Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

Features

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

Routing Suggestions:

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

Health Care Financing Administration

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

TABLE OF CONTENTS

Medicare B Update!

Vol. 13, No. 3
May/June 2000

Publications Staff
Bill Angel
Shari Bailey
Pauline Crutcher
Cynthia Moore
Millie C. Pérez

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

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

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

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A PHYSICIAN'S FOCUS

"The Medicare Coverage Process"

American medicine is the most technologically advanced in the world. New devices, drugs and procedures are becoming available at an unprecedented pace. The lay press is very attuned to new treatments and frequently publicizes them well before they become the standard of care. Patients see ads on TV or the Internet and come to the office requesting the latest thing. Many providers learn of new technological advances and are eager to incorporate them into their practice. How does a provider go about getting Medicare payment for these new drugs, devices or services?

Typically, a new drug or device does not have a Current Procedural Terminologyä (CPT) or Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Therefore, any billing for these services must carry an unlisted code. This means that the Medicare carrier will manually review the claim. The claim should include an invoice and a medical record that describes the clinical aspects of the service. If the service fits a Medicare benefit category and is medically necessary and reasonable, it will be added to the list of covered services. Should Medicare consider the service, device or drug not medically necessary or investigational, it would be added to the carrier's list of noncovered services. As additional studies and information become available, the carrier may take the medication, device or service off of the noncovered list and publish a policy that would contain guidelines for coverage.

Providers wishing to obtain coverage status for particular services should write to the Medical Policy Department of First Coast Service Options, Inc., at:

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

The letter should explain what service is being proposed, how it will benefit the patients, the place of service, the intended CPT codes and expected charges. It is also helpful to include two or three science-based articles from peer reviewed journals indicating significant patient benefit from the services. Letters of FDA approval and any information contained in any of the Compendia are useful. Letters of endorsement from recognized authorities supporting the clinical benefit of the service would also be considered. Several services have moved through this process from the noncovered to covered status. Among them are:

- Percutaneous vertebroplasty;
- Insertable Loop Recorder;
- Sacral Nerve Stimulator;
- Complex Decongestive Physiotherapy; and
- Vagus Nerve Stimulator

Should the carrier decide to not cover the service, the provider has the option of requesting that HCFA formulate a national policy for coverage. Instructions for requesting a national coverage decision can be found at the HCFA website, **www.hcfa.gov**. On the home page click on "*development of coverage policy*" and when you get to that page click on "*Medicare Coverage Process*." Add this site to your "favorites" list, and visit it often. HCFA coverage decisions are binding on all Medicare contractors.

We hope this information will be useful in establishing coverage for new services for your Medicare patients.

Sincerely,

Sidney R. Sewell, MD
Medicare Medical Director

ADMINISTRATIVE

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. Florida Medicare Part B 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 Florida Medicare Part B 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 76).

Florida Medicare Part B 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/Reimbursement" 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. Also presented in this section are changes to the Medicare Physician Fee Schedule (MPFS) and other pricing issues. "Local and Focused Medical Review Policies" follows, then "Electronic Media Claims (EMC)." Additional sections include: "General Information," other information for Medicare providers including Fraud and Abuse issues; and "Educational Resources" that includes Medifest schedules, and reproducible forms. Important addresses and phone numbers are on the back cover.

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.

CLAIMS

ANSI Reason Codes

In 1996, Medicare carriers were required to implement the American National Standards Institute's (ANSI) X12.835 claim adjustment reason codes for inclusion on paper and electronic remittance notices. Note that the messages outlined below do not display on the electronic remittance notices (ERN), only on paper notices. Florida Medicare has determined which of these were most commonly used during the quarter ending December 31, 1999.

Claim adjustment reason codes indicate the reasons for any claim financial adjustments, such as denials, reductions, or increases in payment. *Although the message texts are standard and cannot be modified by the carrier, some messages may be used for different issues*. Listed below are the most common claim adjustment reason codes for the quarter referenced above and the associated ANSI messages, followed by the carrier's explanation of each in *italics*.

ANSI Reason Code	ANSI Message
B6	This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. *A PA group is billing and the performing provider indicated on the claim is not a member of the PA group that is billing.* *B6 may also mean:* *Payment for this physician service is reduced since it is commonly performed in the physician's office. This message refers to the facility pricing (formerly site of service) reduction.*
B7	This provider was not certified for this procedure/service on this date of service. *The physician/supplier was not eligible for benefits at the time services were rendered.*
B11	The claim has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. *This claim has been transferred to another carrier for handling.*
B15	Claim/service denied/reduced because this service/procedure is not paid separately. *The Medicare allowance is included in the payment made for the surgery/procedure.*
B18	Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission. *The procedure code submitted was not valid for the date of service.*
B20	Charges denied/reduced because procedure/service was partially or fully furnished by another provider. *Payment for this service was paid to another provider.*
M77	Incomplete/invalid place of service(s). *A two-digit place of service code must be submitted.*
9	The diagnosis is inconsistent with the patient's age. *The diagnosis is not valid for the patient's age.*
11	The diagnosis is inconsistent with the procedure. *The procedure/item is not payable for the diagnosis as reported.*
16	Claim/service lacks information which is needed for adjudication. *The required UPIN information is invalid or omitted.*
17	Claim/service denied because requested information was not provided or was insufficient/ incomplete. *The information we requested was not received.*
18	Duplicate claim/service. *Duplicate of a charge already submitted.*
22	Claim denied because this care may be covered by another payer per coordination of benefits. *Our records reflect that Medicare is secondary for this patient. Therefore, future claims for this patient should be sent to the MSP area (with a payment sheet from the primary payer) for processing.*
28	Coverage not in effect at the time the service was provided. *The beneficiary was not eligible for Medicare Part B coverage at the time services were rendered.*

ANSI Reason Codes - continued

ANSI Reason Code	ANSI Message
29	The time limit for filing has expired. *The services were submitted after the claim filing time limit.*
31	Claim denied as patient cannot be identified as our insured. *Our records show the patient has no record of Medicare Part B entitlement.*
42	Charges exceed our fee schedule or maximum allowable amount. *Allowance is based on the Medicare fee schedule.*
46	This (these) service(s) is (are) not covered. *The service is not covered under Medicare.*
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. *The services were denied because routine physical exams and any related services are noncovered.*
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. *Service by ambulance not medically indicated.*
52	The referring/prescribing provider is not eligible to refer/prescribe/order the service billed. *This service is not payable when performed/referred/ordered by this provider.*
57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage. *Utilization limits exceeded documentation needed for review.*
59	Charges are reduced based on multiple surgery rules or concurrent anesthesia rules. *The allowance was reduced by 50% due to the multiple surgery guidelines.*
85	Interest amount. *Payment for this claim included interest.*
93	No claim level adjustment. *The service has been allowed the maximum amount.*
125	Claim/service denied/reduced due to a submission/billing error. *The diagnosis was not coded to the highest level of specificity.*

Claims Development Requests

When a claim is submitted to Medicare Part B that lacks information needed to complete processing, in certain circumstances Medicare will request additional information from the provider. Requests for additional information are referred to as additional development requests or ADRs. Most ADRs require that the requested information be returned **within 45 days** from the date of the ADR letter (if the timeframe is other than 45 days, it will be noted in the ADR letter). Responses not received within the specified timeframe may result in a reduction of allowance, denial of service(s), or denial of the entire claim. The 45-day ADR parameter applies only to claims development. Appeals that require additional information are only held open for 30 days and are never referred to as ADRs.

Medicare does not send ADRs for all claims that lack information needed for processing. For example, when an assigned claim is missing information or contains invalid information specific to the proper completion of a HCFA-1500 claim form the claim is "returned as unprocessable." Although claims are not physically returned, payment is denied and the provider receives either a Medicare Remittance Notice (MRN) or an EMC reject notice. Unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted.

Additional Development Request: "No Indication of Name/Address of Specific Performing Provider"

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.

A frequent ADR question asked by Florida Medicare is the one pertaining to performing provider information. It reads, "Please advise the full name, address, Medicare provider number and/or I.D. number of the doctor or supplier performing services on [*service date*] for [*submitted charge*]."

This information is a HCFA-1500 claim form submission requirement. **Effective for claims received on or after July 3, 2000**, Florida Medicare will no longer develop for this information on assigned claims. If the performing provider is not indicated in block 24K of the HCFA-1500 claim form (or electronic equivalent), these services will be returned as unprocessable. Unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted.

Correct Coding Initiative

Implementation of version 6.1 of the Correct Coding Initiative (CCI), originally scheduled for April 1, 2000, has been delayed until May 1, 2000. Version 6.1 includes all previous versions and updates from January 1996 to the present.

The U.S. Department of Commerce, National Technical Information Service (NTIS) has developed a national correct coding policy manual to assist physicians in correctly coding services for reimbursement. Medicare carriers are prohibited from publishing specific correct coding edits (CCE). Concerns about correct coding edit pairs must be submitted in writing to:

The Correct Coding Initiative
AdminaStar Federal
P. O Box 50469
Indianapolis, IN 46250-0469

Information related to CCI may be obtained by ordering a national correct coding policy manual from NTIS.

- Single issues of the national correct coding policy manual may be requested by calling (703) 605-6000.
- Subscriptions to the national correct coding policy may be requested by calling (703) 605-6060 or (800) 363-2068.
- To receive information from NTIS by mail, call (800) 553-6847.
- Ordering and product information is also available on the World Wide Web at **www.ntis.gov/cci**.

***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*.

Health Professional Shortage Area (HPSA) Designations

On September 20, 1999, the Health Resources and Services Administration (HRSA) published the notice "List of Designated Primary Medical Care, Mental Health, and Dental Health Professional Shortage Areas" in the *Federal Register*. This notice was intended to provide a listing of *all* health professional shortage area (HPSA) designations by HRSA through July 30, 1999. Providers may access this *Federal Register* notice at **http://www.access.gpo.gov**. Complete listings of the HPSA designations are provided periodically through the *Federal Register*. A complete listing is provided in the *Medicare B Update!* annually; however, designation changes are published when the carrier is notified by the Health Care Financing Administration (HCFA)

The January/February 2000 *Update!* included an extensive article on HPSAs. The article addressed the process for a physician's services to be eligible for the ten percent bonus payment, claim filing requirements, and clarification on the appeals process. Also provided was a comprehensive listing of the HPSA designations. Since that publication, Florida Medicare has been notified that the designations have been removed for the following counties (all census tracts):

Palm Beach County
Polk City/ Eva

Effective April 1, 2000, incentive payments are no longer available for these counties. Physicians in these counties should discontinue submitting the QB or QU modifiers.

Procedure Code Modifiers

Florida Medicare has received a number of requests to publish a complete list of all procedure code modifiers that can be used when filing claims.

However, it is most appropriate to refer providers directly to the American Medical Association's *Common Procedural Terminology (CPT)* and the Health Care Financing Administration's Common Procedure Coding System (HCPCS, or level II) books. A comprehensive modifier list can be found under the appendix section in each book. The modifiers contained therein are recognized by Medicare and are described in their entirety. Providers should be aware, however, that while Medicare recognizes both CPT and HCPCS modifiers, their usage is not the sole determining factor for service coverage.

Acquiring the 2000 Coding Books

Providers may purchase the 2000 edition of the *CPT* (Level I codes) from the American Medical Association by writing:

American Medical Association
P.O. Box 109050
Chicago, IL 60610-0946

The price for the 2000 *CPT* book is $39.95 per copy for American Medical Association members and $49.95 per copy for non-members. The 2000 HCPCS Level II coding book can be purchased for $31.95 per copy for American Medical Association members and $44.95 per copy for non-members. There is an additional charge of $6.95 for postage and handling for each book. American Medical Association members must provide their American Medical Association number in order to obtain the discounted rate. Make checks payable to the American Medical Association. For VISA, MasterCard or American Express orders, call (800) 621-8335. Allow four to six weeks for delivery. The *2000 CPT* book is also available in a floppy disk format. For additional information, call the toll-free number listed above.

The 2000 alpha-numeric hardcopy, titled *2000 Alpha-Numeric HCFA Common Procedure Coding System*, may also be secured from:

Superintendent of Documents
U.S. Government Printing Office
Washington D.C. 20402
Telephone: (202) 512-1800

Submission of Medical Record Documentation to Utilization Audit

During recent provider meetings, several issues regarding medical record submission were discussed. As a result of suggestions made at the recent "Let's Talk" session, the following information and recommendations have been developed to aid in submitting medical record documentation requested by the Utilization Audit Department.

This article addresses frequently asked questions and provides some helpful tips for submitting complete and timely documentation to Utilization Audit. *This information applies only to the submission of records requested by Utilization Audit and does not apply to documentation attached to initial claims submissions or requests for documentation from areas other than Utilization Audit*.

Mailing Packet

1. **Follow the address on the letter requesting records *exactly***. Any variations or additions to the address listed may cause packages to be routed improperly.

   Address packages for utilization audit as follows:

Standard Mail	or	**Certified or Express Mail**
Utilization Audit, 7T-ROC		Utilization Audit, 7T-ROC
Medicare Part B		Medicare Part B
P.O. Box 44288		532 Riverside Ave.
Jacksonville, FL 32231-4288		Jacksonville, FL 32202

2. Files may be sent via standard mail, or via certified or express mail. Standard mail will assure more rapid processing through the mail processing areas.

Documentation Preparation

1. **Place a copy of the letter requesting the records *on top* of the file(s) being sent**. This letter should be the first item seen when the mail package is opened by the carrier. This enables the mail handlers to deliver the mail more rapidly and with greater accuracy to the appropriate area.
2. **Do not place the files in folders**. Simply place the medical record documentation in a logical order from admission to discharge. Prepare each beneficiary's record separately. **Simply enclose the record packet in a rubber band or staple documents together**.

Frequently Asked Questions

Q1 "What documentation should I send for review?"

A1 Send the information requested by the Prepayment Review Letter in Attachment 1.

Q2 "What is the preferable way to send records to your office?"

A2 Sending records regular mail to the post office box specified in your ADR letter or Prepayment review letter is the best way. The mail moves through the correct channels to our department more rapidly this way. Certified mail must be routed differently and may delay the review process for your facility or practice.

Q3 "Do I have to copy the chart four times if I have four requests on the same beneficiary?"

A3 For requests from Utilization Audit, no. If you receive multiple requests for documentation on the same beneficiary, you may attach all the ADRs, or a cover letter listing the dates of service billed to one copy of the medical record. Please make sure if you choose to do this, verify that all dates of service requested are supported by the documentation submitted. If not, a service or claim may be denied as not documented.

Q4 "Sometimes my records are returned. What should I do if this happens?"

A4 If records are returned, verify the address against those listed above. Then resend the records.

Q5 "How will I know you have received the records if I do not send them return receipt?"

A5 Review your Provider Remittance Notices (PRNs) for final adjudication decisions.

UPIN Directory Available on CD-ROM

Florida Medicare now has available an electronic version of the UPIN Directory on CD-ROM. This directory is free to providers, upon request. The CD-ROM, that contains a complete national listing of all physicians' UPIN records, is current through July 1999 and will be updated yearly. This directory replaces all prior printed versions.

Publication of the UPIN CD-ROM satisfies the needs of laboratories, suppliers, physicians and others in complying with Medicare billing requirements for identifying referring and ordering physicians when filing claims.

To obtain a copy of the CD-ROM, contact Provider Customer Service at (904) 634-4994.

COVERAGE/REIMBURSEMENT

AMBULANCE

Q0186: Paramedic Intercept—New Definition for Rural

The Medicare, Medicaid, and the State Childrens' Health Insurance Program Balanced Budget Refinement Act of 1999, provides a new definition for the term "rural" in the context of the Medicare coverage provision for paramedic intercept services. This new definition is used for claims with service dates on or after January 1, 2000.

The new definition states: "An area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith modification, originally published in the ***Federal Register*** on February 27, 1992 [57 Fed. Reg. 6725])."

Although this changes the existing definition and coverage, paramedic intercept services are only payable when furnished by a volunteer ambulance company that is prohibited by state law from billing third party payers. Florida has no law that prohibits volunteer ambulance suppliers from billing for their services. Therefore, Florida Medicare will continue to deny claims for paramedic intercept services. The reimbursement for this procedure is included in the allowance for advanced life support (ALS) services.

FEE SCHEDULE CHANGES

Corrections

There are two corrections to the first quarter changes to the 2000 Medicare Physician Fee Schedule Database provided in the Special Issue *Medicare B Update!* dated March 3, 2000. On page 2, procedure code 67745 should be 64475; on page 3, code 64262 should be 64626.

Additionally, procedure code J7508 is incorrectly listed as J7808 in the March/April 2000 *Update!* (page 15). We apologize for any inconvenience this may have caused.

HEMATOLOGY/ONCOLOGY

Clarification of Liver Transplant Policy

Effective December 10, 1999, the coverage policy on liver transplantation was revised to remove the exclusion for patients whose end-stage liver disease was caused by hepatitis B (see the *January/February Medicare B Update!* page 26). Since that publication, the Health Care Financing Administration (HCFA) has provided Medicare contractors with the following questions and answers:

Q1 Is transplantation of a donor liver from a hepatitis B donor acceptable, or is this still considered investigational?

A1 There is no national Medicare policy on organ donors. Hospitals are required to abide by any Organ Procurement Transplant Network (OPTN) rule that may be applicable (42 CFR 482.45). If a contractor learns of a transplant center that is not in compliance with the OPTN rules, it should report the information to HCFA so that a review can be initiated. The penalty for noncompliance is the potential loss of certification of the hospital as a transplant center rather than noncoverage of an individual claim.

Q2 Is there any limit to the number of retransplantations; and/or are there any requirements clarifying reasonable and necessary for retransplants?

A2 There are no national Medicare policies that limit the number of retransplantations or clarify when retransplantation is reasonable and necessary, and thus, local contractor discretion applies.

Clarification of Liver Transplant Policy - continued

Q3 Is hepatitis B immunoglobulin or intravenous immunoglobulin (IVIG) for prevention of reinfection of the transplant and its recipient with hepatitis covered?

A3 There is no national Medicare policy on either hepatitis B immunoglobulin or IVIG. Coverage is left to the local contractor's discretion.

Q4 Is it correct that transplantation for other hepatitis types, e.g., hepatitis C, is covered?

A4 Yes. National coverage instructions provide for coverage of liver transplantation for all end-stage liver disease other than malignancy. No type of hepatitis would exclude a person from Medicare coverage.

Q5 Is tumor size an issue in regard to the malignancy exclusion?

A5 No, tumor size is not considered when making a "reasonable and necessary" determination. Malignancy (e.g. liver neoplasm) remains an exclusion to coverage of liver transplantation.

Q6 Should any of the questions above be handled with local medical review policies (LMRPs)?

A6 Contractors may develop LMRPs when there is no national policy or they believe there is potential program abuse or aberrent utilization patterns in their area.

Pancreas Transplants—Revision to National Policy

The national policy for pancreas transplants (procedure code 48554), is revised to state if the pancreas transplant occurs after the kidney transplant, the period of entitlement to immunosuppressive therapy is to be calculated beginning with the date of discharge from the admission for the pancreas transplant.

Billing instructions are revised to add a listing of diagnosis codes for pancreas transplants. Claims for pancreas transplantation will be denied for medical necessity reasons if they do not contain an appropriate ICD-9-CM diagnosis code.

National policy considers pancreas transplantation reasonable and necessary for the following diagnosis codes. However, this is not an inclusive list; carriers are permitted to determine if any additional diagnosis codes will be covered for this procedure. In the event Florida Medicare determines diagnoses are reasonable and necessary, local medical review policy (LMRP) may be developed at a later time.

ICD-9-CM Codes That Support Medical Necessity

250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.10-250.13	Diabetes with ketoacidosis
250.20-250.23	Diabetes with hyperosmolarity
250.30-250.33	Diabetes with coma
250.40-250.43	Diabetes with renal manifestations
250.50-250.53	Diabetes with ophthalmic manifestations
250.60-250.63	Diabetes with neurological manifestations
250.70-250.73	Diabetes with peripheral circulatory disorders
250.80-250.83	Diabetes with other specified manifestations
250.90-250.93	Diabetes with unspecified complication
403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure
404.03	Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure
404.12	Benign hypertensive heart and renal disease, with renal failure
404.13	Benign hypertensive heart and renal disease, with congestive heart failure or renal failure
404.92	Unspecified hypertensive heart and renal disease, with renal failure
404.93	Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure
585	Chronic renal failure

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure. Therefore, it would be inappropriate for the provider to bill 585 on such a patient. In these cases, use one of the following V-codes when a kidney transplant was performed before the pancreas transplant:

V42.0	Organ or tissue replaced by transplant kidney
V43.89	Organ tissue replaced by other means, kidney or pancreas

NOTE: If the kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code ***and*** *a V-code to indicate a previous kidney transplant*

Effective Date

This national policy is effective for services processed on or after April 1, 2000.

Advance Notice Statement

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

LABORATORY/PATHOLOGY

Revised Fees for Thin–Prep Pap Smears

After review of additional information, Florida Medicare is revising the 2000 fees for the gap filled clinical laboratory codes listed below. Fees will be increased to $21.00 for each of these procedures:

G0123, G0143, G0144, G0145, 88142, 88143, 88144, 88145

The revised fees are effective for services rendered on or after January 1, 2000, processed on or after April 3, 2000.

New CLIA Waived Tests

Listed below are the latest tests approved by the Center for Disease Control as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). The Current Procedural Terminology (CPT) codes for these new tests must have the QW modifier to be recognized as a waived test

- Roche Diagnostics/Boehringer Mannheim Chemstrip 101 Urine Analyzer
- LXN IN CHARGE Diabetes Control System
- Fisher HealthCare Sure-Vue Strep A (direct from throat swab)
- Meridian ImmunoCard STAT Mono (for whole blood)
- Applied Biotech SureStep H. pylori WB Test (whole blood),

New waived CPT codes have been assigned for the following tests:

- 82055QW for the STC Diagnostics Q.E.D. A150 Saliva Alcohol Test
- 82055QW for the STC Diagnostics Q.E.D. A350 Saliva Alcohol Test

The CPT code 86588QW (Infectious agent detection by immunoassay with direct optical observation; Streptococcus Group A) was discontinued on 12/31/1999 and has been replaced with the code 87880QW. The following tests were affected by this change:

- QuickVue In-Line One-Step Strep A Test;
- Binax NOW Strep A Test;
- Wyntek Diagnostics OSOM Strep A Test;
- BioStar Acceava Strep A Test (direct specimen only);
- SmithKline ICON Fx Strep A Test (from throat swab only);
- Abbott Signify Strep A Test (from throat swab only);
- Applied Biotech SureStep Strep A (II) (direct from throat swab);
- Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab);
- Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab);
- Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab);
- Mainline Confirms Strep A Dots Test (direct from throat swab); and
- Gnzyme Contrast Strep A (direct from throat swab).

For 2000, code 82120 was established for amines, vaginal fluid, qualitative. In addition, for the combined amines and pH test, the CPT instructs the use of codes 82120 and 83986. Therefore, the Litmus Concepts FemExam TestCard (from vaginal swab) CPT codes have been changed to 82120QW and 83986QW.

More information regarding CLIA waived proedures may be found in the September/October 1999 *Medicare B Update!* (pages 19-24).

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
QuickVue In-Line One-Step Strep A Test	Quidel	87880QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Binax NOW Strep A Test	Binax	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Wyntek Diagnostics OSOM Strep A Test	Wyntek Diagnostics, Inc	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
BioStar Acceava Strep A Test (direct specimen only)	Wyntek Diagnostics, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
SmithKline ICON Fx Strep A Test (from throat swab only)	Binax	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever

New CLIA Waived Tests (continued)

Abbott Signify Strep A Test (from throat swab only)	Wyntek Diagnostics, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Applied Biotech SureStep Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
*STC Diagnostics Q.E.D. A150 Saliva Alcohol Test	STC Technologies Inc.**	82055QW	Quantitative determination of alcohol (ethanol) in saliva
*STC Diagnostics Q.E.D. A350 Saliva Alcohol Test	STC Technologies Inc.**	82055QW	Quantitative determination of alcohol (ethanol) in saliva
Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Mainline Confirms Strep A Dots Test (direct from throat swab)	Applied Biotech, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
Genzyme Contrast Strep A (direct from throat swab)	Genzyme Diagnostics	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
*Roche Diagnostics/Boehringer Mannheim Chemstrip 101 Urine Analyzer	Roche Diagnostics/Boehringer MannheimCorporation	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
*LXN IN CHARGE Diabetes Control System	LXN Corporation	82962, 82985QW	Monitoring of blood glucose levels and measures fructosamine which is used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period.
*Fisher HealthCare Sure-Vue Strep A (direct from throat swab)	CASCO-NERL Diagnostics	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis, and scarlet fever
*Meridian ImmunoCard STAT Mono (for whole blood)	Meridian Diagnostics, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
*Applied Biotech SureStep H. pylori WB Test (whole blood)	Applied Biotech, Inc.	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood

* Newly-added waived test system **This test may not be covered in all instances. Contact your Medicare carrier for claims instructions

PHYSICAL/OCCUPATIONAL THERAPY

Clarification on Physical Medicine Current Procedural Terminology (CPT) Coding Guidance

The following article was prepared by the Health Care Financing Administration (HCFA) to provide guidance and clarification on the coding guidelines regarding the use of physical medicine CPT codes 97032-97036, 97110-97124, 97140, 97504-97542, and 97703-97770.

Determining What Time Counts Towards 15 Minute Timed Codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post- delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician or an assistant under the supervision of a physician or therapist is delivering treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training for a patient with a recent stroke requires both a therapist and an assistant, or even two therapists to manage the patient on the parallel bars, each 15 minutes the patient is being treated can only count as one unit of 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Determining How to Bill Units for 15 Minute Timed Codes

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one-on-one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to eight minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then two units should be billed. Time intervals for larger numbers of units are as follows:

3 units	$\geq$ 38 minutes to < 53 minutes
4 units	$\geq$ 53 minutes to < 68 minutes
5 units	$\geq$ 68 minutes to < 83 minutes
6 units	$\geq$ 83 minutes to < 98 minutes
7 units	$\geq$ 98 minutes to < 113 minutes
8 units	$\geq$ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of two hours. Providers should not bill for services performed for eight minutes or less. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the 8th should be excluded from the total count as the timing of active treatment counted includes all time.

It is advisable that the beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. **If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time**, see examples below.

Example 1: If 24 minutes of 97112 and 23 minutes of 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is two units of 97112 and one unit of 97110, assigning more units to the service that took more time.

Example 2: If a therapist delivers five minutes of 97035 (ultrasound), six minutes of 97140 (manual techniques), and ten minutes of 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of 97110 (the service with the longest time) and the clinical record will serve as documentation that the other two services were also performed.

Other Timed Physical Medicine Codes

Providers report code 96105, assessment of aphasia with interpretation and report, in one-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented on the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for 97545 is two hours and for 97546, one hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 96545 or 97546 would be the treatment period, since a shorter period could be coded with another code such as 97110, 97112, 97114, or 97537. (These codes were developed for reporting services to persons in the Workers' Compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances.)

Questions and Answers Regarding the Prospective Payment System (PPS) for Outpatient Rehabilitation Services

The following questions and answers were prepared by the Health Care Financing Administration (HCFA) to assist carriers in responding to numerous inquiries related to prospective payment system (PPS) for outpatient rehabilitation services. This article does not provide clarification regarding the financial limitation as this limitation has been suspended for two years based on the Balanced Budget Refinement Act of 1999.

Coding Guidelines

Q1 Payment cannot be made for code 97010 when billed alone. Should this code be bundled and if so with which codes?

A1 Yes, code 97010 should be bundled. It may be bundled with any therapy code. Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, payment is never made.

Q2 Should contractors edit when codes 97504 and 97116 are both reported in appropriate clinical situations?

A2 In general, codes 97504 and 97116 should not be billed together. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with a modifier to denote a separate anatomic site.

Q3 Is modifier 59 the correct modifier to use when 97504 and 97116 are both billed?

A3 Yes, 59 is the correct modifier to use.

Q4 Explain the difference between codes 97139 and 97799.

A4 Code 97139 is an unlisted therapeutic procedure, which the AMA's *Current Procedural Terminology (CPT)* defines as "a manner of effecting change through the application of clinical skills and/or services that attempt to improve function" in one or more areas, each 15 minutes. Performance of this code requires that a physician or therapist have direct (one-to-one) patient contact. Code 97799 denotes an unlisted physical medicine/rehabilitation service or procedure, including tests and measurements.

Q5 Does Medicare allow re-evaluation for speech therapy? There are physical and occupational therapy codes for re-evaluation. If speech re-evaluation is allowed, what is the appropriate code to report?

A5 Yes, Medicare does make payment for speech re-evaluation services when medically necessary and appropriate. The appropriate code to report in billing such services is 92506.

Q6 Is code 92525 valid for speech therapy when billing a patient for a modified barium swallowing to evaluate swallowing ability?

A6 Yes.

Q7 Is there a specific code or range of codes to report for cognitive speech therapy training?

A7 For cognitive speech therapy, a speech and language pathologist could use either code 92507 or 97770 but not both for the same treatment.

Q8 What resources are available for providers who have specific questions about coding?

A8 Specific coding questions should be directed to the AMA or to a therapy association.

Q9 We understand there is a new HCPCS code G0169. Can you describe when this code should be reported?

A9. G0169, a new HCPCS Level II code was created for use starting January 1, 2000. It is defined to describe the type of active debridement performed by therapists. (A more complete description can be found in the ***Federal Register***, November 2, 1999, p. 59426.) This code can be used to describe active debridement, whether performed with a scissors, scalpel, or waterjet regardless of the depth of tissue involved. There is no global period on this code. Dressings placed on the wound after debridement are included in this code. We expect therapists to start using this code instead of 10040-10044 and 97799 as soon as feasible.

Billing Guidelines

Q1 Do providers have to bill other payers by modalities?

A2 HCFA's understanding is that some providers bill other payers by modalities; however, it depends on the payer.

Q2 If a patient has therapy (any type) for three minutes, would a provider charge for 15 minutes?

A2 No, this would not constitute a therapy session. (See "Clarification on Physical Medicine Current Procedural Terminology (CPT) Coding Guidance" on page 13)

Q3 If a patient has therapy (any type) for 20 minutes, would a provider charge for 15 minutes?

A4 Yes. (See "Clarification on Physical Medicine Current Procedural Terminology (CPT) Coding Guidance" on page 13)

Q4 Are unused minutes in excess of 15 or 30 minutes charged for future visits?

A4 No. (See "Clarification on Physical Medicine Current Procedural Terminology (CPT) Coding Guidance" on page 13)

Q5 In regards to bundled services, does the time for the bundled service get counted in the time for the primary service? This comes up especially with hot/cold packs, 97010. For example, if a patient has a 25 minute visit with a hot pack for ten minutes and therapeutic exercises for 15 minutes, does this get billed as two units of 97110? Or is the hot pack time not counted and only one unit of 97110 billed?

PPS Questions & Answers - continued

A5 The scenario described is one unit of therapeutic exercise, 97110. The time of the hot and cold pack is not skilled and thus does not count in the total time.

Miscellaneous

Q1 Can occupational therapist and physical therapist dressing changes for wounds be charged?

A1 No. Dressing changes are bundled into the Medicare Physician [and Non-Physician Practitioner] Fee Schedule payment for the service.

Q2 Are providers and practitioners required to charge Medicare and non-Medicare patients the same amounts for outpatient rehabilitation services?

A2 No. Providers and practitioners may charge different amounts for outpatient rehabilitation services furnished to Medicare and non-Medicare patients. However, section 1128(b)(6) of the Social Security Act provides that the Secretary may exclude from participation in the Medicare program and from participation in any State health care program, individuals and entities that charge substantially in excess of their usual charges for furnished services. The determination of whether a charge substantially exceeds a usual charge is made by the Office of the Inspector General.

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.*

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. Effective dates are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy).

LMRP Format Changes

Effective with this issue, the format for local medical review policies (LMRPs) will begin changing. The new format is more consistent with the manner in which the carrier reports LMRPs to the Health Care Financing Administration (HCFA). Information previously available only on the BBS is now provided in the *Update!* including (where applicable) HCFA's national coverage policy, the sources of information used in developing local policy, and the policy's revision history.

More Information

Additional LMRPs may be obtained by accessing the Medicare Online Bulletin Board System (BBS) or on the World Wide Web at **www.floridamedicare.com**.

Medical Policy Table of Contents

The List of Medicare Noncovered Services

The complete list of Medicare noncovered services was published in the March/April 2000 *Medicare B Update!* (pages 19-23). Since that time, a number of changes to this policy have been identified:

Local Noncoverage

- **Arthroscopic Laser Arthrodesis.** Recently, Florida Medicare has been receiving claims for a surgical procedure referred to as an arthroscopic laser arthrodesis/rhizotomy of the facet joint with cancellous bone allograft and autologous platelet gell patch. It has been determined that this procedure is investigational and, therefore, is noncovered by Medicare. This procedure should be billed using procedure code **A9270*** (noncovered item or service).
- **Lidocaine Intravenous for Chronic Pain** was added to the list, effective for services processed on or after April 17, 2000 (to report, use procedure code **A9270***). This addition to the policy was provided in the March/April 2000 *Update!* However, the reason for its noncoverage was inadvertently omitted from that article. This service is noncovered due to it being investigational/experimental.
- **In Vitro Chemosensitivity Assays**: This procedure has previously been published as a noncovered service for Florida Medicare. It has come to our attention that there is some question as to whether this includes In Vitro resistance assays. Therefore, the description for this service is being revised to read "**A9270*** InVitro Chemosensitivity and/or Resistance Assays."
- **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-loaded catheter) including radiologic localization (includes contrast when administered).** This procedure is commonly referred to as "Percutaneous neurolysis of adhesions" or "Percutaneous epidural neuroplasty." This procedure received its own procedure code (**62263***) for 2000. Percutaneous epidural neuroplasty is an interventional pain management technique that is used to treat radiculopathy with low back pain. The stated goals for epidural neuroplasty are to break down fibrous adhesions that may prevent free movement of structures in the intervertebral foramen and in the bony vertebral canal, to remove any barriers (scar) that prevent application of medication to structures believed to be the source of pain, and to apply medication to the structures (e.g., anesthetics, corticosteroids). However, there are limited peer reviewed published

The List of Noncovered Services - continued

studies documenting the safety and effectiveness of this procedure. There are also published articles that call into question the improved patient outcomes, the therapeutic mechanism of the procedure, as well as addresses the significant adverse effects that can result from this procedure. Therefore, Florida Medicare considers procedure code 62263 to be investigational, and, therefore, is a noncovered service. (Note: Procedure codes 62281 and/or 62282 should not be billed to represent this procedure).

- **Homocysteine Testing for Cardiovascular Risk Screening**: Medicare does not provide coverage for screening services with the exception of a few specific services that are provided for by legislation (e.g., pap smears, mammography, and prostate screening). Therefore, Florida Medicare will consider the use of homocysteine testing for the purpose of cardiovascular risk screening to be a noncovered service, and when billed for this purpose, should be billed with **A9270**.

National Noncoverage

- **Brain Imaging Positron Emission Tomography (PET) Scans (**CPT codes **78608** and **78609**): Brain Imaging PET Scans are noncovered nationally by Medicare. Please refer to the Medicare Coverage Issues Manual Section 50-36 for more information regarding Medicare coverage of PET Scans.

**** = Services that are noncovered due to their being investigational/experimental***

E1399: Durable Medical Equipment, Miscellaneous—Billing Clarification

Florida Medicare's local medical review policy (LMRP) for sacral neuromodulation (procedure code 64555) was published in the March/April 2000 *Medicare B Update!* (pages 35-36). The "Coding Guidelines" section refers to the use of HCPCS code E1399 when reporting the test stimulation lead kit, bulk leads, needles, and cables associated with a neuromuscular stimulator (HCPCS code E0745).

Procedure code E1399 is *not* for use when reporting repair of durable medical equipment. DME repair should be reported using HCPCS code E1340 (Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes). E1340 should be billed to the local carrier if the repair or non-routine service involves implanted durable medical equipment (DME). If the DME is other than implanted, the DME regional carrier (DMERC) processes the claim. The DMERC that services Florida is Palmetto GBA Medicare. To contact the DMERC directly call (803) 735-1034, or write to:

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

Medical Policy Procedures : J7190

Policy Number
J7190

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Hemophilia Clotting Factors

AMA CPT Copyright Statement
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HCFA National Coverage Policy
Medicare Carriers Manual, sections 2049.5E, 5245
Coverage Issues Manual, section 45-24
Program Memorandum AB-99-75 (Change request 913)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
11/18/1996

Revision Effective Date
06/19/2000

Revision Ending Effective Date
06/18/2000

Policy Ending Date
N/A

LMRP Description
Hemophilia is a hereditary blood disease characterized by greatly prolonged coagulation time. The blood fails to clot and abnormal bleeding occurs. It is a sex-linked hereditary trait transmitted by normal heterozygous females who carry the recessive gene. It occurs almost exclusively in males. For purposes of Medicare coverage, hemophilia encompasses Factor VIII deficiency (classic hemophilia, hemophilia A), Factor IX deficiency (hemophilia B, Christmas disease, plasma thromboplastin component), and von Willebrand's disease.
Approximately 80% of those with hemophilia have type A and both are associated with recurrent, spontaneous, and traumatic hemarthrosis.
The frequency and severity of hemorrhagic events induced by hemophilia are related to the amount of coagulation factor in the blood. Those with mild

hemophilia (defined as having from 5% to 40% of normal coagulation factor activity) experience complications only afterhaving undergone surgery or experiencing a major physicial trauma. Those with moderate hemophilia (from 1% to 5% of coagulation factor activity) experience some spontaneous hemorrhage but normally exhibit bleeding provoked by trauma. Those with wevere hemophilia (less than 1% of coagulation factor activity) exhibit spontanous hemarthrosis and bleeding. Treatment for these patients is dependent on the severity of the disease and may include the administration of blood clotting factors such as Factor VIII, Factor IX, Factor VIIa and, Anti-inhibitorsto control the bleeding.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare provides coverage of self-administered blood clotting factors for hemophilia patients who are competent to use such factors to control bleeding without medical supervision. Medicare covers blood clotting factors for the following conditions:

- Factor VIII deficiency (classic hemophilia, hemophilia A).
- Factor IX deficiency (hemophilia B, Christmas disease, plasma thromboplastin component).
- von Willebrand's disease.

Anti-inhibitor coagulant complex (AICC) is a drug used to treat hemophilia in patients with factor VIII inhibitor antibodies. AICC has been shown to be safe and effective and is covered by Medicare when furnished to patients with hemophilia A and inhibitor antibodies to factor VIII who have major bleeding episodes and who fail to respond to other less expensive therapies.

HCPCS Section & Benefit Category

Miscellaneous drugs and solutions

HCPCS Codes

J7190	Factor VIII (antihemophilic factor, human) per I.U.
J7191	Factor VIII (anti-hemophilic factor [porcine]), per I.U.
J7192	Factor VIII (antihemophilic factor, recombinant) per I.U.
J7194	Factor IX complex, per IU
J7198	Anti-inhibitor, per i.u.
J7199	Hemophilia clotting factor, not otherwise classified
Q0160	Factor IX (antihemophilic factor, purified, non-recombinant) per I.U.
Q0161	Factor IX (antihemophilic factor, recombinant) per I.U.
Q0187	Factor VIIa (coagulation factor, recombinant) per 1.2 mg

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes That Support Medical Necessity

286.0	Congenital factor VIII disorder
286.1	Congenital factor IX disorder
286.2	Congenital factor XI deficiency
286.3	Congenital deficiency of other clotting factors
286.4	von Willebrand's disease

Diagnoses That Support Medical Necessity

N/A

ICD-9-CM Codes That DO NOT Support Medical Necessity

N/A

Diagnoses That DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnoses

N/A

Coding Guidelines

One hundred international units (IUs) of any of the clotting factors equals one unit (excluding code Q0187). If the number of units is between even hundreds, round to the nearest hundred. Thus, units of 1 to 49 are rounded down to the prior 100 and units of 50 to 99 are rounded up to the next 100 (e.g., 1,249 units are entered on the bill as 12 units; 1,250 units are entered as 13 units). Reimbursement is based upon the least expensive medically necessary blood clotting factors. The blood clotting factors are available both in a heat treated variety and a non-heat treated variety. The Food and Drug Administration (FDA) has determined that both varieties are safe and effective. Therefore, unless the prescription specifically calls for the heat treated variety (HCPCS code J7190 for factor VIII), reimbursement is based on the less expensive, non-heat treated variety (HCPCS code J7191 for factor VIII).

Documentation Requirements

Medical record documentation maintained in the patient's file must document the condition for which the blood clotting factor is being given. In addition, the name of the factor and the dosage required and/or given must be included in the records. This information is normally found in the office/progress notes, pharmacy forms, hospital records, and/or treatment notes.

Utilization Guidelines

N/A

Other Comments

Terms defined:

Hemophilia A (classic hemophilia, VIII deficiency) - is the most common severe bleeding hereditary disorder and is due to deficiency of the coagulation factor VIII. It is classified as severe if the factor VIII:C levels are less than 1%, moderate if levels are 1-5%, and mild if levels are greater than 5%. Approximately one in 10,000 males are affected. The most common sites of bleeding are into joints (knees, ankles, elbows), into muscles, and from the gastrointestinal tract.

Hemophilia B (Christmas disease, factor IX hemophilia) - is a hereditary bleeding disorder due to deficiency of coagulation factor IX. Factor IX deficiency is one-seventh as common as factor VIII deficiency but is

otherwise clinically and genetically identical. Factor IX deficiency occurs in one in 100,000 male births.
Von Willebrand's disease - is the most common congenital disorder of hemostasis. It is a group of disorders characterized by deficient or defective von Willebrand factor (vWF), a protein that mediates platelet adhesion. The subtypes of von Willebrand's disease are: type I, type IIa, type III, and pseudo-von Willebrand's. This disorder affects both men and women, is usually mild, with most bleeding being mucosal (epistaxis, gingival bleeding, menorrhagia).

Sources of Information
Hemophilia. (1999). [On-line]. Available: http://home.mdconsult.com/das/news/body/ctt.
Tabers cyclopedic medical dictionary (17th ed.). (1993). Philadelphia: F. A. Davis Company.
Tierney, L. M., McPhee, S. J., & Papadakis, M. A. (Eds.). (1998). Current medical diagnosis & treatment. (37th ed.). Stamford: Appleton & Lange.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Chapter of the American Society of Hematology. Carrier Advisory Committee meeting held on 2/19/2000.

Start Date of Comment Period
02/11/2000

Start Date of Notice Period
05/01/2000

Revision History
Revision Number:
3

Revised Effective Date:
06/19/2000
Start Date of Comment Period:
02/11/2000
Start Date of Notice Period:
05/01/2000 May/Jun 2000 *Update!*
Explanation of Revision:
Original policy struck out and replaced with information contained in the Medicare Carriers and Intermediary Manuals. The covered diagnosis list is identified in the Intermediary Manual and therefore needed to be applied to both the Intermediary and Carrier.

Start Date of Comment Period:
N/A
Start Date of Notice Period:
01/2000 Jan/Feb 2000 *Update!*
Original Effective Date:
11/18/1996
Revision Date/Number:
01/01/2000 2 (PCR B2000-039)
HCPCS 2000

Start Date of Comment Period:
Start Date of Notice Period:
Original Effective Date:
11/18/1996
Revision Date/Number:
04/01/1998 1 (PCR B98-066)

Start Date of Comment Period:
Start Date of Notice Period:
Original Effective Date:
11/18/1996 (PCR 96-209)

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.

Medical Policy Procedures : Q0136

Policy Number
Q0136

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Non-ESRD Epoetin (Procrit)

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HCFA National Coverage Policy
Program transmittal AB-99-59
Medicare Carriers Manual, Section 2049.5B

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
04/14/1997

Revision Effective Date
04/24/2000

Revision Ending Effective Date
04/23/2000

Policy Ending Date
N/A

LMRP Description
Erythropoietin is a glycoprotein which stimulates red blood cell production. It is produced in the kidneys and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare considers Epogen (EPO) to be medically necessary for the treatment of certain conditions including:

(1)Anemia induced by the drug Zidovudine (AZT)

- EPO is indicated in HIV infected patients to elevate or maintain the red blood cell level as manifested by an increase in the hemoglobin and/or hematocrit and to decrease the need for transfusions.
- EPO therapy is indicated for the patients with endogenous serum erythropoietin levels £ 500m units/ml *and* are receiving a dose of AZT £ 4200 mg/wk.
- The initial recommended starting dose is 100 u/kg as an IV or SC injection 3 times weekly for 8 weeks. If after 8 weeks of therapy, the patient's hematocrit has not increased or transfusion requirements have not decreased, then the dose of EPO can be increased by 50 to 100 u/kg 3 times weekly. If patients have not responded satisfactorily to a 300 u/kg dose 3 times weekly, it is unlikely that the patient will respond to higher doses, and therefore, the EPO should be discontinued.
- The maintenance dose is titrated to maintain the response based on factors such as zidovudine dose and presence of intercurrent infectious or inflammatory episodes.
- If the hematocrit exceeds 40%, the EPO should be stopped until the hematocrit drops to 36%. When resuming treatment, the EPO dose should be reduced by 25%, then titrate to maintain desired hematocrit.

*EPO is not indicated for patients with an endogenous serum erythropoietin level of >500 mu/ml or treatment of anemia in HIV-infected patients due to factors such as iron or folate deficiencies, hemolysis or gastrointestinal bleeding.

(2)Anemia in cancer patients receiving chemotherapy for nonmyeloid malignancies

- The use of EPO has been shown to be effective in treatment of anemia in patients with malignancies where anemia is due to the effect of *concomitantly* administered chemotherapy. EPO should be discontinued when the patient is no longer receiving chemotherapy.
- EPO is indicated to decrease the need for transfusions in patients who will be receiving concomitant chemotherapy for a *minimum of two months*.
- EPO is indicated for patients who had chemotherapy for a non-myeloid malignancy within the past year and presents post-chemo with anemia (i.e., permanent damage resulting from chemo). Documentation should support that the anemia was a result of a chemotherapy agent.
- EPO therapy is indicated for patients with a serum erythropoietin level of £ 500 mu/ml.
- The recommended starting dose is 150 units/kg 3 times weekly. If after 8 weeks the patient is not responding (increase HGB & HCT or decrease transfusion requirements), the dose may be increased up to 300 u/kg 3 times weekly. If patient has not responded satisfactorily to a 300 u/kg dose three times weekly (defined as increase in HGB by 2g or decrease in transfusion requirements), it is unlikely that the patient will respond to higher doses. If the hematocrit exceeds 40%, the EPO should be stopped until the hematocrit drops to 36%. When resuming treatment, the EPO dose should be reduced by 25%, then titrate to maintain desired hematocrit.

(3)Anemia associated with myelodysplastic syndrome (MDS)

- EPO therapy is indicated for patients with a serum erythropoietin level below 500 mu/ml.
- Same dosage as cancer patients on chemotherapy.
- The patient presents with variable clinical features depending on the MDS classification and the degree of disordered hematopoiesis with anemia. Common complaints or symptoms are fatigue, pallor, infection and bleeding or bruising. Diagnosis is usually confirmed by bone marrow aspiration and/or biopsy.

(4)Chronic anemia associated with Rheumatoid Arthritis (RA)

- The patient must have been previously diagnosed with RA using the American College of Rheumatology criteria.
- Usually these patients are on an antimetabolite (e.g., Methotrexate) which are causing the anemia.
- Same recommended dosages as cancer patients on chemotherapy and MDS patients.

(5)Reduction of allogeneic blood transfusion in surgery patients

- EPO is indicated in the treatment of anemic patients (hemoglobin > 10 to ≤ 13 g/dl) scheduled to undergo major, elective orthopedic hip or knee surgery who are expected to require ≥ 2 units of blood and who are not able or willing to participate in an autologous blood donation program.
- The recommended dose is 300 u/kg/day SC for 10 days before surgery, on the day of surgery, and for 4 days after surgery.
- An alternate dose schedule is 600 u/kg SC in once-weekly doses at 21, 14 and 7 days before surgery plus a fourth dose on the day of surgery.
- All patients should receive adequate iron supplementation throughout the course of therapy.
- Anemia is of chronic disease.

General indications and limitations for non-ESRD patients receiving EPO for indications 1-4:

- Prior to and during EPO therapy, the patient's iron status, including transferrin saturation and serum ferritin must be evaluated. Transferrin saturation should be at least 20% *and* ferritin should be at least 100 ng/ml. Virtually all patients will eventually require supplemental iron to increase or maintain transferrin saturation to levels which adequately support EPO stimulated erythropoiesis.
- To initiate EPO therapy, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 30% or a hemoglobin (HGB) < 10g/dl unless there is medical documentation showing the need for EPO despite a HCT > 29.9 or a HGB > 9.9g/dl. It may be medically necessary for a patient to initiate EPO therapy when the hematocrit is greater than 29.9 percent or the hemoglobin is greater than 9.9 g/dl and the patient exhibits severe signs and symptoms such as: extreme weakness and fatigue, cold intolerance, tachycardia, severe pulmonary distress, severe hypotension, angina, congestive heart failure, etc., caused by the anemic condition.
- After reaching a target HCT & HGB of 36 or 12, the EPO should be tapered down to maintain the patient at this level. Normally, dosage is reduced by 25% when lowering the dose. If the dosage is decreased to minimum dosages and the patient's HCT & HGB continues to increase, the EPO should be discontinued. Documentation should support the medical necessity of continuing the same dosage. It may be necessary to initiate and/or maintain patients at higher HCT & HGB levels if the documented symptoms of anemia require the initiation or maintenance at a higher level.

Note: The standards of care regarding EPO dosing has changed from per kg to a standard starting total dose of 30000 u/wk (as divided doses three times a week or two times a week). If the EPO dose must be increased after 8 weeks, then it is not recommended to exceed the dosage indicated under the applicable indication.

HCPCS Section & Benefit Category
Drugs and Biologicals

HCPCS Codes
Q0136 Injection, epoetin alpha, (for non ESRD use), per 1,000 units

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes That Support Medical Necessity

042	Human immunodeficiency virus (HIV) disease
238.7	Neoplasms of uncertain behavior, other lymphatic and hematopoietic (myelodysplastic) tissues
285.8 *	Other specified anemias
285.9 *	Anemia, unspecified
714.0	Rheumatoid arthritis
995.2	Unspecified adverse affect of drug, medicinal and biological substance
E878.1	Surgical operation with implant of artificial internal device
V58.1	Encounter for other and unspecified procedures and after care, chemotherapy

*The anemia diagnoses must be billed with the condition causing the anemia.

Diagnoses That Support Medical Necessity
N/A

ICD-9-CM Codes That DO NOT Support Medical Necessity
N/A

Diagnoses That DO NOT Support Medical Necessity
N/A

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

- To increase the amount of blood which can be drawn for auto-donation prior to surgery,
- For blood loss in patients who refuse transfusions for religious or other reasons.

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.

Noncovered Diagnoses
N/A

Coding Guidelines
- When billing for EPO, round up to the nearest 1,000 units

When billing for non-ESRD EPO the diagnosis for anemia (285.8 or 285.9) must be billed with the condition causing the anemia.

- For patients currently receiving chemotherapy, diagnosis code V58.1 must be coded as the secondary diagnosis to indicate that the anemic condition is chemotherapy-induced. These patients must currently be on a course of chemotherapy for a non-myeloid malignancy.
- For patients with post-chemotherapy anemia, a secondary diagnosis of 995.2 must be coded. These patients must have received chemotherapy within the last year.
- For patients with anemia related to Rheumatoid arthritis, a secondary diagnosis of 714.0 must be coded.
- For AZT-related service, a secondary diagnosis of AIDS (042) must be coded. These patients must have an endogenous serum erythropoietin level ≤ 500 mg units/ml and receiving a dose of AZT ≤ 4200 mg/week.
- A diagnosis of myelodysplastic syndrome (ICD-9-CM 238.7) must be coded as secondary for these patients.
- For reduction of allogeneic blood transfusion in surgery patients, a secondary diagnosis of E878.1 must be coded.

Documentation Requirements
The physician must clearly document in the patient's medical records that all requirements have been met and supports the medical necessity for the use of Procrit, including but not limited to covered diagnoses, appropriate laboratory studies (including date & results of most recent HCT/HGB levels within last month), dosage, route of administration, frequency and duration of the treatment and the patient's response to the therapy. This information is normally found in the office/progress and laboratory results.

Utilization Guidelines
N/A

Other Comments
Terms Defined:
AIDS (Acquired Immune Deficiency Syndrome): a deficiency in the immune system caused by the HIV virus
AZT (Azidothymidine): a drug used for the management of patients with HIV infections
End-Stage Renal Disease (ESRD): relates to kidney function; inability of the kidneys to carry out important functions in the body; removing poisonous wastes, maintaining the proper balance of chemicals, and removing excess fluid
Hematocrit (HCT): a measurement (in percent) of red blood cells in whole blood
Hemoglobin: a substance contained within the red blood cells; responsible for their color, composed of the pigment heme linked to the protein globin; unique property of combining reversibly with oxygen; medium by which oxygen is transported within the body
HIV (Human Immunodeficiency Virus): a virus causing a breakdown of the body's immune system resulting in infections, malignancies and neurologic disease
Myelodysplastic syndrome (MDS): includes a group of clonal hematopoietic diseases characterized by impaired maturation of hematopoietic precursors with the development of progressive peripheral cytopenias. MDS is characterized by erythroid, myeloid, and megabaryocytic forms on bone marrow. There are five distinct forms of MDS: Refractory anemia (RA), RA with sideroblasts, RA with excess blasts (RAEB), chronic myelomonocytic leukemia, and RAEB in transformation.

Sources of Information
2000 Facts and Comparisions
Stein, J. (1994). Internal Medicine. (4th ed.). Mosby-Year Book: St. Louis.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida College of Oncology.
Carrier Advisory Committee held on September 28, 1996.

Start Date of Comment Period
N/A

Start Date of Notice Period
05/01/2000

Revision History
Revision Number:
1
Revised Effective Date:
04/24/2000 (PCR B2000-86)
Start Date of Comment Period:
N/A
Start Date of Notice Period:
05/01/2000 May/Jun 2000 *Update!*
Explanation of Revision:
A recent evaluation of the preoperative indication was completed and a decision was made to cover this indication. Therefore, this policy was revised.

Revision Number:
Original
Start Date of Comment Period:
09/28/96
Start Date of Notice Period:
03/97 Mar/Apr '97 *Update!*
Original Effective Date:
04/14/97 (PCR B97-036)

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.

Medical Policy Procedures: 00001
Policy Number
00001

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Independent Diagnostic Testing Facility (IDTF)

AMA CPT Copyright Statement
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Applicable FARS/DFARS Apply.

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
04/19/1999

Revision Effective Date
04/11/2000
Revision Ending Effective Date
04/10/2000
Policy Ending Date
N/A

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

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

- **Supervising physician**
  - An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of nonphysician personnel who use the equipment. This level of supervision is the requirement for general supervision.
  - The supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. In the case of a procedure requiring the direct or personal supervision of a physician, the IDTF's supervising physician must personally furnish this level of supervision whether the procedure is performed in the IDTF or, in the case of mobile services, at the remote location.
- **Nonphysician personnel**
  - Any nonphysician personnel used by the IDTF to perform tests must demonstrate the basic qualifications to perform the tests in question and have training and proficiency by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician must be certified by an appropriate national credentialing body.
- **Ordering of tests**
  - All procedures performed by the IDTF must be specifically ordered in writing by the physician who is treating the beneficiary, that is, the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. The order must specify the diagnosis or other basis for the testing. The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF's supervising physician is in fact the beneficiary's treating physician. The IDTF may not add any procedures based on internal protocols without a written order from the treating physician.
- **Multi-state entities**
  - An IDTF that operates across state boundaries must maintain documentation that its supervising physicians and technicians are licensed and certified in each of the states in which it is furnishing services.
- **Applicability of state law**
  - An IDTF must comply with applicable laws of any state in which it operates.

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

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

The personnel performing the tests identified under the

HCPCS Codes section must have the applicable certification/licensing as listed below:

- The American Registry of Radiologic Technologists (ARRT) provides credentialing for 3 primary radiologic sciences: radiography, nuclear medicine technology, and radiation therapy technology. Once credentialing is obtained, then a General license is obtained from the Florida State Board. A person holding a license may have one or more of the following certifications:

  General Radiographer: Certified Radiologic Technologist-Radiographer (CRT-R);
  Basic Machine Operator (BMO): Certified Radiologic Technologist-Radiographer (CRT-R)
  Radiation Therapy Technologist: Certified Radiologic Technologist-Radiation Therapy (CRT-T);
  Nuclear Medicine Technologist: Certified Radiologic Technologist-Nuclear Medicine (CRT-N).

In addition to the primary credentialing sciences mentioned above, there are 5 additional advanced examinations a technologist may take to obtain credentialing for. These are: cardiovascular interventional technology, mammography, computerized tomography, magnetic resonance imaging, and quality management.

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

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

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

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

  Certified Ophthalmic Assistant (COA);
  Certified Ophthalmic Technician (COT);
  Certified Ophthalmic Medical Technologist (COMT).

- The Medical Dosimetrist Certification Board provides credentialing for radiation oncologists (MDC).

- The Nuclear Medicine Technology Certification Board (NMTCB) offers the following credential:

  Certified Nuclear Medicine Technologist (CNMT).

- The Board of Certification of the Ophthalmic Photographers' Society offers the following credentialing:

  Certified Retinal Angiographer (CRA)

- Cardiovascular Credentialing International (CCI) offers the following credentials:

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

- The State of Florida offers the following certification:

  Emergency Medical Technician (EMT);
  Paramedic.

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

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

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

- Registered Nurse (RN) with active state licensure and proficiency demonstration.

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

  Registered Electrodiagnostic Technologist (R. EDT.)

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

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

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

  Registered Polysomnographic Technologist (RPSGT)

CPT-4 CODE(S)	CERTIFICATION
54240	ARDMS: RVT CCI: RVS
70030-70160	State license: CRT-R (General Radiographer) Medical Physicist
70190-70330	State license: CRT-R (General Radiographer) Medical Physicist
70336	Demonstrates proficiency
70350-70355	State license: CRT-R (General Radiographer)
70360-70370	State license: CRT-R (General Radiographer) Medical Physicist
70371	State license: CRT-R (General Radiographer)
70380	State license: CRT-R (General Radiographer) Medical Physicist
70450-70488	State license: CRT-R (General Radiographer) Medical Physicist
70490-70492	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist

CPT-4 CODE(S)	CERTIFICATION
70540-70553	Demonstrates proficiency
71100-71130	State license: CRT-R (General Radiographer)
71250-71270	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
71550-71555	Demonstrates proficiency
72010-72120	State license: CRT-R (General Radiographer) Medical Physicist
72125-72133	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
72141-72159	Demonstrates proficiency
72170-72190	State license: CRT-R (General Radiographer) Medical Physicist
72192-72194	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
72196-72198	Demonstrates proficiency
72200-72220	State license: CRT-R (General Radiographer) Medical Physicist
73000-73030	State license: CRT-R (General Radiographer) Medical Physicist
73050-73080	State license: CRT-R (General Radiographer) Medical Physicist
73120-73140	State license: CRT-R (General Radiographer) Medical Physicist
73200-73202	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
73220-73225	Demonstrates proficiency
73500-73520	State license: CRT-R (General Radiographer) Medical Physicist
73540-73565	State license: CRT-R (General Radiographer) Medical Physicist
73590-73610	State license: CRT-R (General Radiographer) Medical Physicist
73620-73660	State license: CRT-R (General Radiographer) Medical Physicist
73700-73702	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
73720-73725	Demonstrates proficiency
74000-74022	State license: CRT-R (General Radiographer) Medical Physicist
74150-74170	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
74181-74185	Demonstrates proficiency
74210-74249	State license: CRT-R (General Radiographer)
74250-74251	General license with training in gastrointestinal radiography
74260-74291	State license: CRT-R (General Radiographer)
74400-74420	State license: CRT-R (General Radiographer)
74710	State license: CRT-R (General Radiographer) Medical Physicist
74775	State license: CRT-R (General Radiographer)
75552-75556	Demonstrates proficiency
76003-76005	State license: CRT-R (General Radiographer)
76010-76066	State license: CRT-R (General Radiographer) Medical Physicist
76070-76076	State license: CRT-R (BMO)
76078	State license: CRT-R (General Radiographer)
76090-76092	ARRT: CRT-R with advanced credentialing in mammography
76093-76094	Demonstrates proficiency
76098	State license: CRT-R (General Radiographer)
76100-76350	State license: CRT-R (General Radiographer)
76355	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
76375-76380	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist
76390-76400	Demonstrates proficiency
76499	Dependent on diagnostic procedure performed
76506	ARDMS: RDMS-Neurosonology
76511-76529	ROUB JCAHPO: COA, COT, COMT
76536	ARDMS: RDMS-Abdomen
76604-76778	ARDMS: RDMS-Abdomen
76800	ARDMS: RDMS-Neurosonology
76805-76818	ARDMS: RDMS-Obstetrics & Gynecology
76825-76828	ARDMS: RDMS-Obstetrics & Gynecology ARDMS: RDCS
76830-76831	ARDMS: RDMS-Obstetrics & Gynecology
76856-76857	ARDMS: RDMS-Obstetrics & Gynecology
76870	ARDMS: RDMS-Abdomen
76872-76873	ARDMS: RDMS-Abdomen
76880	ARDMS: RDMS-Abdomen
76885-76886	ARDMS-RDMS
76977	Demonstrates proficiency
76999	ARDMS: RDMS-Appropriate credentialing based on body area examining

CPT-4 CODE(S)	CERTIFICATION
77417	State license MDC
78000-78099	State license: CRT-N, CNMT
78102-78199	State license: CRT-N, CNMT
78201-78299	State license: CRT-N, CNMT
78300-78350	State license: CRT-N, CNMT
78399	State license: CRT-N, CNMT
78414-78458	State license: CRT-N, CNMT
78460-78483	State license: CRT-N, CNMT
78494-78499	State license: CRT-N, CNMT
78580-78599	State license: CRT-N, CNMT
78600-78607	State license: CRT-N, CNMT
78610-78699	State license: CRT-N, CNMT
78700-78799	State license: CRT-N, CNMT
78800-78807	State license: CRT-N, CNMT
78999	State license: CRT-N, CNMT
92081-92083	JCAHPO: COT, COMT
92100-92130	JCAHPO: COA
92235-92240	JCAHPO: COT, COMT Registered Nurse CRA
92250	JCAHPO: COT, COMT CRA
92265-92275	JCAHPO: COT, COMT Registered Nurse
92283-92284	JCAHPO: COA, COT, COMT
92285	JCAHPO: COT, COMT CRA
92286-92287	JCAHPO: COT, COMT Registered Nurse CRA
92516	Certified Audiologist
92520-92525	Speech Pathologist
92541-92548	Certified Audiologist
92552-92557	Licensed Audiologist
92561-92584	Licensed Audiologist
92585	ABRET: R. EP T., R. EEG T. Audiologist
92587-92589	Licensed Audiologist
93000-93278	CCI: CCT, RCS Registered Nurse (RN) Paramedic
93303-93308	ARDMS: RDCS CCI: RCS
93312	ARDMS: RDCS CCI: RCS
93315	ARDMS: RDCS CCI: RCS
93320	ARDMS: RDCS CCI: RCS
93325	ARDMS: RDCS, RDMS (Obstetrics & Gynecology) CCI: RCS
93350	ARDMS: RDCS CCI: RCS, CCT for stress portion Registered Nurse Paramedic
93501	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93505	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93510-93533	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93555-93572	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse
93600-93642	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse
93660	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse
93724	CCI: CCT Registered Nurse Paramedic
93727-93738	CCI: CCT Registered Nurse Paramedic
93741-93744	CCI: CCT Registered Nurse Paramedic
93770	CCI: CCT Registered Nurse Paramedic
93799	CCI: CCT Registered Nurse Paramedic
93875-93990	ARDMS: RVT CCI: RVS
94010, 94060-94070	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)
94200-94450	State license: RPFT, RRT, CPFT,CRT,
94620-94621	State license: RPFT, RRT Registered Nurse (RN)
94664-94665	State license: CPFT, RPFT,CRT,, RRT Registered Nurse (RN)
94680-94750	State license: RPFT, RRT
94760-94762	Demonstrates proficiency
94770	State license: RPFT, RRT
94799	State license: Appropriate credentialing based on service performing
95004	RN with active state license
95024-95056	RN with active state license
95805, 95807-95811	ABRET: R. EEG T. BRPT: RPSGT State license: CPFT, RPFT, CRTT, RRT
95812-95822, 95827	ABRET: R. EEG T.
95900-95904	AAET: R. EDT. ABRET: R. EP T. Qualified Physical Therapist permitted to perform service under state law
95921-95923	AAET: R. EDT.
95925-95930	ABRET: R. EP T., R. EEG T.
95933-95937	AAET: R. EDT. Qualified Physical Therapist who is permitted to perform service under state law
95950-95953	ABRET: R. EEG T.
95954	ABRET: R. EEG T.
95956-95957	ABRET: R. EEG T.
95958	ABRET: R. EEG T.

CPT-4 CODE(S)	CERTIFICATION
95999	Appropriate credentialing based on service performing
G0004-G0015	CCI: CCT Registered Nurse (RN) Paramedic
G0050	ARDMS: RDMS-Abdomen
Q0035	CCI: CCT Registered Nurse (RN) Paramedic

HCPCS Section & Benefit Category

Diagnostic Ultrasound/Radiology
Non-invasive Vascular Diagnostic Studies/Medicine
Male Genital System
Pulmonary/Medicine
Cardiovascular/Medicine
Diagnostic Radiology
Radiation Oncology/Radiology
Nuclear Medicine/Radiology
Ophthalmology/Medicine
Special Otorhinolaryngologic Services/Medicine
Allergy and Clinical Immunology/Medicine
Neurology and Neuromuscular Procedures/Medicine

HCPCS Codes

54240 Penile plethysmography
70030 Radiologic examination, eye, for detection of foreign body
70100 Radiologic examination, mandible; partial, less than four views
70110 complete, minimum of four views
70120 Radiologic examination, mastoids; less than three views per side
70130 complete, minimum of three views per side
70134 Radiologic examination, internal auditory meati, complete
70140 Radiologic examination, facial bones; less than three views
70150 complete, minimum of three views
70160 Radiologic examination, nasal bones, complete, minimum of three views
70190 Radiologic examination; optic foramina
70200 orbits, complete, minimum of four views
70210 Radiologic examination, sinuses, paranasal, less than three views
70220 Radiologic examination, sinuses, paranasal, complete, minimum of three views
70240 Radiologic examination, sella turcica
70250 Radiologic examination, skull; less than four views, with or without stereo
70260 complete, minimum of four views, with or without stereo
70300 Radiologic examination, teeth; single view
70310 partial examination, less than full mouth
70320 complete, full mouth
70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
70330 bilateral
70336 Magnetic resonance (eg, proton) imaging, temporomandibular joint
70350 Cephalogram, orthodontic
70355 Orthopantogram
70360 Radiologic examination; neck, soft tissue
70370 pharynx or larynx, including fluoroscopy and/or magnification technique
70371 Complex dynamic pharyngeal and speech evaluation by cine or video recording
70380 Radiologic examination, salivary gland for calculus
70450 Computerized axial tomography, head or brain; without contrast material
70460 with contrast material(s)
70470 without contrast material, followed by contrast material(s) and further sections
70480 Computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481 with contrast material(s)
70482 without contrast material, followed by contrast material(s) and further sections
70486 Computerized axial tomography, maxillofacial area; without contrast material
70487 with contrast material(s)
70488 without contrast material, followed by contrast material(s) and further sections
70490 Computerized axial tomography, soft tissue neck; without contrast material
70491 with contrast material(s)
70492 without contrast material followed by contrast material(s) and further sections
70540 Magnetic resonance (eg, proton) imaging, orbit, face, and neck
70541 Magnetic resonance angiography, head and/or neck, with or without contrast material(s)
70551 Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552 with contrast material(s)
70553 without contrast material, followed by contrast material(s) and further sequences
71010 Radiologic examination, chest; single view, frontal
71015 stereo, frontal
71020 Radiologic examination, chest, two views, frontal and lateral;
71021 with apical lordotic procedure
71022 with oblique projections
71023 with fluoroscopy
71030 Radiologic examination, chest, complete, minimum of four views;
71034 with fluoroscopy
71035 Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)
71100 Radiologic examination, ribs, unilateral; two views
71101 including posteroanterior chest, minimum of three views
71110 Radiologic examination, ribs, bilateral; three views
71111 including posteroanterior chest, minimum of four views
71120 Radiologic examination; sternum, minimum of two views
71130 sternoclavicular joint or joints, minimum of three views
71250 Computerized axial tomography, thorax; without contrast material
71260 with contrast material(s)
71270 without contrast material, followed by contrast material(s) and further sections
71550 Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy)

71555 Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72010 Radiologic examination, spine, entire, survey study, anteroposterior and lateral
72020 Radiologic examination, spine, single view, specify level
72040 Radiologic examination, spine, cervical; anteroposterior and lateral
72050 minimum of four views
72052 complete, including oblique and flexion and/or extension studies
72069 Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070 Radiologic examination, spine; thoracic, anteroposterior and lateral
72072 thoracic, anteroposterior and lateral, including swimmer's view of the cervicothoracic junction
72074 thoracic, complete, including obliques, minimum of four views
72080 thoracolumbar, anteroposterior and lateral
72090 scoliosis study, including supine and erect studies
72100 Radiologic examination, spine, lumbosacral; anteroposterior and lateral
72110 complete, with oblique views
72114 complete, including bending views
72120 Radiologic examination, spine, lumbosacral, bending views only, minimum of four views
72125 Computerized axial tomography, cervical spine; without contrast material
72126 with contrast material
72127 without contrast material, followed by contrast material(s) and further sections
72128 Computerized axial tomography, thoracic spine; without contrast material
72129 with contrast material
72130 without contrast material, followed by contrast material(s) and further sections
72131 Computerized axial tomography, lumbar spine; without contrast material
72132 with contrast material
72133 without contrast material, followed by contrast material(s) and further sections
72141 Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142 with contrast material(s)
72146 Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147 with contrast material(s)
72148 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149 with contrast material(s)
72156 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157 thoracic
72158 lumbar
72159 Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72170 Radiologic examination, pelvis; anteroposterior only
72190 complete, minimum of three views
72192 Computerized axial tomography, pelvis; without contrast material
72193 with contrast material(s)
72194 without contrast material, followed by contrast material(s) and further sections
72196 Magnetic resonance (eg, proton) imaging, pelvis
72198 Magnetic resonance angiography, pelvis, with or without contrast material(s)
72200 Radiologic examination, sacroiliac joints; less than three views
72202 three or more views
72220 Radiologic examination, sacrum and coccyx, minimum of two views
73000 Radiologic examination; clavicle, complete
73010 scapula, complete
73020 Radiologic examination; shoulder; one view
73030 complete, minimum of two views
73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
73060 humerus, minimum of two views
73070 Radiologic examination, elbow; anteroposterior and lateral views
73080 complete, minimum of three views
73090 Radiologic examination; forearm, anteroposterior and lateral views
73092 upper extremity, infant, minimum of two views
73100 Radiologic examination, wrist; anteroposterior and lateral views
73110 complete, minimum of three views
73120 Radiologic examination, hand; two views
73130 minimum of three views
73140 Radiologic examination, finger(s), minimum of two views
73200 Computerized axial tomography, upper extremity; without contrast material
73201 with contrast material(s)
73202 without contrast material, followed by contrast material(s) and further sections
73220 Magnetic resonance (eg, proton) imaging, upper extremity, other than joint
73221 Magnetic resonance (eg, proton) imaging, any joint of upper extremity
73225 Magnetic resonance angiography, upper extremity, with ot without contrast material(s)
73500 Radiologic examination, hip, unilateral; one view
73510 complete, minimum of two views
73520 Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis
73540 Radiologic examination, pelvis and hips, infant or child, minimum of two views
73550 Radiologic examination, femur, anteroposterior and lateral views
73560 Radiologic examination, knee; one or two views
73562 three views
73564 complete, four or more views
73565 both knees, standing, anteroposterior
73590 Radiologic examination; tibia and fibula, anteroposterior and lateral views
73592 lower extremity, infant, minimum of two views

73600 Radiologic examination, ankle; anteroposterior and lateral views
73610 complete, minimum of three views
73620 Radiologic examination, foot; anteroposterior and lateral views
73630 complete, minimum of three views
73650 Radiologic examination; calcaneus, minimum of two views
73660 toe(s), minimum of two views
73700 Computerized axial tomography, lower extremity; without contrast material
73701 with contrast material(s)
73702 without contrast material, followed by contrast material(s) and further sections
73720 Magnetic resonance (eg, proton) imaging, lower extremity, other than joint
73721 Magnetic resonance (eg, proton) imaging, any joint of lower extremity
73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)
74000 Radiologic examination, abdomen; single anteroposterior view
74010 anteroposterior and additional oblique and cone views
74020 complete, including decubitus and/or erect views
74022 complete acute abdomen series, including supine, erect, and/or decubitus views, upright PA chest
74150 Computerized axial tomography, abdomen; without contrast material
74160 with contrast material(s)
74170 without contrast material, followed by contrast material(s) and further sections
74181 Magnetic resonance (eg, proton) imaging, abdomen
74185 Magnetic resonance angiography, abdomen, with or without contrast material(s)
74210 Radiologic examination; pharynx and/or cervical esophagus
74220 esophagus
74230 Swallowing function, pharynx and/or esophagus, with cineradiography and/or video
74240 Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB
74241 with or without delayed films, with KUB
74245 with small bowel, includes multiple serial films
74246 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB
74247 with or without delayed films, with KUB
74249 with small bowel follow-through
74250 Radiologic examination, small bowel, includes multiple serial films;
74251 via enteroclysis tube
74260 Duodenography, hypotonic
74270 Radiologic examination, colon; barium enema, with or without KUB
74280 air contrast with specific high density barium, with or without glucagon
74283 Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (eg, meconium ileus)
74290 Cholecystography, oral contrast;
74291 additional or repeat examination or multiple day examination
74400 Urography (pyelography), intravenous, with or without KUB, with or without tomography
74410 Urography, infusion, drip technique and/or bolus technique;
74415 with nephrotomography
74420 Urography, retrograde, with or without KUB
74710 Pelvimetry, with or without placental localization
74775 Perineogram (eg, vaginogram, for sex determination or extent of anomalies)
75552 Cardiac magnetic resonance imaging for morphology; without contrast material
75553 with contrast material
75554 Cardiac magnetic resonance imaging for function, with or without morphology; complete study
75555 limited study
75556 Cardiac magnetic resonance imaging for velocity flow mapping
76003 Fluoroscopic localization for needle biopsy or fine needle aspiration
76005 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction
76010 Radiologic examination from nose to rectum for foreign body, single film, child
76020 Bone age studies
76040 Bone length studies (orthoroentgenogram, scanogram)
76061 Radiologic examination, osseous survey; limited (eg, for metastases)
76062 complete (axial and appendicular skeleton)
76065 Radiologic examination, osseous survey, infant
76066 Joint survey, single view, one or more joints (specify)
76070 Computerized tomography bone mineral density study, one or more sites
76075 Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)
76076 appendicular skeleton (peripheral) (eg, radius, wrist, heel)
76078 Radiographic absorptiometry (photodensitometry), one or more sites
76090 Mammography; unilateral
76091 bilateral
76092 Screening mammography, bilateral (two view film study of each breast)
76093 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
76094 bilateral
76098 Radiological examination, surgical specimen
76100 Radiologic examination, single plane body section (eg, tomography), other than with urography

76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral
76102	bilateral
76120	Cineradiography, except where specifically included
76125	Cineradiography to complement routine examination (List separately in addition to code for primary code)
76150	Xeroradiography
76350	Subtraction in conjunction with contrast studies
76355	Computerized tomography guidance for stereotactic localization
76375	Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging, or other tomographic modality
76380	Computerized tomography, limited or localized follow-up study
76390	Magnetic resonance spectroscopy
76400	Magnetic resonance (eg, proton) imaging, bone marrow blood supply
76499	Unlisted diagnostic radiologic procedure
76506	Echoencephalography, B-scan and/or real time with image documentation (gray scale)(for determination of ventricular size, delineation of cerebral contents and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated
76511	Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification
76512	contact B-scan (with or without simultaneous A-scan)
76513	anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76516	Ophthalmic biometry by ultrasound echography, A-scan;
76519	with intraocular lens power calculation
76529	Ophthalmic ultrasonic foreign body localization
76536	Echography, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation
76604	Echography, chest, B-scan (includes mediastinum) and/or real time with image documentation
76645	Echography, breast(s)(unilateral or bilateral), B-scan and/or real time with image documentation
76700	Echography, abdominal, B-scan and/or real time with image documentation; complete
76705	limited (eg, single organ, quadrant, follow-up)
76770	Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete
76775	limited
76778	Echography of transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler studies
76800	Echography, spinal canal and contents
76805	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)
76810	complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester
76815	limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)
76816	follow-up or repeat
76818	Fetal biophysical profile
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	follow-up or repeat study
76827	Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display; complete
76828	follow-up or repeat study
76830	Echography, transvaginal
76831	Hysterosonography, with or without color flow Doppler
76856	Echography, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete
76857	limited or follow-up (eg, for follicles)
76870	Echography, scrotum and contents
76872	Echography, transrectal;
76873	prostate volume study for brachytherapy treatment planning (separate procedure)
76880	Echography, extremity, non-vascular, B-Scan and/or real time with image documentation
76885	Echography of infant hips, real time with imaging documentation; dynamic (eg, requiring manipulation)
76886	limited, static (eg, not requiring manipulation)
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
76999	Unlisted ultrasound procedure
77417	Therapeutic radiology port film(s)
78000	Thyroid uptake; single determination
78001	multiple determinations
78003	stimulation, suppression or discharge (not including initial uptake studies)
78006	Thyroid imaging, with uptake; single determination
78007	multiple determinations
78010	Thyroid imaging; only
78011	with vascular flow
78015	Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)
78016	with additional studies (eg, urinary recovery)
78018	whole body
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)
78070	Parathyroid imaging
78075	Adrenal imaging, cortex and/or medulla
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78102	Bone marrow imaging; limited area
78103	multiple areas
78104	whole body
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling

78111 multiple samplings
78120 Red cell volume determination (separate procedure); single sampling
78121 multiple samplings
78122 Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)
78130 Red cell survival study;
78135 differential organ/tissue kinetics, (eg, splenic and/or hepatic sequestration)
78140 Labeled red cell sequestration, differential organ/tissue, (eg, splenic and/or hepatic)
78160 Plasma radioiron disappearance (turnover) rate
78162 Radioiron oral absorption
78170 Radioiron red cell utilization
78172 Chelatable iron for estimation of total body iron
78185 Spleen imaging only, with or without vascular flow
78190 Kinetics, study of platelet survival, with or without differential organ/tissue localization
78191 Platelet survival study
78195 Lymphatics and lymph glands imaging
78199 Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78201 Liver imaging; static only
78202 with vascular flow
78205 Liver imaging (SPECT);
78206 with vascular flow
78215 Liver and spleen imaging; static only
78216 with vascular flow
78220 Liver function study with hepatobiliary agents, with serial images
78223 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function
78230 Salivary gland imaging;
78231 with serial images
78232 Salivary gland function study
78258 Esophageal motility
78261 Gastric mucosa imaging
78262 Gastroesophageal reflux study
78264 Gastric emptying study
78270 Vitamin B-12 absorption study (eg. Schilling test); without intrinsic factor
78271 with intrinsic factor
78272 Vitamin B-12 absorption studies combined, with and without intrinsic factor
78278 Acute gastrointestinal blood loss imaging
78282 Gastrointestinal protein loss
78290 Bowel imaging (eg, ectopic gastric mucosa, Meckel's localization, volvulus)
78291 Peritoneal-venous shunt patency test (eg, for LeVeen, Denver shunt)
78299 Unlisted gastrointestinal procedure diagnostic nuclear medicine
78300 Bone and/or joint imaging; limited area
78305 multiple areas
78306 whole body
78315 three phase study
78320 omographic (SPECT)
78350 Bone density (bone mineral content) study, one or more sites; single photon absorptiometry
78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78414 Determination of central c-v hemodynamics (non-imaging)(eg, ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations
78428 Cardiac shunt detection
78445 Non-cardiac vascular flow imaging (ie, angiography, venography)
78456 Acute venous thrombosis imaging, peptide
78457 Venous thrombosis imaging venogram; unilateral
78458 bilateral
78460 Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification
78461 multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification
78464 tomographic (SPECT), single study at rest or stress (exercise and/or pharma cologic), with or without quantification
78465 tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification
78466 Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468 with ejection fraction by first pass technique
78469 tomographic SPECT with or without quantification
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
78478 Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)
78480 Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)
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 and 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)
78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine

78580 Pulmonary perfusion imaging, particulate
78584 Pulmonary perfusion imaging, particulate, with ventilation; single breath
78585 rebreathing and washout, with or without single breath
78586 Pulmonary ventilation imaging, aerosol; single projection
78587 multiple projections (eg, anterior, posterior, lateral views)
78588 Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections
78591 Pulmonary ventilation imaging, gaseous, single breath, single projection
78593 Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection
78594 multiple projections (eg, anterior, posterior, lateral views)
78596 Pulmonary quantitative differential function (ventilation/perfusion) study
78599 Unlisted respiratory procedure, diagnostic nuclear medicine
78600 Brain imaging, limited procedure; static
78601 with vascular flow
78605 Brain imaging, complete study; static
78606 with vascular flow
78607 tomographic (SPECT)
78610 Brain imaging, vascular flow only
78615 Cerebral blood flow
78630 Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography
78635 ventriculography
78645 shunt evaluation
78647 tomographic (SPECT)
78650 CSF leakage detection and localization
78660 Radiopharmaceutical dacryocystography
78699 Unlisted nervous system procedure, diagnostic nuclear medicine
78700 Kidney imaging; static only
78701 with vascular flow
78704 with function study (ie, imaging renogram)
78707 Kidney imaging with vascular flow and function; single study without pharmacological intervention
78708 single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)
78709 multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)
78710 Kidney imaging, tomographic (SPECT)
78715 Kidney vascular flow only
78725 Kidney function study, non-imaging radioisotopic study
78730 Urinary bladder residual study
78740 Ureteral reflux study (radiopharmaceutical voiding cystogram)
78760 Testicular imaging;
78761 with vascular flow
78799 Unlisted genitourinary procedure, diagnostic nuclear medicine
78800 Radiopharmaceutical localization of tumor; limited area
78801 multiple areas
78802 whole body
78803 tomographic (SPECT)
78805 Radiopharmaceutical localization of abscess; limited area
78806 whole body
78807 tomographic (SPECT)
78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine
92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082 intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083 extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 , or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100 Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)
92130 Tonography with water provocation
92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report
92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report
92250 Fundus photography with interpretation and report
92265 Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
92270 Electro-oculography with interpretation and report
92275 Electroretinography with interpretation and report
92283 Color vision examination, extended, eg, anomaloscope or equivalent
92284 Dark adaptation examination with interpretation and report
92285 External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereophotography)
92286 Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count
92287 with fluorescein angiography
92516 Facial nerve function studies (eg, electroneuronography)
92520 Laryngeal function studies
92525 Evaluation of swallowing and oral function for feeding

92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinusoidal vertical axis rotational testing
92547	Use of vertical electrodes (List separately in addition to code for primary procedure)
92548	Computerized dynamic posturography
92552	Pure tone audiometry (threshold); air only
92553	air and bone
92555	Speech audiometry threshold;
92556	with speech recognition
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92561	Bekesy audiometry; diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test
92575	Sensorineural acuity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
92589	Central auditory function test(s) (specify)
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	tracing only, without interpretation and report
93012	Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), per 30 day period of time; tracing only
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
93017	tracing only, without interpretation and report
93024	Ergonovine provocation test
93040	Rhythm ECG, one to three leads; with interpretation and report
93041	tracing only without interpretation and report
93224	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation
93225	recording (includes hook-up, recording, and disconnection)
93226	scanning analysis with report
93230	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation
93231	recording (includes hook-up, recording, and disconnection)
93232	microprocessor-based analysis with report
93235	Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated; includes monitoring and real-time data analysis with report, physician review and interpretation
93236	monitoring and real-time data analysis with report
93268	Patient demand single or multiple event recording with presymptom memory loop, per 30 day period of time; includes transmission, physician review and interpretation
93270	recording (includes hook-up, recording, and disconnection)
93271	monitoring, receipt of transmissions, and analysis
93278	Signal-averaged electrocardiography (SAECG), with or without ECG
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
93304	follow-up or limited study
93307	Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete
93308	follow-up or limited study
93312	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete
93321	follow-up or limited study (List separately in addition to codes for echocardiographic imaging)

93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)
93350	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
93501	Right heart catheterization
93505	Endomyocardial biopsy
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery, percutaneous
93511	by cutdown
93514	Left heart catheterization by left ventricular puncture
93524	Combined transseptal and retrograde left heart catheterization
93526	Combined right heart catheterization and retrograde left heart catheterization
93527	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
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
93555	Imaging supervision, interpretation and report of injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography
93556	pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)
93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure
93571	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)
93572	each additional vessel (List separately in addition to code for primary procedure)
93600	Bundle of His recording
93602	Intra-atrial recording
93603	Right ventricular recording
93607	Left ventricular recording
93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia
93610	Intra-atrial pacing
93612	Intraventricular pacing
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);
93616	with pacing
93618	Induction of arrhythmia by electrical pacing
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; without induction or attempted induction of arrhythmia (This code is to be used when 93600 is combined with 93602, 93603, 93610, 93612)
93620	with induction or attempted induction of arrhythmia (This code is to be used when 93618 is combined with 93619)
93621	with left atrial recordings from coronary sinus or left atrium, with or without pacing, with induction or attempted induction of arrhythmia
93622	with left ventricular recordings, with or without pacing, with induction or attempted induction of arrhythmia
93623	Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia
93631	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction
93640	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;
93641	with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator
93642	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination , and programming or reprogramming of sensing or therapeutic parameters)
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention

93724 Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of trachycardia via implanted pacemaker, and interpretation of recordings)
93727 Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)
93733 Electronic analysis of dual chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis
93734 Electronic analysis of single chamber internal pacemaker system (includes evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); without programming
93735 with reprogramming
93736 Electronic analysis of single chamber internal pacemaker system (may include rate, pulse amplitude and duration, configuration of wave form, and/or testing of sensory function of pacemaker), telephonic analysis
93737 Electronic analysis of single or dual chamber pacing cardioverter-defibrillator only (interrogation, evaluation of pulse generator status); without reprogramming
93738 with reprogramming
93741 Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming
93742 single chamber, with reprogramming
93743 dual chamber, without reprogramming
93744 dual chamber, with reprogramming
93770 Determination of venous pressure
93799 Unlisted cardiovascular service or procedure
93875 Non-invasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)
93880 Duplex scan of extracranial arteries; complete bilateral study
93882 unilateral or limited study
93886 Transcranial Doppler study of the intracranial arteries; complete study
93888 limited study
93922 Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)
93923 Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924 Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926 unilateral or limited study
93930 Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931 unilateral or limited study
93965 Non-invasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971 unilateral or limited study
93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976 limited study
93978 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979 unilateral or limited study
93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981 follow-up or limited study
93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)
94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94060 Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
94070 Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent, with subsequent spirometrics
94200 Maximum breathing capacity, maximal voluntary ventilation
94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94250 Expired gas collection, quantitative, single procedure (separate procedure)
94260 Thoracic gas volume
94350 Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time

94360 Determination of resistance to airflow, oscillatory or plethysmographic methods
94370 Determination of airway closing volume, single breath tests
94375 Respiratory flow volume loop
94400 Breathing response to CO_2 (CO_2 response curve)
94450 Breathing response to hypoxia (hypoxia response curve)
94620 Pulmonary stress testing; simple (eg, prolonged exercise test for bronchospasm with pre- and post-spirometry)
94621 complex (including measurements of CO_2 production, O_2 uptake, and electrocardiographic recordings)
94664 Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665 subsequent
94680 Oxygen uptake, expired gas analysis; rest and exercise, direct, simple
94681 including CO_2 output, percentage oxygen extracted
94690 rest, indirect (separate procedure)
94720 Carbon monoxide diffusing capacity, any method
94725 Membrane diffusion capacity
94750 Pulmonary compliance study, any method
94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761 multiple determination (eg, during exercise)
94762 by continuous overnight monitoring (separate procedure)
94770 Carbon dioxide, expired gas determination by infrared analyzer
94779 Unlisted pulmonary service or procedure
95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests
95024 Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests
95027 Skin end point titration
95028 Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95044 Patch or application test(s) (specify number of tests)
95052 Photo patch test(s)(specify number of tests)
95056 Photo tests
95805 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95807 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808 Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810 sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
95812 Electroencephalogram (EEG) extended monitoring; up to one hour
95813 greater than one hour
95816 Electroencephalogram (EEG) including recording awake and drowsy (including hyperventilation and/or photic stimulation when appropriate)
95819 Electroencephalogram (EEG) including recording awake and asleep (including hyperventilation and/or photic stimulation when appropriate)
95822 Electroencephalogram (EEG); sleep only
95827 all night sleep only
95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
95903 motor, with F-wave study
95904 sensory or mixed
95921 Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including two or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio
95922 vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt
95923 sudomotor, including one or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential
95925 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926 in lower limbs
95927 in the trunk or head
95930 Visual evoked potential (VEP) testing central nervous system, checkerboard or flash
95933 Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95934 H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936 record muscle other than gastrocnmius/soleus muscle
95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve,any one method
95950 Monitoring for identification and lateralization of cerebral seizure focus, electoencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours
95951 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours

95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours
95954	Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)
95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring
95999	Unlisted neurological or neuromuscular diagnostic procedure
G0004	Patient demand single or multiple event recording with presymptom memory loop and 24 hour attended monitoring, per 30 day period; includes transmission, physician review and interpretation
G0005	Patient demand single or multiple event recording with presymptom memory loop and 24 hour attended monitoring, per 30 day period; recording (includes hook-up, recording and disconnection)
G0006	Patient demand single or multiple event recording with presymptom memory loop and 24 hour attended monitoring, per 30 day period; 24 hour attended monitoring, receipt of transmissions, and analysis
G0015	Postsymptom telephonic transmission of electrocardiogram rhythm strip(s) and 24 hour attended monitoring, per 30 day period; tracing only
G0050	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound
Q0035	Cardiokymography

Not Otherwise Classified Codes (NOC)
N/A

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

Diagnoses That Support Medical Necessity
N/A

ICD-9-CM Codes That DO NOT Support Medical Necessity
N/A

Diagnoses That DO NOT Support Medical Necessity
N/A

Reasons for Denial
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy and applicable Local Medical Review Policies.
When the services are performed for screening purposes.
When the medical record does not verify that the service described by the HCPCS code was provided.

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

Noncovered Diagnoses
N/A

Coding Guidelines
The performing provider must have on-site 24-hour availability when the HCPCS code(s) identifies the services as one performed for 24 hours. The use of an answering service or machine for review at a later time to meet the 24-hour requirement, is not appropriate.
Effective 1/1/2000, procedure code 93770 is considered a bundled service and therefore, is not separately reimbursable.
Effective 1/1/2000, 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 Independent Diagnostic Testing Facility must include the information listed below:

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

In addition, documentation must be available upon request verifying that the technician performing the service(s) meet(s) the credentialing requirements as outlined in this policy. In the case where the technologist is obtaining the clinical experience required by the credentialing board prior to taking the examination, the documentation must support this rationale, including when the expected training will be completed.
Also, the IDTF must maintain documentation of sufficient physician resources during all hours of operations to assure that the required physician supervision is furnished.
Documentation must be maintained in the IDTF that the personnel performing the diagnostic test(s) have been adequately trained and demonstrates proficiency in the performance of the service(s). This documentation must contain verification by the supervising physician(s).

Utilization Guidelines
N/A

Other Comments
Terms Defined:

- General supervision - the procedure is furnished under the physician s overall direction and control, but the physician s presence is not required during the performance of the procedure.
- Direct supervision - the physician must be present in the suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- Personal supervision - a physician must be in attendance in the room during the performance of the procedure.

Sources of Information

American Association of Electrodiagnostic Technologists
American Board of Registration of Electroencephalographic and Evoked Potential Technologists, Inc.
American College of Radiology Standards (1997)
American Registry of Radiologic Technologists
American Society of Diagnostic Medical Sonographers
American Speech-Language Hearing Association
Association of Polysomnographic Technologists
Board of Certification of the Ophthalmic Photographers' Society
Cardiovascular Credentialing International
Federal Register, Vol. 62, No. 211, pages 59058-59074 and 59099-59100
Medical Dosimetrist Certification Board
National Board for Respiratory Care
Nuclear Medicine Technology Certification Board

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

Start Date of Notice Period

05/01/2000

Revision History

Revision Number:
5
Revised Effective Date:
04/11/2000
Start Date of Comment Period:
N/A
Start Date of Notice Period:
05/01/2000 May/Jun 2000 *Update!*
Explanation of Revision:
Based on research regarding the appropriate credentialing for personnel performing pulse oximetry, it was found no licensing or credentialing is required, however, the person must demonstrate proficiency in that service. Therefore, the credentialing requirements for procedure codes 94760-94762 were changed.

Start Date of Comment Period:
N/A
Start Date of Notice Period:
03/2000 Mar/Apr 2000 *Update!*
Original Effective Date:
04/19/99
Revision Date/Number:
01/01/2000 4 (PCR B2000-050)

Start Date of Comment Period:
N/A
Start Date of Notice Period:
01/2000 Jan/Feb 2000 *Update!*
Original Effective Date:
04/19/99
Revision Date/Number:
01/01/2000 3 (PCR B2000-001)
2000 HCPCS *Update!*

Start Date of Comment Period:
N/A
Start Date of Notice Period:
11/99 Nov/Dec 1999 *Update!*
Original Effective Date:
04/19/99
Revision Date/Number:
12/15/99 2 (PCR B99-132)

Start Date of Comment Period:
02/12/99
Start Date of Notice Period:
07/99 Jul/Aug 1999 *Update!*
Original Effective Date:
04/19/99
Revision Date/Number:
.08/16/99 1 (PCR B99-078)

Start Date of Comment Period:
11/14/98
Start Date of Notice Period:
03/99 Mar/Apr 1999 *Update!*
Original Effective Date:
04/19/99 PCR B99-046

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.

20550: Injection of Tendon Sheath, Ligament, Trigger Points or Ganglion Cyst

Injection of a tendon sheath, ligament, trigger points or ganglion cyst consists of an anesthetic agent and/or steroid agent injected into an area for the management of pain.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the injection of a tendon sheath, ligament, trigger points or ganglion cyst to be a covered service in the following circumstances:

- patients for whom NSAIDs (Nonsteroidal Anti-inflammatory drugs) have not been effective or are contraindicated,
- documented evidence of a tendon that is painful on motion; sheaths that are visibly swollen because of fluid accumulation and inflammation, or that may remain dry but cause friction rubs felt on movement of the tendon in its sheath or heard with a stethoscope,
- a repeat injection, one week after the initial injection may be necessary when there is evidence of persistent pain or inflammation,
- weekly repeat injections to the shoulder may be necessary over a consecutive four (4) week period. Evidence of partial improvements to the range of motion in an area (especially the shoulder) after an injection would justify a repeat injection.

If documentation in the medical record substantiates that the injections are not effective, further injections would not be considered medically necessary.

HCPCS Codes

20550 Injection, tendon sheath, ligament, trigger points or ganglion cyst

ICD-9-CM Codes That Support Medical Necessity

354.0	Carpal tunnel syndrome
355.5	Tarsal tunnel syndrome
355.6	Lesion of plantar nerve
720.1	Spinal enthesopathy
720.2	Sacroiliitis, not elsewhere classified
723.1	Cervicalgia
724.00	Spinal stenosis, unspecified region
724.1	Pain in thoracic spine
724.2	Lumbago
724.5	Backache, unspecified
724.79	Other disorders of the coccyx
724.8	Other symptoms referable to back
726.0	Adhesive capulitis of shoulder
726.10-726.19	Rotator cuff syndrome of shoulder and allied disorders
726.2	Other affections of shoulder region not elsewhere classified
726.30-726.33	Enthesopathy of elbow region
726.4	Enthesopathy of wrist and carpus
726.5	Enthesopathy of hip region
726.60-726.69	Enthesopathy of knee
726.70-726.79	Enthesopathy of ankle and tarsus
726.8	Other peripheral enthesopathies
726.90	Enthesopathy of unspecified site
727.00-727.06	Synovitis and tenosynovitis
727.40	Synovial cyst, unspecified
727.42	Ganglion of tendon sheath
727.43	Ganglion, unspecified
727.49	Ganglion and cyst of synovium, tendon, and bursa, other
728.71	Plantar fascial fibromatosis
728.79	Other fibromatoses
729.1	Myalgia and myositis, unspecified
729.4	Fasciitis, unspecified
735.4	Other hammer toe (acquired)

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

Multiple injections may be allowed by the same provider on the same day. When appropriate, multiple injections may be billed with an LT or RT modifier. When LT or RT does not apply, a 76 modifier may be used.

Reimbursement for the cost of the drug or biological when used in an injection of a tendon sheath, ligament, trigger point or ganglion cyst (20550) is allowed in addition to the injection.

Trigger point injections are often administered prior to the initiation of physical therapy. It would not be expected to routinely administer trigger point injections prior to physical therapy.

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.

The medical record must clearly indicate the number of injections given per session and the site(s) injected. In addition, records must clearly state the medical necessity for repeat injections.

Effective Date

This local medical review policy is effective for services processed on or after March 6, 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.

33140: Transmyocardial Revascularization—Clarification

The Local Medical Review Policy (LMRP) for Transmyocardial Revascularization (TMR) was published in the January/February 2000 *Medicare B Update!* (pages 33-34). Clarification has been received regarding the use of TMR in conjunction with coronary artery bypass grafting (CABG).

It has been determined that TMR may be used as an adjunct to CABG surgery in certain situations. For example: When a patient scheduled for CABG is found during the procedure to have areas of viable myocardium that cannot be bypassed because of diffuse or distal disease, Medicare will cover adjunctive TMR in those areas refractory to the scheduled therapy when all the criteria identified in the policy are met. Based on the above information, the statement regarding TMR in conjunction with CABG located in the "Reasons for Denial" section of the policy has been deleted.

Medical Policy Procedures: 58340

Policy Number
58340

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Infertility

AMA CPT Copyright Statement
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HCFA National Coverage Policy
Coverage Issues Manual, sections 35-11, 35-24, 50-7
Medicare Carriers Manual, sections 2005.1B, 2472.3, 2472.4C

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
12/16/1996

Revision Effective Date
04/17/2000

Revision Ending Effective Date
04/16/2000

Policy Ending Date
N/A

LMRP Description
Infertility is defined as the inability to conceive (produce offspring) and is of (2) types: (1) primary—never having conceived; (2) secondary—referring to individuals who have previously conceived. There are many causes of infertility for both male and female, as well as multiple approaches to treatment/correction of the condition.

Indications and Limitations of Coverage and/or Medical Necessity
Diagnostic Treatment Procedures:
Reasonable and necessary services associated with treatment for infertility are covered under Medicare. Infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally is expected to be fertile to seek medical consultation and treatment.
Payment is made for diagnostic and/or therapeutic procedures necessary to restore the beneficiary to a state where normal conception can occur. The following is a list of procedures that may be associated with the diagnosis/correction of infertility; it may not be all inclusive. Likewise, these procedures may be medically indicated for conditions other than infertility. The purpose of this policy is to address the use of these procedures for diagnostic and/or therapeutic procedures in the treatment of infertility.

HCPCS Section & Benefit Category
Pathology and Laboratory/Other Procedures
Surgery/Female Genital Surgery

HCPCS Codes
58340	Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
58350	Chromotubation of oviduct, including materials
58750	Tubotubal anastomosis
58760	Fimbrioplasty
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	motility and count
89320	complete (volume, count, motility and differential)
89325	Sperm antibodies
89329	Sperm evaluation; hamster penetration test
89330	cervical mucus penetration test, with or without spinnbarkeit test
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner test

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes That Support Medical Necessity
N/A

Diagnoses That Support Medical Necessity
N/A

ICD-9-CM Codes That DO NOT Support Medical Necessity
N/A

Diagnoses That DO NOT Support Medical Necessity
N/A

Reasons for Denial
InVitro procedures and other methods of artificial insemination are not considered as treatments for infertility but rather as means of producing pregnancy. This is artificial conception as opposed to conventional and is not covered by Medicare.

Procedures listed below are not covered by Medicare:

58321	Artificial insemination; intra-cervical
58322	intra-uterine
58323	Sperm washing for artificial insemination
58970	Follicle puncture for oocyte retrieval, any method

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

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

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
For procedure codes 58340, 58345, 58350, 58750 and 58760 medical record documentation must be maintained by the performing physician. This documentation 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.
For procedure codes 89300, 89310, 89320, 89325, 89329, 89330, and G0027 documentation must be submitted with the claim. Individual consideration is given to each claim submitted for these procedures.

Utilization Guidelines
N/A

Other Comments
Procedures done in a laboratory for evaluation of specimens of varied substances (e.g., blood, semen, cervical mucus) are covered procedures. Any review of claims regarding infertility will be performed by Level III (MD) review.
Refer to policy **55250** (Sterilization) and **54900** (Epididymovasostomy Repair) for related services.

Terms Defined:
Normal conception: occurring by usual means as opposed to assisted techniques (e.g., InVitro and other artificial methods of implantation).

Sources of Information
American Medical Association (1999). Hysterosonography and Hystersalpingography. Cpt Assistant, 9 (7), 8-9.
Brochure: "The Path to Pregnancy", University of Florida, Department of Reproductive Endocrinology

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period
N/A

Start Date of Notice Period
05/01/2000

Revision History
Revision Number:
3 (PCR B2000-81)
Revised Effective Date:
04/17/2000
Start Date of Comment Period:
N/A
Start Date of Notice Period:
05/01/2000 May/Jun 2000 *Update!*
Explanation of Revision:
Revise the "Documentation Requirements" section to reflect those codes requiring documentation to be submitted with the claim.

Revision Number:
2 (PCR B99-007)
Revised Effective Date:
01/01/1999
Start Date of Comment Period:
N/A
Start Date of Notice Period:
01/01/1999 Jan/Feb 1999 *Update!*
Explanation of Revision:
1999 HCPCS

Revision Number:
1 (PCR B98-006)
Revised Effective Date:
01/01/1998
Start Date of Comment Period:
N/A
Start Date of Notice Period:
01/01/1998 Jan/Feb 1998 *Update!*
Explanation of Revision:
1998 HCPCS

Revision Number:
Original
Start Date of Comment Period:
N/A
Start Date of Notice Period:
11/01/1996 Nov/Dec 1996 *Update!*
Original Effective Date:
12/16/1996

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.

Medical Policy Procedures: 83735

Policy Number
83735

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Magnesium

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HCFA National Coverage Policy
Medicare Carrier's Manual, Section 2231.3

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
08/25/1997

Revision Effective Date
04/24/2000

Revision Ending Effective Date
04/23/2000

Policy Ending Date
N/A

LMRP Description
Magnesium is an important activator ion, participating in the function of many enzymes involved in phosphate transfer reactions. Most of the magnesium found within the body exists intracellularly, and since most of it is bound to adenosine triphosphate, this electrolyte is critical in nearly all metabolic processes and most organ functions. Magnesium exerts physiologic effects on the nervous system resembling those of calcium, acting directly upon the myoneural junction. Furthermore, magnesium acts as a cofactor that modifies the activity of many enzymes. Carbohydrate, protein, and nucleic acid metabolism depend on magnesium. Excretion of magnesium is via the kidney, and altered concentration of magnesium in the plasma usually provokes an associated alteration of calcium and potassium. The normal plasma concentration of magnesium is 1.5-2.5 meq/L, with about one-third bound to protein and two-thirds existing as free cation.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider magnesium testing to be medically necessary under any of the following circumstances:

- In the presence of signs or symptoms of hypomagnesemia, which include weakness, muscle cramping, irritability, tetany, electrocardiographic changes, delirium, anorexia, nausea, and vomiting. Conditions which can produce these signs and symptoms include, but are not limited to the following:
  - cardiac arrhythmias
  - malabsorption syndromes
  - alcoholism
  - parenteral alimentation with inadequate magnesium content
  - diarrhea
  - diabetic ketoacidosis
  - diuretic therapy
  - hyperaldosteronism
  - hypoparathyroidism
  - hyperthyroidism
  - chronic renal disease
  - prolonged I.V. therapy
  - prolonged nasogastric suction
  - cis-platinum therapy
  - aminoglycoside toxicity
  - amphotericin toxicity
- In the presence of signs or symptoms of hypermagnesemia, including muscle weakness, mental obtundation, and confusion. Weakness and a fall in blood pressure are evident on examination. There may be respiratory muscle paralysis or cardiac arrest. Conditions which can produce these signs and symptoms include, but are not limited to the following:
  - adrenal insufficiency
  - renal insufficiency
  - ingestion of magnesium-containing drugs, such as antacids and laxatives
  - rhabdomyolysis

HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry

HCPCS Codes
83735 Magnesium

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes That Support Medical Necessity

242.00-242.91	Thyrotoxicosis, with or without goiter
250.10-250.13	Diabetes with ketoacidosis
250.20-250.23	Diabetes with hyperosmolarity
250.30-250.33	Diabetes with other coma
250.40-250.43	Diabetes with renal manifestations
250.50-250.53	Diabetes with ophthalmic manifestations
250.60-250.63	Diabetes with neurological manifestations
250.70-250.73	Diabetes with peripheral circulatory disorders

250.80-250.83	Diabetes with other specified manifestations
252.0	Hyperparathyroidism
252.1	Hypoparathyroidism
252.8	Other specified disorders of parathyroid gland
253.6	Other disorders of neurohypophysis (Syndrome of inappropriate antiduretic hormone [ADH])
255.1	Hyperaldosteronism
255.4	Corticoadrenal insufficiency
259.3	Ectopic hormone secretion, not elsewhere classified
260	Kwashiorkor
261	Nutritional marasmus
262	Other severe, protein-calorie malnutrition
263.0	Malnutrition of moderate degree
263.8	Other protein-calorie malnutrition
275.2	Disorders of magnesium metabolism
275.40-275.49	Disorders of calcium metabolism
276.2	Acidosis
276.4	Mixed acid-base balance disorder
276.5	Volume depletion
276.7	Hyperpotassemia
276.8	Hypopotassemia
293.0-293.1	Acute and subacute delirium
303.90-303.93	Other and unspecified alcohol dependence
305.00-305.03	Alcohol abuse
307.1	Anorexia nervosa
307.51	Bulimia
307.52	Pica
333.2	Myoclonus
333.3	Tics of organic origin
410.00-410.92	Acute myocardial infarction
424.0	Mitral valve disorders
427.0-427.89	Cardiac dysrhythmias
428.0	Congestive heart failure
458.0-458.8	Hypotension
536.2	Persistent vomiting
577.0-577.9	Diseases of pancreas
579.3	Other and unspecified postsurgical malabsorption
579.8	Other specified intestinal malabsorption
584.5-584.9	Acute renal failure
585	Chronic renal failure
588.8	Other specified disorders resulting from impaired renal function
593.81	Vascular disorders of kidney
83.83-83.83	Excessive vomiting in pregnancy
646.80-646.84	Other specified complications of pregnancy
728.89	Other disorders of muscle, ligament, and fascial (rhabdomyolysis)
763.81-763.89	Other specified complications of labor and delivery affecting fetus or newborn
780.01	Coma
780.02	Transient alteration of awareness
780.09	Other alteration of consciousness
780.2	Syncope and collapse
780.31-780.39	Convulsions
781.0	Abnormal involuntary movements
781.7	Tetany
783.0	Anorexia
785.0	Tachycardia, unspecified
785.50-785.59	Shock without mention of trauma
787.01-787.03	Nausea and vomiting
787.91	Diarrhea
790.6	Other abnormal blood chemistry
794.31	Abnormal electrocardiogram [ECG] [EKG]
794.4	Nonspecific abnormal results of function studies, kidney
796.1	Abnormal reflex
799.4	Cachexia
941.00-949.5	Burns
958.4	Traumatic shock
995.2	Unspecified adverse effect of drug, medicinal and biological substance, (amphotericin B and digitalis)
997.1	Cardiac complications
998.0	Postoperative shock
V42.0	Organ or tissue replaced by transplant, kidney
V42.7	Organ or tissue replaced by transplant, liver
V56.0	Extracorporeal dialysis
V56.8	Other dialysis
V58.1	Encounter for other and unspecified procedures and aftercare, chemotherapy (Cis-platinum)
V58.69	Long term (current) use of other medications (high risk)

Diagnoses That Support Medical Necessity
N/A

ICD-9-CM Codes That DO NOT Support Medical Necessity
N/A

Diagnoses That DO NOT Support Medical Necessity
N/A

Reasons for Denial
Serum Magnesium testing performed for reasons 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.

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the test. Additionally, a copy of the test results should be maintained in the medical records.

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

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information
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Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.

Start Date of Comment Period
02/11/2000

Start Date of Notice Period
05/01/2000

Revision History
Revision Number:
4
Revised Effective Date:
04/24/2000 (PCR B2000- 085)
Start Date of Comment Period:
02/11/2000
Start Date of Notice Period
05/01/2000 May/June 2000 *Update!*
Explanation of Revision:
Additional ICD-9-CM codes were added to policy

Start Date of Comment Period:
N/A
Start Date of Notice Period:
Original Effective Date:
08/25/97
Revision Date/Number
10/01/98 3 (PCR B98-145)
1999 ICD-9-CM update

Start Date of Comment Period:
Start Date of Notice Period:
Original Effective Date:
08/25/97
Revision Date/Number:
10/01/97 2 (PCR B97-130)
1998 ICD-9-CM update

Start Date of Comment Period:
Start Date of Notice Period:
Original Effective Date:
08/25/97
Revision Date/Number:
1 (PCR B97-074A)

Start Date of Comment Period:
04/12/97
Start Date of Notice Period:
Original Effective Date:
08/18/97 (PCR B97-074)

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.

Medical Policy Procedures: PHPPROG
Policy Number
PHPPROG

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Psychiatric Partial Hospitalization Program

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HCFA National Coverage Policy
Title XVIII of the Social Security Act, Section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.
Social Security Act, Section 1861 (ff) and 1832 (a). These sections define the partial hospitalization benefit and provide coverage of partial hospitalization in a hospital or CMHC setting.
The Social Security Act, Section 1861(s) (2) (B). This section references partial hospitalization in a hospital outpatient setting.
The Social Security Act, Section 1835 (a). This section references physician certification.
The Social Security Act, Section 1833 (e). This requires services to be documented in order for payment to be made.

42 Code of Federal Regulations 410.2, 410.3, 410.43, 410.110, and 424(e)
Federal Register 2/11/94, (59 FR 6570)
Medicare Hospital Manual, Section 230.5 and 452
Medicare Intermediary Manual (MIM), Section 3112.7, 3190, 3651, 3661
Outpatient Physical Therapy, Comprehensive Outpatient Rehabilitation Facility and Community Mental Health Manual, Section 260 and 414
Coverage Issues Manual (CIM) 35-14, 35-27, 35-92, 80-1
Program Memorandum, 6/95, HCFA Transmittal No. A-95-8
Program Memorandum, 7/96, HCFA Transmittal No. A-96-2
Program Memorandum, 10/96, HCFA Transmittal No. A-96-8
Program Memorandum, 9/99, HCFA Transmittal No. A-99-39
HCFA Ruling 97-1, 2/97

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
06/19/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Individuals requiring psychiatric care generally receive services along a continuum of care which involves three levels - inpatient, partial hospitalization, and outpatient. Psychiatric partial hospitalization is a distinct, organized, ambulatory, and intensive psychiatric outpatient treatment of less than 24 hours of daily care. It is designed to provide patients with profound or disabling mental health conditions an individualized, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with acute mental illness in lieu of inpatient care. Patients are generally directly admitted (transitioned) to a partial hospitalization program (PHP) from an inpatient psychiatric stay or from a failed attempt at being managed as an outpatient. Partial Hospitalization requires admission and certification of need by a physician (M.D./D.O.) trained in the diagnosis and treatment of psychiatric illness. PHPs differ from inpatient hospitalization and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multidisciplinary team, with the patient's involvement.

Indications and Limitations of Coverage and/or Medical Necessity
Eligibility Requirements
The following are facilities eligible for reimbursement for partial hospitalization services and the associated physician supervision requirements of each:

- **Outpatient hospital** - Partial hospitalization services rendered within a hospital outpatient department are considered "incident to" a physician's (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital). If a hospital outpatient department operates a PHP offsite, the services must be rendered under the direct personal supervision of a physician (MD/DO). Direct supervision means that the physician must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service.
- **Community mental health center (CMHC)** - The CMHC must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare. A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Section 1866(e)(2) of the Act. Health Care Finance Administration definition of a CMHC is based on Section 1916 (c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in Section 1861(ff) of the Act.
  Partial hospitalization services provided in a CMHC require general supervision and oversight of the program by a physician (MD/DO). General supervision means the physician must at least be available by telephone.

Patients eligible for Medicare reimbursement for PHP services are:
- Those patients who are directly discharged or transitioned from an inpatient hospital treatment program and the PHP admission is in lieu of continued inpatient treatment.
- Those patients who, in the absence of the partial hospitalization, would require inpatient hospitalization. *It is generally expected that less intensive treatment in an outpatient setting be attempted prior to admission to partial hospitalization. Documentation for such patients should support these attempts, as well as the patient's failure at or inability to be managed in a less intensive outpatient setting.*

The following eligibility requirements must also be met:
- The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition.
- The patient must be under the care of a physician (M.D./D.O.) trained in the diagnosis and treatment of psychiatric illness, who is knowledgeable about the patient and certifies the need for partial hospitalization.
- The patient or legal guardian must provide written informed consent for partial hospitalization treatment.
- The patient must require comprehensive, multimodal

treatment requiring medical supervision and coordination because of a mental disorder, which **severely** interferes with multiple areas of daily life including social, vocational, and/or educational functioning. *Such dysfunction must be an acute illness or exacerbation of a chronic illness (acute in nature).*

- The patient must have the capacity for active participation in all phases of the multidisciplinary and multimodal program (i.e., the patient is medically stable and not limited by another serious medical condition, the patient demonstrates an appropriate level of cognition).
- There must be reasonable expectation of improvement in the patient's disorder and level of functioning as a result of the active treatment provided by the PHP.
- The active treatment must directly address the presenting problems necessitating admission to the PHP. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psychoeducational groups pertinent to the patient's current illness. Medical and psychiatric diagnostic evaluation and medical management are also integral to active treatment. Evidence of active monitoring of the patient's physical status, which could impact the patient's psychiatric condition, is required.
- The individualized treatment plan is developed by a physician and the multidisciplinary team, with the patient's involvement.
- A physician must provide supervision and evaluation of the patient's treatment and the extent to which the therapeutic goals are being met.
- The program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. *It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a partial hospitalization program, as a patient under the influence of a chemical substance would not be capable of actively participating in his/her psychiatric treatment program.*

Admission Criteria (Intensity of Service)

In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness. Patients admitted to a PHP must:

- **Not require a 24-hour a day level of care as provided in an inpatient setting.** *Therefore, it is not expected for the patient to be an inpatient.*
- **Have an adequate support system to sustain/ maintain themselves outside the partial program.** *The patient is expected to have an identifiable significant support system while he/she is not actively engaged in the program (i.e., in the evening, on the weekend, or anytime the PHP services are not available).*
- **Require PHP services at a level of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses.**

Admission Criteria (Severity of Illness)

Patients admitted to a PHP must:

- **Have an acute onset or decompensation of a covered Axis I mental disorder**, as defined by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) published by the American Psychiatric Association (1994), which severely interferes with multiple areas of daily life.
- Demonstrate a degree of impairment severe enough that without care or treatment, the person is likely to suffer from neglect or refuse to care for him or herself and such neglect or refusal poses **a real and present threat of substantial harm** to his or her well being. This degree of impairment requires a multidisciplinary structured program, but is not so severe that the patient is incapable of participating in and benefiting from an active treatment program and is maintained outside the program.
- Not be an immediate/imminent danger to self, others, or property. There may be a **recent history** of self-mutilation, serious risk taking, or other self-endangering behavior. Evidence of appropriate safety measures should be in place to accommodate at-risk patients (e.g., a no harm contract with a specified emergency plan signed by the patient upon admission and re-affirmed upon the end of each treatment day.)

Discharge Criteria (Intensity of Service):

Patients are appropriate for discharge from a partial hospitalization program, based on intensity of service, when:

- **The patient requires stepping up to an inpatient level of care.** The inpatient psychiatric admission (24 hour supervision) becomes necessary when the probability for self-harm, or harm to others exists.
- **The patient requires stepping down to a less intensive level of outpatient care.** Stepping down to a less intensive level of service than a partial hospitalization would be considered when the patient no longer requires the multidisciplinary or multimodal program.

  If transitioning is required prior to discharge from the partial hospitalization program, the medical need for transitioning should be documented in the treatment plan.

  In the **rare circumstance** of inability or failure to transition to a less intensive level, medical records must substantiate the need for a continuation in the PHP.

Discharge Criteria (Severity of Illness):

Patients are appropriate for discharge from a PHP, based on severity of illness, when:

- The patient's clinical condition declines and the individual requires inpatient psychiatric care (24-hour supervision).
- The patient's clinical condition improves or stabilizes and the individual no longer benefits from or requires the intensive, multimodal treatment of the PHP. This would be evidenced by a reduced impairment in daily functioning, symptom reduction, improved capacity to access community supports, accomplishment of treatment goals to extent possible, and ability to return to increased levels of independence in day-to-day activities.

Covered Services:

- Medically necessary diagnostic services related to mental illness.
- Individual or group psychotherapy rendered by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by Florida State law. ** Professional services furnished by physicians, physician assistants, nurse practitioners, and clinical psychologists to patients in PHPs *must* be billed to the carrier.
- Occupational therapy, requiring the skills of an occupational therapist (OT), which is a component of the physician's treatment plan for the patient. The occupational therapy services must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each occupational therapy service modality utilized, and explain how it fits into the treatment of the patient's mental illness and functional deficits. *Providers must not bill occupational therapy services as individual or group psychotherapy services.*
- Services of other staff (social workers, psychiatric nurses and others) trained to work with psychiatric patients.
- Drugs and biologicals that cannot be self-administered and are furnished for psychotherapeutic purposes. *The medication must be safe and effective, and approved by the Food and Drug Administration. It cannot be experimental or administered under investigational protocol.*
- Individualized activity therapy that is not primarily recreational or diversionary. The activity therapy group must be individualized and essential for the treatment of the patient's diagnosed psychiatric condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each activity therapy modality utilized and explain how it fits into the treatment of the patient's illness and functional deficits. *Providers must not bill activity therapies as individual or group psychotherapy services.*
- Family counseling services for which the primary purpose is the treatment of the patient's condition. Such services include the need to observe the patient's interaction with the family for diagnostic purposes, or to assess the capability of and assist the family members in aiding in the management of the patient.
- Patient training and education, when the training and educational sessions are closely and clearly related to the individual's care and treatment of their diagnosed psychiatric condition. *Providers must not bill training and education as individual or group psychotherapy services. Providers must also not bill for general education (e.g., providing information in a group setting regarding a medication the patient is not receiving, information regarding the PHP's schedule, policies, changes in personnel, etc.).*

HCPCS Section & Benefit Category

Medicine, Psychiatry, Central Nervous System Assessments/Tests, Physical Medicine and Rehabilitation

HCPCS Codes

There are no specific CPT or HCPCS codes for partial hospitalization "programs". However, outpatient hospitals are required to report the following appropriate HCPCS codes for the individual or specific partial hospitalization services provided. Effective for dates of services on or after April 1, 2000, Community Mental Health Centers will also be required to utilize the same HCPCS codes for reporting partial hospitalization services.

90801	Psychiatric diagnostic interview examination
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45-50 minutes face-to-face with the patient;
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90857	Interactive group psychotherapy
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes

90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes
90899	Unlisted psychiatric service or procedure
96100	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour
96115	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
96117	Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour
97770	Development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct (one on one) patient contact by the provider, each 15 minutes
G0129	Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day
G0172	Training and educational services furnished as a component of a partial hospitalization treatment program, per day
Q0082	Activity therapy furnished as a component of a partial hospitalization treatment program (e.g., music, dance, art or play therapies that are not primarily recreational), per day

There are HCPCS codes on this list that may not be reimbursable through Medicare due to existing national or Local Medical Review Policies. Please refer to the applicable Medicare manuals and Local Medical Review Policies for coverage criteria information regarding each service

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes That Support Medical Necessity

A diagnosis that falls within the range of ICD-9-CM codes for mental illness (290.0-319). *The diagnosis itself is not the sole determining factor for coverage.*

Diagnoses That Support Medical Necessity

N/A

ICD-9-CM Codes That DO NOT Support Medical Necessity

N/A

Diagnoses That DO NOT Support Medical Necessity

N/A

Reasons for Denial

- Services furnished by a facility other than an outpatient hospital or a community mental health center (CMHC);
- The treatment of chronic conditions without acute exacerbation;
- Individual or group psychotherapy rendered by someone who is not licensed or authorized by Florida State Law;
- Professional services of physicians, physician assistants, nurse practitioners, and clinical psychologists billed to the Intermediary;
- Occupational therapy services related primarily to specific employment opportunities, work skills, or work settings;
- Activity therapy that is primarily recreational or diversionary;
- Any service that does not have a specific treatment goal;
- Daycare programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- Psychosocial programs attempting to maintain psychiatric wellness (e.g., daycare programs for the chronically mentally ill which provide only a structured environment, socialization, and/or vocational rehabilitation);
- Services to a skilled nursing facility or nursing home resident that should be expected to be provided by the nursing facility staff (e.g., adjustment difficulties related to their placement in the skilled nursing facility or nursing home);
- Services to hospital inpatients;
- Meals;
- Transportation;
- Self-administered medications;
- Vocational training;
- General education (e.g., information provided about the partial hospitalization program's schedule, policies, changes in staffing, etc.);
- Biofeedback therapy for ordinary muscle tension or psychosomatic conditions;
- Transcendental meditation; and
- Electroconvulsive therapy (ECT).

Beneficiaries ineligible for partial hospitalization services:

- Patients who do not meet admission criteria for partial hospitalization services;
- Patients who cannot or refuse to participate (due to their behavioral, cognitive or emotional status) with the active treatment of their mental disorder, or who cannot tolerate the intensity of a partial hospitalization program;
- Patients who require 24 hour supervision inpatient hospitalization because of the severity of their mental disorder or their safety or security risk;
- Patients who require primarily social, recreational, custodial, or respite care;
- Patients with multiple unexcused absences or who are persistently non-compliant;
- Individuals with an organic brain disorder(i.e., Dementia, Delirium, Alzheimer's), or other psychiatric or neurologic conditions (Severe Head Trauma) which have produced a severe enough cognitive deficit to prevent establishment of a relationship with the therapist or other group members, or participation in insight oriented processes;
- Patients who have met the criteria for discharge from the partial hospitalization program to a less intensive level of outpatient care.

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.

Noncovered Diagnoses

N/A

Coding Guidelines

Bundling Issues

The professional services (listed below) provided in a CMHC or hospital outpatient department are separately covered and paid as the professional services of physicians and independent practitioners. These direct professional services are "unbundled" and these practitioners (other than physician assistants, [PAs]) may bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient PHP patients and CMHC partial hospitalization patients. The hospital or CMHC can also serve as a billing agent for these professionals, by billing the Part B carrier on their behalf for their professional services (via the HCFA-1500 billing format). The professional services of a PA can be billed to the carrier only by the PA's employer. The following direct professional services are **unbundled** and **not paid as partial hospitalization services**:

- Physician services that meet the criteria for payment on a fee schedule basis (in accordance with 42 CFR 414)
- Physician assistant services (as defined in section 1861(s)(2)(K)(I) of the Act)
- Clinical psychologist services (as defined in section 1861(ii) of the Act) and
- Advanced Registered Nurse Practitioners and Clinical Nurse Specialists (as defined in section 1861(s)(2)(K)(ii) of the Act).

The services of other practitioners, including licensed clinical social workers (LCSWs), are bundled when furnished under the PHP benefit. These bundled services are billed to the Medicare Part A intermediary via the HCFA-1450 (UB-92) billing format, and payment is made on a reasonable cost basis. Administrative (rather than professional) services remain bundled. The distinction between professional and administrative services is whether the services are directly furnished to an individual patient or are performed indirectly under the partial hospitalization program (outpatient hospital or CMHC). Currently, reimbursement for administrative services is made via the provider's cost report settlement. Therefore, administrative services are not separately billable to either the Part A intermediary (via the HCFA-1450) or the Part B carrier (via the HCFA-1500). In addition, effective July 1, 2000, payment for partial hospitalization programs will be made under the hospital outpatient prospective payment system.

- **Outpatient Mental Health Treatment Limitation**

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients.

Documentation Requirements

The following documentation **must** be maintained in the patient's medical record:

PHYSICIAN CERTIFICATION- A physician trained in the diagnosis and treatment of psychiatric illness must certify that the patient being admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification must also include an attestation that the services will be furnished while the individual is under the care of a physician, and that the services will be furnished under a written plan of care. It is generally expected that the physician certification will be completed within 24 hours of the patient's admission to the partial hospitalization program.

PHYSICIAN RECERTIFICATION- Periodic recertification by the physician who is directing or regularly involved in the care of the patient is required at least every 31 days. Recertification should be based on a thorough re-evaluation of the treatment plan in relation to the reason for admission and the progress of the patient.

Certifications may use any format desired and may be part of the treatment plan. However, the following statement must be used.

Certification Language:

"I certify that the patient would require Inpatient psychiatric care if the Partial Hospitalization services were not provided, and services will be furnished under the care of a physician, and under a written Plan of Treatment."

Physician signature:_____Date: _____

Recertification Language:

"I certify that continued Partial Hospitalization services are medically necessary to improve and/or maintain (circle one) the patient's condition and functional level and to prevent relapse or hospitalization."

Physician signature: _____Date: _____

Certifications are prospective; the physician (M.D./D.O.) certifies that future services are required. A physician certification must cover all periods of service. Stamped signatures are not acceptable. A physician certification is required, but does not guarantee approval of services.

A psychologist is not considered a physician for the purpose of establishing a certification or recertification.

INITIAL PSYCHIATRIC EVALUATION- The initial psychiatric evaluation with medical history and physical examination must be performed and placed in the chart generally within 24 hours of admission in order to establish the medical necessity for partial hospitalization services. If the patient is being directly discharged from an inpatient psychiatric admission to a partial hospitalization program, an appropriate update to the inpatient psychiatric evaluation and medical history and physical is acceptable, as long as it is reflective of the patient's condition upon admission to the PHP.

The initial evaluation should include the following documentation to support the medical necessity of the admission:

- Referral source;
- History of substance abuse including the type of substance used, frequency, amount and duration as well as symptoms of withdrawal or other complications (e.g., hepatitis or AIDS resulting from the use of contaminated needles);
- Family, vocational, and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self harm or harm to others, insight, judgment, and capacity for activities of daily living (ADLs) with examples of specifics in each category and the method of elicitation when applicable;
- Physical examination (if not done within the past 30 days and/or not available from another provider for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program;
- ICD-9/DSM-IV diagnoses, including all five axes of the multiaxial assessment as described in DSM-IV, to assist in establishing the patient's baseline functioning;
- An initial treatment plan, including long and short term goals related to the active treatment of the reason for admission and the specific types, amount, duration, and frequency of therapy services required to address the goals; and
- Certification by the physician that the course of the patient's current episode of illness would result in psychiatric inpatient hospitalization if the partial hospitalization services are not initiated at this time.

TREATMENT PLAN- An individualized formal treatment plan must be signed and dated by a physician and established within 7 days of admission to the program. *NO STAMPED SIGNATURES WILL BE ACCEPTED.*

The treatment plan **must** include the following:

- Physical examination (if not done within the past 30 days and/or not available from another provider for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program;
- ICD-9/DSM-IV diagnoses, including all five axes of the multiaxial assessment as described in DSM-IV, to assist in establishing the patient's baseline functioning;

The frequency of treatment plan updates is always contingent upon an individual patient's needs. The treatment planning updates must be based on the physician's periodic consultation with therapists and staff, review of medical records, and patient interviews.

PROGRESS NOTES- A separate progress note must be written for each HCPCS or revenue code billed. The progress note should be legible, dated and signed, and include the credentials of the rendering provider.

The progress note must be written by the team member rendering the service and **must** include the following:

- The type of service rendered (name of the specific psychotherapy group, educational group, etc. if applicable);
- The problem/functional deficit to be addressed during the session, and how it relates to the patient's current condition, diagnosis, and problem/deficit identified in the treatment plan;
- The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal;
- The patient's status (behavior, verbalizations, mental status) during the session; and
- The patient's response to the therapeutic intervention including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms. Functional improvement is considered to be the patient's increasing ability to function outside of the direction or support of a therapist and or therapeutic environment. Measures of functional improvement may include, but are not limited to, patient appearance, patient participation in therapy, or the patient's performance of activities of daily living.

PHYSICIAN SUPERVISION AND EVALUATION- Evidence must be documented in the patient's medical record that a physician has provided direct patient care, provided supervision and direction to the therapist(s) and staff, reviewed the medical record, and determined the extent to which the therapeutic goals are being met.

ITEMIZED STATEMENT- An itemized statement must be maintained which identifies the date, HCPCS code, revenue code, and charge for each individual service rendered.

Utilization Guidelines

N/A

Other Comments

Psychotherapy is the treatment of mental illness and behavior disturbances, in which definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change the maladaptive patterns of behavior and encourage personality growth and behavior.

Sources of Information

Block, B.M., Lefkovitz, P.M. (1996). Standards and guidelines for partial hospitalization adult programs (2nd ed.). Association for Ambulatory Behavioral Healthcare.
Block, B.M., Lefkovitz, P.M. (1996). Standards and guidelines for partial hospitalization chemical dependency programs. Association for Ambulatory Behavioral Healthcare.
Kaplan, H.I., Sadock, B.J., and Grebb, J.A. (1994). Kaplan and Sadock's synopsis of psychiatry (7th ed.). Baltimore: Williams & Wilkins.
Kiser, L.J., Lefkovitz, P.M., et. al. (1996). The continuum of ambulatory mental health services. Association for Ambulatory Behavioral Healthcare.
Wagner, B.D., Plotkin, D.A., et. al. (1997). Standards and guidelines for partial hospitalization geriatric programs (2nd ed.). Association for Ambulatory Behavioral Healthcare.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from the Florida Psychiatric Society.

Start Date of Comment Period
02/21/98

Start Date of Notice Period
05/01/2000 May/June 2000 *Update!*

Revision History
Revision Number:
N/A
Revised Effective Date:
N/A
Explanation of Revision:
N/A

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.

Medical Policy Procedures: 95004

Policy Number
95004

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Allergy Skin Tests

AMA CPT Copyright Statement
CPT codes, descriptions, and other data only are copyright 1998 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

HCFA National Coverage Policy
Coverage Issues Manual 50-53

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
01/01/1993

Revision Effective Date
06/19/2000

Revision Ending Effective Date
06/18/2000

Policy Ending Date
N/A

LMRP Description
Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic, immediate or delayed, and may be caused by a variety of offending agents; pollen, molds, dust, feathers, fur, venoms, foods, drugs, etc. Allergy testing is performed to determine a patient's sensitivity to particular allergens and is based on findings during a complete history and physical exam of the patient.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider allergy testing to be a covered service when medically necessary as evidenced by signs and symptoms or a diagnosis suggestive of allergies such as asthma, allergic rhinitis; or a history of hypersensitivity to animals, hay, pollen, dust, mold, grass, bee/wasp, etc.
The use of sublingual, intracutaneous, and subcutaneous provocative and neutralization testing and neutralization therapy for food allergies are not covered under the Medicare program because available evidence does not show that these tests and therapies are effective.

HCPCS Section & Benefit Category
Medicine/Allergy and Clinical Immunology

HCPCS Codes
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests
95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests
95015	Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, intermediate type reaction, specify number of tests
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests
95027	Skin end point titration
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95078	Provocative testing (e.g., Rinkel test)

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
N/A

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

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

Noncovered ICD-9-CM Code(s)
The following ICD-9-CM codes are noncovered for procedure codes 95004, 95010, 95015, 95024, 95027, 95028, and 95078:

692.5	Contact dermatitis and other eczema due to food in contact with skin
693.1	Dermatitis due to food
995.60-995.69	Anaphylactic shock due to adverse food reaction]

Noncovered Diagnoses
Food allergies are noncovered for procedure codes 95004, 95010, 95015, 95024, 95027, 95028, and 95078.

Coding Guidelines
When coding for allergy skin tests indicate (1) unit for each test performed. For example, if 18 scratch tests are performed with allergenic extracts, bill procedure code 95004 indicating 18 units.

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 history and physical examination notes, office/progress notes, hospital notes, and/or procedure report.

Utilization Guidelines
N/A

Other Comments
Terms Defined:

Allergen: any substance that causes manifestations of allergy.
Allergy: an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.
Asthma: a disease caused by increased responsiveness of the tracheobronchial tree to various stimuli.

Sources of Information
N/A

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with the contractor's Advisory Committee, which includes representatives from numerous societies.
Carrier Advisory Committee meeting held on 02/19/2000.

Start Date of Comment Period
02/11/2000

Start Date of Notice Period
05/01/2000

Revision History
Revision Number:
2
Revised Effective Date:
06/19/2000
Start Date of Comment Period:
02/11/2000
Start Date of Notice Period:
05/01/2000 May/June 2000 *Update!*
Explanation of Revision:
Food allergy testing is nationally noncovered based on Coverage Issues Manual 50-53. Data indicated that allergy skin tests were being performed for food allergies. Therefore, the policy was revised to noncover diagnoses representing food allergy testing.

Revision Number:
1
Start Date of Comment Period:
N/A
Start Date of Notice Period:
N/A
Revised Effective Date:
01/08/1996 PCR 95-149
Explanation of Revision:
Policy reformatted into national format.

Revision Number:
Original
Start Date of Comment Period:
N/A
Start Date of Notice Period:
N/A
Original Effective Date:
01/01/1993

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.

97010: Physical Medicine and Rehabilitation

Billing For Electrostimulation of Wounds

Effective for services processed on or after June 19, 2000, providers should bill for electrostimulation used in the treatment of wound healing using procedure code 97799 (unlisted physical medicine/rehabilitation service or procedure). This applies to *all* electrical stimulation devices, including (but not limited to) those that produce the stimulation by direct current, alternating current, pulsed current, pulsed electromagnetic induction, and pulsed electromagnetic field. It applies to treatment of wounds including pressure ulcers, venous ulcer wounds, and arterial wounds. In order to achieve accelerated wound healing, it may be medically necessary to perform these treatments two to three times per day to each wound site.

As with any unlisted code, each claim will be reviewed for coverage on a case by case basis. All claims submitted with an unlisted service or procedure code must be accompanied by a description of the service or procedure and appropriate documentation. This documentation must support the medical necessity and rationale for using this treatment modality for wound treatment.

ELECTRONIC MEDIA CLAIMS

File Your Medicare Claims Electronically

Electronic Media Claims (EMC) filing enables providers' and suppliers' claims to be received by Medicare the same day of transmission. Due to an increasing volume of claims being filed to Medicare Part B, increasing EMC submissions is an ongoing effort to expedite payments and maintain cost effectiveness to both the Medicare carrier and Medicare providers. EMC is rapidly changing to improve services and enhance features to better serve all Medicare customers.

There are several ways to submit claims electronically:

System to System - The computer you currently have in your office maybe used for this purpose. Upgrading your software and purchasing a modem (if necessary) is all it takes.

Service Bureaus, Billing Services, and Clearinghouses - These are companies that specialize in sending claims electronically to Medicare.

Claims may be submitted seven days a week, 24 hours a day. The only charges incurred are for any long-distance telephone charges that apply.

In the past, only a few kinds of claims could be submitted electronically, but in the last several years Medicare has expanded the claims to include:

Most physicians' claims, plus:

- Ambulance
- Ambulatory Surgical Centers
- Anesthesia
- Chiropractic
- Dialysis
- Extended Care Facility/Skilled Nursing Facility
- Hospital (Inpatient & Outpatient)
- Independent Laboratory
- Injectable Drugs
- Medicare Secondary Payer Claims
- Nursing Home
- Ophthalmologists
- Optometrists
- Physical Therapy
- Podiatry
- Portable X-ray
- Psychiatric
- Radiology

Some claims for surgical procedures may be sent electronically. Additionally, claims with unlisted procedure codes may be sent via EMC, if the service can be described in the narrative record (281 characters or less, including spaces), *and* documentation is not required. An example might be an unlisted injectable drug where the name, strength, and dosage fit in the narrative record. Contact Provider Customer Service at (904) 634-4994 to find out if a specific service may be submitted electronically.

Please call Provider Electronic Services Marketing at (904) 791-8767 for information and assistance in implementing electronic filing of your Medicare claims!

Receive Your Medicare Remittance Electronically

Manually posting Medicare B payments is not necessary! It is possible to receive Medicare remittance notification data electronically. Electronic remittance notification (ERN) allows providers' offices to receive finalized (paid and denied) claims information electronically for automatic posting to an accounts receivable system.

To receive electronic remittance notification, please contact Provider Electronic Services Marketing at (904) 791-8767. Providers can ask their EMC vendor if ERN is a software application they currently support. If a vendor does not support this function, specifications may be accessed on the World Wide Web:

National specifications may be found at
www.hcfa.gov
Florida-specific specifications may be accessed at
www.floridamedicare.com

A paper copy of the specifications may be obtained by calling Provider Electronic Services Marketing.

FRAUD AND ABUSE

Office of Inspector General—Special Fraud Alert

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse, and waste in the Department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections.

To reduce fraud and abuse in the federal health care programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes that are used to obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify practices in the health care industry that are particularly vulnerable to abuse.

This Special Fraud Alert focuses on the rental of space in physicians' offices by persons or entities that provide health care items or services (suppliers)*(1)* to patients that are referred either directly or indirectly by their physician-landlords. In this Special Fraud Alert, we describe some of the potentially illegal practices the OIG has identified in such rental relationships.

Questionable Rental Arrangements for Space in Physician Offices

A number of suppliers that provide health care items or services rent space in the offices of physicians or other practitioners. Typically, most of the items or services provided in the rented space are for patients, referred or sent, either directly or indirectly, to the supplier by the physician-landlord. In particular, we are aware of rental arrangements between physician-landlords and:

- comprehensive outpatient rehabilitation facilities (CORFs) that provide physical and occupational therapy and speech-language pathology services in physicians' and other practitioners' offices;
- mobile diagnostic equipment suppliers that perform diagnostic related tests in physicians' offices; and
- suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that set up "consignment closets" for their supplies in physicians' offices

The OIG is concerned that in such arrangements, the rental payments may be disguised kickbacks to the physician-landlords to induce referrals. We have received numerous credible reports that in many cases, suppliers, whose businesses depend on physicians' referrals, offer and pay "rents" - either voluntarily or in response to physicians' requests - that are either unnecessary or in excess of the fair market value for the space to access the physicians' potential referrals.

The Anti-Kickback Law Prohibits Any Payments to Induce Referrals

Kickbacks can distort medical decision-making, cause overutilization, increase costs and result in unfair competition by freezing out competitors who are unwilling to pay kickbacks. Kickbacks can also adversely affect the quality of patient care by encouraging physicians to order services or recommend supplies based on profit rather than the patients' best medical interests.

Section 1128B(b) of the Social Security Act (the Act) prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value to induce referrals of items or services payable by a Federal health care program. Both parties to an impermissible kickback transaction are liable. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. The OIG may also initiate administrative proceedings to exclude persons from Federal health care programs or to impose civil money penalties for fraud, kickbacks and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.*(2)*

Suspect Rental Arrangements for Space in Physician Offices

The questionable features of suspect rental arrangements for space in physicians' offices may be reflected in three areas:

- the appropriateness of rental agreements;
- the rental amounts; and
- time and space considerations

Below, we examine these suspect areas, which separately or together may result in an arrangement that violates the anti-kickback statute, in order to help identify questionable rental arrangements between physicians and the suppliers to which they refer patients. This list is not exhaustive, but rather gives examples of indicators of potentially unlawful activity.

Appropriateness of Rental Agreements. The threshold inquiry when examining rental payments is whether payment for rent is appropriate at all. Payments of "rent" for space that traditionally has been provided for free or for a nominal charge as an accommodation between the parties for the benefit of the physicians' patients, such as consignment closets for DMEPOS, may be disguised kickbacks. In general, payments for rent of consignment closets in physicians' offices are suspect.*(3)*

Rental Amounts. Rental amounts should be at fair market value, be fixed in advance and not take into account, directly or indirectly, the volume or value of referrals or other business generated between the parties. Fair market value rental payments should not exceed the amount paid for comparable property. Moreover, where a physician rents space, the rate paid by the supplier should not exceed the rate paid by the physicians in the primary lease for their office space, except in rare circumstances. Examples of suspect arrangements include:

- rental amounts in excess of amounts paid for comparable property rented in arms-length transactions between persons not in a position to refer business;

- rental amounts for subleases that exceed the rental amounts per square foot in the primary lease;
- rental amounts that are subject to modification more often than annually;
- rental amounts that vary with the number of patients or referrals;
- rental arrangements that set a fixed rental fee per hour, but do not fix the number of hours or the schedule of usage in advance (i.e., "as needed" arrangements);
- rental amounts that are only paid if there are a certain number of Federal health care program beneficiaries referred each month; and
- rental amounts that are conditioned upon the supplier's receipt of payments from a Federal health care program.

Time and Space Considerations. Suppliers should only rent premises of a size and for a time that is reasonable and necessary for a commercially reasonable business purpose of the supplier. Rental of space that is in excess of suppliers' needs creates a presumption that the payments may be a pretext for giving money to physicians for their referrals. Examples of suspect arrangements include:

- rental amounts for space that is unnecessary or not used. For instance, a CORF requires one examination room and rents physician office space one afternoon a week when the physician is not in the office. The CORF calculates its rental payment on the square footage for the entire office, since it is the only occupant during that time, even though the CORF only needs one examination room;
- rental amounts for time when the rented space is not in use by the supplier. For example, an ultrasound supplier has enough business to support the use of one examination room for four hours each week, but rents the space for an amount equivalent to eight hours per week;
- non-exclusive occupancy of the rented portion of space. For example, a physical therapist does not rent space in a physician's office, but rather moves from examination room to examination room treating patients after the physician has seen them. Since no particular space is rented, we will closely scrutinize the proration of time and space used to calculate the therapist's "rent."

In addition, rental amount calculations should prorate rent based on the amount of space and duration of time the premises are used. The basis for any proration should be documented and updated as necessary. Depending on the circumstances, the supplier's rent can consist of three components: (1) exclusive office space; (2) interior office common space; and (3) building common space.

1. Apportionment of exclusive office space - The supplier's rent should be calculated based on the ratio of the time the space is in use by the supplier to the total amount of time the physician's office is in use. In addition, the rent should be calculated based on the ratio of the amount of space that is used exclusively by the supplier to the total amount of space in the physician's office.
2. Apportionment of interior office common space - When permitted by applicable regulations, rental payments may also cover the interior office common space in physicians' offices that are shared by the physicians and any subtenants, such as waiting rooms. If suppliers use such common areas for their patients, it may be appropriate for the suppliers to pay a prorated portion of the charge for such space. The charge for the common space must be apportioned among all physicians and subtenants that use the interior office common space based on the amount of non-common space they occupy and the duration of such occupation. Payment for the use of office common space should not exceed the supplier's pro rata share of the charge for such space based upon the ratio of the space used exclusively by the supplier to the total amount of space (other than common space) occupied by all persons using such common space.
3. Apportionment of building common space - Where the physician pays a separate charge for areas of a building that are shared by all tenants, such as building lobbies, it may be appropriate for the supplier to pay a prorated portion of such charge. As with interior office common space, the cost of the building common space must be apportioned among all physicians and subtenants based on the amount of non-common space they occupy and the duration of such occupation. For instance, in the example in number one above, the supplier's share of the additional levy for building common space could not be split 50/50.

The Space Rental Safe Harbor Can Protect Legitimate Arrangements

We strongly recommend that parties to rental agreements between physicians and suppliers to whom the physicians refer or for which physicians otherwise generate business make every effort to comply with the space rental safe harbor to the anti-kickback statute. (See 42 CFR 1001.952(b), as amended by 64 FR 63518 [November 19, 1999]). When an arrangement meets all of the criteria of a safe harbor, the arrangement is immune from prosecution under the anti-kickback statute. The following are the safe harbor criteria, all of which must be met:

- The agreement is set out in writing and signed by the parties.
- The agreement covers all of the premises rented by the parties for the term of the agreement and specifies the premises covered by the agreement. If the agreement is intended to provide the lessee with access to the premises for periodic intervals of time rather than on a full-time basis for the term of the rental agreement, the rental agreement specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

Office of Inspector General—Special Fraud Alert

- The term of the rental agreement is for not less than one year.
- The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.
- The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

Arrangements for office equipment or personal services of physicians' office staff can also be structured to comply with the equipment rental safe harbor and personal services and management contracts safe harbor. (See 42 CFR 1001.952(c) and (d), as amended by 64 FR 63518 [November 19, 1999]). Specific equipment used should be identified and documented and payment limited to the prorated portion of its use. Similarly, any services provided should be documented and payment should be limited to the time actually spent performing such services.

What To Do If You Have Information About Fraud and Abuse Against Medicare or Medicaid Programs

If you have information about physicians, DMEPOS suppliers, CORFs or other suppliers engaging in any of the activities described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

Field Offices	States Served	Telephone
Boston	MA, VT, NH, ME, RI, CT	(617) 565-2664
New York	NY, NJ, PR, VI	(212) 264-1691
Philadelphia	PA, MD, DE, WV, VA, DC	(215) 861-4586
Atlanta	GA, KY, NC, SC, FL, TN, AL, MS	(404) 562-7603
Chicago	IL, MN, WI, MI, IN, OH, IA	(312) 353-2740
Dallas	TX, NM, OK, AR, LA, CO, UT, WY, MT, ND, SD, NE, KS, MO	(214) 767-8406
Los Angeles	AZ, NV, So. CA	(714) 246-8302
San Francisco	No. CA, AK, HI, OR, ID, WA	(415) 437-7961

Suspected fraud and abuse may also be reported to Florida Medicare by calling (904) 634-4994, or in writing to:

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

(1.) Persons or entities may be either suppliers or providers. For purposes of this Special Fraud Alert, we will refer to such persons as suppliers.
(2.) Some of the arrangements identified as suspect in this Special Fraud Alert may also implicate the Ethics in Patient Referrals Act, also known as the Stark law (section 1877 of the Act). The interpretation of the Stark law is under the jurisdiction of the Health Care Financing Administration (HCFA).
(3.) This Special Fraud Alert does not address the appropriateness of consignment closet arrangements under HCFA's DMEPOS supplier standards. The interpretation of the DMEPOS supplier standards is a matter under HCFA's jurisdiction.

GENERAL INFORMATION

"Do Not Forward" Initiative

Effective July 1, 2000, Medicare carriers will implement the "Do Not Forward" (DNF) initiative for Medicare checks that could not be delivered to providers. With this initiative, the carrier will use "Return Service Requested" envelopes to prevent the forwarding of Medicare checks to locations other than those recorded on the Medicare provider files.

When a check is returned, if applicable, the U. S. Postal Service will provide Medicare with a new address or reason for nondelivery. However, if a new address is supplied with the returned check, Medicare cannot automatically change the address of the provider or re-mail the check to the provider. The provider must complete a Change of Address Form HCFA-855C or other written notification. The form or written notification must bear an original signature from an authorized representative of the entity that completed the original registration form. No copies, faxes, or stamps are acceptable. For purposes of this process, the most important address is the "Pay To" address. If the provider does not furnish the "Pay To" address on Form HCFA-855C or the written notification, it will be returned and the address will not be updated.

To obtain copies of Form HCFA-855C, providers may call Florida Medicare's Provider Customer Service at (904) 634-4994. Addresses *cannot* be changed based on telephone calls; written notification as described above is required.

New Website for Prompt Payment Interest Rate

Medicare contractors are required to pay interest on "clean" claims that are not paid in a timely manner, under section 3902(a) of title 3l, U.S. Code. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1st. Effective January 1, 2000, providers should consult the Treasury Department web page **— www.publicdebt.treas.gov/opd/opdprmt2.htm —** for the new rate.

"Clean" claims are defined as those which do not require investigation or development external to the carrier's operation on a prepayment basis. Interest is paid on clean claims that are not paid by the 30th day after the date of receipt by the contractor. The current rate, from the above website, is 6.75 percent. Be sure to access this website after July 1, 2000, for the next update to the prompt payment interest rate.

Role of Physicians in the Home Health Prospective Payment System

The following article, provided by the Health Care Financing Administration (HCFA), is to alert the physician community of proposed changes in the home health payment system and to inform them of their responsibilities within that system. The proposed regulation sets forth the methodology for the national prospective payment system applicable to all covered Medicare home health services. The system outlined in the proposed rule would replace the current retrospective reasonable-cost-based system. This supplements the regulation and is not meant to circumvent the normal rule making process. The article provides information regarding:

- *The proposed regulation*
- *Physician responsibilities*
- *Home health certification*
- *Plan of care certification*
- *Payment approach*

Currently, home health agencies (HHAs) receive payment under a cost-based reimbursement system subject to limits referred to as the interim payment system. The Balanced Budget Act of 1997 (BBA '97) mandated the creation of a prospective payment system (PPS) for home health services. A proposed rule codifying the provision may be found at 64 FR 58134 (October 28, 1999). The final regulation governing this section of the BBA'97 is scheduled for July 2000 publication with a planned effective date of October 1, 2000.

While the entire proposed regulation deserves attention, this article supplements the regulation and is not meant to circumvent the normal rule making process. The purpose of this article is to alert the physician community of the proposed changes in the home health payment system and to inform them of their responsibilities within the system. This bulletin is the first in a series of bulletins. A forthcoming bulletin will provide further detail regarding Outcome Assessment Information Set (OASIS)—the home care assessment system. It is recommended that billing offices forward this bulletin to their physicians.

I. The Proposed Regulation

This proposed rule sets forth the methodology for the national PPS applicable to all covered Medicare home health services. It incorporates a national 60-day episode payment, adjusted for patient condition and area wage costs, for all services furnished to an eligible beneficiary under a Medicare home health Plan of Care. The PPS will affect the existing billing and payment practices. Payment for services will remain specific to the individual beneficiary (who is homebound and under a physician's Plan of Care) and to the site of the services delivered.

The basic vehicle for home health claims will remain the UB-92 (HCFA-1450) claim form. The claims will continue to be processed by the current Regional Home Health Intermediaries (RHHIs). RHHIs will also continue to conduct audits of providers' records, as needed, to assure that payments are appropriate for care provided. Treatment must follow a written Plan of Care established and reviewed by the attending physician at least every 60 days.

II. Physician Responsibilities

The fundamental physician responsibility in the PPS is to be the determiner of the patient's health care needs and advocate for the services required to meet those needs. In order to perform this role efficiently, certifying physicians must utilize their intimate knowledge of the patient's medical condition. As such, physicians have two specific responsibilities:

- Certify that the patient is confined to his home and is in need of home health care.
- Develop, certify, and re-certify the Plan of Care, including key aspects of the patients' condition.

III. HCFA-485

Form HCFA-485 is used for Home Health and Plan of Care Certification and re-certification.

A. Home Health Certification

The beneficiary's physician is responsible for signing the Home Health Certification form HCFA-485 upon the initiation of any Plan of Care. Section 1824(a)2 of the Social Security Act states that home health services are required when an individual is confined to his home and needs skilled nursing care on an intermittent basis or physical or speech therapy. If an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues to need occupational therapy; a plan for furnishing such services has to be established by the beneficiary's physician, furnished under the care of the beneficiary's physician, and periodically reviewed by the beneficiary's physician. Upon the completion of every 60-day episode, if the patient is receiving continuous home health care from the same home health agency, the beneficiary's physician is responsible for Home Health re-certification.

B. Plan of Care Certification

The PPS does not introduce change to the Plan of Care. It remains the beneficiary's physician's responsibility to develop a Plan of Care based on his/her intimate knowledge of the medical condition of the home health patient. The Plan of Care developed in consultation with

Role of Physicians in Home Health PPS- continued

the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, and safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

The beneficiary's physician's orders for services in the Plan of Care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the ordered services and at what frequency the services will be furnished. The Plan of Care must be signed and dated by the beneficiary's physician *before* the agency can submit a bill. Any changes in the plan must be signed and dated by the beneficiary's physician. If any services are furnished based on the beneficiary's physician's oral orders, the orders must be put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services. Upon the completion of every 60-day episode, if the patient is receiving continuous home health care from the same home health agency, the beneficiary's physician is responsible for re-certification of the Plan of Care.

IV. Payment Approach

A. 60-Day Episode Payment

An episode, 60 days in length, is the unit of payment for home health PPS. The episode payment is specific to an individual beneficiary. A 60-day episode begins with the first Medicare billable visit as day 1 and ends on and includes the 60th day from the start-of-care date. The next continuous episode re-certification period begins on day 61 and ends on and includes day 120. The 60-day episode payment covers one individual for 60 days of care regardless of the number of days of care actually furnished during the 60-day period unless there is an intervening event (to be discussed in Paragraph IV.B.).

The 60-day episode payment amount will be case-mix adjusted for each patient using the OASIS developed by HCFA as part of the required home care assessment. The system was developed combining 20 data elements to measure case-mix across three domains: clinical severity factors, functional status factors and service utilization factors. Key data elements and their respective values were identified for each dimension to create a case-mix system that included 80 severity categories, or home health resource groups (HHRGs). HHRGs are a case-mix classification system in which patient characteristics and health status information gathered from the OASIS assessment in conjunction with projected therapy use during the 60-day episode are used to determine payment. After obtaining the physician's signature on the Plan of Care, the HHA will submit an initial claim and receive 50 percent of the estimated case-mix adjusted episode payment. Each initial claim must be based on a current OASIS-based case-mix.

At the end of the 60-day episode, the HHA submits a final claim for the beneficiary and receives the remaining 50 percent of the estimated case-mix adjusted episode payment. Each final claim must represent the actual utilization over the utilization period, in line item detail. An initial and final bill must be submitted for each episode period. If care continues at the same provider for a second episode, the initial payment for the second episode will not be made until the final claim for the first episode is received.

An episode may end before the 60th day in the case of a transfer or discharge, and readmission. Such cases call for partial episode payment adjustments (PEP Adjustments) to be described later.

B. Partial Episode Payment Adjustment

PEP Adjustments provide a simplified approach to the episode definition that takes into account key intervening events in a patient's care defined as: a beneficiary-elected transfer to a different agency; or a discharge and return to the same HHA. In such situations, a new 60-day episode clock begins for purposes of payment. When a new 60-day episode begins, the original 60-day episode payment is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care before the intervening event. The prorated payment is the PEP Adjustment. The new 60-day episode interrupting the original episode requires an OASIS assessment and physician's certification signature of the Plan of Care.

C. Significant Change in Condition Adjustment (SCIC Adjustment)

If a patient experiences an unanticipated change in condition during a 60-day episode and the change is significant enough to justify a different payment level or change in the Plan of Care, the episode payment may be adjusted. In such situations, the early part of the episode would be proportionally at one rate and the latter part at an adjusted rate. Physicians would continue to be required to provide and sign change orders in the Plan of Care to accommodate the patient's significant change in condition. The SCIC Adjustment does not restart the 60-day episode clock. The SCIC Adjustment occurs within a given 60-day episode.

Under PPS, an agency is paid for a 60-day period of care, in general, without regard to the amount of services it provides in a 60-day period. Similar to hospital DRG payments, the agency has incentive to provide care efficiently by using as little resources as possible to provide care for the patient. Thus, as a physician, your development and certification of the Plan of Care is critical to assuring both that the patient requires Medicare covered home health services *and* that the appropriate amount has been prescribed. Because payment is based not on the number of visits provided, but the agency's characterization of the patient's condition, your intimate knowledge of the patient's condition is an important validator of the case-mix payment level.

Physicians have played, and will continue to play, a regular role in helping to assure that Medicare home health patients receive appropriate care. While Medicare's medical review and program integrity staff will be monitoring the new PPS system, we continue to rely on physicians as the pivotal profession in health care delivery to help assure the fiscal and clinical validity of the Medicare home health system.

These services are processed by the regional home health care intermediary (RHHI). Any questions regarding this policy should be directed to the RHHI at the following mailing address and telephone number:

Palmetto Government Benefits Administrators, LLC
34650 U.S. Highway 19 North, Suite 202
Palm Harbor, FL 34684-2156

Customer Services telephone number: (727) 773-9225

Consolidated Billing for Skilled Nursing Facilities (SNFs)

The Balanced Budget Refinement Act of 1999 (BBRA) provides updated information concerning consolidated billing for SNFs. Consolidated billing for SNF residents in a Part B stay is still delayed until further notice. Consolidated billing continues to apply to all the services and supplies that a SNF resident receives while in a SNF PPS Part A stay, other than those services that are specifically identified as being excluded from this requirement (e.g., renal dialysis services that are covered under Part B). When a resident receives a type of service that is excluded from consolidated billing, the outside entity that furnishes the service must submit a bill directly to Medicare rather than through the SNF. When billing Medicare directly, the outside entity must bill the Part B carrier, the durable medical equipment regional carrier (DMERC), or the Part A fiscal intermediary as appropriate for the services and supplies rendered to the resident.

The BBRA makes certain additions to the statutory exclusion list at section 1888(e)(2)(A) of the Social Security Act, effective for services furnished on or after April 1, 2000. First, it expands the existing statutory exclusion of Part B covered dialysis services to encompass ambulance services that are furnished in conjunction with the excluded dialysis services. Thus, for ambulance services that are necessary to transport a SNF resident offsite to receive Part B dialysis services, the ambulance supplier will bill Medicare directly rather than through the SNF.

In addition, this provision identifies certain individual excluded services within several broader categories of services that are not excluded. The procedure codes for the excluded services appear below, by service category. Within these categories, the specific services are separately billable by an outside entity when furnished to a SNF resident. All other services within these categories remain subject to consolidated billing and must be billed by the SNF itself when furnished to a SNF resident while in a SNF PPS Part A stay.

Chemotherapy Items

The excluded codes for chemotherapy items are:

J9000	J9050	J9080	J9094	J9110	J9151	J9200	J9230	J9270	J9310	J9370
J9015	J9060	J9090	J9095	J9120	J9170	J9201	J9245	J9280	J9320	J9375
J9020	J9062	J9091	J9096	J9130	J9181	J9206	J9265	J9290	J9340	J9380
J9040	J9065	J9092	J9097	J9140	J9182	J9208	J9266	J9291	J9350	J9390
J9045	J9070	J9093	J9100	J9150	J9185	J9211	J9268	J9293	J9360	J9600

Chemotherapy Administration Services

The excluded codes for chemotherapy administration services are:

36260	36489	36532	36535	96405	96410	96420	96425	96450	96542
36261	36530	36533	36640	96406	96412	96422	96440	96520	
36262	36531	36534	36823	96408	96414	96423	96445	96530	

Radioisotope Services

The excluded codes for applicable radioisotope services are:

79030	79035	79100	79200	79300	79400	79420	79440

Customized Prosthetic Devices

The excluded codes for applicable customized prosthetic devices are:

L5050	L5560	L5637	L5665	L5700	L5816	L5974	L6360	L6635	L6700	L6825	L6965
L5060	L5570	L5638	L5666	L5701	L5818	L5975	L6370	L6637	L6705	L6830	L6970
L5100	L5580	L5639	L5667	L5702	L5822	L5976	L6400	L6640	L6710	L6835	L6975
L5105	L5585	L5640	L5668	L5704	L5824	L5978	L6450	L6641	L6715	L6840	L7010
L5150	L5590	L5642	L5669	L5705	L5826	L5979	L6500	L6642	L6720	L6845	L7015
L5160	L5595	L5643	L5670	L5706	L5828	L5980	L6550	L6645	L6725	L6850	L7020
L5200	L5600	L5644	L5672	L5707	L5830	L5981	L6570	L6650	L6730	L6855	L7025
L5210	L5610	L5645	L5674	L5710	L5840	L5982	L6580	L6655	L6735	L6860	L7030
L5220	L5611	L5646	L5675	L5711	L5845	L5984	L6582	L6660	L6740	L6865	L7035
L5230	L5613	L5647	L5676	L5712	L5846	L5985	L6584	L6665	L6745	L6867	L7040
L5250	L5614	L5648	L5677	L5714	L5850	L5986	L6586	L6670	L6750	L6868	L7045
L5270	L5616	L5649	L5678	L5716	L5855	L5988	L6588	L6672	L6755	L6870	L7170
L5280	L5617	L5650	L5680	L5718	L5910	L6050	L6590	L6675	L6765	L6872	L7180
L5300	L5618	L5651	L5682	L5722	L5920	L6055	L6600	L6676	L6770	L6873	L7185
L5310	L5620	L5652	L5684	L5724	L5925	L6100	L6605	L6680	L6775	L6875	L7186
L5320	L5622	L5653	L5686	L5726	L5930	L6110	L6610	L6682	L6780	L6880	L7190
L5330	L5624	L5654	L5688	L5728	L5940	L6120	L6615	L6684	L6790	L6920	L7191
L5340	L5626	L5655	L5690	L5780	L5950	L6130	L6616	L6686	L6795	L6925	L7260
L5500	L5628	L5656	L5692	L5785	L5960	L6200	L6620	L6687	L6800	L6930	L7261
L5505	L5629	L5658	L5694	L5790	L5962	L6205	L6623	L6688	L6805	L6935	L7266
L5510	L5630	L5660	L5695	L5795	L5964	L6250	L6625	L6689	L6806	L6940	L7272
L5520	L5631	L5661	L5696	L5810	L5966	L6300	L6628	L6690	L6807	L6945	L7274
L5530	L5632	L5662	L5697	L5811	L5968	L6310	L6629	L6691	L6808	L6950	L7362
L5535	L5634	L5663	L5698	L5812	L5970	L6320	L6630	L6692	L6809	L6955	L7364
L5540	L5636	L5664	L5699	L5814	L5972	L6350	L6632	L6693	L6810	L6960	L7366

Note:Claims for customized prosthetic devices are to be billed to the DMERC, not Florida Medicare. They are provided here solely as a convenience. To contact the DMERC directly call (803) 735-1034, or write to:

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

HCFA Announces New Medicare Hospital Outpatient Payment System

The following article is reprinted from a HFCA press release.

The Health Care Financing Administration today [*March 31, 2000*] announced a new Medicare payment system for hospital outpatient services designed to encourage more efficient delivery of care and to ensure more appropriate payment for services by Medicare and its beneficiaries.

Over time, the regulation will save beneficiaries millions of dollars in coinsurance payments for outpatient services. In addition to hospital outpatient services, the new prospective payment system will also apply to partial hospitalization services furnished by community mental health centers.

The final regulation, to be published on April 7 in the *Federal Register*, carries out the payment changes initially proposed by the Clinton Administration, which were enacted in the Balanced Budget Act of 1997 and adjusted in the Balanced Budget Refinement Act of 1999. The proposed regulation was open for comment by individuals and organizations between its publication in September 1998 and July 1999.

HCFA, which oversees the Medicare program, will implement the new payment system expected to go into effect on July 1, 2000. The provisions for provider-based facilities owned by hospitals, including physician office practices, will be effective six months from the publication date.

"This regulation helps Medicare reduce copayments for hospital outpatient services that are being used more frequently by elderly and disabled Americans," said HCFA Administrator Nancy-Ann DeParle. "The new system gives hospitals changed incentives to become more efficient and will result in more consistent payments across hospitals.

"The new prospective payment system increases total payments to hospitals, although individual hospitals may see an increase or a decrease in their payments," DeParle said. "During the transition period, we are protecting hospitals by paying a part of any reduced payments they might incur for outpatient services. For rural hospitals, we will fully cover any payment reductions. And hospitals will receive additional payments for new medical devices and drugs for up to three years."

HCFA will make certain that hospitals and their billing companies have the information and training they need to carry out system changes for the new outpatient prospective payment system. The agency also will monitor the progress of hospitals as they make the necessary changes and will continue to work closely with the hospital associations.

"I am committed to ensuring that the nation's hospitals and other providers are fully educated about this regulation," DeParle said. "We will launch an aggressive and comprehensive campaign to inform people about the rule."

The new payment system is based on groups of services called ambulatory payment classifications (APC), which divides all outpatient services included in the new payment schedule into 451 groups. The services within each group are clinically similar and require comparable resources.

A key provision of the 1997 budget law is a change in beneficiary coinsurance payments. The current coinsurance is based on 20 percent of charges billed by the hospitals and community mental health centers. In fact, for many outpatient services, beneficiaries pay 50 percent or more of the total payment to the hospital for outpatient treatment.

The Clinton Administration has long advocated reducing coinsurance that beneficiaries must pay for hospital outpatient services. In 1997, the administration's budget proposed to reduce coinsurance for beneficiaries to 20 percent of Medicare payment rates by 2007. Congress adopted a variation of the president's proposal in the 1997 budget law.

Coinsurance amounts will be frozen until the coinsurance payment for an APC becomes 20 percent of the total payment. Once coinsurance becomes 20 percent of the total payment, both the Medicare payment and the coinsurance amount will be updated annually so that coinsurance will continue to be 20 percent of the total payment. The actual copayment amounts for an APC will be limited to the Medicare hospital inpatient deductible, which for 2000 is $776. In addition, hospitals have the option of reducing the copayment.

The APC payment rate established for each group applies to all services within the group. Although national payment rates are established for each group, payments will be wage adjusted to reflect geographic differences. Under the final rule, HCFA has developed separate APCs to pay for blood, other blood products and anti-hemophilic factors.

In addition, HCFA modified the proposed regulation to allow a smoother transition to the new fee system for providers. The APC groups were refined based on comments. The changes included paying for corneal tissue, at least temporarily, at its acquisition cost, rather than as part of the payment for overall corneal transplant surgery, and requiring the use of HCPCS codes only for purposes of computing payments for medical visits to clinics and emergency departments.

The regulation excludes ambulance services because a new fee schedule is being developed. Physical, occupational and speech therapies, orthotic and prosthetic devices, durable medical equipment and clinical laboratory services are excluded because they are paid under existing fee schedules.

The final rule incorporates changes in hospital outpatient payments set by the 1999 budget law including:

- Medicare will make additional payments for certain new medical devices and drugs for up to three years.
- During a transition period until 2004, Medicare will pay hospitals a portion of any losses they would otherwise incur resulting from smaller payments than under prior law. For rural hospitals with 100 or fewer beds, these losses will be fully replaced.
- Medicare will make an outlier payment for high-cost cases, with payments projected not to exceed 2.5 percent of total payments to hospital outpatient departments in 2000-2003.
- Certain cancer hospitals will be protected permanently from any reduced Medicare payments.
- Medicare will pay for implanted medical devices under the new payment system, rather than under a medical equipment fee schedule.

HCFA Announces New Medicare Hospital Outpatient Payment System - continued

HCFA will annually review the APC groups, wages and other adjustments. As part of this review, HCFA will consult with an expert panel composed of provider representatives.

A 60-day comment period in the final regulation applies only to the regulatory changes resulting from the 1999 budget law.

The new regulation also addresses the criteria a facility must meet to be designated "provider-based." In recent years, provider-based facilities have expanded, including an increase in hospitals acquiring physician office practices to use as hospital outpatient departments. The regulation also includes requirements for hospitals to furnish an appropriate level of physician supervision in off-site clinics.

Services Provided in Religious Nonmedical Health Care Institutions

The Balanced Budget Act of 1997 (BBA '97) amended the Social Security Act to provide Medicare coverage of services equivalent to a hospital or extended care level of care in a religious nonmedical health care institution (RNHCI), if a beneficiary elects to receive such benefits.

The beneficiary, or his or her legal representative, must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment and that the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

The signed election must include a statement that the receipt of nonexcepted medical services would constitute a revocation of the election and may limit further receipt of payment of religious nonmedical health care services. Medicare will not pay for any religious aspects of care provided in a RNHCI.

These services are processed by the specialty contractor, Riverbend Government Benefits Administrator. Any questions regarding this policy should be directed to Riverbend GBA at the following mailing address and telephone number:

Riverbend Government Benefits Administrator
730 Chestnut Street
Chattanooga, TN37402-1790

Customer Service telephone number: (423) 755-5955

MEDICARE REGISTRATION

Enrollment Tips From Medicare Registration

Several items concerning incomplete applications were published on behalf of Medicare Registration in the March/April 2000 issue of the *Medicare B Update!* (pages 52-53). The following information provides additional tips to assist providers in submitting correct enrollment applications. Any correspondence or change of information request submitted to Medicare Registration should contain the Medicare provider number. Applications may be obtained by contacting Provider Customer Service at (904) 634-4994.

Does Your Legal Business Name Have "P.A." At The End?

If you are applying for a Medicare Part B provider number and your legal business name has "P.A." at the end, (e.g., Shana Mitchell, M.D., P.A.) and you are requesting reimbursement under your tax identification number (TIN), an Individual Reassignment of Benefits Application (HCFA 855R) must be submitted with your General Enrollment Application (HCFA 855).

Incomplete Applications

Medicare Registration is still receiving many applications that are incomplete. Section 5D of the General Enrollment Application (HCFA 855) requests information regarding exclusions/sanctions from any federal agency or program. There are three sections to section 5 that must be completed. Section 5A, 5B ***or*** 5C ***and*** 5D which has two blocks to check. All three blocks of this section must be checked or the applicant must indicate the type and dates of the adverse legal action(s).

Section 6D should contain the name of the managing/directing employee for the address indicated in section 6B.

Incomplete applications that are returned to the provider and then resubmitted for processing will not be given priority. The corrected application will be treated as an initial submission.

Changes to Practice Locations

The Change of Information Application (HCFA 855C) should be completed if changing practice locations. When completing the HCFA 855C due to a change in practice location(s), sections 3B and 3D must be completed showing the "pay to" address and the new office location(s). The HCFA 855C *cannot* be used to add an additional practice location. The General Enrollment Application (HCFA 855) must be used to add additional office locations.

News Regarding Supervising Physicians of Independent Diagnostic Testing Facilities (IDTFs)

All IDTFs must have at least one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of non-physician personnel who use the equipment. This level of supervision is the requirement of "General" supervision. That is, the supervising physician does not necessarily have to be on the premises during the time the services are being performed.

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

The Health Care Financing Administration (HCFA) has directed the Medicare Registration department to interview all supervising physicians of IDTFs, either by phone or in person. In addition, HCFA requires a site visit and review of all IDTFs. A representative of the Medicare Registration Department will visit the facility in an effort to determine if the qualifications for enrollment have been met.

The purpose of the site visit is to verify the following:

1. Verify that the location shown on the HCFA Form 855 is the actual address of the IDTF;
2. Verify that the test required equipment shown in Block 3 of Attachment 2, of the HCFA Form 855, actually exists and is present or available for review;
3. Observe that for diagnostic tests being performed at the IDTF, a certified (or state licensed, where applicable) technician shown in Block 3 of Attachment 2, of the HCFA Form 855, is actually performing the test;
4. For tests that require personal supervision, observe that a supervising physician shown in Block 2, Attachment 2, of the HCFA Form 855, is actually present and with the patient;
5. For tests that require direct supervision, observe that a supervising physician shown in Block 2, Attachment 2, of the HCFA Form 855, is actually present and with the patient;

NOTE: Any procedure which utilizes contrast media, of any type, calls for the direct or personal supervision of at least one of the supervising physician shown in Block 2, Attachment 2, of the HCFA form 855.

For tests that require general supervision:

- Our representative will ask all available technicians if they know the name(s) of the supervisory physician(s), who are supervising tests.
- All technicians must know the name(s) of the supervising physicians and have a means of contacting them.
- Our representative will ask to see written copies of instructions or protocols between the supervising physician and the IDTF.

IDTFs may not enroll in the Medicare Program without at least one supervising physician. Medicare would not have issued a provider number to the IDTF without the specific written consent of the supervising physician(s). It is therefore the responsibility of the supervising physician to notify Medicare Registration should he/she resign their position as supervising physician.

IDTFs are also responsible for notifying Medicare Registration should a supervising physician resign his/her position. If an IDTF finds itself without at least one supervising physician, it should refrain from rendering any further services until able to obtain proper physician oversight.

Supervising physicians are accountable for the supervision and training of non-physician personnel who actually perform the diagnostic procedures. In addition, the maintenance and calibration of the equipment are the continuing responsibility of the supervising physician.

General Supervision Requirements:

In accordance with Code of Federal Regulations (CFR) 410.32, "General Supervision means the procedure is furnished under the physician's over all direction and control, but the physician's presence is not required during the performance of the procedure."

MEDICARE SECONDARY PAYER

Settlement Agreement—INAMED

On April 30, 1999, the Health Care Financing Administration (HCFA) entered into a settlement agreement with INAMED, a silicone gel implant manufacturer, and the class plaintiffs who brought a class action against the manufacturer for injuries and damages caused by their silicone gel implants. Because of INAMED's financial problems and because the plaintiffs and defendants decided to enter into a limited fund settlement, HCFA agreed to accept payment from the parties in full satisfaction of HCFA's MSP claims against class members and INAMED. Medicare beneficiaries who receive payments under the INAMED settlement are not required to reimburse Medicare from the settlement proceeds.

Medicare contractors will advise these beneficiaries that the release of HCFA's claims in the INAMED case does not relieve a beneficiary of the obligation to cooperate with HCFA by providing requested information. Additionally, it does not release that person's obligation to reimburse HCFA if the beneficiary collects funds from another source or a different defendant in connection with a breast implant claim.

Providers are reminded that Medicare remains secondary as to claims or suits against any other manufacturer or defendant. However, providers do not need to take any action concerning this settlement.

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 **two more 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 —** Education at Your Finger Tips
- **Specialty Seminars —** Everything You Need to Know About Your Specialty

Medifest 2000 Registration

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

Registration

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

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.

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

Orlando -
Omni Rosen Hotel
(407) 996-9840

Register TODAY!!
Seating is Limited!

Complete the Registration Form (one form per person)

Please Print

Registrant's Name _____

Provider's Name _____

Title/Position _____

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

Address _____

City, State, ZIP code _____

Phone ( ) _____ Fax ( ) _____

How did you learn about Medifest?

Medicare B Update! _____ *Medicare A Bulletin* ____ BBS _____

Co-worker _____ Other _____ Attended Previously _____ - ____ times

Meeting Dates and Locations

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

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

IMPORTANT STEPS

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

Or mail the form to:

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 2 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

Day1

July 11
August 8

8:30 - 10:00

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

10:30 - 12:00

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

1:30 - 3:00

11 ❑ Reimbursement Efficiency for Part B Providers (B)
12 ❑ Fraud and Abuse (A/B)
13 ❑ Medical Review (A/B)

1:30 - 5:00*

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

3:30 - 5:00

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

Day 2

July 12
August 9

8:30 - 10:00

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

8:30 - 12:00*

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

10:30 - 12:00

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

1:30 - 3:00

39 ❑ Inquiries, Appeals and Overpayment (B)
40 ❑ Medicare Part C (A/B)
41 ❑ Medicare Secondary Payer (A/B)
42 ❑ CORF/ORF (A)
43 ❑ Inpatient/Outpatient PPS (A)
44 ❑ Electronic Media Claims (B)
52 ❑ Peer Review Organization-PRO (A)

1:30 - 5:00*

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

3:30 - 5:00

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

* these classes are scheduled for the entire morning or afternoon session

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 Coding for Beginners

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.

Electronic Media Claims

Audience: New and experienced Part B office staff that 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) Documentation and Coding

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: Physicians and Part B medical coding/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 for Beginners

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 (e.g., physicians, hospitals) 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.

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

FOR PART B PROVIDERS

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.*

Come and learn about…..

- Medicare Parts B & C
- Payment & Informational Modifiers
- E/M Documentation Guidelines
- Reimbursement Acceleration Techniques
- The Fastest Claim Filing Methods
- Effeciency Techniques that Reduce Claim Denials and Unprocessable Claims
- Medicare's Development Processes for Local Medical Review Policies
- Audits - are you at risk?
- Recognizing Fraud & Abuse
- Waiver of Liability and Advance Beneficiary Notice
- Appeals & Overpayments

TIME of seminars is 8:30 AM - 4:30 PM. Please select one of the following dates:

June 12
Provider Focused
June 13
Office Staff Focused

Location:
BCBSF/FCSO Building
532 Riverside Ave
Jacksonville, FL 32202
(904) 791-8299

Two Easy Steps to Register:

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

or

Mail this form to:

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 2: Directions to the facility and a confirmation number will be faxed to you. Please bring this 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.

Provider's Name: _____

Registrant's Name: _____

Registrant's Title or Position: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, ZIP Code: _____

Phone: ( ) _____ Fax: ( ) _____

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.

Medical Specialty Seminar Schedule

Look! Read!

Have you ever struggled with your work or wasted your time trying to learn by "trial and error?
If you answered "yes" then come to Medicare's Specialty Seminar Classes

- Medicare Training that respects your time and your budget!
- From basics to the tough stuff, learn tips and techniques that multiply your productivity.
- Learn how to file claims quickly, easily, and correctly for your specialty

Only $99.00 per session!

Continuing Education Units (CEUs) available for all sessions

Part A Only:

Jacksonville - May 26, 2000
Blue Cross Blue Shield Bldg.
532 Riverside Ave.
(904) 792-8299

8:30 – 11:30 a.m.

❑ Skilled Nursing Facilities

Part A & B:

Jacksonville - July 26, 2000
Blue Cross Blue Shield Bldg.
532 Riverside Ave.
(904) 792-8299

8:30 – 11:30 a.m.

❑ Rehabilitative Services

If you are interested in attending a Specialty Seminar that is not on this schedule, please fax your name, fax number and specialty name to (904) 791-6035. We will notify you if we schedule the seminar you are interested in.
If you have questions for the above seminar please call (904) 791-8299. For directions please call the hotel facility listed above.

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 - $99 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. 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 $99.00 per session!

Provider/Company Name: _____

Registrant's Name: _____

Registrant's Title or Position: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, ZIP Code: _____

Phone: ( ) _____ Fax: ( ) _____

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

MEDICARE PART B PROVIDERS

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

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

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

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.

Claims Submission *(e.g., claim filing questions, unprocessible claims, denials, etc.)*

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

Other

_____
_____
_____

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

FOUR IMPORTANT STEPS

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. Bring this with you the day of the event. If you do not receive a confirmation number, please call (904) 791-8299**

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

Only $49.00 per person!

MEDICARE PART B PROVIDER - REGISTRATION FORM

Registrant's Name: _____

Registrant's Title/Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, ZIP Code: _____

Phone: ( ) _____ Fax: ( ) _____

Please select one of the following dates

Time: **1:00 p.m. - 4:30 p.m.** **$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 A Session

MEDICARE PART A PROVIDERS

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

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

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

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.

Claims Submission *(e.g., claim filing, return to provider reason codes, denial reason codes)*

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

Other

_____
_____
_____

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

FOUR IMPORTANT STEPS

Four Easy Steps to Register:

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

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

STEP 3: **Mail this form and your payment to:**

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

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

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

Only $49.00 per person!

MEDICARE PART A PROVIDER - REGISTRATION FORM

Registrant's Name: _____

Registrant's Title/Position _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, ZIP Code: _____

Phone: ( ) _____ Fax: ( ) _____

Please select one of the following dates

Time: 8:30 a.m. - 12:00 p.m. **$49 per person**

❑ **May 19, 2000**

❑ **July 28, 2000**

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

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* and *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. Write down three ideas for improving, changing and/or enhancing our course curricula.
2. Write down any general improvements, course additions, or course deletions.
3. Submit a copy of your ideas when you arrive at the meeting.
4. Be prepared to discuss your ideas in an open and relaxed forum.

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.

FOR MORE INFORMATION CALL (904) 791-8299

REGISTRATION FORM

for Quarterly Medicare Part A and Part B
Provider Education and Training Advisory Meeting

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: ( )_____

Cost: FREE!!

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

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

Directions to our building will be faxed with your confirmation

Time: **8:30 a.m. - 12:30 a.m.**

✓Check one or both of the following dates:

❑ **June 23, 2000**

❑ **September 27, 2000**

Please RSVP 10 days prior to the event

Two New Computer Based Training Courses Available

In an effort to increase awareness of preventive health services that are covered by Medicare, the Health Care Financing Administration (HCFA) has made available via 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 for a limited time via the Medicare Online Training Website (***www.medicaretraining.com***).

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. They include:

- *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!

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.***

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.*

ORDER FORM - PART B MATERIALS FOR 2000

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

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

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID -

DO NOT FAX - PLEASE PRINT

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 _____ Dermatology _____ Independent Diagnostic Testing Facility _____ Medical Oncology _____ Mental Health _____ Nephrology _____ Nurse Practitioner/CNS/Physician Assistant _____ Orthopedics _____ Physical/Occupational/Speech Therapy _____ Podiatry _____ Radiology _____ Radiation Oncology	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: _____

MEDICARE PART B FINANCIAL SERVICES
PHYSICIAN/SUPPLIER SERVICE REQUEST FORM
P.O. BOX 44141
JACKSONVILLE, FLORIDA 32231

See reverse for instructions on completing this form and documentation requirements

1. PHYSICIAN/SUPPLIER NAME _____ **PHYSICIAN/SUPPLIER #:** _____

ADDRESS: _____ **PHONE #** _____

_____

_____ **CONTACT PERSON:** _____

2. OVERPAYMENT REFUNDS:

Use this section to document the reason for the refund being returned to Medicare. If you do not know the exact amount of the overpayment simply indicate the reason for the refund below and you will be contacted by the Financial Services Department concerning the overpayment amount and how to make a refund.

This form, or a similar document containing the following information, should accompany every voluntary refund so the receipt of check is properly recorded and applied.

Check $ _____ **Check Date** _____ **Check #** _____

For each claim, provide the following:

Patient Name _____HIC #_____Claim Number _____ Amount Refunded $_____ Reason Code:_____ (Select reason code from list below. Use one reason per claim)

Please list all claim numbers involved. Attach separate sheet, if necessary

Reason codes for overpayment (choose one):

Billing/Clerical Error
01 - Corrected Date of Service
02 - Duplicate
03 - Corrected CPT Code
04 - Not Our Patient(s)
05 - Modifier Added/Removed
06 - Billed in Error
07 - Corrected CPT Code

MSP/Other Payer Involvement
08 - MSP Group Health Plan Insurance
09 - MSP No Fault Insurance
10 - MSP Liability Insurance
11 - MSP, Workers Comp.(Including Black Lung)
12 - Veterans Administration

Miscellaneous
13- Insufficient Documentation
14 - Patient Enrolled in an HMO
15 - Services Not Rendered
16 - Medical Necessity
17 - Other (Please Specify)
_____

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine the amount and reason for overpayment.

3. OTHER

☐ Overpayment Review Request (You must attach the overpayment letter along with a detailed explanation of why you believe the refund was requested in error)

☐ Forgery Allegation: Check # _____ Check Date _____ Check $ _____

☐ Request for an Extended Repayment Schedule (Please attached a copy of the refund request letter)

4. OIG REPORTING REQUIREMENTS:

Do you have a Corporate Integrity Agreement with OIG? _____ Yes _____No

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____ Contractor Deposit Control # _____ Date of Deposit: _____

Contractor Contact Name: _____ Phone #: _____ Fax #: _____

Contractor Address:

INSTRUCTIONS FOR COMPLETING THIS FORM

Quick Status Information: (904) 353-3205 9:00 A.M. - 4:25 P.M.

You may contact the Quick Status Department to obtain general information such as status of checks, reviews and inquiries.

Full Service Information: (904) 634-4994 9:00 A.M. - 4:25 P.M.

You may contact the Full Service Department to obtain the information about overpayment account balances and questions regarding the Financial Services Area.

SECTION 1: This section must be completed for all referrals to the Financial Services Department. Please complete all blocks of information listed.

SECTION 2: Complete this section if you are sending a refund check to Medicare Part B with this form or if you are reporting a Medicare Part B overpayment but are unsure of the amount due Medicare.

WE ENCOURAGE YOU TO MAKE A VOLUNTARY REFUND IF YOU KNOW THE AMOUNT OF THE REFUND DUE MEDICARE. SENDING A VOLUNTARY REFUND WILL HELP YOU AVOID ANY CHANCE OF BEING CHARGED INTEREST AS REQUIRED BY THE HEALTH CARE FINANCING ADMINISTRATION IF A REFUND IS NOT RECEIVED WITHIN 30 DAYS FROM THE DATE OF THE OVERPAYMENT LETTER.

PROPER DOCUMENTATION INDICATING THE SPECIFIC CLAIM BEING REFUNDED AND THE REASON FOR THE REFUND IS REQUIRED IN ORDER TO PROPERLY APPLY YOUR REFUND. IF THIS INFORMATION IS NOT RECEIVED, THE REFUND COULD BE APPLIED TO THE WRONG ACCOUNT. IF YOU ARE SENDING A REFUND FOR MORE THAN ONE CLAIM, COMPLETE THE FINANCIAL SERVICES PHYSICIAN/SUPPLIER SERVICE REQUEST FORM AND SEND A COMPLETE EXPLANATION OF THE REASON FOR THE OVERPAID AMOUNT AND A COPY OF THE PROVIDER REMITTANCE NOTICE (PRN) OR A DETAILED LISTING, THAT INCLUDES THE HEALTH INSURANCE CLAIM NUMBER, DATE OF SERVICE AND AMOUNT OF REFUND, EXPLAINING THE CLAIMS IN WHICH THE OVERPAYMENT APPLIES.

IF YOU HAVE RECEIVED A REQUEST FROM OUR OFFICE FOR A REFUND, YOU SHOULD INCLUDE A COPY OF THE REFUND REQUEST LETTER WITH YOUR REFUND PAYMENT.

SECTION 3: Complete this section if you have received an overpayment letter and disagree with the information in the letter, if you suspect a Medicare B check has been forged or if you believe you qualify to refund your overpayment in installments.

SECTION 4: Complete this section if you have a Corporate Integrity Agreement with the Office of Inspector General (OIG).

A

B

C

C (continued)

D

E

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

E (continued)

F

G

H

I

I (continued)

L

M

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

M (continued)

M (continued)

N

O

P

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

P (continued)

R

S

T

U

V

W

X

Y

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

Y (continued)

Modifiers

Procedure Codes

HCPCS Codes

HCPCS Codes (continued)

Anesthesia/Surgery, 00100-69979

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

Anesthesia/Surgery (continued)

Diagnostic Tests 70010-89399

Diagnostic Tests (continued)

Medicine, 90281-99199

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

Medicine (continued)

Medicine (continued)

Evaluation and Management, 99201-99499

* Special *Updates!*

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

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

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

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B Financial Services
P. O. Box 44141
Jacksonville, FL 32231-0048

DURABLE MEDICAL EQUIPMENT (DME)

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

ELECTRONIC MEDIA CLAIMS (EMC)

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

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

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

MISCELLANEOUS

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

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

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

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

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

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

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

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

PHONE NUMBERS

BENEFICIARY

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

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

PROVIDERS

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

EMC

Format Issues & Testing:
(904) 354-5977
Start-Up & Front-End Edits/Rejects:
(904) 791-8767
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Help Desk
(Confirmation/Transmission):
(904) 905-8880

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

*** ATTENTION BILLING MANAGER***

Bulk Rate
U.S. Postage
PAID
Jacksonville, FL
Permit No. 3996

Medicare Part B Financial Services Department

The Financial Services Department assists physician/suppliers and beneficiaries with the following Medicare Part B correspondence:

Overpayments: Medicare Part B funds received in excess of amounts due and payable.

Refunds: Medicare Part B funds returned due to an overpayment

Forgeries: Alleged fraudulent endorsement (s) of a Medicare Part B check.

Garnishments: A court order which allows creditors of the person in question (known as the debtor) to identify and collect funds owed to the debtor by a third party (known as the garnishee).

Tax Levies: A notification received from the Department of Treasury, Internal Revenue Service (IRS) requesting Medicare Part B to withhold payments toward recovery of a debt owed to the IRS.

Bankruptcies: A court document informing the creditors a certain party has filed for protection under various chapters of bankruptcy.

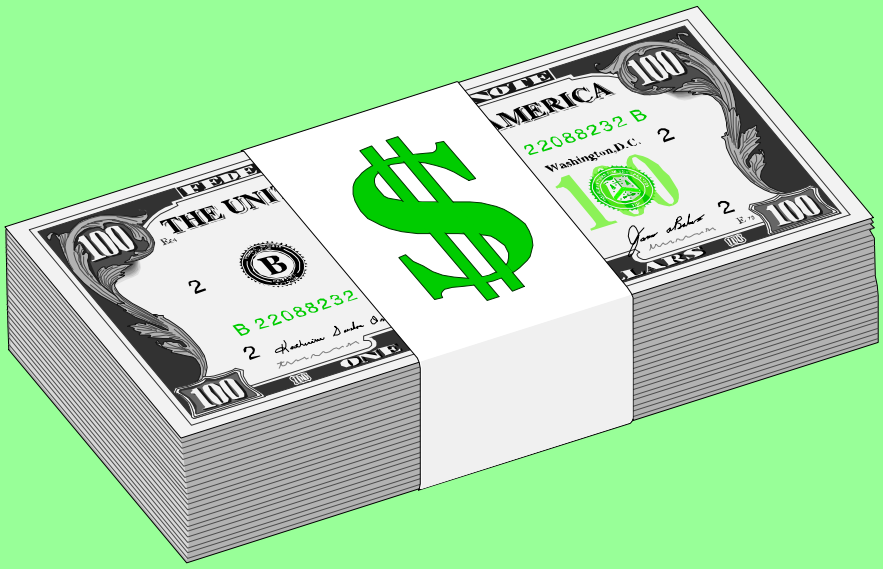
Written Inquiries: questions related to overpayments and other debt collections.

Medicare Part B Financial Services Physician/Supplier Service Request Form

The Financial Services Department Physician/Supplier Service Request Form (pages 78-79) will ensure financial related correspondence and/or refunds are forwarded to the appropriate area for timely resolution. This form may be photocopied, or additional copies may be requested by calling our Provider Customer Service Department. The form should be completed and submitted with any financial related correspondence and/or refund. Mail to:

Medicare Part B
Financial Services Department
P.O. Box 44141
Jacksonville, FL 32231

This pamphlet provides detailed information about the notification and collection of overpayments that are monies owed to Medicare Part B.



NOTE: Physician/suppliers who relocate must timely notify Medicare Registration by using the HCFA 855C (include a copy of your occupational license) to ensure Medicare checks and correspondence are mailed to the correct address the first time. The form should be mailed to:

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

For general questions and other information, physician/suppliers can call Provider Customer Service at (904) 634-4994 (specialty issues) or the Automated Response Unit (ARU) at (904) 353-3205.

Or you may write to our Customer Services Department at the address below:

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

What is an Overpayment?

Overpayments are Medicare funds a physician/supplier or a beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined an overpayment has been made; the amount of the overpayment is a debt owed to the United States government. The following are some examples of overpayments:

- Payment based on a charge that exceeds the fee schedule or reasonable charge (e.g., services which are processed with an incorrect procedure code; thus, the Medicare approved amount is incorrect).
- Duplicate processing of the same charges/claims (e.g., duplicate billing).
- Payment made to incorrect payee.
- Payment for non-covered items/ services or medically unnecessary services.
- Incorrect application of the deductible or coinsurance.
- Payment for items/services provided during a period of patient non-entitlement.
- Claims processed incorrectly by Medicare Part B as the primary payer.

How are Overpayments Detected?

Overpayments are detected in many ways:

- Overpayments can be identified by physicians/suppliers and beneficiaries.
- Overpayments can be identified through the review or hearing process.

- Overpayments can be identified as the result of an investigation of customer complaints or a random sample of physician/supplier billing practices.
- Overpayments can be identified by Federal Agencies (e.g., Health Care Financing Administration, Office of Inspector General, etc.) conducting audits of physician/supplier claims, which may result in the identification of overpayments.

Regardless of how these overpayments are detected, they are referred to the Financial Services Department for collection or resolution

How to Refund Overpayments

Physician/suppliers and beneficiaries occasionally determine overpayments exist before refunds are requested by Medicare Part B. In these instances, voluntary refunds should be made without written overpayment requests.

If a physician/supplier finds that an overpayment exists on all claims associated with their Medicare check, the company check and all Provider Remittance Notices associated with the check should be returned with the completed Financial Services Physician/Supplier Service Request Form.

If an overpayment exists on only one or some of the claims, the physician/supplier should cash the Medicare check and issue a personal check to Medicare for the overpaid amount. Complete the Financial Services Physician/Supplier Service Request Form. Include the reason for the overpaid amount, and a copy of the Provider Remittance Notice or a detailed listing, that includes the health insurance claim number, date of service and amount of refund, for each of the claims in which the overpayment applies.

All physician/supplier and beneficiary overpayments should be refunded to the Financial Services Department. A check in the amount of the overpayment should be made payable to **Medicare Part B** and forwarded to:

Medicare Part B
Financial Services Department
P.O. Box 44141
Jacksonville, FL 32231

Beneficiaries may follow these same instructions. The beneficiary should include the original Medicare check and a copy of the Medicare Summary Notice.

If you receive an overpayment letter:

The overpayment amount should be refunded to Medicare Part B Financial Services within 30 days from the date of the refund request letter.

If you do not make a timely refund:

If you do not refund the overpaid amount within 30 days from the date of the initial refund request letter, we will take the following steps:

- A follow-up letter is sent advising the balance due, interest begins accruing, and offset is initiated.

Interest will accrue at an annual rate specified by law on the outstanding balance. In accordance with the provisions of Section 1833 (j) of the Tax Equity and Fiscal Responsibility Act and 42 CFR 405.376, First Coast Service Options, Inc., is required to charge interest on this account. You will not be assessed any interest if payment is received within 30 days. After this 30-day period, interest will be assessed for the first 30-day period and an additional 30-day period. Interest will continue to accrue for each 30-day period or portion thereof, for which no payment is received. When money is offset (withheld) from your paid claims, it is applied to the accrued interest first and then to the principal.

NOTE: The follow-up letter does not imply that the debtor has another 30-day period to refund the amount due and it does not prevent the withholding of future claim payments after the 30-day period has elapsed

Disagreements with Overpayment Refund Requests

In some cases, a physician/supplier or beneficiary may disagree with the overpayment request (e.g., they do not believe an overpayment exists). In these instances, they should follow the steps for requesting an appeal as outlined in the overpayment refund request letter. Listed below are the general appeal rights:

If the amount of the refund request is under $100 a review may be requested stating the reason for the disagreement. Send the review request to the address referenced in the appeals section of the refund request letter. If the Financial Services Department is referenced, please use the Financial Services Physician/Supplier Service Request form.

If the amount of the refund is $100 or more, a hearing may be requested. You may combine other refund request to meet the $100 or more limit. The address for requesting a hearing is:

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

How to Track Offset Claims

The refund request letters contain a Financial Control Number (FCN). The FCN is used to account for and track monies offset (withheld) from paid claims. The FCN will appear on the Provider Remittance Notice or the Medicare Summary Notice on which the offset (money withheld) was applied. The FCN can then be used to cross-reference the offset claim to the overpayment refund request letter.

Extended Repayment Schedules for Overpayments

The Health Care Financing Administration (HCFA) has established repayment options for debts in excess of $1000.00 for physician/supplier who find it difficult to repay debts to the Medicare program. Requests for extended repayment schedules must be documented in writing to Medicare Part B Financial Services.

Repayment Schedules for 12 Months or Less

The Financial Services Department may approve repayment schedules up to a period of 12 months.

Documentation for this repayment schedule includes:

- A detailed explanation of the problems preventing a lump sum repayment.
- A statement of how much the physician/supplier can pay for each installment and the number of months.
- A Financial Statement of Debtor form (HCFA-379). All blocks on

the HCFA-379 must be completed or must indicate "N/A" (not applicable).
- A copy of the physician/supplier's most recent federal income tax return.

Within 10 to 15 days of the receipt of the request, we will document to the physician/supplier an approval or renegotiate the payment amount. Once the extended repayment schedule is established, the Financial Services Department will provide an amortization schedule based on the approved amount (principal balance and any accrued interest). An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

Repayment Schedules for Longer Than 12 Months

The Financial Services Department does not have the authority to approve an extended repayment schedule longer than 12 months. However, with the proper documentation, the request will be referred.

Requests for extended repayment schedules for longer than 12 months must include extensive and specific financial documentation from the physician/supplier to support the request. The HCFA will make a decision to grant, modify or reject the extended repayment schedule based on the financial documentation submitted with the request.

The documentation required to support a request for an extended repayment schedule for more than 12 months varies. This depends on the debtor's legal identity (as explained below) at the time the overpayment case was established. The Financial Services Department will provide the forms for the documentation upon request.

Sole Proprietors: Sole proprietors (i.e., an individual physician who is not part of a group or individual owner), must complete and submit the following documentation to the Financial Services Department:

- A Financial Statement of Debtor form (HCFA-379). All blocks on the HCFA-379 must be completed or must indicate "N/A" (not applicable).
- A copy of the physician/supplier's most recent federal income tax return.

Entities: Entities (i.e., partnership, group or corporation) must complete and submit the following documentation to the Financial Services department:

- A copy of the federal income tax return for the most recent tax year for both the partnership, group or corporation and the individual debtor or principal owner of the group or corporation.
- A Financial Statement of Debtor form (HCFA-379).
- The most current balance sheet and the balance sheet for the last complete fiscal year.
- The most current income statement and the income statement for the last complete fiscal year.
- A statement of source and application of funds for the period covered by the submitted income statements.
- Cash flow statements for the periods covered by the submitted balance sheets. If the date of request for an extended repayment schedule is more than three months after the date of the most recent balance sheet, a cash flow statement for all months between that date and the date of the request is required.
- A projected cash flow statement covering the remainder of the fiscal year. If fewer than six months remain in the fiscal year, a projected cash flow statement for the following year is required.
- A list of restricted cash funds, by amount, as of the date of the request and the purpose of each.
- A list of investments, by type (stock, bond, etc.,) amount and current market value as of the date of the request.
- A list of notes and mortgages payable by amount as reflected in the balance sheet and their due dates.

An extended repayment period of 12 months or more, the debtor must include at least two letters from separate financial institutions denying the debtor's loan request for the amount of the overpayment. A copy of the loan application(s) is also required.

The financial statements should be completed by the debtor's accountant. The balance sheets and income statements should include the following statements:

Certification by Officer/ Owner of Debtor(s):

"I hereby certify I have examined the balance sheet and income statement prepared by

_____

_____

And to the best of my knowledge and belief, it is true, correct and the complete statement from the books and records of debtor."

Signed

_____

Officer or Owner of Debtor(s)

_____

Title

_____

Date

Misrepresentation or falsification of any information contained in this balance sheet or income statement may be punishable by fine and/or imprisonment under federal law.

Once the Financial Services Department receives all documentation along with requests for extended repayment schedules for longer than 12 months, we prepare the documentation and send our recommendations to the HCFA. The requested repayment schedule is approved, denied or modified by the HCFA. The Financial Services Department is advised of the suggested repayment schedule. When the repayment schedule is established, the Financial Services Department notifies the debtor of the results and sends an amortization schedule based on the approved amount. An explanation of when the payments are due with the appropriate instructions for repayment will also be provided.

If the monthly payments are not received in our office by the due date each month, we will be forced to cancel the extended repayment schedule and begin to withhold your Medicare payments to satisfy the overpayment balance.