

Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

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

Routing Suggestions:

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

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A PHYSICIAN'S FOCUS

Announcing the Appointment of Our New Intermediary Medical Director

In this issue's "A Physician's Focus," I am pleased to announce the appointment of our new Intermediary Medical Director, James J. Corcoran, Jr., M.D., M.P.H.

Jim Corcoran started with First Coast Service Options, Inc. on December 1, 1999, as Intermediary Medical Director (Medicare Part A of Florida). Dr. Corcoran will concentrate on the Intermediary Medical Director responsibilities, while I will continue to concentrate on the Carrier Medical Director (Medicare Part B of Florida) responsibilities. In this column, I would like to provide you with the highlights of Dr. Corcoran's credentials and professional accomplishments.

Dr. Corcoran was born in Ithaca, New York, and raised in Pennsylvania. He received his undergraduate degree from Harvard College and his medical degree from Pennsylvania State University. After an internship in the Boston area, Dr. Corcoran headed south to pursue his residency training in Internal Medicine in Augusta, Georgia. Dr. Corcoran settled in South Carolina and enjoyed private practice in Greenville for seven years. His practice included working with hospital systems as a provider of patient care and an active member of medical staffs. The emergence of electronic networks and the potential new uses of information in health care prompted his interest in obtaining additional education and experiences in management and health care policy. At the Johns Hopkins University School of Public Health, Dr. Corcoran received a Master of Public Health degree in 1995 and completed the Preventive Medicine Residency training program in 1996.

Dr. Corcoran joined the Health Care Services Division of Blue Cross Blue Shield of Florida as an Associate Medical Director in July 1996 and was advanced to a Corporate Medical Director in July 1997. His responsibilities included technology assessment and medical policy. Dr. Corcoran is board certified in Internal Medicine (September 1985) and in Public Health and General Preventive Medicine (January 1998).

I am excited about the opportunity to work closely with Dr. Corcoran in the Medicare program that, in many areas, is the benchmark in health care. We look forward to building relationships with our intermediary and carrier providers. Together, we can improve health care systems by increasing the understanding of how the organization and administration of care affect access, quality, and cost.

Sincerely,

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



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 69), or download the text version from our on-line service, the Medicare Online BBS (see page 67 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," that 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 include: "General Information," other information for Medicare Part B providers including Fraud and Abuse issues; and "Educational Resources" that includes Medifast 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.

Medicare Contractors Applying Deductible, Co-Insurance and Payment Updates Beginning January 10, 2000

The following list of questions and answers was provided by the Health Care Financing Administration (HCFA), for contractors to use in answering inquiries received due to the delayed implementation of the Year 2000 updates (see the Medicare B Update! Special Issue dated September 13, 1999). It is being published here as a convenience to our readers.

Q1 What kind of updates will contractors be applying to Medicare Part B payments?
A1 HCFA had instructed all contractors to make Part B provider/supplier payment updates and other January annual updates (including the Part A deductible and co-insurance changes) on January 17, 2000, rather than on January 1, when the updates are usually applied. The reason for this delay was to reduce the risk of systems problems impacting the Year 2000 rollover. Medicare contractors were instructed to hold all claims with dates of service of January 1, 2000 or later in order to correctly apply the Year 2000 payment update and other annual updates, including any changes in beneficiary coinsurance and deductibles. The updates will be applied to all claims for services provided on or after January 1.

Q2 Why did HCFA initially instruct Medicare contractors to delay making the updates and to hold Year 2000 claims until January 17, 2000, and then, in late December, notify contractors they could make the update earlier, on January 10?

A2 When HCFA initially decided to update pricing and the deductibles and co-payment for Year 2000 claims on January 17, we were extremely concerned about fallout from Y2K millennium rollover problems. However, as our confidence increased from the success of our extensive testing, other issues caused us to modify the instructions. Some contractors had concerns that an operational backlog could result from a 2-week "hold" on claims for claims with a Year 2000 date of service. While the volume of claim receipts for Year 2000 dates of service was likely to be relatively light during the first week of 2000, the volume was expected to increase significantly beginning with the second week of January, mainly at Part B carriers. Moving the Year 2000 production start date to January 10 would result in smaller, more manageable inventories of held claims and would reduce the associated risks. Also, the earlier implementation date would also expedite the detection and correction of any Year 2000 "date of service" claims processing problems that may be encountered.

After careful consideration, HCFA decided to offer contractors the choice of updating on January 10 or 17, as long as their rollover into the first week of the Year 2000 was successful and their choice was approved by HCFA.

Q3 Are all contractors making the update on January 10?

A3 HCFA gave the contractors the option to choose which date to apply the updates, as long as they obtained final approval from HCFA during the first week in January after HCFA could assess the success of the contractor's Day One rollover operations. The Common Working File (CWF) host sites, however, were required to use the January 10 date for implementing the Year 2000 update release, since all claims must be sent to the CWF hosts for pre-payment authorization and validation. The CWF system assures that the beneficiary is (1) entitled to either or both Part A and Part B benefits; (2) that the deductible applied, if any, is accurate; and (3) that the benefits on the claim are available.

Most contractors chose the January 10 option and their choice was approved by HCFA based on the contractor's successful rollover operations. A smaller number of contractors chose the January 17 date to complete further testing of the software release.

NOTE: Florida Medicare chose the January 10 implementation date.

Q4 Why are some contractors able to do update pricing, etc., on January 10, while others cannot update until January 17?

A4 HCFA provided discretion to the contractors as to whether to update on the 10th or 17th of January. Contractors updating on January 17 are *not* experiencing any Y2K problems; these contractors are running more tests of the pricing update to make absolutely certain there are no problems.

Since claims must be held by law a minimum of 14 days before payment, providers should experience little or no difference in the timing of payments made to them by contractors who are running the pricing update in their Data Centers on January 17 versus those running the update on January 10.

Q5 Will the holding of Year 2000 claims until January 17 delay payments to providers?

A5 No, this should not change the timing of payment to providers. 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. When Year 2000 claims are released for processing on January 10 or 17, claims are expected to be finalized for payment very quickly. We do not believe the delay poses a burden to providers.

- Providers were able to start sending in claims for Year 2000 services beginning January 1, and should not experience a delay in payment.
- Q6** Will there be interest payments made on the money owed during this period?
- A6** As always, interest will be paid on any “clean claims” that are held more than 30 days after receipt before payment is made. No claims for service dates held until January 17 will qualify for interest unless they are not paid until after 30 days from receipt.
- Q7** If a provider submitted a claim early in January for a Year 2000 service date, do they have to wait until after January 10 or 17 before knowing whether the contractor accepted these claims?
- A7** Contractors put these claims through their front-end edits and providers receive an acknowledgment report or a rejection report. Providers should check with their Medicare contractor for specific procedures.
- Q8** If providers have questions about the payment update and possible effects the delay might have on them, or if providers believe their payments are not updated timely, who should they contact?
- A8** All providers with questions about the timing of the payment update by their contractor or the payment amounts they are receiving should contact their Medicare contractor for assistance.
- Questions for Florida Medicare may be directed to our customer service area at (904)634-4994.*
- 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.*

Use of GA Modifier: Waiver of Liability

When services are submitted to Medicare for which payment may be denied or reduced as not medically reasonable or necessary, the provider should notify the patient in advance that payment for the service could be denied or reduced. This notification serves as protection for both the provider and the beneficiary. Advance notice should only be given to the patient when the provider has genuine reason to believe that Medicare is likely to deny payment for a specific service based on the reason(s) indicated on the notice. ***It is unacceptable to give notices for all claims or services.*** This includes “blanket” advance notice statements, such as “I agree to pay for whatever Medicare denies,” or similar language.

When a patient is notified in advance that payment for a service may be denied or reduced as not reasonable or necessary, the provider must indicate that advance notice was given using modifier GA.

GA Waiver of liability statement on file

When submitting a claim to Medicare using the GA modifier, it is not necessary to submit a copy of the advance notice form. However, the signed acceptable advance notice form ***must*** be maintained in the patient’s records.

For more information regarding waiver of liability and Medicare’s advance notice requirements, refer to page 4.

CLAIMS

Additional Development Request: "Procedure-to-Place of Service Inconsistent"

Additional Development Requests (ADRs) cost Medicare and providers both time and money. Medicare incurs costs for producing and mailing ADRs; providers spend money on postage to respond, not to mention delays in getting claims paid while Medicare waits for a response. In cases where replies are untimely, claims are denied, resulting in an increase in review requests.

The most frequent ADR question asked by Florida Medicare is the one pertaining to conflicting place of service/procedure information. It reads, "the procedure submitted does not correspond with the place of service indicated on your claim. Please clarify the procedure/

service(s) performed and provide the name and address of the facility where services were rendered (if hospital, indicate in- or outpatient) for services rendered on [date] for [submitted charge]."

Effective for claims received on or after April 1, 2000, Florida Medicare will no longer develop for this information on assigned claims. If the place of service is valid but inconsistent or incompatible with the procedure code billed (e.g., the place of service is inpatient hospital and the procedure code billed is an office visit), these services will be returned as unprocessable. Unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted.

Critical Care Policies—Clarification

Medicare's policies regarding physician billing for evaluation and management (E/M) services, including critical care services, were published in the November/December 1999 Medicare B Update! (pages 10-12). This article clarifies a number of issues related to the interpretation, reporting, and payment of the American Medical Association's (AMA) Current Procedural Terminology (CPT) critical care codes 99291 and 99292. The clarifications pertain mainly to the changes in critical care definitions in the CPT 2000. Several policies in this article are already in effect and are mentioned here again.

Use of Critical Care Codes 99291 and 99292

Definition of Critical Illness or Injury

The AMA's CPT has redefined a critical illness or injury as:

"A critical illness or injury acutely impairs one or more vital organ systems such that the patient's survival is jeopardized."

Please note that the term "unstable" is no longer used in the CPT definition to describe critically ill or injured patients.

Definition of Critical Care Services

CPT 2000 has redefined critical care services as follows:

"Critical care is the direct delivery by a physician(s) of medical care for a critically ill or injured patient.... The care of such patients involves decision making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vital system functions to treat single or multiple vital organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and the application of advanced technology to manage the patient. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above."

"Critical care services include, but are not limited to, the treatment or prevention or further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post-operative complications, or overwhelming infection. Critical care is usually, but not always, given in a critical care area, such as the coronary

care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility."

Guidelines for Medical Review of Critical Illness and Critical Care Service

A clarification of Medicare policy concerning both payment for and medical review of critical care services is warranted, given the CPT redefinition of both critical illness/injury and critical care services.

In order to reliably and consistently determine that delivery of critical care services rather than other evaluation and management services is medically necessary, both of the following medical review criteria must be met in addition to the CPT definitions:

Clinical Condition Criterion. There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently.

Treatment Criterion. Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

Claims for critical care services may be denied if the services are not reasonable and medically necessary. If the services are reasonable and medically necessary but they do not meet the criteria for critical care services, then the services will be re-coded as another appropriate E/M service (e.g., hospital visit).

Providing medical care to a critically ill patient should not be automatically determined to be a critical care service for the sole reason that the patient is critically ill. The physician service must be medically necessary and meet the definition of critical care services as described previously in order to be considered covered.

Example: *A dermatologist treating a rash on an ICU patient who is maintained on a ventilator and nitroglycerine drip that are being managed by an intensivist should not bill for critical care.*

When an entry in a patient's medical record indicates that a result or finding from a single test or procedure is "within normal limits," or indicates improvement in response to therapy, Medicare looks for other indications in the medical record supplied by the provider that all criteria (i.e., the CPT definition and medical review criteria) indicate that medical necessity and coverage are met. A patient with a designated status of "do not resuscitate" (e.g., organ donor) may qualify for critical care services when medical review criteria are met.

In summary, these criteria are consistent with the new CPT definitions of critical illness/injury and critical care services. Application of these criteria is intended to ensure:

- Appropriate billing for critical care services;
- Reliable and consistent medical review of medical records documenting provision of critical care services; and
- Correct payment for critical care and other evaluation and management services.

"Full Attention" Requirement For Critical Care Service

CPT 2000 eliminated the requirement for "constant attention" as a prerequisite for use of critical care codes. The new language states: "The CPT critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time."

Reporting of Physician Time Toward Critical Care Time

CPT 2000 made several changes in what activities may be counted towards critical care time. CPT 2000 states the following: "Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a

medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the medical decision making."

"Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss other patients)."

To ensure proper billing of critical care, the amount of time spent by the physician (in accordance with the statements above) must be documented in the patient's record.

Medical Review Guidelines Regarding "Full Attention" and Physician Time in Critical Care Services.

- The deletion of the requirement for "constant attention" is editorial; that is, the intent of the "full attention" requirement is the same as the "constant attention" requirement.
- Since critical care is a time-based code, the physician's progress notes must contain documentation of the total time involved providing critical care services. If the time is not legibly and unequivocally documented the claim will be subject to re-coding or denial.
- Time involved performing procedures that are not bundled into critical care (i.e., billed separately) may not be included and counted toward critical care time. The physician's progress notes must document that time involved in the performance of separately billable procedures was not counted toward critical care time.
- Time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT 2000), may be counted toward critical care time only when
 - (a) the patient is unable or incompetent to participate in giving a history and/or making treatment decisions,
 - (b) the discussion is absolutely necessary for treatment decisions under consideration that day, and
 - (c) all of the following are documented in the physician's progress note for that day:
 - (i) the patient was unable or incompetent to participate in giving history and/or making treatment decisions, as appropriate,
 - (ii) the necessity of the discussion (e.g., no other source was available to obtain a history or because the patient was deteriorating so rapidly the physician needed to discuss treatment options with family immediately),
 - (iii) the treatment decisions for which the discussion was needed, and
 - (iv) the substance of the discussion as related to the treatment decision.

The policy emphasizes that the physician's progress notes must link the family discussion to a specific treatment issue and explain why the discussion was necessary on that day.

All other family discussions, no matter how lengthy, may not be counted towards critical care time. Examples of family discussions which do not meet the appropriate criteria include regular or periodic updates of the patient's condition, emotional support for the family, and answering questions regarding the patient's condition (only questions related to decision-making regarding treatment, as described above, may be counted toward critical care).

Telephone calls to family members and surrogate decision-makers must meet the same conditions as face-to-face meetings.

- Time involved in activities that do not directly contribute to the treatment of the patient, and therefore may not be counted towards critical care time, include teaching sessions with residents whether conducted on rounds or in other venues.

Non Critically Ill or Injured Patients in a Critical Care Unit

CPT 2000 states: "Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes." This means that the care of a patient who receives medical care in a critical care, intensive care, or other specialized care unit should not be reported with critical care codes unless the services:

- meet the *CPT* definition of critical illness/injury,
- meet the *CPT* definition of critical care services, and
- meet the medical review criteria set forth in the "Guidelines for Medical Review of Critical Illness and Critical Care Service" and "Medical Review Guidelines Regarding 'Full Attention' and Physician Time in Critical Care Services" sections of this article.

Examples of patients who may not satisfy Medicare criteria for critical care payment include:

- patients admitted to a critical care unit because no other hospital beds were available,
- patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs,
- patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin drips) to be administered in the critical care unit.

Care of patients who do not meet all these criteria should be reported using the appropriate evaluation and management codes (e.g., subsequent hospital visit codes 99231 - 99233, or inpatient consultation codes 99251 - 99255) depending on the level of service provided.

Hours And Days Of Critical Care That May Be Billed

Critical care time may be continuous or interrupted.

- Procedure code 99291 is used to report the first hour of critical care on a given date of service. Code 99292 is used to report each additional 30 minutes beyond the first

hour. It may also be used to report the final 15-30 minutes of critical care on a given date. Critical care time of less than 30 minutes is not reported separately. This should be reported using another appropriate E/M code.

- A physician must be prepared to demonstrate that the service billed meets the definition of critical care.
- Medicare may request supporting documentation at any time for any claim (e.g., requesting additional information when more than a total of 12 hours of critical care is billed by a physician for one or more patients on the same day). Medicare may also request documentation whenever there is an indication that the services may not have been critical care.
- Only one physician may bill for a given hour of critical care even if more than one physician is providing care to a critically ill patient.

Bundled Services

The following services, when performed on the day a physician bills for critical care, are *included in the critical care service and should not be reported separately*:

- the interpretation of cardiac output measurements (codes 93561, 93562)
- chest X-rays (codes 71010, 71015, 71020)
- blood gases
- blood draw for specimen (code G0001)
- information data stored in computers (e.g., ECGs, blood pressures, hematologic data [code 99090])
- gastric intubation (code 91105)
- pulse oximetry (codes 94760, 94762)
- temporary transvenous pacing (code 92953)
- ventilator management (codes 94656, 94657, 94660, 94662)
- vascular access procedures (codes 36000, 36410, 36600)
- family medical psychotherapy (code 90846)

Any services performed that are not listed above may be reported separately. (See discussion above under "Reporting of Physician Time Toward Critical Care Time" for details.)

Global Surgery

Use of modifier 25 to permit payment of critical care on the day of a procedure with a global fee period. Critical care cannot be paid on the day the physician also bills a procedure code with a global surgical period unless the critical care is billed with the modifier 25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre- and post-operative care associated with the procedure that is performed.

Prior to 1993, the *CPT* definition of critical care bundled a number of fairly significant procedures into the critical care codes, including endotracheal intubation and placement of catheters. At that time, it would have been consistent with the *CPT* definition for Medicare to deny payment for those procedures when they were billed on the same date as the critical care codes. However, when the *CPT* definition of critical care was revised in 1993, HCFA assigned relative value units to the critical care codes to be consistent with the revised definition.

Services such as endotracheal intubation (*CPT* code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz, (*CPT* code 93503) are no longer bundled into the critical care codes. Therefore,

separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier 25. The time spent performing these unbundled services, e.g., endotracheal intubation, is excluded from the determination of the time spent providing critical care.

Please note this policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (procedure code 92950). CPR has a global period of 0 days and is not bundled into the critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier 25. The time spent performing CPR is excluded from the determination of the time spent providing critical care.

When postoperative (for procedures with a global surgical period) critical care services are provided by a physician other than the surgeon, no modifier is required unless all surgical post-operative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, modifiers 54 and 55 must be used by the surgeon and intensivist who are submitting claims. When modifiers 54 and 55 are used, notations in the medical record from the surgeon and intensivist clearly documenting the transfer of care from the surgeon to the intensivist are required. Critical care services must meet all the conditions described in this article.

Use of Modifier 58

Modifier 58 was established for use when billing for staged or related procedures that are performed during the postoperative period of the first procedure. This modifier is not to be used to report the treatment of a problem that requires a return to the operating room. Under the global surgery rules, separate payment may be made for additional surgical procedure(s) performed during the post-operative period of another surgical procedure if the additional procedure is staged or related or for therapy following a diagnostic surgical procedure. This situation can be identified by using modifier 58 with the staged or related procedure. The following is an example of a *staged* and a *related* procedure.

Initial Procedure

Temporary Colostomy

Breast Biopsy

Second Procedure

Revision of Colostomy
(staged procedure)

Mastectomy
(related procedure)

Payment will not be reduced and a new post-operative period begins when the next staged or related procedure is performed. Services that are defined in the AMA's *Current Procedural Terminology (CPT)* as multiple services/sessions or events (for example, procedure codes 67141, 67208, 67220, or 67227) may not be billed with this modifier.

Teaching Physician Rules for Critical Care Billing

For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the period of time for which the claim is made. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes.

Time spent teaching may not be counted towards critical care time. Time spent by the resident in the absence of the teaching physician cannot be billed by the teaching physician as critical care. Only time spent by the resident and teaching physician together with the beneficiary or the teaching physician alone with the beneficiary can be counted toward critical care time.

The teaching physician's progress note must meet all the requirements described in this article. Furthermore, the medical review criteria are the same for the teaching physician as for other physicians.

Ventilator Management

The Medicare Physician Fee Schedule final rule, published on December 10, 1993, established national policy of paying for either an E/M service or ventilator management but not both. The final rule states, "We will continue to recognize the ventilator management codes (CPT codes 94656, 94657, 94660, and 94662) as physician services payable under the physician fee schedule. Physicians will no longer be paid for ventilation management in addition to an evaluation and management service, even if the evaluation and management service is billed with CPT modifier 25."

CPT 2000: "Add-on" Codes

Some of the procedures listed in the *American Medical Association's Current Procedural Terminology (CPT)* for 2000 are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as "add-on" codes and are reproduced on the following page from Appendix E of the 2000 CPT.

Add-on codes can be readily identified by specific descriptors that indicate phrases such as "each additional" or "(List separately in addition to primary procedure)." The "add-on" concept in CPT applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure (e.g., additional digit(s), lesion(s), neurorrhapy(ies), vertebral segment(s), tendon(s), joint(s)).

Add-on codes are *always* performed in addition to the primary service or procedure and must *never* be reported as "stand alone" codes. All procedures identified in CPT as add-on codes are exempt from the multiple procedure concept.

CPT 2000 Add-on Codes

11001	19126	35400	47550	63088	67320	88155	95962
11101	19291	35500	48400	63091	67331	88311	95973
11201	22103	35681	49568	63308	67332	88312	95975
11732	22116	35682	49905	64472	67334	88313	96412
11922	22216	35863	56606	64476	67335	88314	96423
13102	22226	35700	58611	64480	67340	90472	96570
13122	22328	36218	59525	64484	69990	90781	96571
13133	22585	36248	60512	64623	75774	92547	97546
13153	22614	37206	61609	64627	74301	92978	99100
15001	22632	37208	61610	64727	75946	92979	99116
15101	26125	37250	61611	64778	75964	92981	99135
15121	26861	37251	61612	64783	75968	92984	99140
15201	26863	38102	61795	64787	75993	92996	99292
15221	27358	38746	63035	64832	75996	92998	99354
15241	27692	38747	63048	64837	76125	93320	99355
15261	32501	43635	63057	64859	78020	93321	99356
15351	33530	44015	63066	64872	78478	93325	99357
15401	33572	44121	63076	64874	78480	93571	99358
15787	33924	44139	63078	64876	78496	93572	99359
17003	33961	44955	63082	64901	87163	93623	
19001	35390	47001	63086	64902	88141	95920	

ICD-9-CM Millennium Edition

It has been noticed that providers may be using *proposed* diagnoses from *some* editions of the 2000 ICD-9-CM book. These books contain the following statement: “*HCFA proposed change FY2000 DO NOT USE*”. These diagnoses are *not* to be used to file claims to Medicare at this time.

The September 13, 1999, special issue *Medicare B Update!* titled “Important Year 2000 Information - Submitting, Processing, and Paying Medicare Claims in the Year 2000” notified providers that HCFA would *not* be implementing any changes to ICD-9-CM codes for fiscal year 2000. A future issue of the *Update!* will advise providers when new ICD-9-CM codes are implemented into our claims processing system. Using these diagnoses now may cause claims to be rejected.

2000 HCPCS Update—End of “Grace Period”

The Health Care Financing Administration’s Common Procedure Coding System (HCPCS) update for calendar year 2000 was provided in the December 1999 *Medicare B Update! Special Issue: 2000 HCPCS and MPFSDB Update*. Information regarding procedure codes and modifiers that have been added, changed, or discontinued begins on page 3 of that publication.

Discontinued Procedures and Modifiers

The procedure codes and modifiers listed in the “Modifiers/Procedure Codes Discontinued for 2000” section (pages 20-21) should not be used for service dates after December 31, 1999. However, Florida Medicare will continue to accept claims with discontinued procedure codes and/or modifiers

with 2000 service dates received *prior to April 1, 2000*.

Services rendered in 2000, billed with discontinued procedure codes and/or modifiers, will be allowed at 2000 payment rates when received in this “grace period” (January 1, 2000, through March 31, 2000).

Effective for claims received on or after April 1, 2000, claims for services rendered in 2000 that are billed using discontinued procedure codes and/or modifiers will be returned as unprocessable. In these instances, providers will be notified that a discontinued procedure code and/or modifier was submitted and a valid code must be used. Unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted.

COVERAGE/REIMBURSEMENT

AMBULANCE

Clarification of Medicare Policies Concerning Ambulance Services

This is to notify providers of revisions to Medicare policies concerning ground ambulance transportation services published in the January 25, 1999 *Federal Register*, pages 3637-3650. The final rule became effective on February 24, 1999.

Since the publication of the final rule and subsequent release of the operational guidelines, the Health Care Financing Administration (HCFA) received several requests for clarification on the requirement that the physician certification statement be obtained *prior to nonemergency, scheduled trips or within 48 hours of unscheduled, nonemergency ambulance transports*.

Background

On September 21, 1999, HCFA responded to an inquiry requesting that enforcement of the requirements for obtaining the physician certification statement for nonemergency ambulance services be suspended. The inquiry suggested that the experiences of ambulance suppliers has shown that in a substantial percentage of trips ordered by physicians, ambulance suppliers have been unable to obtain the required certification. The inquiry specifically addressed the 48 hour time frame requirement addressed in the final rule under "Special Rule for Nonemergency, Unscheduled Ambulance Services." The final rule specifies that, in cases where a beneficiary living in a facility who is under the direct care of a physician requires nonemergency unscheduled transport, the physician's certification can be obtained 48 hours after the transport has been provided. For beneficiaries not under the direct care of a physician, whether they reside at home or in a facility (e.g., an extended care or assisted living facility), a physician certification statement is not required.

The September 21, 1999 response noted that *the 48 hour time frame is the standard required by regulation*, but acknowledged that there may be instances when meeting the requirement may not be possible. In response, HCFA agreed to clarify the circumstances when it is acceptable for the ambulance supplier to obtain the physician's signature before the bill is submitted for the service. Further review of this issue indicated that, in addition to establishing instructional guidelines to address this issue, guidelines are also needed to address how Medicare carriers are to proceed with processing claims when an ambulance transport has been furnished and the ambulance supplier, after making several attempts, does not receive the requested documentation from the physician. It has been noted that pending the issuance of guidance from HCFA, some ambulance suppliers have been holding ambulance claims that could not be submitted because of the absence of a signed physician certification statement.

Guidelines for Obtaining the Physician Certification Statement

Whenever possible, ambulance suppliers should obtain the signed certification statement prior to the transport. However, there may be instances in which ambulance suppliers have provided transports but are experiencing difficulty in obtaining the required physician certification statement. In cases where an ambulance supplier has transported a beneficiary but is unable to obtain a signed physician certification statement, for claims for services furnished on or after October 1, 1999, Medicare will process these claims as follows:

Within 90 days following the submission of such claims (or 90 days following January 31, 2000, if the claims have already been submitted), to certify the medical necessity of the furnished service, ambulance suppliers must obtain a signed physician certification statement from the attending physician.

If the ambulance supplier is unable to obtain a signed certification statement from the attending physician the supplier must obtain:

- A signed certification statement from either a physician assistant (PA), clinical nurse specialist (CNS), nurse practitioner (NP), registered nurse (RN) or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished;

OR

- The ambulance supplier must document its attempt to obtain such a statement from the attending physician. Acceptable documentation must include a signed return receipt from the U.S. Postal Service or other similar delivery service. Such a return receipt will serve as proof that the supplier attempted to obtain the required signature from the attending physician.

For services furnished **on or after January 31, 2000**, ambulance suppliers must follow these procedures:

- Before submitting a claim, ambulance suppliers must obtain a signed certification statement from the attending physician. If the ambulance supplier is unable to obtain the signed certification statement from the attending physician, a signed physician certification statement must be obtained from either the PA, NP, CNS, RN, or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's

condition at the time the transport was ordered or the service was furnished;

OR

- If the supplier is unable to obtain the required physician certification statement within 21 calendar days following the date of service, the ambulance supplier must document its attempt to obtain the requested physician certification statement in the same manner as described above and may then submit the claim.

In all cases, the appropriate documentation must be kept on file and, upon request, presented to Medicare. It is important to note that neither the presence nor absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary. ***The ambulance service must meet all other coverage criteria in order for payment to be made.***

These changes are being implemented by Florida Medicare on February 28, 2000, and are effective for services rendered on or after January 31, 2000.

Ambulance Questions and Answers

Florida Medicare has received several inquiries from ambulance suppliers regarding the clarifications to the ambulance policy. Below are the questions and replies:

Q1 The new transmittal includes a Registered Nurse and Discharge Planner to the list of acceptable signatures. Does this mean that if we receive a Physician Certification Statement (PCS) form with a Registered Nurse's signature at the time of the transport, we no longer have to pursue getting a physician signature?

A1 The regulation requires an ambulance suppliers to obtain a signed certification statement from the attending physician before submitting a claim. It is when the supplier is unable to obtain the signed certification statement from the attending physician that signatures may be sought from the other qualified personnel. It is not appropriate to initially nor only seek the signature of an RN or discharge planner at the time of transport.

Q2 If a PCS form is not obtained at the time of transport, can we pursue getting the RN signature or do we have to get the physician's?

A2 Again, the requirement is for the ambulance supplier to obtain the physician's signature. It is only when the supplier is unable to obtain the signed certification statement from the attending physician that signatures may be sought from the other qualified personnel. It would be appropriate to obtain an RN signature after the transport, if the supplier was unable to obtain the attending physician's signature.

Q3 What is the definition of a discharge planner?

A3 A discharge planner is an employee so titled by the hospital or facility where the beneficiary is being treated, who has knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished. Discharge planners typically are licensed clinical social workers, but this is not a requirement.

Q4 Is a fax confirmation acceptable documentation showing attempt to get a required signature?

A4 It is acceptable for the supplier to initially fax the attending physician their standard PCS form. A copy of the form which is signed and faxed back by the physician is also acceptable to keep on file. If no response to the initial fax is received from the attending physician, the

fax confirmation slip is *not sufficient* documentation showing an attempt was made. Acceptable documentation must include a signed return receipt from the U.S. Postal Service or other similar delivery service that can provide evidence the request was delivered and received by the intended party.

Q5 In the transmittal, it states August 30, 1999 and after was the implementation date for the PCS form. According to the Sept./October 1999 *Florida Medicare B Update!*, the implementation date was for "service furnished on or after October 1, 1999." Please provide clarification.

A5 HCFA released program memorandum AB-99-83 in late August. Carriers had thirty days to notify the ambulance suppliers and implement the regulations. Hence, this carrier's effective date is October 1, 1999.

Q6 Could all outstanding PCS forms (Oct.-Jan.) be mailed as return receipt now without further attempts at getting a PCS?

A6 According to this transmittal suppliers can now submit claims with dates of service between October 1, 1999 and January 30, 2000, if they meet one of three conditions within 90 days of submitting such claims:

1. Obtain the attending physician's signature on the PCS form
2. Obtain a signature from other qualified personnel
3. Document a good faith attempt to obtain a PCS from the attending physician (e.g., signed return receipt postal service or other similar delivery system).

Q7 Does the 48-hour period no longer apply?

A7 The transmittal indirectly re-states that the 48 hour time frame is the standard required by regulation for suppliers to obtain a signed certification statement from the attending physician. What transmittal B-00-09 does, is provide guidance to suppliers for cases when they are unable to meet the regulatory standard.

Q8 For claims from Oct-Jan., if we do not get the PCS form signed within 90 days, do we have to make a refund to Medicare?

- A8** As stated in response to question 6, for claims between October 3, 1999 and January 30, 2000 the ambulance supplier has until April 30, 2000 to either:
1. obtain a qualified signature on the PCS form, or
 2. provide acceptable proof of the attempt to obtain the signature of the attending physician.
- In the event the supplier did not perform either requirement, then yes, a refund for submitted claims would be expected.
- Q9** We have a critical care transportation unit that performs a number of inter-facility transports from one hospital to another for a higher level of care. Though this is a scheduled transport, we provide ALS services, will a PCS form be required?
- A9** Yes. A Physician Certification Statement is required for all non-emergency transports, regardless of the level of care provided.
- Q10** Can multiple PCS forms be sent in one envelope to a physician and one return receipt obtained?
- A10** The ambulance supplier must clearly list on the cover letter each beneficiary's name, the date of service and the organization's account number for every PCS form enclosed in the envelope. A copy of the cover letter, PCS form and return receipt must be kept in the account file.

GENERAL SURGERY

Apligraf™ (Graftskin)

Apligraf™ (graftskin) is a viable, bilayered, skin construct; the epidermal layer is formed by human keratinocytes and has a well differentiated stratum corneum. The dermal layer is composed of human fibroblasts in a bovine Type 1 collagen lattice. While matrix proteins and cytokines found in human skin are present in Apligraf™, it does not contain langerhans cells, melanocytes, macrophages, lymphocytes, blood vessels or hair follicles. Apligraf™ is manufactured under aseptic conditions from human neonatal male foreskin tissue.

Indications

Apligraf™ is indicated for use with standard therapeutic compression for the treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency of greater than one-month duration *and* that have not adequately responded to conventional ulcer therapy.

Billing Guidelines

Physicians should bill for the surgical service being performed using the following procedure code(s):

- G0170** Application of tissue cultured skin grafts, including bilaminar skin substitutes or neodermis, including site preparation, **initial 25 sq. Cms.**

- G0171** Application of tissue cultured skin grafts, including bilaminar skin substitutes or neodermis, including site preparation, **each additional 25 sq. Cms.**

Apligraf™ is considered a surgical supply and not a prosthetic, and should be billed using the following codes:

- Q0183** Dermal tissue of human origin, with and without bioengineered or processed elements, but **without** metabolically active elements, per square centimeters.
- Q0184** Dermal tissue of human origin, with and without bioengineered or processed elements, but **with** metabolically active elements, per square centimeters.
- Q0185** Dermal **and epidermal** tissue of human origin, with and without bioengineered or processed elements, with metabolically active elements, per square centimeters.

Reimbursement for the surgical supply is made on an individual consideration basis; an invoice for the supply **must** accompany the claim.

HEMATOLOGY/ONCOLOGY

Extension of Medicare Benefits for Immunosuppressive Drugs

The Balanced Budget Refinement Act of 1999 expanded the period in which certain beneficiaries may receive prescription drugs used in immunosuppressive therapy following covered organ transplants. Beginning January 1, 2000, eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expires during the current calendar year may receive an additional eight months of coverage beyond the 36-month period. The number of months of the extension period for individuals whose 36-month period ends during the next four years may be either more or less than eight months.

The procedure codes affected by this change are:

J7500, J7501, J7502, J7503, J7504, J7505, J7506, J7507, J7808, J7509, J7510, J7513, J7515, J7516, J7517, J7599, J8530, J8610, K0119, K0120, K0121, K0123, K0412, K0418.

When furnished by a supplier, these services should be billed to the Durable Medical Equipment Regional Carrier (DMERC):

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

Palmetto GBA Medicare may also be contacted at (803) 735-1034.

2000 Medicare Allowances for Radionuclide Materials

The following table provides the Medicare allowances for radionuclide material, effective for services rendered on and after January 1, 2000. Note that the five-percent reduction for nonparticipating providers and limiting charge does not apply to these codes.

Code	Allowance	Radionuclide Material
A9500	\$88.00	supply of Technetium Tc Sestamibi, radiopharmaceutical diagnostic imaging agent, per dose (CARDIOLITE, MIBI)
A9502	\$88.00	supply of radiopharmaceutical diagnostic imaging agent, technetium TC 99M tetrofosmin, per unit dose
A9504	\$522.50	Supply of radiopharmaceutical diagnostic imaging agent, technetium TC 99m Apcitide
A9505	\$27.50	supply of Thallous Chloride TI201, radiopharmaceutical diagnostic imaging agent, per mCi (THALLIUM TI-201)
A9507	IC	supply of Radiopharmaceutical diagnostic imaging agent, indium in 11 capromab pendetide, per dose
A9600	\$706.80	Injection, Strontium-89 Chloride, per MCI
A9605	IC	supply of therapeutic radiopharmaceutical, samarium SM 153 Lexidronam, 50 mCi
W4125	\$26.53	Tc-99m Technetium, Pertechnetate, up to 30 mCi
W4128	\$.33	I-131 Iodohippurate Sodium, per uCi (HIPPURAN)
W4130	\$29.85	Tc-99m Technetium, Mebrofenin, up to 10 mCi (CHOLETEC)
W4131	\$107.25	Tc-99m Technetium, Mertiatide, up to 20 mCi (MAG 3, TECHNESCAN MAG 3)
W4132	\$63.87	Tc-99m Technetium, Labeled Red Blood Cells (RBCs), up to 30 mCi (LABELED RBCs)
W4133	\$121.69	Co-57 Cobalt Cyanocobalamin, Phase 1-OR-2 (SHILLING TEST KIT, COBATOPE-57, RUBRATOPE-57)
W4134	\$22.57	Tc-99m Technetium, Pyrophosphosphate, up to 30 mCi (PYP, PHOSPHOTEC, PYROLITE, SODIUM PYROPHOSPHATE)
W4136	\$13.97	Xe-133, Xenon, per 10 mCi
W4139	\$19.80	Tc-99m Technetium Pentetate, up to 30 mCi (PENTETATE DTPA, AN-DTPA, TECHNEPLEX, DTPA, TECHNESCAN DTPA)
W4140	\$21.81	I-123 Sodium Iodide capsule, per 100 uCi (SODIUM IODINE capsules)
W4141	\$12.90	I-131 Sodium Iodide capsule (diagnostic), up to 100 uCi (IODOTOPE, Diagnostic)
W4142	\$121.44	I-131 Sodium Iodine capsule (therapeutic), up to 6 mCi (IODOTOPE< Therapeutic)

COVERAGE/REIMBURSEMENT

Code	Allowance	Radionuclide Materials
W4143	\$17.86	I-131 Sodium Iodide capsule (therapeutic), each additional mCi (IODOTOPE, Therapeutic)
W4144	\$13.75	GA-67, Gallium Citrate, per NCI (NEOSCAN)
W4147	\$115.56	I-131 Sodium Iodide solution (therapeutic), up to 6 mCi (IODOTOPE< Therapeutic solution)
W4149	\$13.86	Tc-99m Technetium, Gluceptate, up to 30 mCi (GLUCO, GLUCOSCAN)
W4150	\$19.80	Tc-99m Technetium, Macroaggregated Albumin, up to 10 mCi (PULMONITE, MAA)
W4151	\$18.15	Tc-99m Technetium, Medronate, up to 30 mCi (AN-MDP, OSTEOLITE< MDP< TECHNESCAN MDP)
W4153	\$ 20.35	Tc-99m Technetium, Sulfur Colloid, up to 10 mCi (AN-SULFUR COLLOID, SC, TESULOID)
W4156	\$28.60	Tc-99m Technetium, Disofenin, up to 10 mCi (HEPATOLITE< HIDA)
W4158	\$275.00	Tc-99M Technetium, Sulfur Collid, up to 10 mCi (an-sulfur colloiid, SC, Tesuloid)
A4642	\$1003.75	Supply of Satumomab Pendetide, radiopharmaceutical diagnostic imaging agent, per dose [In-111 Indium Satumomab Pendetide, per study, up to 5 mCi (In-111 ONCOSCINT, ONCOSCINT CR/OV)]
A4641	\$26.57	ACD Solution, per 10 ml. Vial
A4641	\$203.63	Co-57/Co-58, Cobalt Cyanocobalamin, combined study, Phase 1-AND-2 (SCHILLING TEST KIT, DICOPAC)
A4641	\$2.02	Cr-51, Sodium Chromate, per uCi
A4641	\$401.50	Tc=99m Technetium, Exametazime Labeled WBCS, per study, up to 20 mCi (HMPAO)
A4641	\$45.54	Tc-99m Technetium, Human Serum Albumin, up to 30 mCi (HSA)
A4641	\$385.00	In-111 Indium Oxyquinoline Labeled WBCs, per study, up to 550 uCi (OXINE LABELED LEUKOCYTES)
A4641	\$354.76	In-111 Indium Pentetate, per study, up to 1.5 mCi (DTPA)
A4641	\$5.45	I-131 Sodium Iodine solution (therapeutic), each additional mCi (IODOTOPE, Therapeutic solution)
A4641	\$13.81	Tc-99m Technetium, Oxidronate, up to 30 mCi (HDP)
A4641	\$30.25	Tc-99m Technetium, Pentetate, Aerosol, up to 50 mCi (DTPA)
A4641	IC	Tc-99m Technetium, Albumin Colloid, up to 10 mCi
A4641	IC	Tc-99m Technetium, Albumin Colloid labeled WBC's, per study, up to 10 uCi does (I-125 HSA)
A4641	IC	I-125 Iodine Human Serum Albumin for Plasma Volume, up to 10 uCi dose (I-125 HSA)
A4641	IC	In-111 Indium Oxyquinoline abeled Platelets, per strudy, up to 500 uCi (In-111 OXINE)
A4641	IC	In-111 Indium Pentreotide, up to 6 mCi (Octreoscan)
A4641	IC	Tc-99m Technetium Succimer, up to 10 mCi (DMSA)
A4641	IC	Tc-99m Technetium Teboroxime, up to 40 mCi (CARDIOTEC)
A4641	IC	Tc-99m Technetium Biscate,per 10 mCi (NEUROLITE)
79900	\$1430.06	P-32 Chromic Phosphate (therapeutic), per 15 mCi (P-32 COLLOID)
79900	\$370.65	P-32 Chromic Phosphate (therapeutic), per 5 mCi (P-32 SODIUM)

IC = Allowance determined on an individual consideration basis. For Medicare to make an individual consideration determination, the following information should be provided with the claim, in addition to the billed charge:

- the name of the product
- a copy of the invoice with the product identified
- the number of millicuries (mCi) or microcuries (uCi) provided to the patient

INJECTABLE DRUGS

Injectable Drug Pricing: Correction

The 2000 Medicare allowances for injectable drugs were provided in the January/February 2000 *Medicare B Update!* (pages 16-25). The allowance for procedure J9355 (Trastuzumab, 10mg) was listed as \$4.88 for participating providers; however, the correct allowance should be \$48.84. For nonparticipating providers, the correct allowance is \$46.40; the limiting charge is \$53.36. These values are effective for services rendered on or after January 1, 2000.

LABORATORY/PATHOLOGY

Clinical Diagnostic Laboratory Organ or Disease Panels

The American Medical Association's (AMA) Common Procedural Terminology (CPT) editorial panel has approved new laboratory organ or disease panels for the calendar year (CY) 2000. These codes were intended to be effective January 1, 2000. Because of the Year 2000 (Y2K) programming moratorium, the implementation of these codes has been delayed until April 1, 2000. The following billing guidelines may be used until April 1, 2000.

For a clinical diagnostic laboratory organ or disease panel test (employing an affected multichannel code), furnished on or after January 1, 2000, **and** received prior to April 1, 2000, providers may:

- submit the claim before April 1, 2000, using 1999 CPT codes, or
- hold the claim until April 1, 2000, and then bill using 2000 CPT codes.

Claims submitted **on or after April 1, 2000**, for services furnished in CY 2000, must have the appropriate codes as defined in CPT 2000. The 1999 CPT codes will not be acceptable for claims received after March 31, 2000, for tests performed during the first quarter of CY 2000.

Claims submitted for automated chemistry test services provided during the first quarter of CY 2000 will be processed based on the current guidelines. Duplicate services will be identified when the panel codes submitted during this period are unbundled and the individual test codes are compared to the pending and paid claims. Reimbursement of a service or group of services will be based on the number of automated chemistry tests performed for the same beneficiary on the same day by the same provider from all claims submitted. The organ disease CPT panel codes for 2000 are: **80048, 80053, 80069, and 80076.**

1999 CPT organ or disease panel codes (80049, 80054, and 80058) will be included in the unbundling process for duplicate detection for claims submitted with dates of service January 1, 2000 through March 31, 2000.

The charts on the following page display the 1999 and 2000 calendar year automated multichannel organ or disease codes and the component tests.

PHYSICAL/OCCUPATIONAL THERAPY

Two-Year Moratorium on the Financial Limitation for Outpatient Rehabilitation Services

A two-year moratorium has been placed on the application of the financial limitations (i.e., caps) for outpatient rehabilitation services. Therefore, providers will not be required to track incurred expenses for dates of service January 1, 2000 through December 31, 2001. All claims with dates of service January 1, 2000 through December 31, 2001, will *not* be subject to the \$1,500

financial limitation. This includes claims for all outpatient physical therapy services (including speech-language pathology services) and outpatient occupational therapy services. Although claims for therapy services will not be subject to a financial limitation, such claims may be reviewed to ensure that the services rendered are covered (including being reasonable and necessary).

In addition, effective January 1, 2000, optometrists may refer patients for therapy services, as well as establish and review the plan of treatment.

COVERAGE/REIMBURSEMENT

Calendar Year 1999 Automated Multichannel Chemistry Test and Organ or Disease Panel

(Use through March 31, 2000)

		Hepatic Function Panel 80058	Basic Metabolic 80049	Comprehensive Metabolic 80054
Chemistry	CPT Code			
ALT (SGPT)	84460	X		
Albumin	82040	X		X
Alkaline phosphatase	84075	X		X
AST (SGOT)	84450	X		X
Bilirubin, total	82247	X		X
Bilirubin, direct	82248	X		
CO ₂ (bicarbonate)	82374		X	X
Calcium	82310			X
Chloride	82435		X	X
Creatinine	82565		X	X
Glucose	82947		X	X
Potassium	84132		X	X
Protein, total	84155			X
Sodium	84295		X	X
Urea nitrogen (BUN)	84520		X	X
Cholesterol	82465			
CK,CPK	82550			
GGT	82977			
LDH	83615			
Phosphorus	84100			
Triglycerides	84478			
Uric Acid	84550			

Calendar Year 2000 Automated Multichannel Chemistry Test and Organ or Disease Panel

(Use beginning April 1, 2000)

		Hepatic Function Panel 80076*	Basic Metabolic 80048**	Comprehensive Metabolic 80053***	Renal Function Panel 80069
Chemistry	CPT Code				
Albumin	82040	X		X	X
Alkaline phosphatase	84075	X		X	
ALT (SGPT)	84460	X		X	
AST (SGOT)	84450	X		X	
Bilirubin, total	82247	X		X	
Bilirubin, direct	82248	X			
Calcium	82310		X	X	X
Chloride	82435		X	X	X
Cholesterol	82465				
CK,CPK	82550				
CO ₂ (bicarbonate)	82374		X	X	X
Creatinine	82565		X	X	X
GGT	82977				
Glucose	82947		X	X	X
LDH	83615				
Phosphorus	84100				X
Potassium	84132		X	X	X
Protein, total	84155	X		X	
Sodium	84295		X	X	X
Triglycerides	84478				
Urea nitrogen (BUN)	84520		X	X	X
Uric Acid	84550				

* Code 80058 was deleted from CPT 2000

** Code 80049 was deleted from CPT 2000

***Code 80054 was deleted from CPT 2000

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).

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A9270: The List of Medicare Noncovered Services

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

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

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

Indications and Limitations of Coverage and/or Medical Necessity

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

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

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

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

HCPSC Codes

Local Noncoverage Decisions

Laboratory Procedures

82016*	Acylcarnitines; qualitative, each specimen
82017*	Acylcarnitines; quantitative, each specimen
82172	Apolipoprotein, each
82379*	Carnitine (total and free), quantitative, each specimen

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

82523*	Collagen cross links, any method (Urinary Biochemical Assays for Bone Resorption)	87582	Mycoplasma pneumoniae, quantification
83883	Nephelometry, each analyte not elsewhere specified	87592	Neisseria gonorrhoeae, quantification
84134	Prealbumin	87620	papillomavirus, human, direct probe technique
84999*^	Lymphocyte mitogen response assays used to monitor the treatment of cancer	87622	papillomavirus, human, quantification
86618	Antibody; Borrelia burgdorferi (Lyme disease)	88000-88099	Necropsy (autopsy)
86628	Antibody; Candida	88349	Electron microscopy: scanning
86631	Antibody; Chlamydia	89250-89261	Culture and fertilization of oocyte(s) and other artificial insemination procedures
86910	Blood typing, for paternity testing, per individual; ABO, Rh, and MN	89264	Sperm identification from testis tissue, fresh or cryopreserved
86911	each additional antigen system	A9270*	BRCA1 and BRCA2
87270	Infectious agent antigen detection by direct fluorescent antibody technique; Chlamydia trachomatis	A9270*	In Vitro Chemosensitivity Assays
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative multiple step method; Chlamydia trachomatis	A9270*	Neuronal Thread Protein (NTP)
87470	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique	Drugs and Biologicals	
87471	Bartonella henselae and Bartonella quintana, amplified probe technique	90476	Adenovirus vaccine, type 4, live, for oral use
87472	Bartonella henselae and Bartonella quintana, quantification	90477	Adenovirus vaccine, type 7, live, for oral use
87475	Borrelia burgdorferi, direct probe technique	90581	Anthrax vaccine, for subcutaneous use
87477	Borrelia burgdorferi, quantification	90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
87482	Candida species, quantification	90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
87485	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique	90632	Hepatitis A vaccine, adult dosage, for intramuscular use
87487	Chlamydia pneumoniae, quantification	90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
87492	Chlamydia trachomatis, quantification	90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
87511	Gardnerella vaginalis, amplified probe technique	90645	Hemophilus Influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
87512	Gardnerella vaginalis, quantification	90646	Hemophilus Influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
87515	hepatitis B virus, direct probe technique	90647	Hemophilus Influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
87520	hepatitis C, direct probe technique	90648	Hemophilus Influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
87522*	hepatitis C, quantification	90660	Influenza virus vaccine, live, for intranasal use
87525	hepatitis G, direct probe technique	90665	Lyme disease vaccine, adult dosage, for intramuscular use
87526	hepatitis G, amplified probe technique	90680	Rotavirus vaccine, tetravalent, live, for oral use
87527	hepatitis G, quantification	90690	Typhoid vaccine, live, oral
87531	Herpes virus-6, direct probe technique	90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPS), for intramuscular use
87532	Herpes virus-6, amplified probe technique	90692	Typhoid vaccine, heat-and phenol-inactivated (H-P), for subcutaneous or intradermal use
87533	Herpes virus-6, quantification	90693	Typhoid vaccine, Acetone-Killed, Dried (AKD), for subcutaneous or jet injection use (U.S. military)
87534	HIV-1, direct probe technique	A9270*	Becaplermin (Regranex)
87537	HIV-2, direct probe technique	A9270	Muse
87538	HIV-2, amplified probe technique	J3520	Edetate disodium, per 150 mg (chemical endarterectomy)
87539	HIV-2, quantification	J3530	Nasal vaccine inhalation
87540	Legionella pneumophila, direct probe technique		
87541	Legionella pneumophila, amplified probe technique		
87542	Legionella pneumophila, quantification		
87557	Mycobacteria tuberculosis, quantification		
87562	Mycobacteria avium-intracellulare, quantification		
87580	Mycoplasma pneumoniae, direct probe technique		
87581	Mycoplasma pneumoniae, amplified probe technique		

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

Procedures			
01990	Physiological support for harvesting of organs from brain-dead patients	94015	Patient initiated spirometric recording per 30 day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)
01995	Regional I.V. administration of local anesthetic agent or other medication (upper or lower extremity)		
11975	Insertion, implantable contraceptive capsules	94016	Patient initiated spirometric recording per 30 day period of time; physician review and interpretation only
11977	Removal with reinsertion, implantable contraceptive capsules	95806	Sleep Study unattended by a technologist
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets underneath the skin)	95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk, with report
15820-15821	Blepharoplasty, lower lid		hand, with or without comparison with normal side
15824-15829	Rhytidectomy	95832	total evaluation of body, excluding hands
15831-15839	Excision, excessive skin and subcutaneous tissue (including lipectomy)	95833	total evaluation of body, including hands
15876-15879	Suction assisted lipectomy	95834	
17380	Electrolysis epilation, each ½ hour		
27599*^	Tidal knee irrigation	95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
43999*^	Gastric Electrical Stimulation		hand, with or without comparison with normal side
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection) with occlusion of oviducts by device (eg, band, clip, or Falope ring)	95852	Biothesiometry
58671	Artificial insemination; intra-cervical	95999*	Current Perception Threshold Testing (CPT)
58321	Artificial insemination; intra-uterine	95999	Surface electromyography
58322	Sperm washing for artificial insemination	95999*	Stand-by anesthesia
58323	Follicle puncture for oocyte retrieval, any method	99360	Abdominal Aorta Transplant from a Cadaver
58970	Embryo transfer, intrauterine	A9270*	Adoptive Immunotherapy
58974	Gamete, zygote, or embryo	A9270*	Balloon Lacrimoplasty
58976	intrafallopian transfer, any method	A9270*	Blood Brain Barrier Disruption
58999^	Pap plus speculscopy (PPS)	A9270*	Cellular Therapy
59012	Cordocentesis (intrauterine), any method	A9270*	Disposable Pain Control Infusion Pump (PCIP)
64999*^	Bretylium Bier Block	A9270	Epiduroscopy/Myeloscropy
76499*^	MRI for use in measuring the blood flow, spectroscopy imaging of cortical bone and calcification, and procedures involving resolution of bone or calcification	A9270*	Epiluminescence microscopy
		A9270*	Fetal Tissue Transplantation
		A9270*	Fiberoptic Endoscopy Evaluation of swallowing with sensory testing (FEEST)
77520*	Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment set-up and verification images	A9270*	Gamma Knife for lesions outside the head
		A9270	High Voltage Pulsed Current (HVPC) Therapy
77523*	Proton beam treatment to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment set-up and verification images	A9270	Lidocaine Intravenous For Chronic Pain
		A9270*	Large and Small Bowel Transplants
92548*	Computerized dynamic posturography	A9270*	Light reflecting rheography
92970*	Cardioassist-method of circulatory assist; internal	A9270*	Matrix Pro Elect/Matrix Elect DT
		A9270*	Meniscal Allograft Transplantation
92971*	Cardioassist-method of circulatory assist; external	A9270*	Neocontrol (Magnetic Incontinence Chair)
		A9270	OssaTron treatment
92997-92998	Percutaneous transluminal pulmonary artery balloon angioplasty	A9270*	Politzer Procedure
93720-93722*	Plethysmography, total body	A9270*	Shark Cartilidge Injections
93740	Temperature gradient studies	A9270*	Silicone Oil Injections
93799*^	Metaidobenzylguanidine (MIBG) imaging	A9270*	SPECT with Altropane for early diagnosis of Parkinson's disease
		A9270*	The Canalith Repositioning Procedure
94014	Patient initiated spirometric recording per 30 day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation	A9270*	Ultrasound Guided Sclerotherapy
		D9248	ZStat flu Influenza Test Kits
		G0167	Non-intravenous conscious sedation
			Hyperbaric oxygen treatment not requiring physician attendance, per treatment session

National Noncoverage Decisions
Devices

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

Laboratory Procedures

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

Drugs and Biologicals

90669^ Pneumococcal conjugate vaccine, polyvalent, for intramuscular use
A4260* Levonorgestral (contraceptive) implants system, including implants and supplies
A4261 Cervical cap for contraceptive use
A9270 Oral Medication
A9270* Rebetrone
J3570* Laetrile (Amygdalin, Vit B17)
J8499^ Prescription drug, oral, nonchemotherapeutic, not otherwise specified
J8499*^ Sublingually administered antigens

Procedures

15775-15776 Punch graft for hair transplant
20979* Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
32491* Removal of lung, other than total pneumonectomy; excision-plectomy of emphysematous lung(s) (bullous or non-bullous), for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure (prior to 1/1/97 HCPCS code G0061)
35452* Transluminal balloon angioplasty (PTA) in treatment of obstructive lesions of aortic arch
53899*^ Bladder Stimulator
55970-55980* Intersex surgery
56805 Clitoroplasty for intersex state
57335 Vaginoplasty for intersex state
59899*^ Ambulatory home monitoring of uterine contractions
64999*^ Stereotactic cingulotomy as a means of psychosurgery
65760-65767, Refractive keratoplasty to correct
65771* refractive error
69949*^ Cochleostomy with neurovascular transplant for Meniere's Disease
72159 Magnetic resonance angiography, spine canal and contents, with or without contrast material(s)
72198 Magnetic resonance angiography, pelvis, with or without contrast material(s)
73225 Magnetic resonance angiography, upper extremity, with or without contrast material(s)
78351* Dual Photon Absorptiometry, one or more sites
78810* Tumor Imaging, Positron Emission Tomography (PET), metabolic evaluation
90760 Routine physical exam
90875-90876 Individual psychophysiological therapy incorporating biofeedback

90899*^
90908
(prior to 1/1/97)
92310

92314

93760
93762
93784-93790*
95199^
95999*^

97780-97781*
98943

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Transcendental meditation
Biofeedback (psychiatric only)

Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia

Thermogram; cephalic peripheral

Ambulatory blood pressure monitoring
Repository antigen
EEG monitoring during open heart surgery and in immediate post-op period
Acupuncture
Chiropractic manipulative treatment (CMT); extraspinal, one or more regions
Noncovered service by podiatrist
Noncovered service by chiropractor
Carbon Dioxide Therapy
Cardiointegram (CIG) as an alternative to stress test or thallium stress test
Carotid body resection to relieve pulmonary symptoms, including asthma
Carotid sinus nerve stimulator for treatment of paroxysmal supraventricular tachycardia
Chelation Therapy (EDTA) for treatment of arteriosclerosis
Colonic irrigation
Cosmetic surgery
Diathermy or ultrasound treatments performed for respiratory conditions or diseases
Ear/carbon therapy
Electrical aversion therapy for treatment of alcoholism
Electrical continence
Electrosleep therapy
Electrotherapy for the treatment of facial nerve paralysis (Bell's Palsy)
Eye exam, routine
Fabric wrapping of abdominal aneurysms
Gastric balloon for treatment of obesity
Hair analysis
Hemodialysis for treatment of schizophrenia
Indirect Calorimetry used to assess nutritional status as a respiratory therapy
Intestinal bypass for obesity
Intravenous histamine therapy
Investigational IOLS in FDA Core Study or Modified Core Study
Partial ventriculectomy (also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery)
Pelvic floor stimulator
Platelet-derived wound healing formula (Procuren)
Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents

A9270	Speech therapy by pathologist/speech therapist
A9270*	Sweat test as predictor of efficacy of sympathectomy in PVD
A9270*	Thermogenic therapy
A9270*	Tinnitus masking
A9270*	Transfer factor for treatment of multiple sclerosis
A9270*	Transilluminator light scanning or diaphanography
A9270*	Transvenous (catheter) pulmonary embolectomy
A9270*	Treatment of decubitus ulcers by ultraviolet light, low intensity direct current, topical application of oxygen and topical dressings with balsam of Peru in castor oil
A9270*	Treatment of motor function disorders with electrical nerve stimulation
A9270*	Ultrafiltration independent of conventional dialysis
A9270*	Vertebral Axial Decompression (VAX-D)
A9270	Vitamin B ₁₂ injections to strengthen tendons, ligaments of the foot
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122	Colorectal cancer screening; barium enema
M0100*	Gastric freezing
V5010	Hearing exam for the purpose of a hearing aid

These lists of noncovered services are not all inclusive.

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

Deletions From National Noncoverage

11920-11922 Tattooing

Documentation must be submitted with the claim for coverage of tattooing to be considered. Reimbursement will be made on an individual consideration basis.

ICD-9-CM Codes That Support Medical Necessity

N/A

Reasons for Denial

See criteria for noncoverage.

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

N/A

Documentation Requirements

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

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

Effective Date

The procedures identified in this policy in **bold type** are effective for services processed on or after April 17, 2000.

Advance Notice Statement

An advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for a service that is considered investigational/experimental, or is not approved by the FDA, or because there is a lack of scientific and clinical evidence to support the procedure's safety and efficacy. See page 4 for details concerning ABNs.

G0108, G0109: Diabetes Outpatient Self-Management Training

Diabetes mellitus is a chronic disorder of carbohydrate, fat and protein metabolism, characterized by hyperglycemia and glycosuria from inadequate production or utilization of insulin. The diagnosis of diabetes mellitus is made based on the test results of a random plasma glucose greater than 200 mg/dl, fasting plasma (8-14 hours) greater than or equal to 126 mg/dl on two occasions, or a two-hour plasma glucose greater than 200 mg/dl after a 75 gm glucose challenge.

Diabetes mellitus is classified according to two syndromes: Type 1 diabetes and Type 2 diabetes. Type 1 diabetes is characterized by beta cell destruction, usually leading to absolute insulin deficiency. It has two forms: Immune-mediated diabetes mellitus and idiopathic diabetes mellitus. Type 1 diabetes is usually immune-mediated. Type 2 diabetes is a term for individuals who have insulin resistance and usually have relative (rather than absolute) insulin deficiency.

Since diabetes is a chronic illness, the patient requires continual medical care and education in order to prevent acute complications and reduce the risk of long-term medical problems. A critical element for the successful treatment of all patients with diabetes is participation in a comprehensive self-management care and education program. Ongoing support, maintenance, and modifications in treatment regimes and lifestyle changes all

require continued patient and caregiver participation.

A diabetes outpatient self-management training service is a program that educates beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and it motivates patients to use the skills for self-management.

This policy addresses Medicare's coverage of diabetes outpatient self-management training services based on section 4105 of the Balanced Budget Act of 1997.

Indications and Limitations of Coverage and/or Medical Necessity

Prior to July 1, 1998, Medicare provided additional reimbursement for diabetic education programs when performed in an outpatient hospital and met certain criteria outlined in Section 80-2 of the Coverage Issues Manual (CIM). Since that time further legislation regarding coverage of outpatient diabetic education has been received and is identified below.

Medicare will consider diabetes outpatient self-management training services (procedure codes G0108 and G0109) medically reasonable and necessary for services performed on or after July 1, 1998, when the following conditions are met:

- The services are furnished by a certified provider who meets quality standards as identified by the National Diabetes Advisory Board (NDAB). To be considered a quality diabetes self-management education program, the program must provide comprehensive instruction in the content areas that impact the target population and the participants enrolled. Standard 12 of the NDAB standards identifies the 15 content areas. The curriculum, teaching strategies, and materials used should be appropriate for the audience and should consider: type and duration of diabetes, age, cultural sensitivity, and individual learning abilities and special educational needs. The NDAB standards are listed beginning at the top of the next column.
- Education is provided by a program that is recognized by the American Diabetes Association. This is indicated by an Education Recognition Program (ERP) certificate administered through the American Diabetes Association.
- The physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must be related to the beneficiary's diabetic condition to ensure therapy compliance, or to provide the individual with the necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to successfully manage his/her condition.

During the initial period of onset of the disease, diabetes self-management education is critical to the treatment and management of the illness and should be introduced within the first week of diagnosis. Normally, as a general guideline, it would not be medically necessary for a beneficiary to receive more than 10 hours of instruction for the initial training. This training should be provided within 12 weeks of the initial diagnosis. In addition, diabetes self-management training normally occurs in group sessions. However, individual training sessions may be provided for a beneficiary if his/her physician decides that it is medically necessary (e.g., language or physical challenges, such as severely impaired hearing or sight).

Self-management education starts with an assessment of the individual's educational needs that will assist in the planning of teaching/learning strategies and will be the foundation of an education and lifestyle plan. Patient outcomes will be monitored for lifestyle changes and revised as necessary.

After completion of the initial self-management diabetes training, ongoing support and maintenance should be provided by the beneficiary's physician and/or support system. Additional self-management education training sessions may be necessary in situations where a modification has occurred in the treatment regime (e.g., a change from oral medications to insulin, inability to stabilize patient, etc.). **Training sessions performed as a refresher course (e.g., annually) without documentation supporting a change in the treatment regime are not covered.**

The National Diabetes Advisory Board (NDAB) standards are:

I. STRUCTURAL STANDARDS

A. Organizational support by sponsoring organization

- Standard 1: Maintain written policy affirming education as an integral component of diabetes care.
- Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget and instructional materials.
- Standard 3: Clearly define and document organizational relationships, lines of authority, staffing, job descriptions, and operational policies.

B. Community needs assessment

- Standard 4: Assess service area to define target population and determine appropriate allocation of personnel and resources.

C. Program management

- Standard 5: Establish standing advisory committee including at least a physician, nurse educator, dietitian, behavioral science expert, consumer, and community representative to oversee the program.
- Standard 6: The advisory committee should participate in annual planning to determine target population, program objectives, participant access, and follow-up mechanisms, instructional methods, resource requirements, and program evaluation.
- Standard 7: Professional program staff should have sufficient time and resources for lesson planning, instruction, documentation, evaluation, and follow-up.
- Standard 8: Assess community resources periodically.

D. Program staff

- Standard 9: Designate a coordinator responsible for program planning, implementation, and evaluation.
- Standard 10: Program instructors should include at least a nurse educator and dietitian with recent didactic and experiential training in diabetes clinical and educational issues.
- Standard 11: Professional program staff should obtain continuing education about diabetes, educational principles, and behavioral change strategies.

E. Curriculum

- Standard 12: The program must be capable of offering, based on target population needs, instruction in the following 15 content areas:
 1. diabetes overview
 2. stress and psychosocial adjustment
 3. family involvement and social support
 4. nutrition
 5. exercise and activity
 6. medications

7. monitoring and use of results
8. relationships among nutrition, exercise, medication, and glucose levels
9. prevention, detection and treatment of acute complications
10. prevention, detection and treatment of chronic complications
11. foot, skin, and dental care
12. behavior change strategies, goal setting, risk factor reduction, and problem solving
13. benefits, risks and management options for improving glucose control
14. preconception care, pregnancy, and gestational diabetes
15. use of health care systems and community resources.

Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

- Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.
- Standard 15: The program must be conveniently and regularly available.
- Standard 16: The program must be responsive to requests for information and referrals from consumers, health professionals, and health agencies.

II. PROCESS STANDARDS

A. Assessment

- Standard 17: Develop and update an individualized assessment for each participant, including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes, behavior and goals; support systems; barrier to learning; and socioeconomic factors.

B. Plan and Implementation

- Standard 18: Develop an individualized education plan, based on the individualized assessment, in collaboration with each participant.
- Standard 19: Document the assessment, intervention, evaluation, and follow-up for each participant, and collaboration and coordination among program staff and other providers, in a permanent record.

C. Follow-up

- Standard 20: Offer appropriate and timely educational intervention based on periodic assessments of health status, knowledge, skills, attitude, goals, and self-care behaviors.

III. OUTCOME STANDARDS

A. Program

- Standard 21: The advisory committee should review program performance annually, and use the results in subsequent planning and program modification.

B. Participant

- Standard 22: The advisory committee should annually review and evaluate predetermined outcomes for program participants.

ICD-9-CM Codes That Support Medical Necessity

250.00-250.93

Reasons for Denial

Diabetic self-management training performed as a refresher course without a change in the patient's treatment regime is not covered.

Coding Guidelines

Prior to billing for diabetes outpatient self-management training services, all providers must submit to the Medicare contractor an Education Recognition Program (ERP) certificate from the American Diabetes Association.

Services for diabetes outpatient self-management training must be billed with the appropriate HCPCS code, G0108 or G0109, in one hour increments only. If the training session lasts 90 minutes, only one hour can be billed for that session. The extra 30 minutes may count toward future sessions.

The number of patients in a group does not need to be identified when billing for procedure code G0109.

Payment for diabetes outpatient self-management training services rendered in a Federal Qualified Health Center (FQHC) or a Rural Health Center (RHC) setting by a nonphysician practitioner is bundled under the facility cost payment that is made by the intermediary under the all-inclusive rate.

Documentation Requirements

In order for diabetic self-management training sessions to be covered by Medicare, documentation must be available to support that the educational program is certified by the American Diabetes Association as evidenced by the Education Recognition Program (ECP) certificate.

In addition to the above requirement, the following documentation must be maintained in the patient's medical record:

- A physician order, referral, or attestation for the diabetic self-management training sessions. This order must certify that the beneficiary's diabetic condition warrants this comprehensive plan of care.
- An individualized assessment with updated information including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes, behavior and goals; support systems; barriers to learning; and socioeconomic factors.
- An individualized mutually agreed upon education plan established by the team (patient, physician, and health care team members) based on the individualized

assessment, including but not limited to the specific problems to be addressed, specific educational modalities, specific goals of the educational session, and the amount, frequency, and duration of each educational modality.

- Documentation (e.g., progress notes) for each date of service that reflect the service(s) provided and instruction given. In addition, the documentation should indicate the patient's response to the service and the progress toward the goals. The daily note must be signed and dated by the qualified team member who rendered the service.

Documentation supporting the continuation of the diabetic self-management training session beyond the expected 10 hours during the initial phase must be available. In addition, repeat sessions during the follow-up phase must indicate the patient's treatment regime has

changed and that additional training sessions are needed to educate the patient for continual self-management of the disease.

Also, since diabetes self-management training normally occurs in group sessions, the documentation maintained on file must be available to support the medical necessity for performing individual training sessions.

Effective Date

This local medical review policy is effective for services processed on or after April 17, 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.

G0166 (93799): External Counterpulsation—Clarification

The local medical review policy (LMRP) for Enhanced External Counterpulsation (EECP) was published in the January/February 2000 *Medicare Part B Update!* (pages 30-31). The "Documentation Requirements" section stated that 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.

For dates of service on or after January 1, 2000, documentation is no longer required to be submitted with the claim. However, the medical record documentation must be maintained in the patient's file. Services furnished on or after this date should be submitted using HCPCS code G0166. Note that enhanced external counterpulsation (EECP) is now simply referred to as "external counterpulsation (ECP)."

For claims with dates of service *prior to* January 1, 2000, ECP should be billed with the unlisted procedure code 93799; documentation *must* be sent with these claims.

J1561, J1562: Intravenous Immune Globulin—Revision

This LMRP was last published in the September/October 1999 Medicare B Update! Since that time, the policy has been revised to remove the requirement regarding maintenance of IgG serum trough at a specific level. Therefore, it is being published in its entirety.

Intravenous Immune Globulin is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Indications and Limitations of Coverage and/or Medical Necessity

The use of intravenous Immune Globulin should be reserved for patients with serious defects of antibody function. The goal is to provide IgG antibodies to those who lack them. Florida Medicare will provide coverage for intravenous Immune Globulin when it is used in treatment of the following conditions:

- Primary Humoral Immunodeficiency
 - Common variable immunodeficiency
 - Wiskott-Aldrich syndrome
 - X-linked agammaglobulinemia
 - Severe combined immunodeficiency
- Recurrent severe infection and documented severe deficiency or absence of IgG subclass
- Clinically significant functional deficiency of humoral immunity as evidenced by documented failure to produce antibodies to specific antigens *and* a history of recurrent infections.

- Idiopathic Thrombocytopenic Purpura (ITP)
 - Doses should be based on the patient's clinical appearance and platelet count. Infusions are usually administered when there are signs and symptoms of bleeding and/or a platelet count less than 30,000/mm³.
- Chronic Lymphocytic Leukemia with associated hypogammaglobulinemia
 - There should be evidence of specific antibody deficiency and the presence of repeated bacterial infections.
- Symptomatic Human Immunodeficiency Virus (HIV)-less than 13 years of age *and* CD4+ lymphocyte count 200/mm³ or greater
 - Indications for intravenous immunoglobulin would include:
 - Children less than 13 years of age
 - Entry CD4+ lymphocyte counts greater than or equal to 200/mm³
 - Clinically symptomatic or asymptomatic but immunologically abnormal
- Low-birth weight infants weighing between 500 and 1750 grams at birth
 - Indications for intravenous immunoglobulin would include:
 - Weight at birth between 500-1750 grams
 - Expected to survive for more than 48 hours
 - Stable cardiovascular function
 - Intravenous access for medical therapy

- Bone marrow transplantation
Indications for intravenous immunoglobulin would include:
Patients 20 years of age or older
Seropositive for cytomegalovirus (CMV) before transplantation
Seronegative, had seronegative marrow donors, and undergoing allogeneic transplantation for hematologic neoplasms
- Kawasaki Disease (mucocutaneous Lymph Node Syndrome)
For diagnoses of Guillain Barre syndrome, chronic inflammatory demyelinating polyneuropathy, autoimmune hemolytic anemia, autoimmune neutropenia, acquired inhibitor of clotting factor VIII, immune thrombocytopenic purpura in pregnancy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. Intravenous immunoglobulin may be recommended when *other therapy has failed or is contraindicated, and for potentially severe or life threatening manifestations of these diseases.*
- Acute Inflammatory Demyelinating Polyradiculoneuropathy, Guillain-Barre Syndrome, and Myasthenia Gravis:
It is noted that not all patients with these diseases need treatment with intravenous immunoglobulin. The following situations would constitute appropriate indications:
Other therapy has failed or is contraindicated
Difficulty with venous access for plasmapheresis
Recommended for rapidly progressive forms of these diseases
- Autoimmune Hemolytic Anemia
It is noted that not all patients with this disease need treatment with intravenous immunoglobulin. Intravenous immunoglobulin should be used for patients whose condition is resistant to conventional forms of therapy and/or demonstrates severe or life threatening manifestations of this disease.
- Autoimmune Neutropenia
This disease is usually benign and self-limiting, and does not require treatment. Not all patients with this disease need treatment with intravenous immunoglobulin. Occasionally, however, it is marked by repeated infection. Intravenous immunoglobulin may be recommended for the treatment of patients with an absolute neutrophil count less than 800/mm³ with recurrent bacterial infections.
- Coagulopathy due to inhibitors or antihemophilic factor (Factor VIII)
This is a relatively rare bleeding disorder caused by circulating autoantibodies against Factor VIII. Not all patients with this disease need treatment with intravenous immunoglobulin. Patients who develop serious hemorrhage may be administered intravenous immunoglobulin, in addition to other appropriate therapies.
- Immune Thrombocytopenic Purpura in Pregnancy
Pregnant women with this disease are at risk for delivering thrombocytopenic infants. Protection of the fetus becomes an important consideration in the management of a pregnant woman with immune

thrombocytopenic purpura. Intravenous immunoglobulin can be recommended in the following:

Pregnant women who have previously delivered infants with autoimmune thrombocytopenia
Pregnant women who have platelet count less than 75,000/mm³ during the current pregnancy
Pregnant women with past history of splenectomy

- Inflammatory Myopathies: Refractory Polymyositis and Refractory Dermatomyositis
The criteria for the use of intravenous immunoglobulin in polymyositis or dermatomyositis is: patients who are *refractory* to standard therapy which includes patients who are refractory to corticosteroids; patients who have been unable to successfully taper corticosteroids below moderately high doses; patients developing *severe* side effects due to steroid therapy; *and* patients who have also failed at least one immunosuppressive agent (e.g., azathioprine, Methotrexate, cyclophosphamide, cyclosporine) .

HCPCS Codes

J1561 Injection, immune globulin, intravenous, 500 mg
J1562 Injection, immune globulin, intravenous 5 g

ICD-9-CM Codes That Support Medical Necessity

042	279.06	286.0	358.0	996.85
204.10	279.09	287.3	446.1	
204.11	279.12	288.0	710.3	
279.03	279.2	357.0	710.4	
279.04	283.0	357.8	765.02-765.07	

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

Evaluation and management services will be reimbursed in addition to payment for intravenous administration (CPT 90780-90781).

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly document the medical necessity to initiate intravenous Immune Globulin therapy and the continued need thereof. Required documentation of medical necessity should include:

- history and physical
- office/progress note(s)
- test results with written interpretation
- an accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/dosage

Effective Date

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

J2430: Pamidronate (Aredia®, APD)

Pamidronate, a bisphosphonate which is administered intravenously, is used to inhibit bone resorption and to decrease serum calcium. In Paget's disease (osteitis deformans), Pamidronate reduces the rate of bone turnover by an initial blocking of bone resorption, resulting in a decrease in serum alkaline phosphatase and a decrease in urinary hydroxyproline excretion.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider Pamidronate medically reasonable and necessary for any of the following FDA approved indications:

- Hypercalcemia of malignancy, with or without bone metastases, that is inadequately controlled by hydration alone.
- Symptomatic Paget's disease (osteitis deformans) characterized by abnormal and accelerated bone metabolism in one or more bones. Signs and symptoms may include bone pain, deformity, and/or fractures; neurologic disorders associated with skull lesions and spinal deformities.
- Adjunct treatment of osteolytic lesions of breast cancer or myeloma.

Dosage and Administration

Hypercalcemia- intravenous infusion, 60 mg administered over a period of four to twenty-four hours.
Paget's disease- intravenous infusion, a total of 90 to 180 mg per treatment period.
Breast cancer or Myeloma- intravenous infusion, 90 mg over a period of 2-4 hours once a month.

HCPCS Codes

J2430 Injection, pamidronate disodium, per 30mg

ICD-9-CM Codes That Support Medical Necessity

174.0-174.9
175.0-175.9
203.00-203.01
275.42
731.0

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation maintained by the performing physician must substantiate the medical necessity for the use of Pamidronate 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.

If the provider of the service is other than the ordering/referring physician, that provider must maintain copies of the ordering/referring physician's order for the drug. The physician must state the clinical indication/medical need for using this drug in the order.

Effective Date

This local medical review policy is effective for services processed on or after April 17, 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.

J9999: Antineoplastic Drugs—Additions to Policy

The complete local medical review policy (LMRP) for Antineoplastic Drugs was published in the March/April 1999 *Medicare B Update!* (pages 45-48). An additional article, regarding the addition of three new drugs was published in the November/December 1999 *Medicare B Update!* (pages 27-28). Three new drugs, Etoposide (J9181 & J9182), Fludarabine (J9185), and Mitoxantrone (J9293), have since been added to the policy. The entire Antineoplastic Drugs policy will be published in a future issue of the *Update!*

Etoposide (Etopophos®, Toposar®, VePesid®, VP-16)

Etoposide is a podophyllotoxin which inhibits DNA synthesis prior to mitosis by blocking topoisomerase II.

Etoposide is FDA approved for the treatment of testicular carcinoma and small cell lung carcinoma.

Florida Medicare will cover Etoposide for its FDA approved uses, as well as for the treatment of the following off-labeled indications:

- Gastric carcinoma
- Hepatoblastoma
- Neuroblastoma

- Non-small cell lung carcinoma
- Thymoma
- Osteosarcoma
- Ewing's sarcoma
- Soft tissue sarcoma
- Cutaneous T cell lymphomas
- Breast carcinoma
- Kaposi's sarcoma
- Endometrial carcinoma
- Ovarian carcinoma
- Testicular carcinoma
- Bladder carcinoma
- Wilms' Tumor
- Retinoblastoma
- Primary brain tumors
- Adrenocortical carcinoma
- Non-Hodgkin's lymphomas
- Hodgkin's lymphoma
- Multiple myeloma
- Acute lymphocytic leukemia
- Acute nonlymphocytic leukemia
- Chronic myelocytic leukemia
- Gestational trophoblastic tumor

HCPCS CODES

J9181 Etoposide, 10 mg
J9182 Etoposide, 100 mg

ICD-9-CM Codes That Support Medical Necessity

151.0-151.9	175.0-175.9	200.00-200.88
155.0	176.0-176.9	201.00-201.98
155.2	182.0	202.00-202.98
160.0-160.9	183.0	203.00-203.01
162.2-162.9	186.0-186.9	204.00-204.01
164.0	188.0-188.9	205.00-205.01
170.0-170.9	189.0	205.10-205.11
171.0-171.9	190.5	206.00-206.01
173.0-173.9	191.0-191.9	207.00-207.01
174.0-174.9	194.0-194.9	236.1

Fludarabine (Fludara®)

Fludarabine phosphate is a nucleotide analog which is incorporated into DNA and inhibits further DNA synthesis.

Fludarabine is FDA approved for treatment of chronic lymphocytic leukemia.

Florida Medicare will cover Fludarabine for its FDA approved uses, as well as for the treatment of the following off-labeled indication:

- Acute Non-Lymphocytic Leukemia
- Non-Hodgkin's Lymphoma

HCPCS CODES

J9185 Fludarabine phosphate, 50 mg

ICD-9-CM Codes That Support Medical Necessity

200.00-200.88	204.10-204.11	206.00-206.01
202.00-202.98	205.00-205.01	207.00-207.01

Mitoxantrone Hydrochloride (Novantrone®)

Mitoxantrone hydrochloride is an anthracenedione which inhibits DNA and RNA synthesis.

Mitoxantrone hydrochloride is FDA approved for treatment of advanced symptomatic prostate carcinoma and acute non-lymphocytic leukemia.

Florida Medicare will cover Fludarabine for its FDA approved uses, as well as for the treatment of the following off-labeled indication:

- Breast carcinoma
- Acute lymphocytic Leukemia
- Non-Hodgkin's Lymphoma

HCPCS CODES

J9293 Injection, mitoxantrone HCL, per 5 mg

ICD-9-CM Codes That Support Medical Necessity

174.0-174.9	200.00-200.88	205.00-205.01
175.0-175.9	202.00-202.98	206.00-206.01
185	204.00-204.01	207.00-207.01

Additional Changes to Policy

The following changes have also been made, based on new information regarding appropriate ICD-9-CM codes for six of the drugs currently in the policy:

Doxorubicin (J9000) – 194.0 and 236.1
Aldesleukin (J9015) - 205.10-205.11
Docetaxel (J9170) – 140.0-149.9, 161.0-161.9, and 185
Gemcitabine (J9201) – 174.0-174.9, 175.0-175.9, and 183.0
Paclitaxel (J9265) – 195.0
Trastuzumab (J9355) - 198.89

Documentation Requirements

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

Effective Date

The addition of Etoposide, Fludarabine, and Mitoxantrone Hydrochloride is effective for services processed on or after April 17, 2000.

The additional ICD-9-CM codes for Doxorubicin, Aldesleukin, Docetaxel, Gemcitabine, Paclitaxel, and Trastuzumab are effective for services processed on or after February 28, 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.

Florida Medicare Program Safeguards—Focused Medical Review

14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14300, and 14350: Skin Tissue Rearrangement

This group of procedure codes in the American Medical Association's (AMA) *Current Procedural Terminology (CPT)* were recently analyzed as part of the focused medical review (FMR) process that is mandated by the Health Care Financing Administration (HCFA). The time period covered by this particular analysis is the first half of 1998. The group consists of six primary and four secondary procedure codes related to

repair of integumentary defects by transfer or rearrangement of adjacent skin tissue. Examples of these procedures include techniques such as Z-plasty, W-plasty, M-plasty, rotation flaps, and double pedicle flaps. **The appropriate selection of these procedure codes involves careful measurement, and documentation of the measurement in square centimeters, of the wound(s) to be repaired, as well as documentation of the anatomical site of the**

repair. These codes are reported based on the size of the defect to be repaired, not the size of the tissue flap used. These procedure codes are also seen used in addition to the free skin graft codes (15000 group) when a graft is required to close the original defect created by the lesion removal. In general, these procedure codes describe methods used to accomplish wound closure when simple primary closure (linear suturing) is insufficient.

Code	Descriptor
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	defect 10.1 sq cm to 30 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10 sq cm or less
14061	defect 10.1 sq cm to 30.0 sq cm
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
14350	Filletted finger or toe flap, including preparation of recipient site

Several items of interest were noted during the analysis of this code group:

- Many of the diagnosis codes did not seem appropriate for the size of the tissue rearrangement being billed. In other words, a significant number of the *CPT* codes billed were for tissue transfers of 30 sq. cm. or greater, unusual or complicated wound closure, for defect repairs of the skin related to the removal of neoplasms of relatively small areas, such as the lip or auricle of the ear.
- The Moh's Micrographic Surgical Procedure (*CPT* 17304) was very often the procedure of choice for removal of squamous and basal cell carcinomas of the lip, nose, and eye areas. This procedure requires that lesion removal occurs by removal of layers until

a cancer-free layer is isolated. This usually results in two to five layers of excision and *potentially* rather large defects. This procedure code further describes that the surgeon must also perform analysis of the specimens *during* the procedure, thus creating a dual role for the physician.

- A large number of the ICD-9-CM codes billed with these procedures seemed more generic than one would expect with such detailed procedures (e.g., "other and unspecified parts of face," "other malignant neoplasm," etc.).

During the analysis, it was also discovered that these *CPT* codes were used to bill for wound closures that did not include lesion removal. Lesion removal is an inherent component of the codes in this group, thus limiting their appropriate use for lesion excision that also requires this type of wound closure. In this light, utilizing these codes for wound closure, as in traumatic injury or general surgical wounds, is inappropriate coding. The following are examples of wound closure codes that may have been billed *inappropriately*, as evidenced by submitted diagnoses on the claims:

ICD-9 Code	Description
610.8	Benign mammary dysplasia, other specified benign mammary dysplasia
875.1	Open wound of chest wall, complicated
881.10	Open wound of elbow, forearm, and wrist
890.0	Open wound of hip and thigh, without mention of complication
V51	Aftercare involving the use of plastic surgery

Based on review of the medical records, the billed *CPT* codes are accurately documented in most cases; the defect sizes documented are reflected in the *CPT* descriptors for the codes billed. However, it is felt that several providers may be

measuring defects inaccurately. Although documentation in the medical records is stated in centimeters, it would seem more appropriate to have documented the measurement in millimeters, based on the improbable size of some of the documented defects. Some providers may be adding length and width measurements rather than estimating defect size in *square* centimeters. Also, some providers may be measuring the size of the skin flaps utilized for the *repair* instead of the defect left by removal of the original lesion, as is specified in the *CPT* descriptors for these codes.

One would expect the codes in this group that represent repair of defects of 10 sq cm and smaller to be used more frequently than those that represent the larger defects. If the majority of measurements documented in the reviewed medical records are in fact *defect* measurements, then it would be reasonable to expect that the utilization of the codes representing larger (>10.1 sq cm) defects would be the exception and not the norm. This could potentially require the review of a larger number of medical records for an overall analysis of all billed codes per provider. It appears that there is a possibility that a large number of *CPT* codes are chosen and billed based on skin flap size, and not defect size. ***Providers should measure the size of the defect left by removal of the original lesion, instead of the size of the skin flaps utilized for the repair,*** to ensure the appropriate code(s) is billed.

Analysis of the medical records associated with this FMR code grouping revealed that documentation by Florida physicians indicated there was some misunderstanding and misuse of the codes in this group. Therefore, providers must ensure that they are in compliance with the *CPT* guidelines for these procedure codes. Recovery of inappropriately paid dollars will be undertaken.

20974: Osteogenic Stimulator for Fracture Healing

The Medicare Coverage Issues Manual is being revised to define nonunion of long bone fractures as existing when fracture healing has ceased for three or more months as confirmed by serial radiographs. Previously, nonunion of long bone fractures was considered to exist only after six or more months had elapsed without healing.

This change is effective for services processed on or after April 1, 2000. The complete local medical review policy (LMRP) for this service will be published in a future issue of the *Medicare B Update!*

22899: Coverage for Percutaneous Vertebroplasty

Percutaneous vertebroplasty is a therapeutic, interventional neurosurgical and radiological procedure that consists of the percutaneous injection of a biomaterial, methyl methacrylate, into a lesion of a cervical, thoracic, or lumbar vertebral body. The procedure is utilized for pain relief and bone strengthening of weakened vertebral bodies.

The procedure is performed under fluoroscopic guidance, although some prefer the use of computed tomography (CT) with fluoroscopy for needle positioning and injection assessment. An intraosseous venogram is sometimes performed before cement injection to determine whether the needle is positioned within a direct venous anastomosis to the central or epidural veins, to minimize extravasation into venous structures. General anesthesia or neuroleptanalgesia with additional local anesthesia (1% lidocaine) is utilized, as pain may intensify during cement injection. The methyl methacrylate is injected into the vertebral body until resistance is met or until cement reaches the posterior wall. The procedure usually lasts from 1 to 2 hours, unless cement is injected into two or more vertebral bodies. The patient must remain flat for about three hours following the procedure.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the performance of a percutaneous vertebroplasty procedure medically reasonable and necessary for the following indications:

- Painful osteolytic vertebral metastasis;
- Painful myeloma;
- Painful and/or aggressive heman-gioma; and
- Painful, debilitating, osteoporotic vertebral collapse/compression fractures that have not responded to appropriate medical treatment (e.g., 2-4 week period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic).

The decision to perform this procedure should be multidisciplinary, taking into consideration the following factors: the local and general extent of the disease, the spinal level involved, the severity of pain experienced by the patient, previous treatments and their outcomes, as well as the patient's neurological condition, general state of health and life expectancy.

Percutaneous vertebroplasty is contraindicated in coagulation disorders due to the large diameter of the needles used for injection.

Relative contraindications to performance of a percutaneous vertebroplasty are extensive vertebral destruction, significant vertebral collapse (i.e., vertebra reduced to less than one-third its original height), neurological symptoms related to compression, and when there is no neurosurgical backup for emergency decompression in the event a neurological deficit develops during the injection of methyl methacrylate.

HCPSC Codes

22899 Unlisted procedure, spine

ICD-9-CM Codes That Support Medical Necessity

170.2
198.5
203.00-203.01
228.09
238.6
733.13
805.00-805.9

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

When billing for percutaneous vertebroplasty, utilize HCPCS code 22899. The associated services (e.g., fluoroscopy, CT, venogram, injection, etc.) are included in the reimbursement for the procedure, and are not separately reimbursable. Therefore, the following codes must not be billed in addition to HCPCS code 22899: 22305, 22851, 36005, 75872, 76000, 76003, 99141, and/or L8699.

HCPCS code 22899 should only be billed one time per vertebra, regardless of the number of injections to the one vertebra.

If more than one vertebra is injected, HCPCS code 22899 may be billed in accordance with multiple surgery billing guidelines.

Documentation Requirements

Medical record documentation (e.g., office/progress notes, procedure notes) must be submitted by the provider and must indicate the medical necessity for performing this service. The documentation must also support that the service was performed.

When the service is performed for painful, debilitating, osteoporotic vertebral collapse/compression fractures, documentation must support that conservative treatment has failed.

Effective Date

This local medical review policy is effective for services processed on or after April 17, 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.

27599, 29870, 29874: Autologous Cultured Chondrocyte Implantation

Autologous cultured chondrocyte implantation is a two-stage procedure that is performed for the treatment of patients with a symptomatic focal chondral lesion of the femoral condyle (medial, lateral, or trochlear) of the knee joint. The goal of autologous cultured chondrocyte implantation is to restore the articular surface and regenerate hyaline cartilage without compromising the integrity of healthy tissue or the subchondral bone.

The first stage of the procedure requires obtaining a small cartilage biopsy arthroscopically from a minor load-bearing area of the knee. The patient's chondrocytes are isolated for the cartilage matrix in the laboratory. The cells are expanded in culture to a population of approximately twelve million viable cells (this takes 3-4 weeks), which is then placed in suspension and returned for implantation. The second stage requires bringing the patient back to surgery to have an arthrotomy performed to complete debridement, periosteal patch, and implantation of the cultured chondrocytes.

Immediately following the second stage surgical procedure, the patient must begin a carefully monitored and controlled physical therapy program that will continue over the following months. Low impact activity may be resumed as early as six months after treatment. High level activity should be restricted for at least twelve months, as this will allow the repair tissue to complete its maturation.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the use of autologous cultured chondrocyte implantation to be medically reasonable and necessary for the treatment of a symptomatic focal chondral lesion of the femoral condyle (medial, lateral, or trochlear) in the following circumstances:

- Patients between the ages of 15 and 55 years of age;
- A Grade III or Grade IV, full thickness articular cartilage loss on a weight-bearing surface of the femoral condyle (medial, lateral, or trochlear) must be present;
- The patient's lesion must be symptomatic, defined as lesion-related pain, swelling and catching/locking, which limits activities of daily living;
- The focal chondral defect size should be between 1-10 cm.
- The knee must be stable and aligned (corrective procedure in combination with or prior to chondrocyte implantation may be necessary);
- For the treatment of an acute traumatic injury or for the treatment of lesions that have failed to respond to previous treatment methods (e.g., cartilage debridement, microfracture, or abrasion arthroplasty).

Autologous cultured chondrocyte implantation is not considered appropriate in the following circumstances. Therefore, Florida Medicare will not consider its use in these patients to be medically reasonable and necessary:

- A patient who has had a previous total meniscectomy;
- A patient with known history of anaphylaxis to gentamicin or sensitivities to materials of bovine origin;
- A patient with infection at any of the proposed operative sites;

- A patient with osteoarthritis or inflammatory diseases; and/or
- A patient over the age of 55.

HCPSC Codes

27599	Unlisted procedure, femur or knee
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)

ICD-9-CM Codes That Support Medical Necessity

717.9
836.2

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.

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

This procedure is a two-part procedure requiring two separate surgical stages. The first stage requires an arthroscopy to obtain a small cartilage biopsy from a minor load-bearing area of the knee for autologous chondrocyte tissue culture. The second stage requires an arthrotomy to be performed to complete debridement, perform a periosteal patch, and then implant the cultured chondrocytes into the pouch created by the patch. The appropriate codes for billing each stage of the procedure are as follows:

- If the initial arthroscopic procedure is a diagnostic arthroscopy, then the appropriate code to bill would be the arthroscopy code 29870 [Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)]. In this case, the surgeon would take a biopsy for autologous chondrocyte tissue culture once the focal chondral lesion was discovered.
- If the initial arthroscopic procedure is performed to surgically evaluate the degree of focal chondral lesion and/or specifically for chondrocyte tissue biopsy (in a patient with a known chondral lesion of the femoral condyle), then the appropriate code to bill would be the arthroscopy code 29874 (Arthroscopy, knee, surgical; for removal of loose body or foreign body [eg, osteochondritis dissecans fragmentation, chondral fragmentation]).
- The second step of the procedure (arthrotomy with debridement, formation of periosteal patch, and implantation of the cultured chondrocytes) should be billed with the procedure code 27599 (unlisted procedure, femur or knee). This unlisted code would include the debridement, periosteal patch, and implantation of the cultured chondrocytes, and should not be billed separately.

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the first stage arthroscopic procedure. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or procedure report.

Medical record documentation must be submitted with each claim when billing the second stage of the procedure using the unlisted procedure code 27599. Documentation should clearly support the conditions set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. These include a grade III or grade IV, full thickness articular cartilage loss (focal chondral lesion) on a weight-bearing surface of the femoral condyle (medial, lateral, or

trochlear). The focal chondral defect size should be between 1cm and 10cm. The patient's lesion must be symptomatic, defined as lesion-related pain, swelling and catching/locking which limits activities of daily living. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or procedure report.

Effective Date

This local medical review policy is effective for services performed on or after April 17, 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.

62310, 62311, 62318, 62319: Epidural/Subarachnoid Injections

Epidural/subarachnoid injections have a number of applications for diagnostic purposes, therapeutic purposes, and for postoperative pain control. This policy will specifically address the use of epidural/subarachnoid injections, single or continuous, of diagnostic or therapeutic substances (including anesthetic, antispasmodic, opioid, steroid, or other solution) for these purposes. This does not include neurolytic substances.

The injection of an anesthetic agent can be used as a diagnostic tool when performing differential neural blockade on an anatomic basis in the evaluation of acute, subacute, and/or chronic pain. The injection of an anesthetic agent can also be used therapeutically to treat certain acute and/or chronic pain conditions.

The injection of a steroid agent into the epidural/subarachnoid space is performed to reduce inflammation and irritation in and around the nerve root for the treatment of certain acute, subacute and/or chronic pain conditions.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the use of epidural/subarachnoid injections for diagnostic and/or therapeutic purposes to be medically reasonable and necessary once the patient has failed to respond to conservative management of the presenting condition. The medical record should document failure of conservative management prior to initiating this level of intervention.

Epidural/Subarachnoid Injections for Diagnostic Purposes

Florida Medicare will consider the use of epidural/subarachnoid injections for diagnostic purposes to be medically reasonable and necessary in the following circumstances:

- To identify specific pain pathways and to aid in the differential diagnosis of the origin and site of pain in certain acute and/or chronic pain conditions.
- To be used in a prognostic manner to predict the effects of destruction of a given nerve in certain chronic pain conditions.

Epidural/Subarachnoid Injections for Therapeutic Purposes

Florida Medicare will consider the use of epidural/subarachnoid injections for therapeutic purposes to be medically reasonable and necessary for the treatment of the following circumstances:

- Chronic pain syndromes (generally lasting more than six months) including chronic cervical, thoracic, and lumbar pain with radiculopathy, spinal stenosis, phantom limb pain, reflex sympathetic dystrophy, complex regional pain syndrome, and vertebral compression fractures.
- Chronic pain due to intervertebral disc disease with neuritis, radiculitis, or myelopathy.
- Intractable post-herpetic neuralgia.
- Chronic severe pain due to carcinoma.
- Post-laminectomy syndrome (failed back syndrome).
- Post-traumatic neuropathy of the spinal nerve roots.
- Acute/subacute pain syndromes including cervical, thoracic, and lumbar pain with radiculopathy and intervertebral disc disease with neuritis, radiculitis, or myelopathy that has failed to respond to adequate conservative management. (Subacute conditions would refer to recurrent and/or exacerbation of an acute condition).

Diagnostic and/or therapeutic injections are considered to be medically necessary for the management of acute, subacute or chronic pain syndromes that have failed to respond to conservative management. However, it is prudent medical practice to evaluate the patient thoroughly and to provide the modality most likely to establish or treat the presumptive diagnosis. If the first procedure fails to produce the desired effect and rules out that possibility, then it would be appropriate to proceed to the next logical treatment. Therefore, it would generally not be expected to see epidural injections, sympathetic nerve blocks, multiple facet joint injections, and paravertebral nerve blocks in any and all combinations to be administered to the same patient on the same day. Such therapy can lead to an improper diagnosis or unnecessary treatment. Furthermore if the patient has **no** positive response to the first epidural injection, repeat injections would not be considered medically reasonable and necessary.

Epidural/Subarachnoid Injections for Acute Postoperative Pain Control

Florida Medicare will consider the use of epidural/subarachnoid injections for postoperative pain management in the following circumstances:

- When the surgeon and/or anesthesiologist determines postoperative pain is sufficient to require this level of pain management.
- For those procedures for which the surgeon and/or anesthesiologist feels it is reasonable to expect that postoperative pain will be sufficient to require this level of pain management.

HCPCS Codes

62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62311	lumbar, sacral (caudal)
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62319	lumbar, sacral (caudal)

ICD-9-CM Codes That Support Medical Necessity

053.10-053.19	723	724.2
141.0-239.9	723.1	724.3
337.21	723.4	724.4
337.22	724.01	733.13
353.0-353.6	724.02	953.0-953.8
722.0-722.93	724.1	V58.49

Note that the appropriate ICD-9-CM code to bill for post-operative pain management is V58.49 (Other specified aftercare following surgery).

Reasons for Denial

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

Noncovered ICD-9-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 appropriate code to bill for the fluoroscopic guidance component (if fluoroscopy is utilized) for these procedures codes (62310, 62311, 62318, and 62319) would be procedure code 76005: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction.

It would not be appropriate to bill procedure code 72275 (Epidurography, radiological supervision and interpretation) for the fluoroscopy and injection of contrast material in addition to procedure codes (62310, 62311, 62318, and 62319). These codes state in their descriptors "with or without contrast (for either localization or epidurography)." Therefore, the injection of contrast is included in the injection code. It would be appropriate to bill procedure code 72275 if epidurography is the only procedure being performed and if "radiological supervision and interpretation" by the radiologist were performed.

CPT codes 62310-62311 are for "single injections (not via an indwelling catheter)" and codes 62318-62319 are for "injection, including catheter placement, continuous infusion or intermittent bolus." Therefore, billing any combination of these two sets of codes (62310-62311 and 62318-62319) would not be allowed for the same patient on the same date of service.

There can be several scenarios in the case of epidural/subarachnoid injections used for postoperative pain management. Each has specific coding applications as detailed in the following circumstances:

- The catheter is used for the surgical anesthesia and then used postoperatively for pain management. In this case, it would be appropriate to bill the applicable anesthesia code for the procedure on the date of surgery and bill 01996 (daily management of epidural or subarachnoid drug administration) for subsequent days until the catheter is removed. It would not be appropriate to bill 62318 or 62319 in this case.
- The catheter is placed preoperatively for postoperative pain management only. In this case, the patient received another form of anesthesia (e.g., general anesthesia) and an epidural/subarachnoid catheter is placed preoperatively because the surgeon and/or anesthesiologist believes postoperative pain can reasonably be expected to be sufficient to require this level of pain management. In this situation, it would be appropriate to bill the applicable anesthesia code, as well as the appropriate injection code (62318 or 62319) for the placement of the epidural/subarachnoid catheter. The subsequent days that an injection is given through the catheter for pain management would then be billed using 01996 as above.
- The catheter is placed postoperatively for pain management. In this case, once the patient is awake and the surgeon and/or anesthesiologist feels that the postoperative pain is sufficient to require this level of pain control, then both the applicable anesthesia code and the appropriate injection code for the placement and injection of the epidural/subarachnoid injection, would be appropriate to bill. Subsequent days that an injection was given through the catheter would be billed using 01996 as above.

Note that the appropriate ICD-9-CM code to bill for acute postoperative pain management is V58.49 (Other specified aftercare following surgery).

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or procedure report.

In addition, the medical record should clearly document the nature of the chronic pain condition. This should include the location, intensity, type of pain present, contributing factors (if any), duration of condition, and treatment regimes

that have been utilized. Documentation should demonstrate failure of conservative management in the treatment of the patient's condition.

Effective Date

This local medical review policy is effective for services performed on or after April 17, 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.

64555: Sacral Neuromodulation

Sacral neuromodulation is a new treatment modality used in the management of patients who suffer from refractory urinary urge incontinence, significant urgency/frequency and urinary retention in patients without mechanical obstruction. The aim of therapy is to modulate the micturition reflex by electrically stimulating the sacral nerves which influence the bladder and pelvic floor muscles.

This therapy involves the surgical implantation of a system for long term use. The system consists of a lead, a neurostimulator and an extension that connects the two. Under general anesthesia, the lead is placed through an open incision over the selected foramen. The proximal end of the lead is tunneled around to the neurostimulator implanted into the lower abdomen or upper buttock. An extension connects the neurostimulator to the lead. Noninvasive programming of the neurostimulator parameters and modes occurs post-operatively.

Indications and Limitations of Coverage and/or Medical Necessity

The three major categories of treatment for managing chronic urinary incontinence are behavioral, pharmacological, and surgical. As a general rule, the first management choice should be the least invasive treatment with the fewest potential adverse effects that is appropriate for the patient. Following this general rule, Florida Medicare will consider sacral neuromodulation medically reasonable and necessary for the following conditions:

- For the treatment of patients with urinary urge incontinence or significant symptoms of urgency/frequency who have found behavioral and pharmacological treatments ineffective or not well tolerated. In addition, the symptoms of frequency and/or leakage must have resulted in significantly limiting the patient's ability to work or participate in activities outside the home.

Common behavioral techniques used in treatment include bladder training, pelvic muscle rehabilitation such as Kegel exercises in conjunction with bladder training, timed voiding and fluid management.

Pharmacological treatment includes the use of anticholinergic agents (e.g., oxybutynin, dicyclomine hydrochloride) as first-line pharmacological therapy. Propantheline is used as a second-line anticholinergic agent in patients who can tolerate the full dose. Tricyclic antidepressants (TCAs) have been used in carefully selected patients.

- For the treatment of patients with idiopathic non-obstructive chronic urinary retention who have found conservative treatment ineffective or not well tolerated. This therapy is not intended for patients with mechanical obstruction such as benign prostatic hypertrophy, cancer, or urethral stricture.

Conservative treatment currently available includes self or indwelling catheterization.

Pharmacological treatment includes the use of alpha blockers and cholinergics.

All potential surgical implantation candidates are subject to a test stimulation procedure. This procedure consists of a unilateral percutaneously placed temporary lead in the sacral plexus (usually at S3) that is electrically stimulated by an external neurostimulator. The patient's response to sacral nerve stimulation is assessed over the next three to seven days through the use of a patient maintained detailed voiding diary. A successful test is one in which the patient's incontinence symptoms have improved during the test period by at least 50% over baseline. For the patient with urgency/frequency this means a reduction in the number of voids per day, increase average voided amount, and/or a reduction in the degree of urgency associated with each void. For the patient with non-obstructed urinary retention, this means a reduction in the residual catheter volume.

Patients are contraindicated for implantation if they have not demonstrated an appropriate response to test stimulation, or they are unable to operate the implantable pulse generator.

The effectiveness of this treatment on patients with neurogenic etiologies has not been established. Therefore, patients with neurogenic bladders are ineligible for coverage.

Sacral neuromodulation must be performed using devices approved by the FDA for these indications. Any additional conditions of the FDA approval must also be met (e.g., requiring formal physician training).

HCPSC Codes

- | | |
|-------|---|
| 64555 | Percutaneous implantation of neurostimulator electrodes; peripheral nerve |
| 64575 | Incision for implantation of neurostimulator electrodes; peripheral nerve |
| 64585 | Revision or removal of peripheral neurostimulator electrodes |
| 64590 | Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling |

- 64595 Revision or removal of peripheral neurostimulator pulse generator or receiver
- 95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
- 95971 simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
- 95972 complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour
- 95973 complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) (Use 95973 in conjunction with code 95972)
- E0745 Neuromuscular stimulator, electronic shock unit
- E0751 Implantable neurostimulator pulse generator or combination of external transmitter with implantable receiver (includes extension)
- E0753 Implantable neurostimulator electrodes, per group of four
- E1399 Durable medical equipment, miscellaneous

ICD-9-CM Codes That Support Medical Necessity

788.20-788.29
788.31
788.41

Reasons for Denial

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

Noncovered ICD-9-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 guidance to determine simple versus complex neurostimulators is based on the device's capability. The stimulation programming codes are based upon what the system is capable of affecting rather than which parameters are being utilized during the programming session.

E0745 Neuromuscular stimulator, electronic shock unit is an external unit used during trial stimulation. The Durable Medicare Equipment Regional Carrier (DMERC) has jurisdiction for processing claims for the rental of this unit. For region C, the DMERC is Palmetto GBA Medicare (the address and telephone number are on the back page of this publication).

To report the test stimulation lead kit, bulk leads, needles and cables, use code E1399 Durable medical equipment, miscellaneous. Florida Medicare will process such claims for implanted durable medical equipment. An invoice as well as the documentation listed below must be provided.

Documentation Requirements

Documentation maintained by the treating physician must indicate the medical necessity of this procedure. The selected behavioral and pharmacological treatments tried and the patient's response to them must be included. A report of the trial stimulation with the patient's response must be included. The medical record must document how these significant symptoms of urinary incontinence, urgency/frequency, or retention have affected the patient's ability to work or perform activities outside the home.

Other Comments

Terms defined:

Urge incontinence - sudden strong urge to urinate followed by an involuntary loss of urine.

Urgency/frequency - uncontrollable urge to urinate followed by frequent, small volume voids.

Urinary retention - the inability to completely empty the bladder of urine.

Effective Date

This local medical review policy is effective for services processed on or after April 17, 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.

64470, 64472, 64475, 64476: Paravertebral Facet Joint Nerve Injection

A paravertebral facet joint or facet joint nerve block is a local anesthetic procedure that is performed to temporarily denervate (block) the facet joint. This procedure is one of the methods used to document and/or confirm suspicions of structural lesions causing neck/back pain. It is used to differentiate between facet joint syndrome and other causes of neck/

back pain. It is a diagnostic procedure that, in many cases, becomes therapeutic as well.

During this procedure a needle is placed in the paravertebral facet joint or facet joint nerve, generally under fluoroscopic guidance, and a long-acting local anesthetic agent (with or without a steroid) is injected in the joint to temporarily denervate the facet joint. After a satisfactory blockade of the pain has been

obtained, the patient is asked to indulge in the activities that usually aggravated his/her pain and to record his/her impressions to the effect of the procedure 4-8 hours after the injection. Temporary or prolonged abolition of the pain suggests that facet joints were the source of the symptoms, and appropriate therapeutic treatment may then be prescribed (e.g., facet nerve denervation) for long-term pain relief.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the use of paravertebral facet joint or facet joint nerve injection to be medically reasonable and necessary when facet joint pain is suspected in patients with neck/back pain that may or may not have a radicular component, is not associated with a neurologic deficit, and the pain is aggravated by rotation or hyperextension of the spine.

Assessment of the outcome of this procedure depends upon the patient's responses. It is therefore, important to make a careful pre-operative evaluation including satisfactory patient education.

Conservative treatment of facet joint syndromes include local heat, traction, and nonsteroidal anti-inflammatory medications. Medical record documentation should demonstrate failure of conservative management of the patient's condition prior to initiating facet joint nerve injections. However, facet joint nerve injections may be necessary for proper evaluation and management of neck/back pain in a given patient. It is prudent medical practice to evaluate the patient thoroughly and to provide the modality most likely to establish the diagnosis or treat the presumptive diagnosis. If the first procedure fails to produce the desired effect or rules out the diagnosis, it would be reasonable to proceed to the next logical test or treatment, as indicated. Therefore, it would not generally be expected to see epidural/subarachnoid injections, multiple facet joint nerve injections, and lumbar sympathetic injections in any and all combinations to be administered to the same patient on the same date of service. Such therapy can lead to an improper diagnosis and/or unnecessary treatment. Also, because this procedure is primarily of a diagnostic nature, frequent facet joint nerve injections would not generally be expected.

HCPCS Codes

64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
64472	cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64475	lumbar or sacral, single level
64476	lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

ICD-9-CM Codes That Support Medical Necessity

721.0-721.42
722.81-722.83
723.1
724.1
724.2
724.3

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

For fluoroscopic guidance and localization for needle placement in conjunction with procedure codes 64470, 64472, 64475, and 64476, use procedure code 76005: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or

sacroiliac joint), including neurolytic agent destruction.

If more than one level is injected, use code 64472 (cervical or thoracic, each additional level) in conjunction with 64470 (cervical or thoracic, single level) or use 64476 (lumbar or sacral, each additional level) in conjunction with 64475 (lumbar or sacral level, single level).

Injecting any substance through the needle, including small amounts of contrast to confirm the position of the needle, is considered an integral component of the procedure and is not reimbursed separately.

When destruction of the facet joint nerve is performed following the nerve injection, only the codes for nerve destruction (64622, 64623, 64626, or 64627) should be billed as those codes include the facet joint nerve injection.

Documentation Requirements

Medical record documentation maintained by the performing physician must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or procedure report.

Documentation should demonstrate failure of conservative management in the treatment of the patient's condition. In addition, the pre-procedure evaluation leading to suspicion of the presence of facet joint pathology must be documented in the patient's medical record along with post-procedure conclusions.

Effective Date

This local medical review policy is effective for services performed on or after April 17, 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.

78472, 78473, 78481, 78483, 78494, 78496: Coverage for Cardiac Blood Pool Imaging

Radionuclide ventriculography is one of the most widely used techniques for evaluating ventricular function. This essentially noninvasive method of assessing ventricular function can be easily performed and provides a reproducible, accurate evaluation of both right ventricular and left ventricular function. Currently, there are two techniques for assessment of ventricular performance using radionuclides: the first-pass technique and gated blood pool imaging. Information that can be derived from these studies includes assessment of left and/or right ventricular ejection fraction, regional wall motion, left ventricular volumes, and diastolic function.

Gated blood pool imaging (multigated acquisition, or MUGA), also known as equilibrium radionuclide angiography, is the most widely used technique to assess ventricular function. In this technique, the patient's erythrocytes are labeled with technetium-99m, and the imaging is performed by synchronizing acquisition to the R wave of the electrocardiogram (ECG). Sampling is performed repetitively over several hundred heartbeats with physiological segregation of nuclear data according to occurrence within the cardiac cycle.

First-pass radionuclide angiography utilizes a high-count-rate gamma camera and involves sampling for only seconds during the initial transient of the technetium-99m bolus through the central circulation. The high-frequency components of this radioactive passage are recorded and analyzed quantitatively. After data acquisition, right and left ventriculograms are constructed from which ejection fractions and ventricular volumes can be calculated.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider cardiac blood pool imaging studies (procedure codes 78472, 78473, 78481, 78483, 78494, and 78496) medically reasonable and necessary for the following indications:

- Evaluation of a patient with suspected or known Coronary Artery Disease (CAD). A radionuclide ventriculogram assists in stratifying patients into low and high risk, thereby providing prognostic value. However, perfusion imaging is superior to exercise radionuclide ventriculograms. Therefore, current practice is to perform stress myocardial perfusion imaging in patients with suspected CAD.
- Evaluation of a patient after a Myocardial Infarction (MI). Assessment of the impact of the MI on ventricular function, identification of the physiologic importance of coronary stenosis outside the infarct distribution (i.e., extent in which viable myocardium is jeopardized), and risk stratification for future cardiac events is determined. Normally, a resting study is recommended.
- Assessment of right ventricular function, especially in patients with cor pulmonale or an acute inferior MI caused by right ventricular infarction.
- Evaluation and monitoring of a patient with dilated or hypertrophic cardiomyopathy. Restrictive cardiomyopathy is normally diagnosed with other noninvasive methods; therefore, radionuclide studies do not have a role in the diagnosis of restrictive cardiomyopathy.

- Evaluation of a patient with suspected or known valvular heart disease to determine ventricular function and estimate the degree of valvular regurgitation. Serial evaluations may be necessary in patients with asymptomatic aortic regurgitation to determine surgical timing. In addition to obtaining a resting left ventricular ejection fraction (usually by the gated blood pool technique) in the timing of surgery, exercise duration is also a key indicator.
- Evaluation and management of a patient with congestive heart failure. The most important imaging procedure is two-dimensional echocardiography, which can evaluate ventricular chamber size, regional and global wall motion, left ventricular wall thickness, and valvular function. Radionuclide angiography provides assessment of left ventricular ejection fraction and is quantified more easily by a radionuclide rather than an echocardiographic technique.
- Evaluation and management of a patient with a neoplastic disease who will be receiving an anthracycline like neoplastic drug. Doxorubicin (an example of an anthracycline) is associated with the development of irreversible cardiotoxicity when given in doses of 450 mg/m² or greater. Therefore, a resting left ventricular ejection fraction is recommended before starting therapy and again after receiving cumulative doses of 300 mg/m² and 450 mg/m². Other anthracyclines include drugs such as Daunorubicin, Epirubicin, Idarubicin, Mitoxantrone, and Valrubicin.
- Detection and quantification of intracardiac shunts for patients with congenital heart disease. The first pass technique is better than the gated technique for this indication.
- Evaluation of ventricular function during exercise to determine cardiac reserve in patients with congenital heart disease.
- To distinguish systolic from diastolic dysfunction in a patient with exertional dyspnea thought to be cardiac in etiology.
- Evaluation of a patient after cardiac surgery (e.g., coronary artery bypass graft) to determine the effect of the intervention on left ventricular function and the results are being used in the management of the patient (i.e., changes to patient's medication regime or medical intervention will occur).

HCPSC Codes

- | | |
|-------|---|
| 78472 | Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing |
| 78473 | multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification |
| 78481 | Cardiac blood pool imaging (planar), first pass technique; single study at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification |

78483	multiple studies, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78494	Cardiac blood pool imaging, gated equilibrium; SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)

ICD-9-CM Codes That Support Medical Necessity

410.00-410.92	416.9	745.0-745.9
411.1	424.0	746.00-746.9
411.81	424.1	786.05
413.0-413.9	425.1	E930.7
414.00-414.05	425.4	E933.1
414.8	428.0-428.9	V67.0
414.9		

Coding Guidelines

Procedure code 78496 (cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique) is considered an add-on code and, therefore, should only be billed in conjunction with procedure code 78472 (cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress, wall motion plus ejection fraction, with or without additional quantitative processing).

In certain indications, it is common for a patient to undergo a myocardial perfusion imaging study (78460-78465, 78478-78480) and a cardiac blood pool imaging study during the same session. However, it is not ex-

pected that two different techniques (e.g., 78478 and 78472) will be billed, since the information such as wall motion and/or ejection fraction is obtained from the cardiac blood pool imaging technique. In this type of scenario, the billing of the lesser code is considered a duplicate of the cardiac blood pool imaging code.

It is not expected for a provider to bill for the multiple study procedure codes (78473 and 78483) on the same day, since the multiple study is performed using either the gated equilibrium method or the first pass technique.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of cardiac blood pool imaging studies. In addition, the results of the study must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital records, and/or test results.

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

Effective Date

This local medical review policy is effective for services processed on or after April 17, 2000.

Advance Notice Requirement

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.

82607, 82608: Vitamin B-12 (Cyanocobalamin) Assay

Vitamin B-12 (cyanocobalamin), is a water soluble hematopoietic vitamin found in foods of animal origin. It is necessary for the metabolism of protein, fats and carbohydrates. It is essential for normal blood formation and normal neural function. Causes of vitamin B-12 deficiency usually include the absence of intrinsic factor, which is vital for the absorption of vitamin B-12 by the gastrointestinal tract. Since vitamin B-12 is present in all foods of animal origin, dietary B-12 deficiency is rare. It is usually only seen in vegans (strict vegetarians). Deficiency of vitamin B-12 leads to macrocytic anemia. The normal adult daily intake of vitamin B-12 is between 2.0 ug and 5.0 ug.

The serum vitamin B-12 assay is intended to measure the serum vitamin B-12 level. The measurement is used to diagnose anemia due to gastrointestinal malabsorption and inadequate dietary intake of vitamin B-12. The normal adult vitamin B-12 levels are between 150 pg/mL and 350 pg/mL.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a vitamin B-12 assay level medically necessary for the following indications:

- To initially evaluate a patient presenting with signs and symptoms suggestive of vitamin B-12 deficiency. These patients could present with a megaloblastic anemia determined by other lab indices, peripheral neuropathy, and/or altered cerebral functioning such as dementia.
- To evaluate a patient with a previously identified gastrointestinal disease such as malabsorption syndromes, sprue or a patient that has undergone gastric or ileal surgery and a vitamin B-12 deficiency is suspected.

Note: Sequential vitamin B-12 testing is not necessary for the purpose of monitoring the effectiveness of vitamin B-12 therapy. Since vitamin B-12 is administered as treatment for anemia, the tests that are usually ordered for monitoring are the complete blood count (CBC), the hematocrit (HCT) and the hemoglobin (HGB).

HCPCS Codes

82607	Cyanocobalamin (Vitamin B-12);
82608	unsaturated binding capacity

ICD-9-CM Codes That Support Medical Necessity

266.2	294.8	579.0
281.0	298.9	579.1
281.1	311	579.2
281.3	357.4	579.3
285.8	555.9	579.9
285.9	558.9	

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

N/A

Documentation Requirements

Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing a vitamin B-12 assay. Additionally, a copy of the lab results should be maintained in the medical records.

If the provider of the services is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the vitamin B-12 level. The physician must state the clinical indication/medical necessity for the vitamin B-12 level in the order for the test.

Effective Date

This local medical review policy is effective for services processed on or after April 17, 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.

84436, 84437, 84439, 84443, 84479, 84480, 84481, 84482: Thyroid Function Tests—Revision

The 2000 HCPCS changes regarding thyroid function tests were published in the January/February 2000 Medicare B Update! on page 28. However, the policy for thyroid function tests has not been published in its entirety since the July/August 1997 Update! The policy is now being published due to the addition of ICD-9-CM codes 296.00-296.99 and E939.8

Thyroid function tests are standard tests used for the diagnosis of thyroid dysfunction, for investigation of conditions in which thyroid disease is in the differential diagnosis, and for the monitoring of treatment of diseases of the thyroid. Thyroid function tests include the total thyroxine (TT4), T3 resin uptake (T3 uptake), free thyroxine (FT4), triiodothyronine (TT3), free triiodothyronine (FT3), and thyroid stimulating hormone (TSH).

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider thyroid function tests to be medically necessary under any of the following circumstances:

A patient has signs and symptoms of hypothyroidism, which can include the following:

- ataxia
- bradycardia and hypothermia
- coarseness or loss of hair
- constipation
- decreased concentration
- depression
- dry skin and cold intolerance
- fatigue
- goiter
- hoarseness
- hyperlipidemia
- irregular or heavy menses and infertility
- memory and mental impairment
- myalgias
- myxedema, fluid infiltration of tissues
- reflex delay, relaxation phase
- weight gain
- yellow skin

A patient has signs and symptoms of hyperthyroidism, which can include the following:

- alterations in appetite
- changes in vision, photophobia, eye irritation, diplopia, or exophthalmos (proptosis)
- dependent lower extremity edema
- exertional intolerance and dyspnea
- fatigue and muscle weakness
- frequent bowel movements
- heat intolerance and increased sweating
- impaired fertility
- menstrual disturbance (decreased flow)
- mental disturbances
- nervousness and irritability
- palpitations and tachycardia
- pretibial myxedema (with Graves disease)
- sleep disturbances
- sudden paralysis
- thyroid enlargement/tenderness
- tremor
- weight loss

- Once thyroid levels have stabilized, testing would normally not be performed more than once every six months.
- More frequent testing may be medically necessary at the time of initial diagnosis of hyperthyroidism or hypothyroidism until desired thyroid levels are achieved.
- More frequent testing may also be medically necessary if there are acute changes in the patient's condition, or if it is necessary to adjust a patient's dosage.

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

- A Thyroid Function Test may be performed for the monitoring of a patient's response to the administration of lithium. A Thyroid Function Test would normally be performed 6 months after the initiation of lithium and yearly thereafter for monitoring purposes.

Note: A Thyroid Function Test performed prior to the initiation of lithium in an asymptomatic patient is considered screening and is noncovered by Medicare.

HCPCS Codes

84436	Thyroxine; total
84437	requiring elution (e.g., neonatal)
84439	free
84443	Thyroid stimulating hormone (TSH)
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	Triiodothyronine (T-3); total (TT-3)
84481	free
84482	reverse

ICD-9-CM Codes That Support Medical Necessity

193	310.1	703.8
226	311	704.00
237.4	333.1	729.1
239.7	356.9	729.82
240.0-240.9	358.0	733.09
241.0-241.9	359.5	759.2
242.00-242.91	368.2	775.3
243	374.41	780.09
244.0-244.9	376.21	780.50
245.0-245.9	376.30-376.31	780.79
246.0-246.9	376.33-376.34	780.8
253.2	427.0	781.3
253.3-253.4	427.1	782.3
253.7	427.2	783.1
255.4	427.31	783.2
272.0	427.32	783.4
272.1	427.81-427.9	784.1
272.2	560.1	784.49
275.40-275.49	564.0	785.0
276.1	564.7	785.1
278.01	625.3	786.03-786.09
290.10-290.3	626.0-626.2	794.5
293.1	626.4	799.2
296.00-296.99	648.10-648.14	E939.8
300.00-300.02	701.1	

Reasons for Denial

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

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

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

ICD-9-CM code E939.8 is to be used for the monitoring of a patient's response to the administration of lithium.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing thyroid function tests. Initially a comprehensive history and physical examination should be performed and documented that includes the following:

- cardiovascular examination
- neuromuscular examination
- patient's complaints or symptoms
- pulse rate
- thyroid palpation
- weight and blood pressure

During follow-up visits, an appropriate interim history and physical examination should be performed in conjunction with appropriate laboratory tests. An interim history should assess response to therapy, changes in medication or therapy, and evaluation of the clinical improvement in symptoms, as well as possible side effects of the medication or therapy.

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.

90801: Psychiatric Diagnostic Interview Examination

This policy was last published in the May/June 1996 Medicare B Update! Since that time, the policy has been revised to clarify the Medicare Contractor's definition of an "extended hiatus" as it refers to patient treatment. Therefore, it is being published in its entirety.

Although the emphasis, types of details, and style of a psychiatric interview differ from the medical interview, the purpose is the same: to establish a therapeutic doctor-patient relationship, gather accurate data in order to formulate diagnoses and initiate an effective treatment plan.

A psychiatric diagnostic interview examination consists of elicitation of a complete medical and

psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians and/or family. There may be overlapping of the medical and psychiatric history depending upon the problem.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider psychiatric diagnostic interview examination to be medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

Psychiatric diagnostic interview examination is not considered to be medically reasonable and necessary when the patient has a previously established diagnosis of organic brain disorder (dementia) unless there has been an acute and/or marked mental status change requiring a diagnostic psychiatric exam to rule out additional psychiatric or neurologic processes which may be treatable.

A psychiatric diagnostic interview should be conducted once, at the outset of an illness or suspected illness. It may be utilized again for the same patient if an extended hiatus in treatment occurs or if the patient requires admission to an inpatient status for a psychiatric illness. An extended hiatus is generally defined as approximately 6 months from the last time the patient was seen or treated for their psychiatric condition. Routine re-evaluation of the patient in the chronic care setting is not considered medically necessary.

HCPCS Codes

90801 Psychiatric diagnostic interview examination

ICD-9-CM Codes That Support Medical Necessity 290.0-318.1

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Coding Guidelines

An evaluation and management (E/M) service including consultation codes (**CPT codes 99201-99350**) may be substituted for the initial interview procedure provided required elements of the E/M service billed are fulfilled.

Pharmacologic management (CPT code 90862) is included in the basic allowance of the psychiatric diagnostic interview exam (CPT code 90801) when performed on the same day by the same provider.

Documentation Requirements

Medical record documentation maintained by the provider must indicate the medical necessity of the psychiatric diagnostic interview examination including the following:

- the presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to significantly alter baseline functioning and
- the diagnostic interview examination report which includes:
 - the reason for the interview/patient's chief complaint
 - a referral source (if applicable)

- history of present illness, including length of existence of problems/symptoms/conditions
- past history (psychiatric)
- significant medical history and current medications
- social history
- family history
- mental status exam
- strengths/liabilities
- multi-axis diagnosis or diagnostic impression list-including problem list
- treatment plan

In circumstances where other informants (family or other sources) are interviewed in lieu of the patient, documentation must include the elements outlined previously, as well as the specific reason(s) for not interviewing the patient. Any notations where family members gave any patient history should be included. This should be a rare occurrence.

Effective Date

This local medical review policy is effective for services processed on or after April 17, 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.

92548: Computerized Dynamic Posturography—Noncoverage Continued

Information regarding Florida Medicare's decision to noncover computerized dynamic posturography (CDP) was originally published in the January/February 1997 Medicare B Update! (page 19).

Computerized dynamic posturography (CDP) measures patient postural sway by recording foot forces generated when the patient is either translated horizontally and/or rotated either backward or forward. In some instances, the patient is confronted by moving visual scenes meant purposely to disorient the patient regarding the true position of the body. The most widespread application of dynamic posturography is in the evaluation of patients with dizziness and disequilibrium where a vestibular disorder is considered likely. However, recent reviews and ongoing research continue to generally conclude that CDP does not (1) reliably distinguish among multiple causes of dizziness, (2) localize the site of pathological lesions, or (3) test only the vestibulospinal reflexes. Thus there appears to be widespread consensus that CDP offers little additional information in establishing a specific diagnosis in patients with complaints of dizziness or imbalance over and above currently available methods. There is some literature to support CDP in distinguishing organic from functional dizziness, but it remains to be determined if there is a useful role for CDP in designing and/or monitoring rehabilitation programs for appropriately selected patients. Therefore, Florida Medicare will continue to *noncover* 92548 (computerized dynamic posturography).

Advance Notice Statement

An advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for a service that is considered investigational/experimental, or is not approved by the FDA, or because there is a lack of scientific and clinical evidence to support the procedure's safety and efficacy. Refer to page 4 for more information concerning advance beneficiary notice requirements.

93000, 93005, 93010: Electrocardiography—Revisions to Policy

The local medical review policy (LMRP) for electrocardiography was published in the September/October 1999 Medicare B Update! (pages 35-36). Since that time, requests for an expansion of coverage and clarification of coding guidelines have been received. The following represents the expanded coverage (additional allowable ICD-9-CM codes), and a clarification to the "Coding Guidelines" section of the policy.

Indications and Limitations of Coverage and/or Medical Necessity

Evaluation of a patient's response to the administration of an agent known to result in cardiac and EKG abnormalities (for patients with suspected, or at increased risk for developing, cardiovascular disease or dysfunction). Examples of these agents are antineoplastic drugs, lithium, tranquilizers, anticonvulsants, and antidepressant agents.

Note: An EKG performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities is considered screening and is noncovered by Medicare.

ICD-9-CM Codes That Support Medical Necessity

E933.1 E936.0-E936.3 E939.0-E939.9

Coding Guidelines

When using diagnosis code V72.81, it is expected that the medical record would contain information supporting either of the two pre-operative evaluation indications listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy (previously published in the September/October 1999 Medicare B Update!).

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.

93012, 93014, 93268, 93270, 93271, 93272, G0004, G0005, G0006, G0007, G0015, G0016: Patient Demand Single or Multiple Event Recorder

This policy was last published in the November/December 1998 Medicare B Update! (pages 35-37). Since that time, the policy has been revised to clarify coverage regarding the diagnosis 785.1 (Palpitations). Therefore, it is being published in its entirety.

An event recorder is a portable unit, attached to a patient, which permits the patient to record an EKG rhythm strip at the onset of symptoms (i.e., syncope, dizziness) or in response to a physician's order (i.e., immediately following strong physical exertion). Most devices also permit the patient to simultaneously voice-record in order to describe the symptoms and/or activity concurrently. There are two basic types of event recorders (post-event and pre-event), which are differentiated on the basis of memory.

In the post-event recorder without memory, the unit may continuously monitor the EKG via attached leads. The patient wears the recorder continuously, activating it when the symptoms appear. The patient may carry a miniature solid state recorder (sufficiently small to fit into a pocket or purse) with which the rhythm can be recorded whenever the symptoms appear, simply by placing the recorder on the precordium. Some newer devices are the size of a credit card, and can be carried in a wallet or worn as a necklace. The recorded data is stored in the memory until the patient submits the information either directly or telephonically to an EKG receiver, where it is recorded. When a tape is employed, the tape is then erased, and subsequent data can be recorded and transmitted to facilitate the recording of rhythm or pattern during several symptomatic episodes. When digital acquisition devices are used, a prolonged, continuous event can be recorded and stored or the device can be programmed to acquire multiple events.

With a pre-event recorder, employing a memory loop, the rhythm is monitored continuously via leads

either at the extremities or over the precordium and a recorder resembling a wristwatch or a miniaturized device is worn as a necklace or on a belt. Patients activate the unit when they experience the symptoms, so that an abnormal rhythm or an EKG synchronous with the symptoms can be recorded. The loop recorder is capable of recording information several seconds or minutes before or after a recognized event; the number of events and the allotment of recording time prior to and after activation of the unit are programmable.

When the goal is to correlate the patient's rhythm or EKG pattern with symptoms that are very infrequent (at weekly intervals or more), the patient activated event recorder is the optimal choice. However, if the patient's symptoms are of such brief duration (seconds) or severity (frank syncope) to preclude capture by such a unit, then a loop event recorder is required. It is important to correlate an abnormal rate and rhythm with cardiovascular symptomatology and determine the precise mechanism of the arrhythmia.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the use of patient demand single or multiple event recorders medically reasonable and necessary under the following circumstances:

- The patient demand single or multiple event recorder is utilized to detect, characterize, and document symptomatic transient arrhythmias.
- A definitive diagnosis has not been made after all of the following conditions have been met:

The patient has undergone a complete history and physical by a physician prior to the initiation of monitoring.

The history and physical must indicate that the patient is experiencing recurrent, transient symptoms suggestive of cardiac arrhythmia [Note: *Palpitations are extremely common in healthy individuals. Therefore, if ICD-9-CM code 785.1 (Palpitations) is billed as the diagnosis supporting medical necessity, the history and physical or other pertinent medical record documentation must support the presence of associated symptoms such as dizziness, shortness of breath, chest discomfort, or an underlying history of cardiac disease*]; and

The patient has undergone a 12 lead EKG and rhythm strip.

- A physician overseeing the medical management of the patient orders the medically necessary patient demand event recorder.
- Any device used for event recording must be FDA approved for the indication for which it is being utilized.
- The FDA approved device must be capable of transmitting EKG leads I, II, or III (the standard limb leads). To generate a sufficient EKG rhythm strip, the device must either have “built in” electrodes, such that placement of the device on the patient’s precordium produces an EKG reading of lead I, II, or III, or the device involves the proper placement/attachment of at least two electrodes to the patient. Because it is not practical to attach electrodes to the arms and legs, modifications of the standard limb leads must be utilized. Electrode placement for the monitor limb leads is similar to standard placement, except that the left and right shoulder or subclavian areas and the lower left quadrant of the abdomen are used for electrode placement. The following are the sites for proper lead placement to generate a lead I, II, or III:

LEAD	+ ELECTRODE	- ELECTRODE
I	Lt. subclavian (shoulder)	Rt. subclavian (shoulder)
II	Lt. lower quadrant abdomen	Rt. subclavian (shoulder)
III	Lt. lower quadrant abdomen	Lt. subclavian (shoulder)

- The transmission of the EKG lead I, II, or III must be sufficiently comparable to readings obtained by conventional EKG to permit proper interpretation of abnormal cardiac rhythms. EKG tracings normally consist of three identifiable waveforms: the P wave (depicting atrial depolarization), the QRS complex (depicting ventricular depolarization), and the T wave (depicting ventricular repolarization). The lead II rhythm strip depicts the heart’s rhythm more clearly than any other waveform.
- A provider of the service must be capable of receiving and recording transmissions 24 hours per day, every day of the year. This is applicable to those HCPCS codes whose descriptor indicates “24 hour attended monitoring” (e.g., G0004, G0005, G0006, G0007, G0015, and G0016). This includes receipt of the EKG signal, as well as the voice transmission relating any associated symptoms.

- The designated monitoring facility must have on-site 24 hour availability of an attendant trained in equipment operation and on-line analysis of the transmitted EKG tracing when HCPCS codes requiring 24 hour attended monitoring are ordered.
- The transmissions must be received by a person capable of responding to the transmission. The transmission is not to be received by an answering machine for review at a later time when HCPCS codes requiring 24 hour attended monitoring are ordered.
- The person receiving the transmission must be a technician, nurse, or physician trained in interpreting EKGs and abnormal rhythms. A physician must be available for immediate consultation to review the transmission, in case of significant symptoms or EKG abnormalities, when HCPCS codes requiring 24 hour attended monitoring are ordered.
- A provider of the service must be capable of immediately notifying the patient’s attending physician when indicated. The referring physician’s telephone number and other emergency instructions for the patient should be included in the referral for the monitoring services.
- The recording device and transmission equipment must be verifiably in the patient’s possession for the entire thirty day period of submission.
- The patient must be instructed in and capable of facile operation of both the recording device and the transmission device. Therefore, the patient must not be limited by a medical condition that would indicate that the patient is incapable of the proper operation of the device (i.e., a patient with senile dementia, OBS, Alzheimers, mental retardation, etc.). If a responsible party is required to assist the patient in the device operation and transmissions, that party must be present on a 24 hour basis. The instructions regarding the operation of the device, changing the batteries, etc. must be given by the provider of the monitoring service to the patient/responsible party prior to initiation of use of the patient demand event recorder.

HCPCS Codes

93012	Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), per 30 day period of time; tracing only
93014	physician review with interpretation and report only
93268	Patient demand single or multiple event recording with presymptom memory loop, per 30 day period of time; includes transmission, physician review and interpretation
93270	recording (includes hook-up, recording, and disconnection)
93271	monitoring, receipt of transmissions, and analysis
93272	physician review and interpretation only
G0004	Patient demand single or multiple event recording with presymptom memory loop and 24-hour attended monitoring, per 30-day period; includes transmission, physician review and interpretation
G0005	Patient demand single or multiple event recording with presymptom memory loop and 24-hour attended monitoring, per 30-day period; recording (includes hook-up, recording and disconnection)

- G0006 Patient demand single or multiple event recording with presymptom memory loop and 24-hour attended monitoring, per 30-day period; 24-hour attended monitoring, receipt of transmissions, and analysis
- G0007 Patient demand single or multiple event recording with presymptom memory loop and 24-hour attended monitoring, per 30-day period; physician review and interpretation only
- G0015 Post-symptom telephonic transmission of electrocardiogram rhythm strip(s) and 24-hour attended monitoring, per 30-day period; tracing only
- G0016 Post-symptom telephonic transmission of electrocardiogram rhythm strip(s) and 24-hour attended monitoring, per 30-day period; physician review and interpretation only

ICD-9-CM Codes That Support Medical Necessity

780.2	E942.0
780.4	E942.1
785.1	

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.

The use of a patient activated single or multiple event recorder for transmission of EKGs which are prescheduled and unrelated to symptoms or which are in a "time sampling mode" of operation.

The use of a patient activated single or multiple event recorder for outpatient monitoring of recently discharged asymptomatic post-infarct patients.

The use of a patient activated single or multiple event recorder for telephonic analysis of cardiac pacemakers.

The use of a patient activated single or multiple event recorder as a substitute for more conventional methods of diagnosing symptomatic, transient cardiac arrhythmias (i.e., complete history and physical, standard EKG and rhythm strip).

The use of a patient activated single or multiple event recorder for the purpose of stress testing.

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

HCPSC codes 93012 and 93014 are used to report event recorders with post-symptom recorders.

HCPSC codes 93268, 93270, 93271, and 93272 are used to report event recorders with pre-symptom memory loops.

HCPSC codes G0004, G0005, G0006, G0007, G0015, and G0016 are used to report event recorders with 24 hour attended monitoring.

HCPSC codes G0004-G0007 provide both pre-symptom and post-symptom recording. HCPSC codes G0015 and G0016 only provide post-symptom recording. Therefore, G0004-G0007 must not be reported with G0015 or G0016, as this would represent duplicate billing.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician (i.e., complete history and physical, 12 lead EKG, and rhythm strip performed prior to initiation of the patient demand event recorder) must indicate the medical necessity for use of the patient demand single or multiple event recorder. If ICD-9-CM code 785.1 (Palpitations) is the diagnosis billed, the history and physical or other pertinent medical record documentation must support the presence of associated symptoms such as dizziness, shortness of breath, chest discomfort, or an underlying history of cardiac disease.

If the provider of the service is other than the ordering/referring physician, the physician referral order must state the indication/medical necessity for the patient demand event recorder, and the provider of the service is responsible for ensuring that all of the necessary coverage criteria have been met prior to the initiation of the patient demand event recorder.

The EKG rhythm strip transmission and interpretation must include the following information: the name of the patient, the presenting diagnosis, the time and date of the transmission, the lead of the EKG transmission, the PR interval, the QRS interval, the rate, the rhythm, the signature of the person interpreting the EKG strip, cardiovascular symptomatology reported by the patient at the time of the transmission, any necessary actions (e.g., notification of physician, emergency instructions given to patient, etc.) taken by the person interpreting the EKG rhythm strip.

The medical record documentation must indicate how the information obtained via the patient demand event recorder is actively utilized by the patient's physician to medically manage the patient (e.g., an adjustment of the patient's antiarrhythmic medications, further diagnostic evaluation of the symptomatology, pacemaker insertion, etc.)

Other Comments

The technical component of these services includes:

- Provision of the transtelephonic transmitter with batteries;
- Patient hook-up and usage instructions;
- Use of the receiving equipment;
- Work of the technical staff receiving the transmission;
- All recordings;
- Notification of the referring physician of the results; and
- Generation and transmission of the final printed report.

The referring physician may not bill for the technical service.

The professional component of these services must be performed by a physician. It includes:

- The review of the transmission;
- Both EKG and the patient's clinical history;
- Interpretation of the data;
- Verbal notification to the referring physician as indicated; and
- Formulation of the report.

Effective Date

This policy is effective for services processed on or after April 17, 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.

93303, 93304, 93307, 93308, 93320-93321, 93325: Transthoracic and Doppler Echocardiography and Doppler Flow Velocity Mapping—Correction to Policy

This local medical review policy (LMRP) was published in the January/February 2000 *Medicare B Update!* (pages 48-49). The LMRP in that article is correct; however, the title of the policy is not. The correct title is shown above; procedure code 93303 should have been included, and 93305 should not. There is no procedure code 93305.

93501, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533: Cardiac Catheterization

Cardiac catheterization is a technique in which a flexible catheter is passed along veins or arteries into the heart and associated vessels for the measurement of physiological data and imaging of the heart and great vessels. This technique is utilized when there is a need to confirm the presence of a clinically suspected condition, define its anatomical and physiological severity, and determine the presence of associated conditions. This need most commonly arises when clinical assessment suggests that the patient may benefit from an interventional procedure (e.g., coronary angioplasty, balloon valvuloplasty or heart surgery).

Indications and Limitations of Coverage and/or Medical Necessity

Left Heart Catheterization:

A left heart catheterization (procedure codes 93510, 93511, 93514, and 93524) will be considered medically necessary for asymptomatic patients with any of the following situations/conditions:

- There is evidence of high risk on non-invasive testing. Exercise ECG (electrocardiogram) testing documents an abnormal ST segment depression (magnitude equal to or greater than 1.5mm depression, persistent post-exercise changes, depression in multiple leads).
OR
an abnormal systolic blood pressure response during progressive exercise, with sustained decrease of greater than 10mmHg or flat blood pressure (less than or equal to 130mmHg); associated with ECG evidence of ischemia.
OR
other potentially important determinant such as exercise induced ST segment elevation in leads other than a VR or exercise induced ventricular tachycardia.
Myocardial perfusion scintigraphy documents an abnormal blood flow distribution in the anterior wall or more than one vascular region at rest or with exercise, or an abnormal distribution (ischemia) associated with increased lung uptake produced by exercise in the absence of severely depressed left ventricular function at rest.
Radionuclide ventriculography documents a fall in ventricular ejection fraction of greater than or equal to 10% during exercise, or left ventricular ejection fraction of less than 50% at exercise or rest when suspected to be due to coronary artery disease.

- After successful resuscitation from cardiac arrest that occurred without obvious precipitating cause, when a reasonable suspicion of coronary artery disease exists.
- The presence of two or more major risk factors and a positive exercise test in patients without known coronary heart disease.
- The presence of prior myocardial infarction with normal left ventricular function at rest, and evidence of ischemia by non-invasive testing
- After coronary bypass surgery or percutaneous transluminal angioplasty when there is evidence of ischemia by non-invasive testing.
- Before high risk noncardiac surgery in patients who have evidence of ischemia by non-invasive testing.
- Periodic evaluation of patients after cardiac transplantation.

A left heart catheterization will be considered medically necessary for symptomatic patients with any of the following situations/conditions:

- Angina pectoris that has proven inadequately responsive to medical treatment, percutaneous transluminal angioplasty, thrombolytic therapy or coronary bypass surgery. "Inadequately responsive" is taken to mean that patient and physician agree that angina significantly interferes with a patient's occupation or ability to perform his or her usual activities.
- Unstable angina pectoris defined as:
 - Increased severity and frequency of chronic angina pectoris within the past two months, despite medical management, including onset of angina at rest.
 - New onset (within two months) of angina pectoris which is severe or increases despite medical treatment.
 - Acute coronary insufficiency, with pain at rest usually of greater than or equal to 15 minutes duration, associated with ST-T wave changes, within the preceding two weeks.
- Prinzmetal's or variant angina pectoris (pain experienced at rest).
- Any angina pectoris in association with any of the following:
 - Evidence of high risk as manifested by exercise ECG testing in addition to failure to complete Stage II of Bruce protocol or equivalent workload (less than or equal to 6.5 METS with other protocols) due to ischemic cardiac symptoms.
 - OR

Exercise heart rate at onset of limiting ischemia symptoms of less than 120/minute (without beta blockers).

OR

Evidence of high risk as manifested by radionuclide exercise testing (myocardial perfusion scintigraphy, radionuclide ventriculography, or focal metabolic abnormality or mismatch).

- The coexistence of a history of myocardial infarction, a history of hypertension and ST segment depression on the baseline ECG.
- Intolerance to medical therapy because of uncontrollable side effects.
- Episodic pulmonary edema or symptoms of ventricular failure without obvious cause.
- Any angina pectoris associated with a series of progressively more abnormal exercise ECG or other non-invasive stress test.
- Any angina pectoris in a patient that cannot be risk stratified by other means as a result of an inability to exercise because of an amputation, arthritis, limb deformity, or severe peripheral vascular disease.

A left heart catheterization will be considered medically necessary for atypical chest pain of uncertain etiology with any of the following situations/conditions:*

** (For the purpose of this policy, atypical chest pain is defined as single or recurrent episodes of chest pain suggestive, but not typical, of the pain of myocardial ischemia. This discomfort may have some features of ischemic pain together with features of noncardiac pain. Chest pain that has no features of cardiac pain, as well as typical chest pain of myocardial ischemia or angina as determined by a careful medical history, is excluded from definition.)*

- Atypical chest pain when ECG or radionuclide stress test indicates that high risk coronary disease may be present.
- When the presence of atypical chest pain due to coronary artery spasm is suspected.
- When there are associated symptoms or signs of abnormal left ventricular function or failure.
- Atypical chest pain when non-invasive studies are questionable or cannot be adequately performed.
- When non-invasive tests are negative but symptoms are severe and management requires that significant coronary artery disease be excluded.

A left heart catheterization will be considered medically necessary after a myocardial infarction (greater than 10 days up to 8 weeks) with any of the following situations/conditions:

- Angina pectoris occurring at rest or with minimal activity.
- In selected patients, heart failure during the evolving phase, or left ventricular ejection fraction 45%, primarily when associated with some manifestation of recurrent myocardial ischemia or with significant ventricular arrhythmias.
- Evidence of myocardial ischemia on laboratory testing: exercise induced ischemia (with or without exercise induced angina pectoris), manifested by greater than or equal to 1 mm of ischemic ST segment depression or exercise induced reversible thallium perfusion defect or defects, or exercise induced reduction in the ejection fraction or wall motion abnormalities on radionuclide ventriculographic studies.

- Non-Q-wave myocardial infarction.
- Mild angina pectoris.
- A past history of documented myocardial infarction or unstable angina pectoris, or both present greater than six months before the current infarction.
- Thrombolytic therapy during the evolving phase, particularly with evidence of reperfusion.

A left heart catheterization will be considered medically necessary for valvular heart disease with any of the following situations/conditions:

- When valve surgery is being considered in a patient with chest discomfort or ECG changes, or both, suggesting coronary artery disease.
- When valve surgery is being considered in female patients who are postmenopausal.
- When aortic or mitral valve surgery is being considered.
- When one or more major risk factors for coronary artery disease are present: heavy smoking history, diabetes mellitus, hypertension, hyperlipidemia, strong family history of premature coronary artery disease.
- When reoperation for aortic or mitral valve disease is being considered in patients who have not had coronary angiography for one year or more.
- In the presence of infective endocarditis when there is evidence for coronary embolism.

A left heart catheterization will be considered medically necessary for any of the following conditions:

- In disease affecting the aorta when knowledge of the presence or extent of coronary artery involvement is necessary for management (for example, the presence of aortic aneurysm or ascending aortic dissection), arteritis or homozygous type II hypercholesterolemia in which coronary artery involvement is suspended.
- The presence of left ventricular failure without obvious cause and adequate left ventricular systolic function.
- When patients with hypertrophic cardiomyopathy have angina pectoris uncontrolled by medical therapy, or are to undergo surgery for outflow obstruction.
- The presence of dilated cardiomyopathy.
- Recent blunt trauma to the chest and evidence of acute myocardial infarction in patients who have no evidence of preexisting coronary artery disease.
- When patients are to undergo other cardiac surgical procedures, such as pericardiectomy or removal of chronic pulmonary emboli.

Right Heart Catheterization:

Right heart catheterization (procedure code 93501) is not routinely part of coronary angiography, but is an associated procedure in a significant number of patients. This procedure should be performed under the following circumstances:

- Patients with known history of congestive heart failure.
- Patients with cardiomyopathy documented by non-invasive workup.
- Patients with known or suspected valvular heart disease.
- Patients with known or suspected intracardiac shunt (e.g., atrial-septal defect [ASD], ventricular-septal defect [VSD]).
- Patients with previous myocardial infarction.

- Patients with unexplained symptoms (e.g., shortness of breath), suspected to have cardiac origin.
- Patients in whom pulmonary artery disease is known or suspected (e.g., pulmonary hypertension, status post-pulmonary emboli).

Combined Heart Catheterization:

In conjunction with left heart catheterization, right heart catheterization can be useful in providing cardiac output and hemodynamics that may be important therapeutic directives (see “ICD-9-CM Codes That Support Medical Necessity”).

ICD-9-CM Codes That Support Medical Necessity

Appropriate ICD-9-CM codes for combined heart catheterization (CPT codes 93526, 93527, 93528, 93529) include the following:

394.0-394.9	412	423.2
395.0-395.9	415.11	424.0-424.3
396.0-396.9	415.19	425.0-425.9
397.0-397.9	416.0	428.0-428.9
398.90-398.91	416.8	429.71
402.01	420.0	745.4
402.11	420.90-420.99	786.05
402.91	422.0	786.06
410.00-410.92	422.90-422.99	V42.1

Coding Guidelines

Effective January 1, 1998, to report coronary angiography without left heart catheterization, use code 93508 (Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization). 93508 is to be used only when left heart catheterization (93510, 93511, 93524, 93526) is not performed. 93508 is to be used only once per procedure.

Effective January 1, 1998, these four codes can be used to report cardiac catheterization for congenital cardiac anomalies:

93530	Right heart catheterization, for congenital cardiac anomalies
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies

All cardiac catheterization procedures can be performed **only** in the following places of service:

21	Inpatient Hospital
22	Outpatient Hospital
99	Free Standing Cardiac Catheterization Facility

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of cardiac catheterization covered by the Medicare program. Also, the hard copy test results and interpretation of the catheterization must be included in the patient's medical record.

If the provider of the cardiac catheterization is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the study.

Effective Date

This local medical review policy is effective for services processed on or after February 7, 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.

94760, 94761, 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

Single and Multiple Determinations:

Florida Medicare will consider ear or pulse oximetry for oxygen saturation (CPT Codes 94760, 94761) to be medically necessary when the patient has a condition resulting in hypoxemia and there is a need to assess the status of a chronic respiratory condition, supplemental oxygen requirements and/or a therapeutic regimen (see “ICD-9-CM Codes That Support Medical Necessity”).

HCPCS Codes

94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)

ICD-9-CM Codes That Support Medical Necessity

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

Continuous Overnight Monitoring:

Florida Medicare 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

Reimbursement for noninvasive ear or pulse oximetry for oxygen saturation: single determination (CPT

code 94760) is included in the basic allowance of noninvasive ear or pulse oximetry for oxygen saturation, multiple determination (CPT code 94761) when performed on the same day by the same provider. Effective January 1, 2000, procedure codes 94760 and 94761 are considered bundled services and, therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day.

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 studies. 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

The original effective date for this local medical review policy was June 5, 1995. The policy revision statement in the coding guidelines section of the policy regarding the change in billing status is effective for services processed on or after January 1, 2000.

Advance Notice Requirement

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.

98940-98942: Chiropractor—Correction

Florida Medicare's local medical review policy for chiropractic spinal manipulation services was published in the January/February 1999 *Medicare B Update!* (pages 62-64). The article reported the ICD-9-CM codes that support medical necessity for these services. ICD-9-CM codes 715.08 and 715.88 were included; however, these are not valid codes. The correct codes are 715.09 (Osteoarthritis, generalized, multiple sites) and 715.89 (Osteoarthritis involving, or with mention of more than one site, but not specified as generalized, multiple sites).

Effective Date

The addition of codes 715.09 and 715.89 is effective for claims processed on or after February 28, 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.

ELECTRONIC MEDIA CLAIMS

Why Send Medicare Claims Electronically?

Weigh The Benefits!

Are you interested in electronically filing Medicare claims? Would you like your office to run more efficiently? If the answer to these questions is “Yes!,” contact Provider Electronic Services Marketing at (904)791-8767.

If you’re not convinced, weigh the potential benefits of a conversion to electronic submission:

- Electronic claims filing can improve a provider’s office cash flow by reducing the time it takes for Medicare to pay. Payment for paper claims may not be released by Medicare for 28 days, while electronically filed claims may be paid after 14 days.
- Electronic claims also lead to better claim tracking. With paper, tracking a claim is not possible until it has been entered into the Medicare claims processing system. With electronic claims, an EDI Services Transmission Acknowledgment receipt is issued upon completion of transmission. Telephone lines are available 24-hours-a-day, 7-days-a-week, enabling providers to transmit at their convenience.

Other potential benefits include (but are not limited to):

- Electronic Remittance Notification (ERN) - receive Medicare Remittance Notification online
- Electronic Claims Status (ECS) - track and monitor claims in the Medicare system that are not yet finalized
- Electronic Rejects - receive rejected claims electronically the day following transmission for correction
- Reduced Costs - eliminate mailing and paper-associated costs while reducing in-house clerical costs

For additional information on becoming an EMC sender, call Provider Electronic Services Marketing at (904)791-8767.

FRAUD AND ABUSE

Fraud and Abuse in the Medicare Program

In Case You Didn't Know...

In recent years, fraudulent or abusive activities in the health care industry have drawn considerable public interest, through the media and other private organizations, as well as state and federal governments, including their agencies and contractors. The Medicare program has been the focus of much of this attention, raising some questions Are fraud, waste, and abuse rampant in the Medicare program? Is there a crackdown or "witch hunt" for even the smallest of offenses? These issues are discussed below.

At a national level, fraud, waste, and abuse in the Medicare program are estimated at \$12.6 billion annually, representing approximately 7.1 percent of all payments made. In prior years, that estimate was as high as \$23 billion annually, or 14 percent of all payments made. The decrease is due to several factors:

- **The federal government's increased focus on protecting the Medicare trust fund:** Since the early 1990s, Medicare's solvency has been unclear, intensifying concern about the propriety of program payments. Safeguarding the Medicare trust fund, thus, became a top priority, leading to additional efforts in detecting, preventing, and recovering inappropriate payments.
- **Legislation passed in the mid-1990s that specifically addresses fraud, waste, and abuse in both federal and private health care programs:** The provisions of law extend efforts in education and law enforcement, allow for more stringent fines and penalties, and more clearly defines fraud in the health care industry.
- **An increased awareness in the health care and patient communities:** Watchful health care givers and their patients often take steps to avoid becoming victims of fraudulent or abusive activities.

Significant strides have been taken to protect the Medicare trust fund; however, fraud and abuse in Medicare and other federally funded and private health benefit programs, are still a concern. Medicare is large and intricate, and it is not always easy to identify or prevent inappropriate activities; therefore, some degree of fraud and waste may be unavoidable.

Answering the second question — "Is there a 'witch hunt'?" — is both simple and complex. Simply, the answer is "No." There are more effective ways to safeguard the Medicare program.

One popular belief is that individuals or organizations identified as engaging in inappropriate activity are subject to imminent prosecution. To the contrary, stewards of the Medicare program (i.e., the federal

government, its agencies and contractors, and law enforcement) must be prudent in making decisions that may adversely affect individuals and organizations.

While health care fraud was essentially overlooked until recent years, efforts are increasing in the investigation and prosecution of health care fraud cases. These actions, however, are reserved for instances of willful and intentional acts of wrongdoing that are substantiated through documented patterns of abuse. There are other effective avenues for addressing these issues. For example:

- **Education:** Health care providers have a responsibility to understand the rules governing the Medicare program from which they seek payment for services and items they furnish. The federal government, its agencies, and its contractors have an equal responsibility in ensuring that information regarding the Medicare program is made available to their customers. Sometimes, inappropriate payments are made from a lack of knowledge or misunderstanding of information. Many issues may be resolved by simple educational efforts.
- **Review of claims:** Medicare claims are routinely reviewed on a pre- and post-payment basis to establish that the services or items reported are medically documented in the patient's records and reported accurately. These reviews may result in the affirmation of payment, the identification of overpaid funds, or the denial of payments.
- **Development of clear coverage and policy guidelines:** To ensure that payments are made only for medically reasonable and necessary services, coverage, payment, and claim filing guidelines are developed so that health care providers and their patients can understand the scope and limitations of their Medicare benefits.
- **Overpayments:** Inappropriate payments are identified through various approaches; often, however, overpaid funds may not have been caused by an intentional act. In these cases, refunds of overpayments may be requested and collected without any additional punitive action.

Combating fraud, waste, and abuse in the Medicare program is a priority. Medicare fraud and abuse are steadily declining. That trend is expected to continue, with constant vigilance and improved "safeguarding" efforts — that is, better administration of the Medicare program, education of the health care community and the public, and better proactive approaches to detecting, preventing, and recovering inappropriate payments.

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 February 2, 2000, the interest rate applied to Medicare overpayments is **13.5** percent based on the new revised PCR rate. The accompanying table lists previous interest rates.

<u>Period</u>	<u>Interest Rate</u>
October 28, 1999 - February 1, 2000	13.375 %
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

Assignment of Group Provider Numbers

The Medicare Registration department has received numerous requests for assignment of provider numbers for non-physician practitioners. In most cases, these non-physician practitioners are requesting reimbursement under a tax identification number (TIN) belonging to their employer or legal business with whom they contract. When a non-physician practitioner is approved to receive reimbursement under a TIN that is active on the Medicare Part B file, the legal business will be assigned a group provider number for billing. The individual currently identified under the TIN and the non-physician practitioner will be assigned a group member provider number (normally a five-character numeric or alphanumeric with an alpha suffix). If reimbursement is not currently being generated under the legal business name for the provider that is already on file with a TIN, a HCFA-855R form is also required from each individual.

If a request is received from a non-physician practitioner requesting reimbursement under a TIN that is not active in the Medicare system, completion of a general enrollment application (HCFA-855) is required from the legal business belonging to that TIN. A group provider number and group member provider numbers will not be assigned until receipt of both the HCFA-855 for the entity and HCFA-855R for each member. Below are some examples to assist with understanding the process:

EXAMPLE 1

Information On Medicare File

TIN = 111111111

Legal Business Name: Joseph Magilicutt M.D., P.A.

Provider Number = 11111

Applications (HCFA-855 and HCFA-855R) are received for John Brown (physician assistant) to receive reimbursement under TIN 111111111. Since this TIN has already been enrolled, legal business,

Joseph Magilicutt M.D., P.A. will receive a group provider number. Joseph Magilicutt, M.D. and John Brown, P.A. will receive group member provider numbers. If reimbursement is not currently being generated in the exact name of "Joseph Magilicutt M.D., P.A.", Joseph Magilicutt, M.D. must complete a HCFA-855R.

EXAMPLE 2

Information On Medicare File

SSN = 999999999

Name On File: Joseph Magilicutt, M.D.

Provider Number 11111

Applications (HCFA-855 and HCFA-855R) are received for John Brown, P.A. (physician assistant) to receive reimbursement under TIN 111111111 and legal business name Joseph Magilicutt M.D., P.A.. The legal business, Joseph Magilicutt M.D., P.A., must complete a HCFA-855 for assignment of a group provider number since the TIN has not been enrolled. Joseph Magilicutt M.D. must complete a HCFA-855R for assignment of a group member number. John Brown, P.A. may not receive a Medicare Part B provider number until the legal business (Joseph Magilicutt, M.D., P.A.) has enrolled.

Non-physician practitioners enrolling into the Medicare Part B Program who do not have an active Florida Medicare provider number must complete a General Enrollment application (HCFA-855).

When an employee/employer relationship is indicated on a HCFA-855R, a copy of a W2 or W4 must be attached.

Copies of HCFA-855 and HCFA-855R forms may be obtained by contacting Medicare's Provider Customer Service department at (904) 634-4994.

Changing Specialties

In most cases, the specialty of a provider is self-designated. For example, a physician may specialize in dermatology at one office and in internal medicine at another practice location.

When requesting a change in specialty, providers should indicate under what specialty they intend to practice for each practice location.

Requests for changing specialties should be submitted on a Change of Information Application (HCFA-855C) to:

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

Copies of HCFA-855C forms may be obtained by contacting Florida Medicare's Provider Customer Service department at (904) 634-4994.

Provider Change of Address

Providers who have recently moved or plan to make changes to their practice must complete a Change of Information Application (HCFA-855C). The application must be completed and submitted to:

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

A Change of Information Application is needed in the following situations:

- the practice location address or the billing address changes
- a provider is retiring or will no longer be practicing in the state of Florida
- a provider associated with a group is leaving the group (a completed HCFA-855R may be submitted instead)
- individual name changes
- doing business as (d/b/a) name changes
- telephone or fax number changes
- organization name changes (if the name change does not involve a change of ownership)
- billing service/management service organization name changes
- deleting practice locations
- specialty changes
- adding or deleting an authorized representative
- potential termination of current ownership

When a provider has made any of the above changes and has not completed a HCFA-855C or notified Medicare Registration of the changes, a completed Change of Information Application must be submitted as soon as possible.

The Health Care Financing Administration (HCFA) requires any changes in the information reported on the original applications must be reported to the Medicare contractor within 30 calendar days. Any changes not identified above (e.g., managing employee) must be submitted on the HCFA-855 and/or HCFA-855R. Providers are required to complete only the section(s) of the application where changes exist, and to sign the attestation statement.

Providers may contact Medicare Customer Service at (904) 634-4994 to obtain the correct forms needed for any of the above changes.

Incomplete Applications

Medicare Registration continues to receive many incomplete applications. Providers should ensure *all* sections and blocks on enrollment applications are completed prior to submission.

When application packages are mailed, a handout labeled "Helpful Hints Regarding The Application" and a matrix are included in the package. Using both of these tools, in addition to the instruction in the front of the application, should greatly reduce the need for Medicare to return applications for additional information and/or documentation. When an application is returned to the provider due to being incomplete and is subsequently resubmitted, the application process begins anew.

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 host only 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



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.

Complete the Registration Form (one form per person)

Registration

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

Payment

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

Cancellations and Refunds

- All cancellation requests must be received 7 days prior to the seminar to receive a refund.
- All refunds are subject to a \$20 per person cancellation fee. NO refunds or rainchecks will be issued for cancellations received 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

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	Day 2 March 29 July 12 August 9
<p>8:30 - 10:00</p> <p>01 <input type="checkbox"/> General Session (A/B) Participants are encouraged to attend this session. Topics to be discussed include:</p> <ul style="list-style-type: none"> • Medifest registration packet • Incident to • Advanced Beneficiary Notice • ARNP/PA services • Latest program changes <p>10:30 - 12:00</p> <p>02 <input type="checkbox"/> E/M Documentation (B) 03 <input type="checkbox"/> Global Surgery (B) 04 <input type="checkbox"/> Primary Care (B) 05 <input type="checkbox"/> Medicare Part C (A/B) 06 <input type="checkbox"/> Inquiries, Appeals and Overpayment (B) 07 <input type="checkbox"/> Partial Hospitalization Program (A) 08 <input type="checkbox"/> Reimbursement Efficiency for Part A Providers (A) 09 <input type="checkbox"/> PC-ACE™ for HCFA-1500 Claims Filing (B) 10 <input type="checkbox"/> Direct Data Entry (A)</p>	<p>8:30 - 10:00</p> <p>25 <input type="checkbox"/> Global Surgery (B) 26 <input type="checkbox"/> Primary Care (B) 27 <input type="checkbox"/> Reimbursement Efficiency for Part B Providers (B) 28 <input type="checkbox"/> Fraud and Abuse (A/B) 29 <input type="checkbox"/> Medicaid (A/B)</p> <p>8:30 - 12:00 *</p> <p>30 <input type="checkbox"/> HCFA-1500 Claims Filing (B) 31 <input type="checkbox"/> ICD-9-CM for Beginners (A/B) 32 <input type="checkbox"/> UB-92 Claims Filing (A)</p> <p>10:30 - 12:00</p> <p>33 <input type="checkbox"/> Global Surgery (B) 34 <input type="checkbox"/> Reimbursement Efficiency for Part B Providers (B) 35 <input type="checkbox"/> Medical Review (A/B) 36 <input type="checkbox"/> Fraud and Abuse (A/B) 37 <input type="checkbox"/> How to Help Your Patients Understand Medicare (A/B) 38 <input type="checkbox"/> Electronic Media Claims (B)</p>
<p>1:30 - 3:00</p> <p>11 <input type="checkbox"/> Reimbursement Efficiency for Part B Providers (B) 12 <input type="checkbox"/> Fraud and Abuse (A/B) 13 <input type="checkbox"/> Medical Review (A/B) 14 <input type="checkbox"/> PC-ACE™ for UB-92 Claims Filing (A) 15 <input type="checkbox"/> Direct Data Entry (A)</p> <p>1:30 - 5:00 *</p> <p>16 <input type="checkbox"/> HCFA-1500 Claims Filing (B) 17 <input type="checkbox"/> E/M Documentation & Coding (B) 18 <input type="checkbox"/> CPT Coding for Beginners (B) 19 <input type="checkbox"/> ICD-9 for Beginners (B)</p> <p>3:30 - 5:00</p> <p>20 <input type="checkbox"/> Reimbursement Efficiency for Part B Providers (B) 21 <input type="checkbox"/> Fraud and Abuse (A/B) 22 <input type="checkbox"/> Inquiries, Appeals and Overpayment (B) 23 <input type="checkbox"/> Medicaid (A/B) 24 <input type="checkbox"/> Electronic Media Claims (B)</p>	<p>1:30 - 3:00</p> <p>39 <input type="checkbox"/> Inquiries, Appeals and Overpayment (B) 40 <input type="checkbox"/> Medicare Part C (A/B) 41 <input type="checkbox"/> Medicare Secondary Payer (B) 42 <input type="checkbox"/> CORF/ORF (A) 43 <input type="checkbox"/> Inpatient/Outpatient PPS (A) 44 <input type="checkbox"/> Electronic Media Claims (B)</p> <p>1:30 - 5:00 *</p> <p>45 <input type="checkbox"/> E/M Documentation & Coding (B) 46 <input type="checkbox"/> CPT Coding for Beginners (B)</p> <p>3:30 - 5:00</p> <p>47 <input type="checkbox"/> Inquiries, Appeals and Overpayment (B) 48 <input type="checkbox"/> Medicare Part C (A/B) 49 <input type="checkbox"/> Reimbursement Efficiency for Part A Providers (A) 50 <input type="checkbox"/> Skilled Nursing Facilities (A) 51 <input type="checkbox"/> How to Help Your Patients Understand Medicare (A/B)</p>

***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 101”

**Are You New At Billing or Coding Medicare Claims? or
Are You A Newly Licensed or Certified Medical Service Provider?
We Have A Special Seminar Designed Just For You!**

*In this **full day** hands on session you will receive an overview of Medicare Policies and Reimbursement Processes.*

\$149

Come and learn about.....

- Medicare A,B & C
- Payment & informational Modifiers
- Using the new E/M Guidelines
- How to Accelerate Reimbursement
- Fastest claim filing methods
- When to bill Medicare
- How Medicare policies are made
- Audits - are you at risk?
- Recognizing Fraud & Abuse
- What is a Waiver of Liability and when is it needed?
- Appeals & Overpayments

Please select one of the following dates:

Session 1 Physician Focused

- ☐ June 5th
- ☐ June 8th
- ☐ June 12th
- ☐ June 15th

Session 2 Office Staff Focused

- ☐ June 6th
- ☐ June 9th
- ☐ June 13th
- ☐ June 16th

Tampa
Miami
Jacksonville
Gainesville

For locations please refer to: www.floridamedicare.com

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),**
(Pre payment required) **Account #756240 - \$149 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 to you. Please bring this number with you the day of the event. If you do not receive a confirmation number, please call (904) 791-8299. **Registration deadline is May 26, 2000.**

TIME of Seminar: 8:30 am - 4:30pm

Only \$149.00 per person!

Registrant's Name: _____

Registrant's Title Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, ZIP Code: _____

Phone: (____) _____ Fax: (____) _____

*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.*

PART A PROVIDERS

MEDICARE 101 COURSE

SURVEY

To better serve our provider community we are designing a new Medicare 101 Seminar series. We recognize that the information needs and interests are different for new medical practitioners versus new billing staff. Our goal is to focus the instruction time on the policies and guidelines of highest interest to our course participants. We are requesting your guidance to achieve this goal.

Listed below are the chapter titles that may be included in the *Medicare 101 for Part A Providers* text. Please indicate if the topic should be a high (A), moderate (B) or low (C) priority subject for the course presentation for the different types of course participants.

Topic	Physicians and Administrators	Coding and Claim Filing Staff
1. Evaluation and Management Documentation		
2. Evaluation and Management Coding		
3. Fraud and Abuse		
4. Medicare Benefits under Part A		
5. HCFA 1450 Claim form		
6. Reconsiderations and Appeals		
7. Medical Review		
8. Medicare Part C		
9. Medicare Secondary Payer		
10. Prospective Payment System		
11. Reimbursement Efficiency Tips and Tools		
12. Medicare Registration		
13. Help Your Patients Understand Medicare		
14. Please suggest other topics of interest: _____ _____		

Thank you for your time and attention to this survey. Your support is appreciated in helping us reach our goal of producing an educational experience that meets our provider community's needs.

Please fax your response to the Medicare Education and Outreach Department at **(904) 791-6035** or mail it to P.O. Box 2078, Jacksonville, FL 32231 before May 30, 2000.

PART B PROVIDERS

MEDICARE 101 COURSE

SURVEY

To better serve our provider community we are designing a new Medicare 101 Seminar series. We recognize that the information needs and interests are different for new medical practitioners versus new billing staff. Our goal is to focus the instruction time on the policies and guidelines of highest interest to our course participants. We are requesting your guidance to achieve this goal.

Listed below are the chapter titles that may be included in the *Medicare 101 for Part B Providers* text. Please indicate if the topic should be a high (A), moderate (B) or low (C) priority subject for the course presentation, for the different types of course participants.

Topic	Physicians and Other Practitioners	Coding and Claim Filing Staff
1. Evaluation and Management Documentation		
2. Evaluation and Management Coding		
3. Recognizing and Preventing Fraud and Abuse		
4. Surgery Coding, the Modifiers that Process Claims		
5. What is required in the HCFA 1500 Claim Form		
6. Medicare Guidelines for Inquires, Appeals and Overpayments		
7. Medical Audits and Reviews		
8. Medicare Part C		
9. Medicare Secondary Payer, When to Bill Medicare		
10. Primary Care Coverage Policies		
11. Reimbursement Efficiency Tips and Tools		
12. Medicare Registration Process		
13. Help Your Patients Understand Medicare		
14. Please suggest other topics of interest: _____ _____		

Thank you for your time and attention to this survey. Your support is appreciated in helping us reach our goal of producing an educational experience that meets our provider community's needs.

Please fax your response to the Medicare Education and Outreach Department at **(904) 791-6035** or mail it to P.O. Box 2078, Jacksonville, FL 32231 before May 30, 2000.

“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, online 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****MEDICARE PART A 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: 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, unprocessable 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
<p><u>Four Easy Steps to Register:</u></p> <p>STEP 1: FAX registration form to (904)791-6035.</p> <p>STEP 2: Make checks payable to: First Coast Service Options(FCSO) Account #756240. \$49 per person.</p> <p>STEP 3: Mail this form and your payment to: Seminar Registration PO Box 45157 Jacksonville, FL 32231</p> <p>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</p> <p><i>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.</i></p> <p>Only \$49.00 per person!</p>	<p>Registrant’s Name: _____</p> <p>Registrant’s Title/ Position _____</p> <p>Provider’s Name: _____</p> <p>Medicare Billing Provider/Group Number: _____</p> <p>Address: _____</p> <p>City, State, Zip Code: _____</p> <p>Phone: () _____ Fax: () _____</p> <p style="text-align: center;">Please select one of the following dates.</p> <p>Time: 1:00 p.m. - 4:30 p.m.</p> <p><input type="checkbox"/> March 17, 2000 \$49 per person</p> <p><input type="checkbox"/> May 19, 2000</p> <p><input type="checkbox"/> July 28, 2000</p> <p>Location: FCSO/Blue Cross Blue Shield of FL 532 Riverside Ave. Jacksonville, FL 32202</p>

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: <ul style="list-style-type: none">• Inpatient/ Outpatient Prospective Payment System• Ambulance• Rural Health Clinics• Home Health Services• End Stage Renal Disease/Nephrology• Partial Hospital Programs/Mental Health• CORE/ORF Services/ Physical Therapy/Occupational Therapy• Federal Register Rules• Revenue/Line Item Billing Guidelines	Included in this group would be topics such as: <ul style="list-style-type: none">• 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**

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

☐

June 23, 2000

☐

September 27, 2000

**Directions to our building will be faxed with your
confirmation**

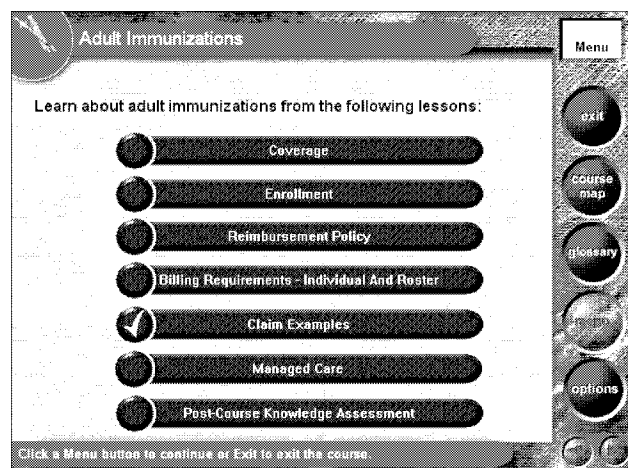
Please RSVP 10 days prior to the event



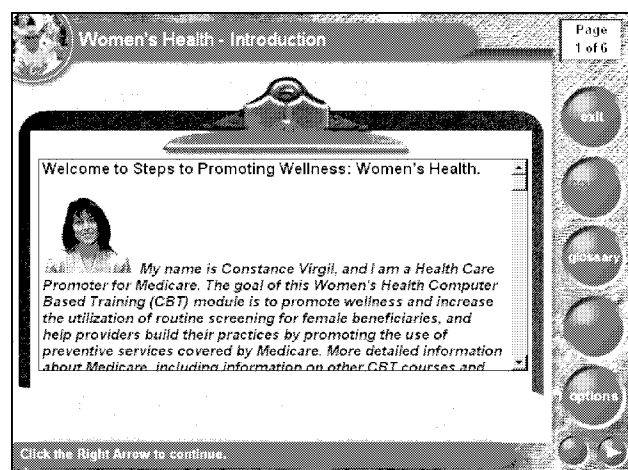
New Computer Based Training Courses Available

To increase awareness of preventive health services that are covered by Medicare, the Health Care Financing Administration (HCFA) has made available on the Medicare Online Training Website (www.medicaretraining.com), two new *free* computer based training (CBT) courses – *Women's Health* and *Adult Immunizations*.

Every year, pneumonia and flu take the lives of 40,000 to 70,000 Americans. Ninety percent of these deaths are in the Medicare population. The goals of the *Adult Immunizations* course are to help physicians better understand the importance of immunizations, and identify ways to increase immunization rates in the healthcare community.



The *Women's Health* course describes Medicare's coverage criteria as they relate to mammograms, pap tests, pelvic exams, and colorectal screenings. The course also identifies how physicians should bill for these services.



In an effort to reach larger audiences with their message in 1999, HCFA provided a series of satellite broadcasts for healthcare professionals throughout the United States. Broadcast attendees were given the opportunity to interact with a panel of medical and healthcare industry experts who discussed important healthcare issues in a national context. Free video tapes of these broadcasts may be ordered via the Medicare Online Training Website (www.medicaretraining.com), for a limited time.

The CBT courses offer the convenience of learning at one's own pace. In each course, users are given the opportunity to practice what they've learned through quizzes and tests. Users may take as long as they want to complete each course, and may take them as often as they like.

With the addition of *Women's Health* and *Adult Immunizations*, there are now 10 free CBT courses available:

- *World of Medicare* - an introduction to the Medicare program
- *ICD-9-CM Coding* - instructs providers in the proper use of the ICD-9-CM manual for correct diagnosis coding
- *Medicare Fraud & Abuse* - emphasizes the prevention and early detection of fraud and abuse
- *Front Office Management* - provides essential knowledge needed for "checking in" Medicare patients
- *Medicare Secondary Payer (MSP)* - provides basic information about the MSP program
- *HCFA-1500* - provides essential information required to properly complete the HCFA-1500 claim form
- *HCFA-1450 (or UB-92)* - provides essential information required to properly complete the HCFA-1450 claim form.
- *Medicare Home Health Benefit* - emphasizes the guidelines that providers must follow when dealing with Home Health Agencies

Two additional CBT courses on *Medicare Coverage and Payment* and *Medicare Appeals* are scheduled for release later in 2000.

Medicare Provider Website Replaces BBS

A new Website for Medicare providers serviced by First Coast Service Options, Inc. (FCSO) is now available at www.floridamedicare.com. Medicare is migrating (gradually moving) *all* information currently on the Medicare Online Bulletin Board System (BBS) to the Website. Once the migration is complete, the BBS will be phased out within *three to six months*. Therefore, BBS users may wish to start becoming familiar with the new Website.

Information Available on www.floridamedicare.com

- Medicare Part A: final and draft LMRPs, reason code list
- Medicare Part B: Medigap list, crossover information, final LMRPs
- Shared information (pertains to Medicare Part A and B): EDI forms and programming specifications, UPIN, HMO, Medpard listings
- And more coming soon!

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.

Features

- Search through documents for specific information
- Download any file to your own computer for future offline access

Most files on the site are in PDF® format

PDF® (Portable Document Format) is an Adobe® Systems, Inc. file format that preserves the look and feel of an original document, complete with fonts, colors, images, and layout. Because PDF® lets a user view and print a document exactly as the author designed it, regardless of the original application, it has become an Internet standard for electronic distribution.

Providers wishing to view files on www.floridamedicare.com need Adobe Acrobat Reader® on their computers. Acrobat Reader® is free (and freely distributable) software that lets users view and print PDF® documents. Most Internet browsers and new computers come with Acrobat Reader®; it can also be downloaded from the Adobe® Website at www.adobe.com.

Important Website Links

Health Care Financing Administration (HCFA) — <http://www.hcfa.gov>

Medicare Payment Systems — <http://www.hcfa.gov/medicare/payment.htm>

- Ambulance Fee Schedule
- Ambulatory Surgical Centers (ASC)
- Home Health Care
- Hospital Outpatient Prospective Payment System
- Medicare PPS Excluded Cancer Hospitals
- Physician Fee Schedule
- Skilled Nursing Facility (SNF)

Clinical Laboratory Fee Schedules — <http://www.hcfa.gov/stats/pufiles.htm>

National Learning Resources — <http://www.hcfa.gov/learning/default.htm>

- Free Medicare Education and Training for Providers; Computer Based Training and Satellite Broadcast programs

Public Use Files (PUF) — <http://www.hcfa.gov/stats/pufiles.htm>

Providers

- Provider of Services Listing - Hospital

Payment Rates - Institutional Providers

- HCFA Hospital Wage Index Survey File
- Hospital Wage Indices File
- PPS SSA/PIPS MSA State and County Crosswalk File
- Reclassified Hospital by Provider File
- HCFA Case-Mix Index File
- ICD-9-CM Version 16.0 File
- Prospective Payment System (PPS) - Payment Impact File
- Prospective Payment System (PPS) - Standardizing File
- SNF Prospective Payment Rates
- Home Health Prospective Payment System
- Provider Specific File (component of PRICER program)
- After Outlier Removed/Before Outlier Removed (AOR/BOR) Tables
- DRGs Relative Weight File

Payment Rates — Non-Institutional Providers

- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule
- Ambulatory Surgical Center (ASC) Base Eligibility File
- Physician Fee Schedule Payment Amount File National/Carrier
- Carrier/Locality State & County File
- National Physician Fee Schedule Relative Value File
- Clinical Diagnostic Laboratory Fee Schedule

Utilities/Miscellaneous

- Alpha-Numeric HCPCS File
- HCFA Capital-Related Tax Adjustment File
- Berenson-Eggers Type of Service (BETOS) File

HCFA Paper Forms and Instructions (Part A & B) — <http://www.hcfa.gov/medicare/edi/edi5.htm>

- HCFA 1500, 1450, 1491, 1490S, EDI Enrollment Forms and Instructions.

Medicare EDI (Electronic Data Interchange) — <http://www.hcfa.gov/medicare/edi/edi.htm>

- Facts, Advantages, Formats/Instructions, Current Events/News, Paper Forms/Instructions, EDI Enrollment Form, FAQ, EDI Statistics, Y2K - EDI, EMC software

Fraud and Abuse

Department of Health and Human Services (DHHS),

Office of the Inspector General (OIG) Fraud Alerts — <http://www.dhhs.gov/oig/frdalrt/index.htm>

- Special Fraud Alerts, Medicare Advisory Bulletins and Special Advisory Bulletins.

Department of Health and Human Services (DHHS),

Office of Inspector General's (OIG) List of

Excluded Individuals/Entities (LEIE) — <http://www.dhhs.gov/progorg/oig/cumsan/index.htm>

- The Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) provides information to health care providers, patients, and others regarding individuals and entities that are excluded from participation in Medicare, Medicaid, and other Federal health care programs.

List of Parties Excluded From Federal Procure-

ment and Non-procurement Programs — <http://epls.arnet.gov/>

Other Important Links

Code of Federal Regulations (CFR) — <http://www.access.gpo.gov/nara/cfr/index.html>

- The *Code of Federal Regulations* (CFR) is a codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the Federal Government.

Government Printing Office — <http://www.access.gpo.gov/>

- Federal Register, Congressional Bills, Congressional Record, Public Laws, and U.S. Code.

UPIN online search (all states) — <http://www.cpg.mcw.edu/www/upin.html>

Correct Coding Initiative (CCI) — <http://www.ntis.gov/yellowbk/1nty667.htm>

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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 <i>do not</i> 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 <i>Medicare B Update!</i>	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**

ORDER FORM - YEAR 2000 MEDIFEST AND SPECIALTY SEMINAR BOOKS

The following materials will soon be available for purchase by Medicare providers. To order, please complete and submit this form along with a check or money order made payable to **First Coast Service Options, Inc.** Be sure to include the account number listed by each item.

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	2000 Medifest Book This is the same manual provided to Medifest attendees and includes information on claim form completion instructions, local medical review policies, home health services and more.	756245	\$85.00
_____	General Program Modules These are specific modules extracted from the 2000 Medifest Book _____ Advance Beneficiary Notice/ Notice of Noncoverage _____ "Incident To" Provision _____ Program Changes	756245	\$15.00 per book
_____	Medicare Part B Specialty Seminar Books These are the same manuals provided to specialty seminar attendees and include information on coding, coverage and medical policy, basic CPT, ICD-9-CM, primary care, evaluation and management documentation guidelines and more. The most current edition will be shipped. _____ Ambulatory Surgical Center _____ Ambulance _____ Anesthesia _____ Cardiology _____ Chiropractic _____ Clinical Laboratory/Pathology _____ Dermatology _____ Independent Diagnostic Testing Facility _____ Medical Oncology _____ Mental Health _____ Nephrology _____ Nurse Practitioner/CNS/Physician Assistant _____ Orthopedics _____ Pathology _____ Physical/Occupational/Speech Therapy _____ Podiatry _____ Radiology _____ Radiation Oncology _____ Urology _____ Vision	756245	\$30.00 per book

NOTE: Please indicate with an (X) the book(s) you would like to purchase.

Subtotal \$ _____

Tax (6.5%) \$ _____

Total \$ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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*** Special Updates!**

*Notification of Changes to Ambulance
Coverage Regulations* April 1999

*Revisions to the 1999 Medicare Physician
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*Submitting, Processing and Paying
Medicare Claims in the Year 2000* September 1999

*2000 HCFA Common Procedure Coding
System and Medicare Physician Fee
Schedule Database Update* December 1999

* 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
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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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