O. Box 2078
Jacksonville, FL 32231-0048

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

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

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

PHONE NUMBERS

BENEFICIARY

Outside Duval County (in Florida):
(800) 333-7586
Duval County (or outside Florida):
(904) 355-3680
Hearing Impaired:
(800) 754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this service by providers is not permitted and may be considered program abuse.

PROVIDERS

Express Line/ARU Status Inquiries:
(904) 353-3205
Specialty Customer Service Reps:
(904) 634-4994

EMC

Format Issues & Testing:
(904) 354-5977
Start-Up & Front-End Edits/Rejects:
(904) 791-8767
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Help Desk
(Confirmation/Transmission):
(904) 791-9880

OCR

Printer Specifications/Test Claims:
(904) 791-8132

MEDICARE ONLINE BBS

Access:
(800) 838-8859
(904) 791-6991
Technical Problems:
(904)791-8384

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
(803) 735-1034

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

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*** ATTENTION BILLING MANAGER***