Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Important Information for Readers of the *Medicare B Update!*

This issue marks the final publication that will be printed for the remainder of the current fiscal year that ends September 30, 2000. There will not be a printed September/October 2000 issue.

The September/October 2000 edition will be available on our website, **www.floridamedicare.com**. This will allow readers of the *Update!* to access date sensitive information more quickly than is possible via traditionally-published materials.

Effective for fiscal year 2001, the *Update!* will be produced on a quarterly basis. The initial quarterly issue of the *Update!* will be for the first quarter of *calendar year* 2000, and will be available in mid-November. It will provide information that will be effective January 1, 2001, including the 2001 HCPCS changes. The quarterly format *Update!* will be provided to readers approximately forty-five days prior to implementation of HCFA's quarterly system releases. Additionally, the website will be updated throughout the quarter between publications to ensure providers are furnished with the latest information in plenty of time to allow them to make necessary changes.

These "in-between" items will soon be found in a new ***"Hot Topics!"*** section within the Part B Publications area of the website. Information posted to the website in this manner will be provided in the subsequent quarterly issue of the *Update!*

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

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

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

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

A Physician's Focus

"What's New In Medicare?"

Medicare continues to adjust its benefits package to insure appropriate payments for medically necessary services. In an effort to explain coverage and allow Medicare beneficiaries access to the newest technology, President Clinton has directed Medicare to pay for the cost of covered services for Medicare patients enrolled in clinical trials of new drugs and services.

Previously, our policy was to exclude from coverage all services that were "related to" non-covered services (Medicare Carriers Manual, section 2300).

This new directive will make it easier for seniors to participate in trials of the newest technology available. In the past, Medicare patients have sometimes been excluded from such trials due to Medicare's position of not paying for services "related to" noncovered services.

This means that, in the future, Medicare may pay for the cost of doctor's office visits and tests and other care that is needed by patients for their illness, even if they are participating in a clinical study. Medicare would normally cover these costs if the patient were not in a clinical trial. In all likelihood, patients will have to be enrolled in a formal clinical trial in order for Medicare to cover services under this provision. Information on available clinical trials may be obtained by visiting, **www.clinicaltrials.gov**.

Remember that we have not received official notification from HCFA on this clarification. We will be providing official details, as they become available.

Medicare has had a program for coverage of some devices under its Investigational Device Exemption (IDE) program for the past several years. Physicians conducting clinical trials for the Food and Drug Administration (FDA) approved category B devices may receive local carrier coverage by contacting us and providing the following information:

- A copy of their letter assigning them to the approved study.
- Two or three articles from peer reviewed journals indicating some patient benefit from the device (if available).
- A copy of the clinical trial protocol.
- A copy of the approved patient protocol.
- Any letters of endorsement from authorities in the field supporting the clinical benefit of the device.
- Identification of appropriate CPT/HCPCS codes and ICD-9 codes.
- Intended site of service.
- Expected charges.
- Any other pertinent information.

Once we receive the information it usually takes 30-60 days to render a decision. Additional information on these and other Medicare topics can be found by visiting **www.floridamedicare.com** and **www.hcfa.gov**.

Sincerely,

Sidney R. Sewell, MD
Medicare Medical Director

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

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 78).

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

Correct Coding Initiative Version 6.1

Implementation of version 6.1 of the Correct Coding Initiative (CCI) has again been delayed from the originally scheduled date of April 3, 2000. Version 6.1 is effective for services *rendered* on or after June 5, 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) Designation

A comprehensive article on Health Professional Shortage Areas was published in the January/February 2000 *Medicare B Update!* (pages 7-9). Included in that article was a table outlining the complete list of geographic HPSAs for Florida. Since that time, the following change has been made:

> **Effective June 1, 2000, Walton County is being added as a geographic HPSA.**

Walton County is considered a non-metropolitan or rural HPSA; therefore, eligible physicians should bill services rendered on or after June 1, 2000, in Walton County using modifier QB (Physician service rendered in a rural HPSA) to receive the HPSA incentive.

Eligibility

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

Only physicians are eligible for the HPSA incentive payments. The following degrees/credentials are considered physicians eligible for the incentive payments: M.D., D.O., D.C., D.P.M., D.D.S., and O.D. ❖

UPIN Directory on CD-ROM

An article regarding the availability of the UPIN Directory on CD-ROM and how to obtain one was provided in the May/June 2000 *Medicare B Update!* (page 8). Florida Medicare was delivered a limited supply of these CDs, and that supply has now been exhausted. Providers who would still like to obtain a CD-ROM may obtain one by contacting the U.S. Government Printing Office. When ordering from GPO, *there is a $29.00 charge for the UPIN CD* (no shipping or handling charge).

If ordering over the phone - (202) 512-1800 - the Government Printing Office will accept MasterCard, VISA and Discover cards. The items must be paid for when ordering.

To order by mail, write and make check payable to:

Superintendent of Documents
P O Box 371954
Pittsburgh, Pa. 15250-1954
❖

COVERAGE/REIMBURSEMENT

AMBULATORY SURGICAL CENTER

ASC Approved Procedures

The following is a current inclusive list of surgical procedures that may be reimbursed when billed by an Ambulatory Surgical Center (ASC). Facility charges for procedures other than those on the list are not covered by Medicare, although the physician's fee may be payable. The beneficiary is liable for such non-covered facility charges; waiver of liability does not apply.

As a result of the American Medical Association's (AMA) January 1, 2000 update for the Current Physician's Terminology (CPT) book, some codes on the ASC list have been deleted. Replacement codes, where applicable, are added to the ASC list for services furnished on or after January 1, 2000.

Also effective January 1, 2000 added to the ASC list is CPT code 36833 (payment group 4). This addition is the result of a code already on the ASC list (36832) whose description was split by the AMA in the 1999 CPT book. CPT codes 15580 and 15625 are deleted from the ASC list and are not being replaced due to the revised CPT code descriptions.

The first column lists the procedure code and the second column indicates its payment group. Discontinued and replacement codes are identified in **bold** type.

G0105	2	12034	2	15200	3	15756	3	19126	3	20665	1
10180	2	12035	2	15201	2	15757	3	19140	4	20670	1
11042	2	12036	2	15220	2	15758	3	19160	3	20680	3
11043	2	12037	2	15221	2	15760	2	19162	7	20690	2
11044	2	12044	2	15240	3	15770	3	19180	4	20694	1
11404	1	12045	2	15241	3	15840	4	19182	4	20900	3
11406	2	12046	2	15260	2	15841	4	19260	5	20902	4
11424	2	12047	2	15261	2	15842	4	19290	1	20910	3
11426	2	12054	2	15350	2	15845	4	19291	1	20912	3
11444	1	12055	2	15400	2	15920	3	19318	4	20920	4
11446	2	12056	2	15570	3	15922	4	19328	1	20922	3
11450	2	12057	2	15572	3	15931	3	19330	1	20924	4
11451	2	13100	2	15574	3	15933	3	19340	2	20926	4
11462	2	13101	3	15576	3	15934	3	19342	3	20955	4
11463	2	13120	2			15935	4	19350	4	20960	4
11470	2	13121	3	**15580 is deleted due to a change in description**		15936	4	19357	5	20962	4
11471	2	13131	2			15937	4	19364	5	20970	4
11604	2	13132	3			15940	3	19366	5	20972	4
11606	2	13150	3	15600	3	15941	3	19370	4	20973	4
11624	2	13151	3	15610	3	15944	3	19371	4	20975	2
11626	2	13152	3	15620	4	15945	4	19380	5	21010	2
11644	2	13160	2			15946	4	20005	2	21025	2
11646	2	13300	4	**15625 is deleted due to a change in description**		15950	3	20200	2	21026	2
11770	3	14000	2			15951	4	20205	3	21034	3
11771	3	14001	3			15952	3	20206	1	21040	2
11772	3	14020	3			15953	4	20220	1	21041	2
11960	2	14021	3	15630	3	15956	3	20225	2	21044	2
11970	3	14040	2	15650	5	15958	4	20240	2	21050	3
11971	1	14041	3	15700	1	16015	2	20245	3	21060	2
12005	2	14300	4	15710	2	16030	1	20250	3	21070	3
12006	2	14350	3	15720	2	16035	2	20251	3	21100	2
12007	2	15000	2	15732	3	19020	2	20525	3	21206	5
12016	2	15050	2	15734	3	19101	2	20650	3	21208	7
12017	2	15100	2	15736	3	19110	2	20660	2	21209	5
12018	2	15101	3	15738	3	19112	3	20661	3	21210	7
12020	1	15120	2	15740	2	19120	3	20662	3	21215	7
12021	1	15121	3	15750	2	19125	3	20663	3	21230	7

ASC Approved Procedures - continued

21235	7	21555	2	23330	1	24076	2	24560	1	25248	2
21240	4	21556	2	23331	1	24077	3	24565	2	25250	1
21242	5	21600	2	23395	5	24100	1	24566	2	25251	1
21243	5	21610	2	23397	7	24101	4	24575	3	25260	4
21244	7	21620	2	23400	7	24102	4	24576	1	25263	2
21245	7	21700	2	23405	2	24105	3	24577	1	25265	3
21246	7	21720	3	23406	2	24110	2	24579	3	25270	4
21248	7	21725	3	23410	5	24115	3	24582	2	25272	3
21249	7	21800	1	23412	7	24116	3	24586	4	25274	4
21267	7	21805	2	23415	5	24120	3	24587	5	25280	4
21270	5	21810	2	23420	7	24125	3	24600	1	25290	3
21275	7	21820	1	23430	4	24126	3	24605	2	25295	3
21280	5	21920	1	23440	4	24130	3	24615	3	25300	3
21282	5	21925	2	23450	5	24134	2	24620	2	25301	3
21300	2	21930	2	23455	7	24136	2	24635	3	25310	3
21310	2	21935	3	23460	5	24138	2	24655	1	25312	4
21315	2	22100	3	23462	7	24140	3	24665	4	25315	3
21320	2	22101	3	23465	5	24145	3	24666	4	25316	3
21325	4	22102	3	23466	7	24147	2	24670	1	25320	3
21330	5	22103	3	23480	4	24150	3	24675	1	25330	5
21335	7	22305	1	23485	7	24151	4	24685	3	25335	3
21337	2	22310	1	23490	3	24152	3	24800	4	25350	3
21338	4	22315	2	23491	3	24153	4	24802	5	25355	3
21339	5	22325	3	23500	1	24155	3	24925	3	25360	3
21340	4	22326	3	23505	1	24160	2	25000	3	25365	3
21343	5	22327	3	23515	3	24164	3	25020	3	25370	3
21355	3	22328	3	23520	1	24201	2	25023	3	25375	4
21360	4	22505	2	23525	1	24301	4	25028	1	25390	3
21365	5	22900	4	23530	3	24310	3	25031	2	25391	4
21385	5	23000	2	23532	4	24320	3	25035	2	25392	3
21386	5	23020	2	23540	1	24330	3	25040	5	25393	4
21387	5	23030	1	23545	1	24331	3	25065	1	25400	3
21390	7	23035	3	23550	3	24340	3	25066	2	25405	4
21395	7	23040	3	23552	4	24342	3	25075	2	25415	3
21400	2	23044	4	23570	1	24350	3	25076	3	25420	4
21401	3	23065	1	23575	1	24351	3	25077	3	25425	3
21406	4	23066	2	23585	3	24352	3	25085	3	25426	4
21407	5	23075	2	23600	1	24354	3	25100	2	25440	4
21421	4	23076	2	23605	2	24356	3	25101	3	25441	5
21422	5	23077	3	23615	4	24360	5	25105	4	25442	5
21440	3	23100	2	23616	4	24361	5	25107	3	25443	5
21445	4	23101	7	23620	1	24362	5	25110	3	25444	5
21450	3	23105	4	23625	2	24363	7	25111	3	25445	5
21451	4	23106	4	23630	5	24365	5	25112	4	25446	7
21452	2	23107	4	23650	1	24366	5	25115	4	25447	5
21453	3	23120	5	23655	1	24400	4	25116	4	25449	5
21454	5	23125	5	23660	3	24410	4	25118	2	25450	3
21461	4	23130	5	23665	2	24420	3	25119	3	25455	3
21462	5	23140	4	23670	3	24430	3	25120	3	25490	3
21465	4	23145	5	23675	2	24435	4	25125	3	25491	3
21470	5	23146	5	23680	3	24470	3	25126	3	25492	3
21480	1	23150	4	23700	1	24495	2	25130	3	25505	1
21485	2	23155	5	23800	4	24498	3	25135	3	25515	3
21490	3	23156	5	23802	7	24500	1	25136	3	25520	1
21493	3	23170	2	23921	3	24505	1	25145	2	25525	4
21494	4	23172	2	23930	1	24515	4	25150	2	25526	5
21495	4	23174	2	23931	2	24516	4	25151	2	25535	1
21497	2	23180	4	23935	2	24530	1	25170	3	25545	3
21501	2	23182	4	24000	4	24535	1	25210	3	25565	2
21502	2	23184	4	24065	1	24538	2	25215	4	25574	3
21510	3	23190	4	24066	2	24545	4	25230	4	25575	3
21550	1	23195	5	24075	2	24546	5	25240	4	25605	3

ASC Approved Procedures - continued

25611	3	26261	3	26536	5	26992	2	27372	7	27607	2
25620	5	26262	2	26540	4	27000	2	27380	1	27610	2
25624	2	26320	2	26541	7	27001	3	27381	3	27612	3
25628	3	26350	1	26542	4	27003	3	27385	3	27613	1
25635	1	26352	4	26545	4	27030	3	27386	3	27614	2
25645	3	26356	4	26548	4	27033	3	27390	1	27615	3
25660	1	26357	4	26550	2	27035	4	27391	2	27618	2
25670	3	26358	4	26551	4	27040	1	27392	3	27619	3
25675	1	26370	4	26553	2	27041	2	27393	2	27620	4
25676	2	26372	4	26554	2	27047	2	27394	3	27625	4
25680	2	26373	3	26555	3	27048	3	27395	3	27626	4
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26070	2	26474	2	26685	3	27250	1	27443	5	27691	4
26075	4	26476	1	26686	3	27252	2	27500	1	27692	3
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26123	4	26492	3	26765	4	27310	4	27513	5	27715	4
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26130	3	26496	3	26785	2	27320	2	27517	1	27732	2
26135	4	26497	3	26820	5	27323	1	27520	1	27734	2
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26145	3	26499	3	26842	4	27327	2	27530	1	27742	2
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26205	3	26510	3	26860	3	27333	4	27552	1	27758	4
26210	2	26516	1	26861	2	27334	4	27560	1	27759	4
26215	3	26517	3	26862	4	27335	4	27562	1	27760	1
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ASC Approved Procedures - continued

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ASC Approved Procedures - continued

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ASC Approved Procedures - continued

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56301 is deleted. To report use 58670 3

56302 is deleted. To report use 58671 3

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56317 is deleted. To report use 49651 7

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56351 is deleted. To report use 58558 3

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62274 is deleted. To report use 62310 1 *or* 62311 1

62275 is deleted. To report use 62310 1

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62276 is deleted. To report use 62319 1

62277 is deleted. To report use 62318 1 *or* 62319 1

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62279 is deleted. To report use 62319 1

62280 1
62282 1

62288 is deleted. To report use 62310 1 *or* 62311 1

62289 is deleted. To report use 62311 1

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ASC Approved Procedures - continued

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64443 is deleted. To report use 64476 1

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DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND ORTHOTICS

Carrier Jurisdiction List for Durable Medical Equipment, Prosthetic and Orthotic Devices (DMEPOS)

The following table contains an updated list of the codes for Durable Medical Equipment Regional Carrier (DMERC) and local carrier jurisdictions, effective for services rendered on or after July 1, 2000. Note that some codes have been added or discontinued for this year for this list. Refer to the December 1999 *Special Issue Update!—2000 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update* for more information regarding new and discontinued codes. Note also that inclusion of a code on this list does not imply coverage (e.g., codes A4260 and A4261 are noncovered).

CODE	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4210	Needle Free Injection Device	DME REGIONAL Carrier
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical , Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4253 - A4259	Blood Glucose Test; Lancets; Calibrator Solution	DME REGIONAL Carrier
A4260	Levonorgestrel Implant	Local Carrier
A4261	Cervical Cap for Contraceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier

DMEPOS Jurisdiction List - continued

A4310 - A4335	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4338	Indwelling Catheter, Foley Type	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4340	Indwelling Catheter, Specialty Type	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4344 - A4346	Indwelling Catheter, Foley Type	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4347 - A4359	Incontinence/Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4361 - A4421	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4454	Tape	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4455	Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4460	Elastic Bandage	Local Carrier if incident to a physician's service (not separately payable). If secondary surgical dressing, DME REGIONAL Carrier. (See MCM 2079)
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier

DMEPOS Jurisdiction List - continued

A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Thracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4560 - A4572	Pessary; Sling; Splint; Rib Belt	DME REGIONAL Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	Local Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME Regional Carrier
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4646	Imaging Agent; Contrast Material	Local Carrier
A4647	Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4650 - A4705	Supplies for ESRD	DME REGIONAL Carrier
A4712	Water, Sterile	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4714 - A4927	Supplies for ESRD	DME REGIONAL Carrier
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier

DMEPOS Jurisdiction List - continued

A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A5500 - A5508	Therapeutic Shoes	DME REGIONAL Carrier
A6020	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A6025	Silicone Gel Sheet	DME REGIONAL Carrier
A6154 - A6406	Surgical Dressing	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
A7000 - A7017	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier
A9160 - A9170	Administrative, Miscellaneous, and Investigational	Local Carrier
A9190 - A9270	Noncovered Items or Services	Local Carrier or DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9605	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
A9901	Delivery	DME REGIONAL Carrier
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0116	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier
E0176 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0241 - E0246	Bath and Toliet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0297	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier
E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heel Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0480	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier

DMEPOS Jurisdiction List - continued

E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier
E0600 - E0606	Suction Pump/Room Vaporizers	DME REGIONAL Carrier
E0607 - E0609	Monitoring Equipment	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0621 - E0635	Patient Lifts	DME REGIONAL Carrier
E0650 - E0673	Pnuematic Compressor and Appliances	DME REGIONAL Carrier
E0690	Ultraviolet Cabinet	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulator	Local Carrier
E0751 - E0753	Implantable Nerve Stimulator	Local Carrier
E0755 - E0776	Stimulator; Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier
E0785	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0948	Trapeze Equipment	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier
E1353 - E1385	Additional Oxygen Related Equipment	DME REGIONAL Carrier

DMEPOS Jurisdiction List - continued

E1390	Oxygen Concentrator	DME REGIONAL Carrier
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier
E1405 - E1406	Additional Oxygen Equipment	DME REGIONAL Carrier
E1510 - E1699	Artificial Kidney Machines and Accessories	DME REGIONAL Carrier
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1830	Dynamic Flexion Devices	DME REGIONAL Carrier
E1900	Speech Augmentation Communication Devices	DME REGIONAL Carrier
G0001 - G0148	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7190 - J7192	Factor VIII	Local Carrier
J7194	Factor IX	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300	Intrauterine Copper Contraceptive	Local Carrier
J7310	Ganciclouir	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7315 - J7320	Injection	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7608 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
J7799	NOC, Other than Inhalation Drugs through DME	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemotherapeutic	DME REGIONAL Carrier
J8510 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0112 - K0116	Spinal Orthotics	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0268	Humidifier	DME REGIONAL Carrier
K0269	Aerosol Compressor	DME REGIONAL Carrier

DMEPOS Jurisdiction List - continued

K0270	Ultrasonic Generator	DME REGIONAL Carrier
K0280 - K0281	Ostomy & Urological Supplies	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
K0283	Saline Solution, Metered Dose	DME REGIONAL Carrier
K0407 - K0411	Urologicals	DME REGIONAL Carrier
K0415 - K0416	Antiemetic Drugs	DME REGIONAL Carrier
K0440 - K0451	Maxillofacial Prosthesis	DME REGIONAL Carrier
K0452	Wheelchair Bearings	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0456 - K0459	Heavy Duty Equipment	DME REGIONAL Carrier
K0460 - K0461	Power Add-on Converters for Wheelchairs	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0501	Aerosol Compressor	DME REGIONAL Carrier
K0529	Nebulizer Supply - Water/Solution	DME REGIONAL Carrier
K0531	Accessory for Respiratory Assist Device	DME REGIONAL Carrier
K0532 - K0534	Respiratory Assist Device	DME REGIONAL Carrier
L0100 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME REGIONAL Carrier
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8490	Prosthetics	DME REGIONAL Carrier
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME REGIONAL Carrier
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier
M0064 - M0302	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0034 - Q0035	Influenza Vaccine; Cardio-kymography	Local Carrier
Q0068	Extracorporeal Plasmapheresis	Local Carrier
Q0081	Infusion Therapy	Local Carrier

DMEPOS Jurisdiction List - continued

Q0082	Activity Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy	Local Carrier
Q0086	Physical Therapy Evaluation/Treatment	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0132	Dispensing Fee - Nebulizer Drug	DME REGIONAL Carrier
Q0136	Injection, Epoetin Alpha	Local Carrier
Q0144	Arithromycin Dihydrate	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
Q0156 - Q0161	Albumin	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
Q0163 - Q0181	Anti-emetic	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
Q0183 - Q0185	Artificial Skin	Local Carrier
Q0186	Paramedic Intercept	Local Carrier
Q0187	Factor VIIa	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
Q9920 - Q9940	Injection of EPO	DME REGIONAL Carrier when self-administered or for Method II beneficiaries, otherwise Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME REGIONAL Carrier
V2781	Progressive Lens	DME REGIONAL Carrier
V2785	Processing—Corneal Tissue	Local Carrier
V2799	Miscellaneous Vision Service	DME REGIONAL Carrier
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME REGIONAL Carrier
V5362 - V5364	Speech Screening	Local Carrier ❖

Updated Allowances for Local Carrier Jurisdiction DMEPOS Services

The following changes are effective for services processed on or after April 3, 2000:

CODE	DESCRIPTION	ALLOWANCE
E0751	Implantable Neurostimulator	$5678.88
E0753	Implantable Neurostimulator Electrodes	$1323.96
L8600	Implantable Breast Prosthesis	$472.94 ❖

HEMATOLOGY/ONCOLOGY

Pancreas Transplants—Revision to Effective Date

The national coverage policy for Pancreas Tranplantation was published in the May/June 2000 *Update!* (page 10), with an effective date of April 1, 2000. The effective was delayed after publication of the May/June issue; the policy is effective for services rendered on or after **June 5, 2000**. ❖

INFLUENZA/PPV VACCINES

Pneumococcal Pneumonia Virus Vaccines

Effective for claims with dates of service on or after July 1, 2000, the requirement that the pneumococcal pneumonia vaccine (PPV) be ordered by a physician who is a doctor of medicine or osteopathy has been eliminated. Thus, on and after that date, a beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. The requirement to provide the beneficiary with a record of his/her vaccination is eliminated as well. Additionally, for services rendered on or after July 1, 2000, the requirement to enter the UPIN in Item 17A of the form HCFA-1500 for PPV claims has also been eliminated.

More information concerning PPV vaccines, including simplified roster billing, may be found in the September/October 1999 *Medicare B Update!* (pages 6-14). ❖

Centralized Billing by Mass Immunizers for Influenza and PPV Vaccines

Centralized billing is a process in which a provider, who is a mass immunizer for influenza and Pneumococcal (PPV) immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations will be reimbursed per the Medicare Physician Fee Schedule for the appropriate locality. The vaccines will be reimbursed at the standard method used by Medicare for reimbursement of drugs and biologicals, which is based on the lower of cost or 95 percent of the Average Wholesale Payment (AWP).

Multi-state mass immunizers interested in centralized billing must contact HCFA central office (CO), in writing, at the following address by April 1 of the year they wish to begin centrally billing. **For the season that begins in October 2000, the deadline will be extended through July 21, 2000.**

Division of Practitioner Claims Processing
Provider Billing and Education Group
Health Care Financing Administration
7500 Security Boulevard
Mail Stop C4-11-27
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria. In addition, in order to continue participation in the program, providers who have participated in past seasons will also be required to abide by the revised criteria.

Criteria for Centralized Billing

- To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.
- Multi-state mass immunizers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration).

Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries can not be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.

- The carrier assigned to process the claims for centralized billing will be chosen at the discretion of HCFA based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance.
- The payment rates for the administration of the vaccinations will be based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, the multi-state mass immunizer must be willing to accept that payments received may vary based on the geographic locality where the service was performed.
- The payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals which is based on the lower of cost, or 95 percent of the AWP.
- Multi-state mass immunizers must agree to submit their claims in an Electronic Media Claims standard format using either the National Standard Format (NSF) or American National Standards Institute (ANSI) X12.837 format. Paper claims will not be accepted.
- In addition to the roster billing instructions found in the Medicare Carriers Manual section 4480.6, *Simplified Roster Bills*, multi-state mass immunizers must complete on the electronic format the area that corresponds to Item 32, (Name and Address of Facility) on Form HCFA-1500, in order for the carrier to be able to pay correctly by geographic locality. This would be the BA0 record of the NSF or the NM1, N2 and N3 segments of the ANSI format.
- Multi-state mass immunizers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. The assigned Medicare carrier must be contacted prior to the season for exact requirements. The responsibility lies with the multi-state mass immunizer to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the carrier will not be able to process incomplete or incorrect claims.
- Multi-state mass immunizers must obtain an address for each beneficiary so that an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an EOMB or MSN from a carrier other than the carrier that normally processes their claims, which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, multi-state mass immunizers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the carrier selected by HCFA. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Multi-state mass immunizers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. The Medicare carrier selected to process the claims can provide this information.
- Though multi-state mass immunizers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the carrier selected by HCFA to process the flu and PPV claims. This can be done by completing Form HCFA-855 (Provider Enrollment Application) which can be obtained from that carrier.
- If a multi-state mass immunizer's request for centralized billing is approved, the approval is limited to the upcoming flu season. It is the responsibility of the multi-state mass immunizers to reapply to HCFA CO for approval each year by April 1 for the year prior to the beginning of the flu season for which they wish to bill. Claims submitted without approval will be denied.
- Each year the multi-state mass immunizers must contact the assigned carrier to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
- The multi-state mass immunizer will be responsible for providing the beneficiary with a record of the PPV vaccination.

The information requested in items one through six below must be included with the multi-state mass immunizer's annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;
2. Estimates for the number of beneficiaries who will receive PPV vaccinations;
3. The approximate dates for when the vaccinations will be given;
4. A list of the states in which flu and PPV clinics will be held;
5. The type of services generally provided by your corporation (e.g., ambulance, home health, or visiting nurse); and
6. Whether the nurses who will administer the flu and PPV vaccinations are employees of your corporation or will be hired by your corporation specifically for the purpose of administering flu and PPV vaccinations.

TrailBlazer Health Enterprises has been designated the sole carrier for the payment of flu and PPV claims for multi-state centralized billers beginning October 1, 2000. For more information, contact TrailBlazer at:

TrailBlazer Health Enterprises
P.O. Box 660160
Dallas, TX 75266-0160

TrailBlazer may be visited on the Web at **www.the-medicare.com**, or from a link at the HCFA website, **www.hcfa.gov**. ❖

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INJECTABLE DRUGS

Allowances for Injectable Drugs

Medicare Part B allowances for certain injectable drugs have been updated, effective for services processed on or after April 3, 2000. The new allowances are:

CODE	NAME OF INJECTABLE DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J0170	Injection, Adrenalin, epinephrine, up to 1 ml ampule	$1.55	$1.47	$1.69
J0200	Injection, alatrofloxacin mesylate, 100 mg	$18.01	$17.11	$19.68
J0456	Injection, azithromycin, 500 mg	$23.22	$22.06	$25.37
J0635	Injection, calcitriol, 1 mcg ample	$13.21	$12.55	$14.43
J0696	Injection, ceftriaxone sodium, per 250 mg	$14.06	$13.36	$15.36
J0740	Injection, cidofavir, 375 mg	$763.80	$725.61	$790.87
J1260	Injection, Dolasetron Mesylate, 10 mg	$15.81	$15.02	$17.27
J1438	Injection, etanercept, 25 mg	$134.41	$127.69	$146.84
J1440	Injection, filgrastim (G-CSF), 300 mcg	$171.38	$162.81	$187.23
J1441	Injection, filgrastim (G-CSF), 480 mcg	$273.03	$259.38	$284.80
J1650	Injection, enoxaparin sodium, 10 mg	$5.53	$5.25	$6.04
J1960	Injection, levorphanol tartrate, up to 2 mg	$3.76	$3.57	$4.11
J1980	Injection, hyoscyamine sulfate, up to 0.25 mg	$6.38	$6.06	$6.97
J2430	Injection, pamidronate disodium, per 30 mg	$253.20	$240.54	$276.62
J2995	Injection, streptokinase, per 250,000 iu *(effective 6/5/2000)*	$115.64	$109.86	$126.34
J3240	Injection, thyrotropin alfa, 0.9 mg	$494.00	$469.30	$539.70
J3250	Injection, trimethobenzamide HCl, up to 200 mg	$3.04	$2.89	$3.32
J3265	Injection, torsemide, 10 mg/ml	$1.94	$1.84	$2.07
J3360	Injection, diazepam, up to 5 mg	$1.42	$1.35	$1.86
J3470	Injection, hyaluronidase, up to 150 units	$16.87	$16.03	$9.27
J7516	Cyclosporin, parenteral, 250 mg	$25.08	$23.83	$27.40
J7517	Mycophenolate mofetil, oral, 250 mg	$2.20	$2.09	$2.40
J9015	Aldesleukin, per single use vial	$612.75	$582.11	$669.43
J9045	Carboplatin, 50 mg	$103.84	$98.65	$113.45
J9170	Docetaxel, 20 mg	$283.65	$269.47	$309.89
J9185	Fludarabine phosphate, 50 mg	$237.02	$225.17	$258.94
J9340	Thiotepa, 15 mg	$107.31	$101.94	$117.24
J9350	Topotecan, 4 mg (Hycamtin)	$602.44	$572.32	$658.17
J9355	Trastuzumab, 10 mg	$51.29	$48.73	$56.03
J9600	Porfimer sodium 75 mg	$2,603.66	$2,473.48	$2,844.50
Q0136	Injection Epoetin Alpha, (for non ESRD use), per 1000 units	$11.84	$11.84	$11.84

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

NEPHROLOGY

Live Kidney Donor (Modifier Q3)

Information concerning proper billing of modifier Q3 originally appeared in the May/June 1996 Medicare B Update! *(page 33).*

Modifier Q3 should be used to report all services associated with postoperative medical complications directly related to a live kidney donation**.** Physician services provided to a live donor must be submitted to Medicare Part B using the **recipient's** name and Medicare number. Postoperative physician services provided to a living donor are paid at 100 percent of the allowed amount.

HCPCS Modifier

Q3 Live kidney donor: services associated with postoperative complications directly related to the donation

Billing Guidelines

Patient A receives a kidney removed from **Patient B**.

For **Patient B**, the donor, the provider should submit procedure code 50320 (Donor nephrectomy from living donor) with modifier Q3. **All services related to the nephrectomy should be billed with modifier Q3 and should be submitted under Patient A's name and Medicare number.**

For **Patient A**, the recipient, the provider should bill the appropriate CPT code for the kidney transplantation.

RADIOLOGY

Revised Allowances for Portable X-Ray Services

Effective for services processed on or after June 19, 2000, allowances for portable X-ray services have been increased. The new amounts are:

PROC	DESCRIPTION	PAR ALLOWANCE	NONPAR ALLOWANCE	LIMITING CHARGE
R0070	transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen	$78.00	$74.10	$85.21
R0075	transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, per patient	$78.00	$74.10	$85.21

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.

LMRP Format

The LMRP format is now more consistent with the manner in which the carrier reports LMRPs to the Health Care Financing Administration (HCFA). Information now provided in the *Update!* includes (where applicable) HCFA's national coverage policy, the sources of information used in developing local policy, and the policy's revision history.

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).

More Information

Additional LMRPs may be obtained by accessing Florida Medicare's provider website at **www.floridamedicare.com**.❖

Medical Policy Table of Contents

The List of Medicare Noncovered Services

Addition to Policy

The following addition to **Local Noncoverage** is effective August 21, 2000:

Circulator Boot System - The circulator boot is a system of equipment used in the treatment of arterial diseases in the leg. The equipment includes a heart monitor to detect the QRS complex of the EKG, a rapid action valve for pressurizing and exhausting the boots, adjustable boot or miniboot to enclose the leg from the groin to the toes, and disposable double-walled plastic bags to enclose the leg. The circulator boot system is designed to compress chosen portions of the leg in the end-diastolic portion of the heart cycle in a series of treatments, each lasting approximately 40 minutes.

The circulator boot system uses timed compression based on the patient's heart cycle. This same method is utilized for a nationally covered treatment called External Counterpulsation (ECP). According to section 35-74 of the Coverage Issues Manual, "these and similar devices are cleared by the FDA for use in treating a variety of conditions…Medicare coverage is limited to its use in patients with stable angina." In addition, the Coverage Issues Manual also states that "other uses of this device and similar devices remain noncovered."

The information on the circulator boot system indicates that this device is similar to ECP. The compression of the leg boot is based on synchronization with the patient's cardiac cycle. Based on the statement in the Coverage Issues Manual, it has been determined that the circulator boot system is a noncovered service by Medicare.

This procedure should be billed using procedure code A9270 (noncovered item or service).

The List of Medicare Noncovered Services - continued

Correction to Previously Published Policy

The May/June 2000 *Medicare B Update!* (page 16) indicated several changes to the noncoverage policy. The effective dates for some of these changes were inadvertently omitted from that article.

Under the heading of **Local Noncoverage**, the following changes are effective for services processed on or after June 19, 2000:

- Arthroscopic Laser Arthrodesis (A9270*)
- In Vitro Chemosensitivity and/or Resistance Assays (A9270*)
- Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., spring-wound catheter) including radiologic localization (includes contrast when administered) (62263*)
- Homocysteine Testing for Cardiovascular Risk Screening (A9270)

Under the heading of **National Noncoverage**, the reason for noncoverage of these services was omitted. These services are noncovered due to being investigational/experimental; they have been noncovered nationally since January 1, 1994.

- Brain Imaging Positron Emission Tomography (PET) Scans (CPT codes 78608* and 78609*)

For more information concerning noncoverage, refer to the March/April 2000 *Update!* (pages 19-23).

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

Independent Diagnostic Testing Facility (IDTF)

The local medical review policy (LMRP) for IDTFs was published in its entirety in the May/June 2000 *Medicare B Update!* (pages 22-38). Since that time, the following changes have been made to the policy:

- The statement indicating that the carrier would allow up to one year from the date the applicant enrolled as an IDTF to obtain applicable certification/licensure was deleted. Florida Medicare now requires that all IDTF applicants meet the credentialing criteria as outlined in the policy on the date the applicant enrolls as a new IDTF.
- The credentialing requirements for procedure codes 76511-76519 have been revised and are as follows:

CPT-4 CODE (S)	CERTIFICATION
76511-76513, 76529	ARDMS: RDMS-Ophthalmology JCAHPO: COA, COT, COMT
76516-76519	ARDMS: ROUB, RDMS-Ophthalmology JCAHPO: COA, COT, COMT

- The statement indicating that documentation must support when the technician is obtaining clinical experience prior to taking the certification examination and when the expected training will be completed has been deleted from the "Documentation Requirements" section of the policy.

Effective Date

These changes are effective for services processed on or after August 21, 2000.

Advance Notice Statement

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

Medical Policy Procedures: A0320

Policy Number
A0320

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Ground Ambulance Services

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Sections 2120.1-2124.H, 2125, 3102, 5116, 5215
Program Memorandum, B-00-09 (change request 1065)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
06/16/1997

A0320 - continued

Revision Effective Date
08/21/2000

Revision Ending Effective Date
08/20/2000

Policy Ending Date
N/A

LMRP Description
The Medicare program includes an ambulance benefit. Covered services may be provided either by a freestanding ambulance supplier or a participating Part A provider such as a hospital or skilled nursing facility. Three basic requirements must be met for ambulance services to be covered:

The ambulance and crew must meet specific requirements outlined in the Medicare Carrier Manual.

The transportation must be medically reasonable and necessary as outlined in the Medicare Carrier Manual.

This requires that other means of transportation be medically contraindicated, in other words, that the patient cannot be safely transported by any other means.

The origin and destination requirements outlined in the Medicare Carriers Manual must be met.

Indications and Limitations of Coverage and/or Medical Necessity
Situations in which a patient is considered to be in a life threatening/acute condition or not able to be safely transported by other than an ambulance cannot be exhaustively defined. Nor can these "conditions" be represented accurately by the current ICD-9-CM diagnosis coding structure. Therefore, the conditions and ICD-9-CM diagnosis codes listed below are used as examples to assume that the patient meets the above coverage requirements during routine claims processing.

The Carrier reserves the right to validate coverage based on the narrative description of the patient's condition and pertinent physical objective findings of the crew's patient assessment on a pre or post payment basis, whenever it deems necessary, to ensure appropriate payments.

Some of the most common situations which suggest transportation by ambulance would be medically indicated are listed below. Additionally, a listing of ICD-9-CM codes is given upon which the Carrier will presume medical necessity is met on a *prepayment* basis. In no case will transportation be reimbursed if the patient could have been transported by any other means.

- The patient's condition necessitated emergency care and resulted from an acute injury or illness in which the patient was left in an unstable condition. Examples include a patient that has had a major bone compound fracture where bleeding and signs of shock are present, a patient who has suffered a serious cardiac event where blood pressure and pulse are unstable, and a patient who has suffered multiple trauma, and a spinal cord injury is suspected.
- The patient needed to be restrained to prevent injury to himself or others (e.g., combative, abusive, convulsive).
- The patient was unconscious, unable to respond to stimuli.
- The patient was in shock as evidenced by some of the following signs and symptoms secondary to the patient's condition: blood pressure of less than 90/60, pulse >100 or <45, respirations greater than 24, significant changes in mental status, cold and/or cyanotic skin, excessive perspiration.
- Emergency measures or treatment were required (e.g., administration of emergency drugs, cardiopulmonary resuscitation, continuous cardiac monitoring).
- The patient required IV fluids to maintain adequate blood pressure (e.g., dehydration, bleeding, cardiac arrhythmias, etc.) or an access line was established to administer emergency medication(s).
- The patient's acute condition required oxygen as part of the emergency treatment procedures enroute to destination (this does not include patients who already require oxygen therapy on an ongoing basis to manage an existing condition).
- The patient required immobilization to prevent further injury of a fracture or possible fracture or was in a condition that movement by any other means of transportation would potentially make the condition worse.
- The patient has sustained an acute stroke or myocardial infarction (this does not include patients who have a history of stroke or myocardial infarction and are able to be transported by other means because no acute medical condition exists).
- The patient was experiencing symptoms indicative of a possible myocardial infarction or stroke.
- The patient has or was experiencing a severe hemorrhage.
- The patient is bed confined (definition of bed confined must be met).

Bed Confined
The patient's condition must be documented to include the reason why the patient was bed confined. Bed confined is defined as unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. Bed confined is not synonymous with nonambulatory since the paraplegic or quadriplegic is nonambulatory but spends significant time in a wheelchair. Bed confined is also not equivalent to bedrest, which is a recommended state of affair that does not exclude an occasional ambulation to the commode or chair.

The patient's condition was such that the patient could be moved *only by stretcher* and any other method of transport would result in injury or would be detrimental to the patient's health.

A0320 - continued

Physician Certification

In addition to the above indications, the final rule as published in the January 25, 1999 Federal Register states that ambulance suppliers must obtain a physician's written order certifying the need for scheduled and unscheduled nonemergency ambulance service. In addition to the physician's signature, it is acceptable to obtain signed certification statements when professional services are furnished by physician assistants, nurse practitioners, or clinical nurse specialists (where all applicable State licensure or certification requirements are met).

The physician's certification must be dated no more than 60 days prior to the date that the service is provided. In cases where a beneficiary requires a nonemergency, unscheduled transport, the physician's certification can be obtained 48 hours after the ambulance transportation has been provided. Ambulance suppliers are required to retain the certificate on file and, upon request, present the requested certification. This requirement applies to both repetitive and one-time ambulance transports.

Ambulance suppliers should obtain the signed certification statement prior to the transport. However, there may be instances in which ambulance suppliers have provided transports but are experiencing difficulty in obtaining the required physician certification statement. The guidelines for obtaining the physician certification statement and required steps in obtaining this certification are contained in Program Memorandum B-00-09 (Change request 1065, dated February, 2000) with further clarification published in the March/April 2000 *Medicare B Update!* (pages 12-14).

NOTE: A physician's certification is not required for nonemergency, unscheduled transportation of beneficiaries residing at home or in facilities where they are not under the direct care of a physician. These situations should be rare because most transports occur for beneficiaries receiving dialysis or diagnostic tests.

HCPCS Section & Benefit Category

Ambulance

HCPCS Codes

A0320	Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed
A0322	Ambulance service, BLS, emergency transport, supplies included, mileage separately billed
A0324	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed
A0326	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed
A0328	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed
A0330	Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed
A0380	BLS mileage (per mile)
A0390	ALS mileage (per mile)
A0420	Ambulance waiting time (ALS or BLS), one – half (1/2) hour increments

Waiting Time Table

Units	Time
1	½ to 1 hour
2	1 to 1 ½ hours
3	3 ½ to 2 hours
4	2 to 2 ½ hours
5	2 ½ to 3 hours
6	3 to 3 ½ hours
7	3 ½ to 4 hours
8	4 to 4 ½ hours
9	4 ½ to 5 hours
10	5 to 5 ½ hours

A0424	Extra ambulance attendent, ALS or BLS (requires medical review)
A0999	Unlisted ambulance service

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

205.20-250.23	Diabetes with hyperosmolarity (severe diabetic complication)
250.30-250.33	Diabetes with other coma
251.0	Hypoglycemic coma
255.4	Corticoadrenal insufficiency
293.0	Acute delirium
298.8	Other and unspecified reactive psychosis (psychosis requiring restraints)
345.3	Grand mal status
410.00-410.92	Acute myocardial infarction
411.0-411.89	Other acute and subacute forms of ischemic heart disease
413.0-413.9	Angina pectoris
414.10-414.19	Aneurysm of heart
415.11-415.19	Pulmonary embolism and infarction
426.0-426.9	Conduction disorders
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure (severe)
430-434.91, 436	Cerebrovascular disease (severe cerebral vascular problems)
441.00-441.9	Aortic aneurysm and dissection
442.0-442.9	Other aneurysm
493.01, 493.11, 493.21, 493.91	Asthma with status asthmaticus
518.0	Pulmonary collapse
518.4	Acute edema of lung, unspecified
518.5	Pulmonary insufficiency following trauma and surgery
518.81	Acute respiratory failure
518.82	Other pulmonary insufficiency, not elsewhere classified
519.00-519.09	Tracheostomy complications
531.00-531.21, 531.40-531.61, 532.00-532.21, 532.40-532.61, 533.00-533.21, 533.40-533.61, 534.00-534.21, 534.40-534.61, 535.01, 535.11, 535.21, 535.31, 535.41, 535.51, 535.61	Diseases of esophagus, stomach, and duodenum (severe gastrointestinal complication)

A0320 - continued

578.9	Hemorrhage of gastrointestinal tract, unspecified
669.10-669.14	Shock during or following labor and delivery
669.90-669.94	Unspecified complication of labor and delivery
719.49	Pain in joint, multiple sites (severe joint pain causing immobility)
780.01	Coma
780.2	Syncope and collapse
780.31-780.39	Convulsions
785.50-785.59	Shock without mention of trauma
786.09	Other symptoms involving respiratory system and other chest symptoms (severe respiratory distress)
786.50-786.59	Chest pain
789.00-789.09	Abdominal pain (severe)
799.0	Asphyxia
799.1	Respiratory arrest
800.00-804.99	Fracture of skull
805.00-809.1	Fracture of neck and trunk
820.00-823.92	Fracture of femur, patella, tibia, and fibula
835.00-835.13	Dislocation of hip
850.1-854.19	Intracranial injury, excluding those with skull fracture
860.0-869.1	Internal injury of thorax, abdomen, and pelvis
871.0-871.9	Open wound of eyeball
925.1-929.9	Crushing injury
948.00-948.99	Burns classified according to extent of body surface involved
952.00-952.9	Spinal cord injury without evidence of spinal bone injury
958.4	Traumatic shock
959.01-959.3, 959.6-959.8	Injury, other and unspecified (severe injuries to include those with open fractures, unstable fractures where movement could result in further injury, moderate to heavy bleeding, traumatic amputations, incapacitating pain)
960.0-979.9	Poisoning by drugs, medicinal, and biological substances
980.0-989.9	Toxic effects of substances chiefly nonmedicinal as to source
991.6	Hypothermia (severe with decreased level of consciousness)
993.3	Caisson disease
994.0	Effects of lightening
994.1	Drowning and nonfatal submersion
994.7	Asphyxiation and strangulation
994.8	Electrocution and nonfatal effects of electric current
995.0	Other anaphylactic shock
995.60-995.69	Anaphylactic shock due to adverse food reaction
999.4	Anaphylactic shock due to serum

***Please note that the descriptor listed is the condition which will be presumed to meet medical necessity criteria. It is not always the descriptor as it appears in the ICD-9-CM code book. An example is 789.00-789.09, which reads as "abdominal pain" in the book. This code is listed on the previous page with the descriptor of "severe abdominal pain" as only pain of a severe, incapacitating nature would meet the medical necessity criteria.

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
Ambulance services will be denied when the patient's condition does not warrant its use either because the patient could have been safely transported by another means of transportation, independent of whether or not it was available, or if the patient's condition did not require the skills of specially trained staff or equipment due to an acute condition or injury. A denial will also occur if all the requirements identified in the Medicare Carriers Manual are not met (e.g., ambulance and crew requirements, physician certification, bed confined).

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

Noncovered Diagnoses
N/A

Coding Guidelines
Origin and destination modifiers are to be used with codes A0320-A0390. The first position alpha code equals origin and the second position alpha code equals destination. The origin and destination codes are:

D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled Nursing Facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X*	Intermediate stop at physician's office en route to the hospital (includes HMO non-hospital facility, clinic, etc.)

* Destination code only

In addition to the origin and destination codes, one of the following modifiers must be billed with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

The charges for mileage must be coded on a "loaded" basis (i.e. from the pick up of the patient to his/her destination). Separate charges for "unloaded" mileage should not be coded. Charges for unloaded mileage will be denied.

A0320 - continued
The waiting time code (A0420) may be used only in unusual circumstances. It is reasonable to assume that the ambulance personnel would spend up to one-half hour in the processing of paperwork in the delivery of a patient to the hospital. Therefore, the waiting time code should be used only if the patient's condition dictated a delay beyond that one-half hour. Procedural delays (e.g, those not related to the patient's condition) are not billable under this code.

Documentation Requirements
Appropriate documentation for review includes a ambulance transport sheet, an itemized breakdown of charges, and a physician certification for nonemergency transports.

If Medicare coverage criteria is not met, a copy of the notice of non-coverage signed and dated by the patient must be available for review. This notice must be given to the patient prior to transport.

If an ICD-9-CM code cannot appropriately be selected which reflects the need for an ambulance transport, the claims should be accompanied by a trip sheet which clearly describes the medical conditions of the patient if submitting a paper claim or a narrative statement via EMC transmission.

Utilization Guidelines
N/A

Other Comments
N/A

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.

Start Date of Comment Period
N/A

Start Date of Notice Period
07/01/2000

Revision History

Revision Number:	1	(PCR B2000-120)
Start Date of Comment Period:		N/A
Start Date of Notice Period:		07/01/2000
		Jul/Aug 2000 *Update!*
Original Effective Date:		06/16/1997
Revised Effective Date:		08/21/2000
Explanation of Revision:		This policy is being formally finalized. The information regarding the covered indications and diagnoses were published in the May/June 1997 *Medicare B Update!* with implementation occurring June 16, 1997.

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: J0001

Policy Number
J0001

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Self-Administered Drugs

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 2049
Program Memorandum AB-00-21 (change request 1164)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
04/19/99

Revision Effective Date
04/14/2000

Revision Ending Effective Date
04/13/2000

Policy Ending Date
N/A

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

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

- Blood clotting factors;
- Drugs used in immunosuppressive therapy;
- Erythropoietin (EPO);
- Osteoporosis drugs for certain homebound patients;
- Certain oral anti cancer drugs; and
- Certain oral anti-nausea drugs given in conjunction with oral or IV chemotherapy.

J0001 - continued

Indications and Limitations of Coverage and/or Medical Necessity

Based on national coverage guidelines, drugs and biologicals which are self-administered by the patient are not a benefit of Medicare. **The drugs identified in the "HCPCS Codes" section of this policy have been determined to be self-administered drugs and therefore are not covered.**

HCPCS Section & Benefit Category

Drugs and Biologicals

HCPCS Codes

J0275	Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)
J1438	Injection, etanercept, 25mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Enbrel)
J1825	Injection, interferon beta-1a, 33 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Avonex)
J1830	Injection, interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Betaseron)
J3490	Unclassified drugs Somatropin (Genotropin, Humatrope, Norditropin, Nutropin AQ, Saizen, Serostim)
J9218	Leuprolide acetate, per 1 mg

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

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

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

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

N/A

Documentation Requirements

N/A

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

Drug Facts and Comparison
1998 Physicians' Desk Reference
1999 Physician's Desk Reference

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

07/01/2000

Revision History

Revision Number:	3 (PCR B2000-099)
Start Date of Comment Period:	N/A
Start Date of Notice Period:	07/01/2000 Jul/Aug 2000 *Update!*
Revised Effective Date:	04/14/2000
Explanation of Revision:	Program memorandum AB-00-21 suspends the 8/13/97 memo regarding self-administered drugs covered by Medicare program. Therefore, revision is needed to delete information regarding the 8/13/97 letter.

Start Date of Comment Period:	N/A
Start Date of Notice Period:	01/01/2000 Jan/Feb 2000 *Update!*
Original Effective Date:	04/19/1999
Revision Date/Number:	01/01/2000 2 (PCR B2000-036) HCPCS 2000

Start Date of Comment Period:	04/30/1999
Start Date of Notice Period:	11/01/1999 Nov/Dec '99 *Update!*
Original Effective Date:	04/19/1999
Revision Date/Number:	12/20/1999 1 (PCR B99-134)

Start Date of Comment Period:	08/21/1998
Start Date of Notice Period:	03/1999
Original Effective Date:	04/19/1999 (PCR B99-065)

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: J1745

Policy Number
J1745

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Infliximab (Remicade™)

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
08/21/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Infliximab (Remicade™) is a chimeric monoclonal antibody that binds specifically to tumor necrosis factor alpha (TNFα) and blocks its activity. Overproduction of tumor necrosis factor alpha, which is a key inflammatory mediator, leads to inflammation in conditions such as Crohn's disease, rheumatoid arthritis and other autoimmune diseases.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the use of Infliximab to be medically reasonable and necessary in the following circumstances:

- To reduce the symptoms of moderately to severely active Crohn's disease for patients who have had an inadequate response to conventional therapy (e.g., corticosteriods, aminosalicylates, and immunosuppressive agents). Normally, the patient receives a one-time infusion for this indication with repeat infusions for episodic exacerbations. Subsequent treatments will be covered if the patient responds to the initial treatment as demonstrated by a reduction in signs and symptoms.
- To reduce the number of draining enterocutaneous fistulas for patients with fistulizing Crohn's disease. Normally, the patient receives an infusion for this indication at weeks zero, two, and six. Subsequent treatments will be covered if the patient responds to the initial treatment as demonstrated by a reduction in signs and symptoms.
- To treat rheumatoid arthritis, when used in combination with methotrexate, for patients exhibiting active disease who have had an inadequate response to methotrexate alone. An adequate trial of methotrexate should last a minimum of three months. Normally, the patient receives an infusion of Infliximab for this indication at weeks zero, two, and six, and then approximately every eight weeks.

  Note: For patients, who have not had an adequate trial of methotrexate or are unable to tolerate methotrexate, treatment with Infliximab alone would be non-covered by Florida Medicare.

HCPCS Section & Benefit Category
Drugs and Biologicals

HCPCS Codes
J1745 Injection, infliximab, 10mg

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
565.1	Anal fistula
569.81	Fistula of intestine, excluding rectum and anus
714.0	Rheumatoid arthritis

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
The use of Infliximab for any clinical indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

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

J1745 - continued

Noncovered Diagnoses
N/A

Coding Guidelines
For billing the administration of Infliximab, use CPT infusion codes 90780 and 90781.

Documentation Requirements
Medical record documentation that is maintained by the performing physician must substantiate the medical necessity for the use of Infliximab by clearly indicating the relevant clinical signs and symptoms related to the medical condition for which this drug is indicated. The documentation must also include all prior treatment regimes and the patient's response to that therapy.
For Crohn's disease, episodic retreatment will be covered if the medical record substantiates that the patient had a reduction in the clinical signs and symptoms of the disease after the initial treatment.
For rheumatoid arthritis, the medical record must clearly indicate that the patient is receiving Infliximab in combination with Methotrexate.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information
Elliott, M., Maini, R., Feldmann, M., Kalden, J., Antoni, C., Smolen, J., Leeb, B., Breedveld, F., Macfarlane, J., Bijl, H., Woody, J. (1994). Randomized double-blind comparison of chimeric monoclonial antibody to tumour necrosis factor α (cA2) versus placebo in rheumatoid arthritis. The Lancet, 344, 1105-1110.

Maini, R., St. Clair, E.W., Breedveld, F., Furst, D., Kalden, J., Weisman, M., Smolen, J., Emery, P., Harriman, G., Feldmann, M., Lipsky, P. (1999). Infliximab (chimeric anti-tumor necrosis factor α monoclonal antibody) versus placebo in rheumatoid arthritis patients receiving concomitant methotrexate: a randomized phase III trial. The Lancet, 354, 1932-1939.

Maini, R., Breedveld, F., St. Clair, E.W., Furst, D., Kalden, J., Smolen, J., Davis, D., Macfarlane, J., Antoni, C., Leeb, B., Elliott, M., Woody, J., Schaible, T., Feldmann, M. (1998). Therapeutic efficacy of multiple intravenous infusions of anti-tumor necrosis factor α monoclonal antibody combined with low-dose weekly methotrexate in rheumatoid arthritis. Arthritis & Rheumatism, 41, (9), 1552-1563.

Remicade™ package insert, 1999.

Rutgeerts, P., D'Haens, G., Targan, S., Vasiliauskas, E., Hanauer, S., Present, D., Mayer, L., VanHogezand, R., Braakman, T., DeWoody, K., Schaible, T., VanDeventer, S. (1999). Efficacy and safety of retreatment with anti-tumor necrosis factor antibody (infliximab) to maintain remission in crohn's disease. Gastroenterology, 117, 761-769.

United States Pharmacopeia Drug Information, Volume 1, Drug Information Monograph 1999.

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 numerous societies.

Carrier Advisory Committee meeting held on 2/19/2000

Start Date of Comment Period
02/11/2000

Start Date of Notice Period
07/01/2000

Revision History
Revision Number:	Original (PCR B2000-109)
Start Date of Comment Period:	02/11/2000
Start Date of Notice Period:	07/01/2000 Jul/Aug 2000 *Update!*
Original Effective Date:	08/21/2000

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

Medical Policy Procedures: J1950

Policy Number
J1950

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Leuprolide Acetate

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
02/01/1995

Revision Effective Date
04/14/2000

J1950 - continued

Revision Ending Effective Date
04/13/2000

Policy Ending Date
N/A

LMRP Description
Leuprolide Acetate injection is a synthetic analog of the naturally occurring gonadotropin-releasing hormone (GnRH or LH-RH). The analog possesses greater potency than the natural hormone. Gonadotropin-releasing hormone is produced in the arcuate nucleus of the hypothalamus and controls release of the gonadotropins, follicle-stimulating hormone (FSH) and luteinizing hormone (LH).

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

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

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

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

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

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

Dosage and Frequency
- Endometriosis: Intramuscular, 3.75 mg depot suspension, (J1950) is administered once a month, or 11.25 mg every three months for a maximum duration of six months.
- Uterine leiomyomata: Intramuscular, 3.75 mg depot suspension, (J1950) is administered once a month for a maximum duration of three months or one 11.25 mg injection.
- Prostatic carcinoma: Intramuscular, 7.5 mg, (J9217) is administered once a month, 22.5 mg once every three months, or 30 mg dose every four months.
- Prostatic carcinoma: Subcutaneous, 1.0 mg (J9218) is administered on a daily basis by the patient in the home setting.

Based on national coverage guidelines, drugs and biologicals that are self-adminstered by the patient are not a benefit of Medicare. Leuprolide Acetate (J9218) is considered a self-administered drug and, therefore, is not a coverded drug.

HCPCS Section & Benefit Category
Drugs and Biologicals

HCPCS Codes
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
185	Malignant neoplasm of prostate
280.0	Iron deficiency anemias, secondary to blood loss (chronic)
285.1	Acute posthemorrhagic anemia
617.0-617.9	Endometriosis

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.

J1950 - continued

Noncovered Diagnoses

N/A

Coding Guidelines

When J9217 leuprolide acetate (for depot suspension) is billed with ICD-9-CM code 185 and there is no supporting documentation of medical need (cachexia, infection, or allergy to goserelin acetate), an acceptable advance notice of Medicare's possible denial of payment for the additional expense of J9217 must be given to the patient if the provider does not want to accept financial responsibility for each injection. The beneficiary's liability, however, must not exceed the difference in the Medicare allowance between the two medications (J9217 and J9202). Use the GA modifier to indicate that the "Advance Notice to Beneficiary" statement is on file for the difference in cost of the two drugs.

Documentation Requirements

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

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

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

Utilization Guidelines

N/A

Other Comments

Terms Defined:

Antineoplastic: preventing the development, growth, or proliferation of malignant cells.

Depot: a body area in which a substance (e.g., a drug) can be accumulated, deposited, or stored and from which it can be distributed.

Follicle-stimulating hormone: hormone produced by the anterior pituitary. It stimulates growth of the follicle in the ovary and spermatogenesis in the testis.

Gonadotropin: hormones produced by the anterior lobe of the hypophysis which include the follicle-stimulating hormone (FSH) and luteinizing hormone (LH) in the female and interstitial cell stimulating hormone (ICSH) in the male.

Luteinizing hormone: hormone secreted by anterior lobe of the hypophysis that stimulates development of the corpus luteum.

Sources of Information

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Dorland's Illustrated Medical Dictionary. (26th ed.). Philadelphia: W.B. Saunders Company.

Drug Information for the Health Care Professional (1998). (18th ed.). (Vol. 1). Rockville: United States Pharmacopeial Convention, Inc.

Katzung, B. G. (1998). Lange: Basic and Clinical Pharmacology (7th ed.). Stamford: Appleton & Lange.

Oncology Drug Information. (1997). (1st ed.). Rockville: United States Pharmacopeia Convention, Inc.

Package Insert Lupron Depot® (Leuprolide acetate for depot suspension)

Physicians' Desk Reference (1998). (52nd ed). Montvale: Medical Economics Company, Inc.

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

07/01/2000

Revision History

Revision Number:	7	(PCR 2000-115)
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	07/01/2000 Jul/Aug 2000 *Update!*	
Revised Effective Date:	04/14/2000	
Explanation of Revision:	Program Memorandum AB-00-21 dated April 2000, regarding the coverage of self-administered injectable drugs instructed the Contractor to base policy on information existing before the August 13, 1997 letter. Based on the information found in the Medicare Carriers Manual, this Contractor is considering Leuprolide Acetate (code J9218) a self-administered drug, and therefore, not covered.	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	03/01/99	
Original Effective Date:	02/01/95	
Revision Date/Number:	04/19/99	6 (PCR B99-060)
Start Date of Comment Period:	11/06/98	
Start Date of Notice Period:	03/99 Mar/Apr '99 *Update!*	
Original Effective Date:	02/01/95	
Revision Date/Number:	04/19/99	5 (PCR B99-055) Original Policy Struck out

J1950 - continued

Start Date of Comment Period:		
Start Date of Notice Period:		
Original Effective Date:	02/01/95	
Revised Effective:	06/18/96	4
	(PCR 96-062)	
Revision Date/Number:	06/05/95	3
	(PCR 95-012B)	
	04/24/95	2
	(PCR 95-012A)	
	04/24/95	1
	(PCR 95-012)	
	02/01/95	
	(PCR 95-051)	

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: J2792

Policy Number
J2792

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Rho (D) Immune Globulin Intravenous

AMA CPT Copyright Statement

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
08/21/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Rho (D) Immune Globulin Intravenous (Rho [D] IGIV) is a gamma globulin (IgG) which contains antibodies to Rho (D). Rho (D) IGIV currently has two medical applications. The first application is to suppress Rh isoimmunization in nonsensitized Rho (D) antigen-negative individuals following Rho (D) antigen-positive red blood cell or whole blood exposure. Rho (D) antigen-positive red blood cell or whole blood exposure can occur by fetomaternal hemorrhage during delivery of an Rho (D) antigen-positive infant, during an abortion (spontaneous or induced), during amniocentesis, abdominal trauma or during a mismatched transfusion (transfusion accident).

The second application of Rho (D) IGIV is to increase platelets in non-splenectomized, Rho (D) positive children with acute/chronic and adults with chronic immune thrombocytopenic purpura (ITP), or ITP secondary to human immunodeficiency virus (HIV) infection.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Rho (D) Immune Globulin Intravenous medically necessary for the following Food and Drug Administration (FDA) approved indications:

1.) For the suppression of Rh isoimmunization. These include:

A.) Rho (D) negative female children and adults in their childbearing years upon exposure to incompatible blood transfusions or massive fetal hemorrhage.

B.) Non-sensitized Rho (D) negative women within 72 hours after abortions (spontaneous or induced), amniocentesis, chorionic villus sampling, ruptured tubal pregnancy, abdominal trauma, transplacental hemorrhage, or in the normal course of pregnancy unless the blood type of the fetus or the father is known to be Rho (D) negative. Maternal bleeding due to threatened abortion should be treated by administration of Rho (D) as soon as possible.

C.) Non-sensitized Rho (D) negative women during pregnancy at 28 weeks gestation and within 72 hours following delivery which meet the following criteria:

- The mother must be Rho (D) negative;
- The mother is carrying a child whose father is either Rho (D) positive or Rho (D) unknown;
- The baby is either Rho (D) positive or Rho (D) unknown, and isoimmunized to the Rho (D) factor.

If product recommended dosages are exceeded, the provider must document medical necessity in the medical record.

J2792 - continued

2.) For the treatment of immune thrombocytopenic purpura (ITP) for non-splenectomized Rho (D) positive individuals in clinical situations requiring an increase in platelet count to prevent excessive hemorrhage in:
- Children with acute or chronic ITP;
- Adults with chronic ITP;
- Children and adults with ITP secondary to HIV infection.

For the purpose of this policy, ITP is defined by the following criteria:
- Signs and symptoms of bleeding, a platelet count of less than 30,000/mm3, Rho (D) positive status and non-splenectomized status.
- Acute ITP: for duration of less than 6 months.
- Chronic ITP: for duration of greater than 6 months.

All patients should be monitored to determine clinical response by assessing platelet counts, red blood cell counts, hemoglobin (Hgb) and reticulocyte levels.

HCPCS Section & Benefit Category
Drugs and Biologicals

HCPCS Codes
J2792 Injection, rho D immune globulin, intravenous, human, solvent detergent, 100 I.U.

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

287.3	Primary thrombocytopenia
656.10-656.13	Rhesus isoimmunization
773.0	Hemolytic disease due to Rh isoimmunization
999.7	Rh incompatibility reaction

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.

Rho (D) Immune Globulin Intravenous should not be administered as immunoglobulin replacement therapy for immune globulin deficiency syndromes.

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 Diagnosis
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation (e.g. history and physical, office/progress notes) maintained by the performing physician must clearly indicate the medical necessity to initiate Rho (D) Immune Globulin therapy and the continued need thereof. Documentation must clearly indicate relevant signs and symptoms related to the condition for which this therapy is indicated.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information

Anemia, Neutropenia and Thrombocytopenia: Pathogenesis and Evolving Treatment Options in HIV-Infected Patients. HIV Clinical Management vol. 10. (1999). Medscape Website. [On-line]. Available: http://www.medscape.com/medscape/HIV/ClinicalMgmt/CM.v10/CM.v10-06.html

Fauci, A., Braunwald, E., Isselbacher, K., Wilson, J., Kasper, D., Hauser, S., & Longo, D. (eds.). (1998). Harrison's principles of internal medicine. (14th ed.). New York: McGraw-Hill.

Food and Drug Administration Drug and Device Product Approvals. [On-line.]. Available: http://www.fda.gov/cder/da/ddpa.htm

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Tierney, L., McPhee, S., & Papadakis, M. (1998). Current medical diagnosis and treatment (37th ed.). Stamford: Appleton & Lange.

United States Pharmacopoeia Drug Information (USPDI). 1999.

WinRho SDF™ package insert, 1999.

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
07/01/2000

Revision History

Revision Number:	Original (PCR B2000-092)
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	Jul/Aug 2000 *Update!*
Original Effective Date:	08/21/2000

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

Medical Policy Procedures: J3240

Policy Number
J3240

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Thyrotropin Alfa (Thyrogen®)

AMA CPT Copyright Statement

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
08/21/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
Thyrotropin Alfa (Thyrogen®) is a highly purified recombinant form of human thyroid stimulating hormone (TSH). It is used as an adjunctive diagnostic tool for serum thyroglobulin (Tg) testing with or without radioiodine imaging in the follow-up of patients with well-differentiated thyroid cancer.

Patients with thyroid carcinoma generally undergo total or near total thyroidectomy, often followed by radioiodine therapy. After surgery these patients require synthetic thyroid hormone replacement therapy to suppress the secretion of thyrotropin (TSH). This hormone replacement therapy prevents symptoms of hypothyroidism and suppresses serum levels of TSH to avoid TSH-stimulated tumor growth. Although survival rates are good for thyroid carcinoma, these patients require long-term follow-up monitoring for recurrent thyroid carcinoma and/or metastasis, which can occur decades later. This follow-up generally includes periodic serum thyroglobulin (Tg) levels (thyroglobulin levels are used as a tumor marker for thyroid carcinoma) and radioiodine imaging. Serum thyroglobulin testing and radioiodine imaging are the most sensitive for detecting recurrent disease when the serum TSH levels are significantly elevated (ideally between 30-50 microU/ml).

Elevation of TSH can be accomplished by withdrawal of thyroid hormone replacement therapy or administration of recombinant thyroid stimulating hormone (thyrotropin alfa). Withdrawal of thyroid replacement therapy and subsequent high serum levels of TSH result in symptoms of hypothyroidism. These symptoms can include extreme fatigue, depression, weight gain, cold intolerance, muscle weakness and cramps. The severity of these symptoms can be debilitating for some of these patients due to the high TSH levels required to perform these tests.

Thyrotropin alfa provides an alternative to thyroid hormone withdrawal for follow-up thyroid carcinoma testing. However, thyroglobulin testing and radioiodine imaging following administration of thyrotropin alfa have not shown to be as sensitive in detecting metastatic and/or recurrent thyroid carcinoma as testing following hormone withdrawal. This creates a substantial risk of missing recurrent carcinoma or of underestimating the extent of the disease. Therefore, careful consideration should be given when the physician and patient elect to use thyrotropin alfa rather than hormone withdrawal in follow-up testing. The patient should be given adequate education regarding this increased risk before this decision is made.

Indications and Limitations of Coverage and/or Medical Necessity
Thyroid hormone withdrawal thyroglobulin testing with radioiodine imaging remains the standard diagnostic modality to assess the presence, location and extent of thyroid cancer.

Florida Medicare will consider the use of recombinant thyroid stimulating hormone (thyrotropin alfa) to be medically reasonable and necessary for the follow-up monitoring of patients with thyroid carcinoma when the following criteria are met:

The patient has been diagnosed with well-differentiated thyroid carcinoma and has undergone a total or near total thyroidectomy and follow-up testing is being performed to detect metastatic and/or recurrent thyroid carcinoma; and

The patient is unable to mount an adequate endogenous TSH response to thyroid hormone withdrawal or hormone withdrawal is medically contraindicated for the patient. This includes, but is not limited to those individuals with a second malignancy, other endocrine diseases, myasthenia gravis, or mental illness (e.g., depression); and/or

The patient has experienced significant distress during previous thyroid hormone withdrawal, to the extent that the treating physician believes use of a less sensitive test is justified.

J3240 - continued

The dosage for thyrotropin alfa (Thyrogen®) is 0.9 mg. given intramuscularly every 24 hours for two doses or every 72 hours for three doses. For radioiodine imaging, radioiodine administration should be given 24 hours following the final thyrotropin alfa injection. Scanning should then be performed 48 hours after radioiodine administration. For serum thyroglobulin testing, the serum sample should be obtained 72 hours after the final injection of thyrotropin alfa.

HCPCS Section & Benefit Category

Drugs and Biologicals

HCPCS Codes

J3240 Injection, thyrotropin alfa, 0.9 mg

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

193	Malignant neoplasm of thyroid gland
V10.87	Personal history of malignant neoplasm of thyroid

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

For services performed on or after January 1, 2000, use procedure code J3240 (Injection, Thyrotropin Alfa, 0.9 mg.). For services performed before January 1, 2000, use procedure code J3490 (Unclassified drugs).

Documentation Requirements

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

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information

American Association of Clinical Endocrinologists and The American College of Endocrinology. (1996). AACE Clinical Practice Guidelines for the Management of Thyroid Carcinoma. [On-line], Available: http:aace.com/clin/guides/thycancer.html

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Ozata, M., Suzuki, S., Miyamoto, T., Tsuan, R., Fierro-Renoy, F., & DeGroot, L. (1994). Serum thyroglobulin in the follow-up of patients with treated differentiated thyroid cancer. Journal of Clinical Endocrinology and Metabolism, 79, 98-104.

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 February 19, 2000.

Start Date of Comment Period

02/11/2000

Start Date of Notice Period

07/01/2000

Revision History

Revision Number:	Original (PCR B2000-102)
Start date of comment period:	02/11/2000
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	Jul/Aug 2000 *Update!*
Original Effective Date:	08/21/2000

Advance Notice Statement

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

Medical Policy Procedures: 53850

Policy Number
53850

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Prostate Treatments

AMA CPT Copyright Statement

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
06/16/1997

Revision Effective Date
05/23/2000

Revision Ending Effective Date
05/22/2000

Policy Ending Date
N/A

LMRP Description
The prostate gland is located below the internal urethral orifice, behind the symphysis pubis and close to the rectal wall. The gland averages 4 cm in width at its base, 3 cm from top to bottom, 2 cm from front to back, and 20 g in weight.

Clinically, the prostate gland is important because of its affinity for congestive, inflammatory, hyperplastic, and malignant diseases. Since the prostate gland is close to the rectal wall, it is easily palpable by rectal examination, and this makes diagnosis of problems at an early stage possible. Because of the anatomic relationship of the prostate gland to the urethra, most prostatic diseases present as urinary tract symptoms.

Benign prostatic hyperplasia (BPH), the most common benign neoplasm in the aging human male, has a high prevalence that increases progressively with age. The prevalence of histologically identifiable BPH for 60 year old males is greater than 50 percent. By age 85, the prevalence is approximately 90 percent.

BPH is fundamentally a disease that causes morbidity through the urinary symptoms with which it is associated. While a minority of men undergo prostatectomy for absolute indications such as recurrent or refractory urinary retention, urinary tract infections, obstructive uropathy or severe hematuria, the majority of men undergo an operation to relieve bothersome urinary symptoms such as frequency, urgency and sensation of incomplete emptying and to improve their quality of life. For many years prostatectomy, particularly transurethral prostatectomy, has been the standard treatment for symptomatic BPH. More recently, however, a plethora of competing therapies is being used to treat patients with symptomatic BPH. These treatments include transurethral incision for the prostate, laser prostatotomy, balloon dilation, hyperthermia, insertion of prostatic stents, a-adrenergic blocking drugs and hormonal therapy. In addition, a "watchful waiting" approach can be followed.

This policy addresses two treatment options for BPH: Transurethral Microwave Thermotherapy (TUMT), and Transurethral Radiofrequency Thermotherapy.

Indications and Limitations of Coverage and/or Medical Necessity

Transurethral Microwave Thermotherapy (TUMT) [53850]:

TUMT provides simultaneous microwave heating of the prostate with temperatures of 45-55 C and conductive cooling of the urethra. This treatment results in high-power microwave application deep in the lateral lobes, leading to irreversible cell damage of prostatic tissue without damaging the urethra. TUMT effectively maintains temperatures in the urethra sphincter, and rectum at physiologically safe temperatures while targeting heat deep within the prostate transition zone. This is accomplished by combining the use of a water-cooled catheter with microwave radiation to the prostate lobes.

The treatment of symptomatic BPH with microwave thermotherapy is indicated and covered when the treatment is performed using an FDA device approved for this specific indication and the patient meets the following criteria:

- Prostatic lengths between 30-50 mm as determined by ultrasound;
- American Urology Association (AUA) symptom greater than or equal to 9 or Madsen symptom index greater than 8;
- Free peak uroflow rate (PFR) less than 15cc/sec with a voided volume greater than or equal to 150cc.

Contraindications

1. Peripheral arterial disease with intermittent claudication or Leriches syndrome (e.g., claudication of the buttocks and perineum).
2. Clinical or histological evidence of prostatic cancer or bladder cancer.
3. Severe urethral stricture preventing catheterization.
4. Presence of an active cardiac pacemaker, an implantable defibrillator, or a metallic implant in the region of the hip or pelvis.

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Note: The use of the device must be prescribed and administered under the direct supervision of a qualified and trained physician, after appropriate urologic evaluation of the patient. The treating physician should be present at all times during the treatment.

Transurethral Radiofrequency Thermotherapy 53852:

Thermotherapy for BPH is based on the principle that heating the adenoma (greater than 45°) causes necrosis of obstructing tissue and leads to relief of prostatic obstruction. Transurethral Radiofrequency Thermotherapy uses radiofrequency (RF) energy (460-490kHz) for prostatic heating. Normally, the RF signal that is generated is carried into the prostate via needles. Thermal energy is generated through inductive heating of water molecules and by friction. The amount of heat energy produced and the subsequent thermal effect are determined by the amount of the tissue contact (length of the needle) and by the wattage energy. These physical properties allow RF energy to achieve: target tissue ablation; precision tissue ablation allowing for the preservation of adjacent tissues and organs; and customized tissue ablation.

The treatment of BPH with radiofrequency thermotherapy is indicated and covered when the treatment is performed using an FDA device approved for this specific indication and the patient meets the following criteria:

- Diagnosis of symptomatic BPH with duration of symptoms greater than 3 months;
- American Urology Association (AUA) symptom score value greater than or equal to 13;
- Peak urine flow rate (Qmax) less than 15cc/sec on a voided volume of greater than 125cc;
- Prostate size greater than 15 grams; and
- Post void residual (PVR) less than 350cc.

Contraindications

1. Active Urinary Tract Infection
2. Prostate or bladder malignancy
3. Prominent median lobe BPH
4. Neurogenic bladder
5. Previous prostate surgery

Note: The use of the device must be prescribed and administered under the direct supervision of a qualified and trained physician, after appropriate urologic evaluation of the patient. The treating physician should be present at all times during the treatment.

HCPCS Section & Benefit Category

Surgery/Urinary System

HCPCS Codes

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy

53852 by radiofrequency thermotherapy

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

600 Hyperplasia of prostate

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

N/A

Documentation Requirements

Medical records maintained in the patient's file must document the patient's prostatic length and/or size, symptoms, AUA symptoms or Madsen symptom index, and the peak flow rate. For patients undergoing radiofrequency thermotherapy, the patient's post void residual must also be documented. In addition, a description of the thermotherapy procedure must be documented. This information is usually found in the office/progress notes, history and physical, and/or procedure note.

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 the Florida Urological Society.

Start Date of Comment Period

N/A

Start Date of Notice Period

07/01/2000

Revision History

Revision Number:	4	PCR B2000-103
Start Date of Comment Period:		N/A
Start Date of Notice Period:		07/01/2000 Jul/Aug 2000 *Update!*
Revised Effective Date:		05/23/2000
Explanation of Revision:		A re-evaluation of the patient coverage criteria for TUMT was performed and resulted in the deletion of the post void residual requirement.

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Start Date of Comment Period:	N/A	
Start Date of Notice Period:	11/01/99 Nov/Dec '99 *Update!*	
Original Effective Date:	06/16/1997	
Revision Date/Number	12/15/1999 (PCR B99-125)	3
Start Date of Comment Period:	8/21/1998	
Start Date of Notice Period:		
Original Effective Date:	06/16/1997	
Revision Date/Number	01/01/1999 (PCR B98-157)	2
Start Date of Comment Period:		
Start Date of Notice Period:	12/1997	
Original Effective Date:	06/16/1997	
Revision Date/Number	01/01/1998 (PCR B98-005) 1998 HCPCS	1
Start Date of Comment Period:	01/18/1997	
Start Date of Notice Period:	05/01/1997	
Original Effective Date:	06/16/1997 PCR B97-066	

Advance Notice Statement

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

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

The complete LMRP covering epidural and subarachnoid injections was published in the March/April 2000 *Medicare B Update!* (pages 33-35). Since that time, a correction has been noted. Under the heading "ICD-9-CM Codes that Support Medical Necessity," code 723 was inadvertently listed. This should have indicated diagnosis code **723.0**; 723 is not a valid ICD-9-CM code. ❖

Medical Policy Procedures: 71010

Policy Number
71010

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Chest X-Ray

AMA CPT Copyright Statement

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
06/01/94

Revision Effective Date
07/10/2000

Revision Ending Effective Date
07/09/2000

Policy Ending Date
N/A

LMRP Description
Radiologic examination of the chest (chest X-ray) facilitates the detection, diagnosis, staging and management of pathophysiologic processes involving thoracic, cardiovascular, pulmonary and mediastinal structures, contiguous coverings and the bony thorax. These examinations are covered by Florida Medicare when medically necessary and appropriate for evaluation and management of a specific symptom, sign, disease or injury.

Indications and Limitations of Coverage and/or Medical Necessity
Chest X-rays are utilized in a variety of clinical states. Generally accepted medical diagnoses are enunciated as Covered ICD-9-CM Codes (Covered Codes). This Carrier will utilize these Covered Codes, and medical consultation, to assess medical necessity and appropriate utilization. Routine, screening, pre-operative or periodic examinations in the absence of symptoms, signs or disease will not be reimbursed.

Florida Medicare will cover chest X-rays in instances of:

- injury to the chest area (heart, lungs, mediastinum, sternum, ribs);
- signs and symptoms suggestive of chest structure abnormalities (e.g., coughing, positive TB skin test, hemoptysis, shortness of breath, dyspnea);
- underlying medical conditions with possible manifestations involving chest structures in which a chest X-ray would be deemed necessary to fully evaluate the condition (e.g., cardiac, metastatic CA);
- preoperative clearance for medical conditions which may pose a risk factor with the administration of general anesthesia, (e.g., congestive heart failure, COPD);
- follow-up of an invasive procedure such as thoracentesis or central venous line placement.

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HCPCS Section & Benefit Category

Radiology

HCPCS Codes

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 (e.g., lateral decubitus, Bucky studies)

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Infectious and Parasitic Diseases

010.00-011.96	Primary tuberculosis infection and pulmonary tuberculosis
012.00-012.86	Other respiratory tuberculosis
015.70-015.76	Tuberculosis of other specified bone
015.80-015.86	Tuberculosis of other specified joint
018.01-018.96	Military tuberculosis
020.2-020.5	Plague
021.2	Pulmonary tularemia
022.1	Pulmonary anthrax
025	Melioidosis
027.0	Listeriosis
027.2	Pasteurellosis
031.0	Pulmonary diseases due to other mycobacteria
033.0-033.9	Whooping cough
039.1	Actinomycotic infections, pulmonary
039.8	Actinomycotic infections, of other specified sites
042	Human immunodeficiency virus (HIV) disease
052.1	Varicella (hemorrhagic) pneumonitis
073.0	Ornithosis with pneumonia
074.1	Epidemic pleurodynia
074.20-074.23	Coxsackie carditis
075	Infectious mononucleosis
080	Louse-borne (epidemic) typhus
081.0	Murine (endemic) typhus
084.0-084.8	Malaria
086.0	Chagas' disease with heart involvement
093.0-093.9	Cardiovascular syphilis
095.1	Syphilis of lung
098.83	Gonococcal pericarditis
098.84	Gonococcal endocarditis
098.85	Other gonococcal heart disease
100.0	Leptospirosis icterohemorrhagica
112.4-112.5	Candidiasis of lung and Candidiasis disseminated
114.0	Primary coccidioidomycosis (pulmonary)
114.1	Primary extrapulmonary coccidioidomycosis
114.3	Other forms of progressive coccidioidomycosis
114.4	Chronic pulmonary coccidiodomycosis
114.5	Pulmonary coccidiodomycosis, unspecified
115.03-115.05	Infection by Histoplasma capsulatum
115.13-115.15	Infection by Histoplasma duboisti
115.93-115.95	Histoplasmosis, unspecified
116.0-116.2	Blastomycotic infection
117.1	Sporotrichosis
117.3	Aspergillosis
117.5	Cryptococcosis
120.0-120.2	Schistosomiasis [bilharziasis]
121.0-121.8	Other trematode infections
122.0	Echinococcus granulosis infection of liver
122.1	Echinococcus granulosis infection of lung
130.3	Myocarditis due to toxoplasmosis
130.4	Pneumonitis due to toxoplasmosis
135	Sarcoidosis
136.1	Behcet's syndrome
136.3	Pneumocystosis
137.0	Late effects of respiratory or unspecified tuberculosis

Neoplasms

141.0-141.9	Malignant neoplasm of tongue
142.0-142.9	Malignant neoplasm of major salivary glands
143.0-143.9	Malignant neoplasm of gum
144.0-144.9	Malignant neoplasm of floor of mouth
145.0-145.9	Malignant neoplasm of other and unspecified parts of mouth
146.0-146.9	Malignant neoplasm of oropharynx
147.0-147.9	Malignant neoplasm of nasopharynx
148.0-148 9	Malignant neoplasm of hypopharynx
149.0-149.9	Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx
150.0-150.9	Malignant neoplasm of esophagus
151.0-151 9	Malignant neoplasm of stomach
153.0-153.9	Malignant neoplasm of colon
154.0-154.8	Malignant neoplasm of rectum, rectosigmoid junction, and anus
162.0-162.9	Malignant neoplasm of trachea, bronchus and lung
163.0-163.9	Malignant neoplasm of pleura
164.0-164.9	Malignant neoplasm of thymus, heart, and mediastinum
165.0-165.9	Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs
170.3	Malignant neoplasm of ribs, sternum, and clavicle
171.0-171.9	Malignant neoplasm of connective and other soft tissue
172.0-172.9	Malignant melanoma of skin
174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
180.1	Malignant neoplasm of exocervix
180.8-180.9	Malignant neoplasm of other specified sites of cervix and cervix uteri, unspecified
182.0-182.8	Malignant neoplasm of body of uterus
183.0-183.9	Malignant neoplasm of ovary and other uterine adnexa
184.4	Malignant neoplasm of vulva, unspecified

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185	Malignant neoplasm of prostate
186.0-186.9	Malignant neoplasm of testis
188.0-188.9	Malignant neoplasm of bladder
189.0-189.9	Malignant neoplasm of kidney and other and unspecified urinary organs
193	Malignant neoplasm of thyroid gland
194.3	Malignant neoplasm of pituitary gland and craniopharyngeal duct
195.0-195.2	Malignant neoplasm of head, face, and neck, thorax, and abdomen
195.4	Malignant neoplasm of upper limb
195.8	Malignant neoplasm of other specified sites
196.0-196.1	Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck, intrathoracic lymph nodes
196.8-196.9	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites and site unspecified
197.0-197.3	Secondary malignant neoplasm of lung, mediastinum, pleura and other respiratory organs
198.0-198.1	Secondary malignant neoplasm of kidney and other urinary organs
198.3-198.6	Secondary malignant neoplasm of brain and spinal cord, other parts of nervous system, bone and bone marrow, and ovary
198.81	Secondary malignant neoplasm of breast
199.0	Malignant neoplasm without specification of site, disseminated
200.00-200.88	Lymphosarcoma and reticulosarcoma
201.02	Hodgkin's paragranuloma, intrathoracic lymph nodes
201.04	Hodgkin's paragranuloma, lymph nodes of axilla and upper limb
201.08	Hodgkin's paragranuloma, lymph nodes of multiple sites
201.12	Hodgkin's granuloma, intrathoracic lymph nodes
201.14	Hodgkin's granuloma, lymph nodes of axilla and upper limb
201.18	Hodgkin's granuloma, lymph nodes of multiple sites
201.22	Hodgkin's sarcoma, intrathoracic lymph nodes
201.24	Hodgkin's sarcoma, lymph nodes of axilla and upper limb
201.28	Hodgkin's sarcoma, lymph nodes of multiple sites
201.42	Lymphocytic-histiocytic predominance, intrathoracic lymph nodes
201.44	Lymphocytic-histiocytic predominance, lymph nodes of axilla and upper limb
201.48	Lymphocytic-histiocytic predominance, lymph nodes of multiple sites
201.62	Mixed cellularity, intrathoracic lymph nodes
201.68	Mixed cellularity, lymph nodes of multiple sites
201.72	Lymphocytic depletion, intrathoracic lymph nodes
201.78	Lymphocytic depletion, lymph nodes of multiple sites
201.92	Hodgkin's disease, unspecified, intrathoracic lymph nodes
201.98	Hodgkin's disease, unspecified, lymph nodes of multiple sites
202.00-202.92	Other malignant neoplasms of lymphoid and histiocytic tissue
202.94	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, lymph nodes of axilla and upper limb
203.00-203.81	Multiple myeloma and immunoproliferative neoplasms
212.2-212.9	Benign neoplasm of respiratory and intrathoracic organs
213.3	Benign neoplasm of ribs, sternum, and clavicle
213.4	Benign neoplasm of scapula and long bones of upper limb
214.2	Lipoma, intrathoracic organs
215.2	Other benign neoplasm of upper limb, including shoulder
215.4	Other benign neoplasm of thorax
227.6	Benign neoplasm of aortic body and other paraganglia
228.00	Hemangioma, of unspecified site
228.09	Hemangioma, of other sites
228.1	Lymphangioma, any site
230.1	Carcinoma in situ, esophagus
231.1-231.2	Carcinoma in situ, trachea, bronchus and lung
231.8-231.9	Carcinoma in situ, other specified parts or respiratory system; respiratory system and part unspecified
233.0	Carcinoma in situ, breast
235.7	Neoplasm of uncertain behavior of trachea, bronchus and lung
235.8	Neoplasm of uncertain behavior of pleura, thymus, and mediastinum
235.9	Neoplasm of uncertain behavior of other and unspecified respiratory organs
236.0	Neoplasm of uncertain behavior of uterus
236.2-236.3	Neoplasm of uncertain behavior of ovary and other and unspecified female genital organs
236.91	Neoplasm of uncertain behavior of kidney and ureter
237.2-237.4	Neoplasm of uncertain behavior of adrenal gland, paraganglia, and other and unspecified endocrine glands
238.0-238.1	Neoplasm of uncertain behavior of bone and articular cartilage and connective and other soft tissue
238.3	Neoplasm of uncertain behavior of breast
239.1	Neoplasm of unspecified nature, respiratory system
239.3	Neoplasm of unspecified nature, breast

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Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders

254.0-254.9	Diseases of thymus gland
276.2-276.4	Acidosis, alkalosis, and mixed acid-base balance disorder
276.6	Fluid overload
277.00-277.01	Cystic fibrosis
277.3	Amyloidosis
277.5	Mucopolysaccharidosis

Mental Disorders

306.0-306.2	Musculoskeletal, respiratory, and cardiovascular malfunction arising from mental factors

Diseases of the Nervous System and Sense Organs

354.8	Other mononeuritis of upper limb

Diseases of the Circulatory System

391.0-391.9	Rheumatic fever with heart involvement
392.0	Rheumatic chorea with heart involvement
393	Chronic rheumatic pericarditis
394.0-394.9	Diseases of mitral valve
395.0-395.9	Diseases of aortic valve
396.0-396.9	Diseases of mitral and aortic valves
397.0-397.9	Diseases of other endocardial structures
398.0	Rheumatic myocarditis
398.90-398.99	Other and unspecified rheumatic heart diseases
401.0-401.9	Essential hypertension
402.00-402.91	Hypertensive heart disease
403.00-403.91	Hypertensive renal disease
404.00-404.01	Malignant hypertensive heart and renal disease, without mention of congestive heart failure or renal failure, or with congestive heart failure
404.03	Malignant hypertensive heart and renal disease with congestive heart failure and renal failure
404.11	Benign hypertensive heart and renal disease with congestive heart failure
404.13	Benign hypertensive heart and renal disease with congestive heart failure and renal failure
404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart failure and renal failure
405.0-405.19	Secondary hypertension
411.0-411.89	Other acute and subacute forms of ischemic heart disease
412	Old myocardial infarction
413.0-413.9	Angina pectoris
414.00-414.9	Other forms of chronic ischemic heart disease
415.0-415.19	Acute pulmonary heart disease
416.0-416.9	Chronic pulmonary heart disease
417.0-417.9	Other diseases of pulmonary circulation
420.0	Acute pericarditis in diseases classified elsewhere
420.90-420.99	Other and unspecified acute pericarditis
421.0-421.9	Acute and subacute endocarditis
422.0-422.99	Acute myocarditis
423.0-423.9	Other diseases of pericardium
424.0-424.99	Other diseases of endocardium
425.0-425.9	Cardiomyopathy
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure
429.0-429.1	Myocarditis, unspecified and myocardial degeneration
429.3-429.6	Ill-defined descriptions and complications of heart disease
429.71	Acquired cardiac septal defect
429.79	Certain sequelae of myocardial infarction, other
429.81-429.9	Other ill-defined heart diseases and heart disease, unspecified
441.00-441.03	Dissection of aorta
441.1	Thoracic aneurysm, ruptured
441.2	Thoracic aneurysm without mention of rupture
441.6-441.7	Thoracoabdominal aneurysm, ruptured and thoracoabdominal aneurysm without mention of rupture
442.81-442.82	Aneurysm of other specified artery, artery of neck and subclavian artery
442.89	Aneurysm, other
444.0-444.1	Arterial embolism and thrombus of abdominal aorta and of thoracic aorta
446.1	Acute febrile mucocutaneous lymph node syndrome [MCLS]
446.4	Wegener's granulomatosis
446.5	Giant cell arteritis
446.6	Thrombotic microangiopathy
446.7	Takayasu's disease
447.0	Arteriovenous fistula, acquired
447.2	Rupture of artery
451.89	Phlebitis and thrombophlebitis, other
453.2	Other venous embolism and thrombosis of vena cava
453.8	Other venous embolism and thrombosis of other specified veins
456.0-456.1	Esophageal varices with or without mention of bleeding
456.20-456.21	Esophageal varices in diseases clarified elsewhere
459.2	Compression of vein

Diseases of the Respiratory System

464.10-464.11	Acute tracheitis
464.20-464.21	Acute laryngotracheitis
464.30-464.31	Acute epiglottitis
464.4	Croup
466.0-466.19	Acute bronchitis and bronchiolitis
476.1	Chronic laryngotracheitis
478.31-478.32	Paralysis of vocal cords or larynx, unilateral, partial or unilateral, complete
480.0-480.9	Viral pneumonia
481	Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia]
482.0-482.9	Other bacterial pneumonia
483.0	Mycoplasma pneumoniae
483.8	Pneumonia due to other specified organism
484.1-484.8	Pneumonia in infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified

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486	Pneumonia, organism unspecified
487.0-487.1	Influenza with pneumonia and with other respiratory manifestations
490	Bronchitis, not specified as acute or chronic
491.0-491.9	Chronic bronchitis
492.0-492.8	Emphysema
493.00-493.91	Asthma
494	Bronchiectasis
495.0-495.9	Extrinsic allergic alveolitis
496	Chronic airway obstruction, not elsewhere classified
500	Coal workers' pneumoconiosis
501	Asbestosis
502	Pneumoconiosis due to other silica or silicates
503	Pneumoconiosis due to other inorganic dust
504	Pneumonopathy due to inhalation of other dust
505	Pneumoconiosis, unspecified
506.0-506.9	Respiratory conditions due to chemical fumes and vapors
507.0-507.8	Pneumonitis due to solids and liquids
508.0-508.9	Respiratory conditions due to other and unspecified external agents
510.0-510.9	Empyema
511.0-511.9	Pleurisy
512.0-512.8	Pneumothorax
513.0-513.1	Abscess of lung and mediastinum
514	Pulmonary congestion and hypostasis
515	Postinflammatory pulmonary fibrosis
516.0-516.9	Other alveolar and parietoalveolar pneumonopathy
517.1-517.8	Lung involvement in conditions classified elsewhere
518.0-518.89	Other diseases of the lung
519.00-519.9	Other diseases of respiratory system

Diseases of the Digestive System

530.0	Achalasia and cardiospasm
530.10-530.89	Diseases of the esophagus
551.3	Diaphragmatic hernia with gangrene
552.3	Diaphragmatic hernia with obstruction
553.3	Diaphragmatic hernia

Diseases of the Genitourinary System

611.71	Mastodynia

Complications of Pregnancy, Childbirth, and the Puerperium

639.5-639.6	Complications following abortion and ectopic and molar pregnancies, shock and embolism
642.50-642.54	Severe pre-eclampsia
642.60-642.64	Eclampsia
642.70-642.74	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension
648.50-648.54	Congenital cardiovascular disorders
668.00-668.04	Pulmonary complications of the administration of anesthetic or other sedation in labor and delivery
668.10-668.14	Cardiac complications of the administration of anesthetic or other sedation in labor and delivery
669.00-669.04	Maternal distress
669.10-669.14	Shock during or following labor and delivery
669.20-669.24	Maternal hypotension syndrome
671.30-671.31	Deep phlebothrombosis, antepartum, unspecified as to episode of care or not applicable or delivered, with or without mention of antepartum condition
671.33	Deep phlebothrombosis, antepartum condition or complication
671.40	Deep phlebothrombosis, postpartum, unspecified as to episode of care or not applicable
671.42	Deep phlebothrombosis, postpartum, delivered with or without mention of antepartum condition
671.44	Deep phlebothrombosis, postpartum condition or complication
672.00	Pyrexia of unknown origin during the puerperium, unspecified as to episode of care or not applicable
672.02	Pyrexia of unknown origin during the puerperium, delivered with or without mention of antepartum condition
672.04	Pyrexia of unknown origin during the puerperium, postpartum condition or complication
673.00-673.84	Obstetrical pulmonary embolism

Diseases of the Skin and Subcutaneous Tissue

682.2	Other cellulitis and abscess, trunk

Diseases of the Musculoskeletal System and Connective Tissue

710.0-710.1	Systemic lupus erythematosus and systemic sclerosis
714.2	Other rheumatoid arthritis with visceral or systemic involvement
733.6	Tietze's disease
737.10-737.11	Kyphosis (acquired)(postural) and kyphosis due to radiation
737.30-737.34	Kyphoscoliosis and scoliosis
738.3	Acquired deformity of chest and rib
739.2	Nonallopathic lesions, thoracic region
739.8	Nonallopathic lesions, rib cage

Congenital Anomalies

745.0-745.9	Bulbus cordis anomalies and anomalies of cardiac septal closure
746.00-746.7	Other congenital anomalies of heart
746.81-746.84	Other specified anomalies of the heart
746.87	Malposition of heart and cardiac apex
746.89	Other specified anomalies of heart
746.9	Unspecified anomaly of heart
747.0-747.49	Other congenital anomalies of circulatory system
748.3-748.5	Congenital anomalies of respiratory system
748.60-748.69	Other congenital anomalies of lung
748.8-748.9	Other specified and unspecified anomalies of respiratory system
750.3	Tracheoesophageal fistula, esophageal atresia and stenosis
750.4	Other specified anomalies of esophagus

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750.6	Congenital hiatus hernia
754.81-754.82	Pectus excavatum and pectus carinatum
756.2-756.3	Other congenital musculoskeletal anomalies, cervical rib and other anomalies of ribs and sternum
756.6-756.79	Anomalies of diaphragm; abdominal wall
756.81-756.83	Other specified anomalies of muscle, tendon, fascia, and connective tissue
759.3-759.4	Situs inversus; conjoined twins
759.7	Multiple congenital anomalies, so described
759.82	Marfan syndrome

Certain Conditions Originating in the Perinatal Period

760.3	Other chronic maternal circulatory and respiratory diseases
768.2-768.9	Intrauterine hypoxia and birth asphyxia
769	Respiratory distress syndrome
770.0-770.9	Other respiratory conditions of fetus and newborn
771.0-771.1	Congenital rubella and congenital cytomegalovirus infection
771.3	Tetanus neonatorum
771.7	Neonatal Candida infection
773.3	Hydrops fetalis due to isoimmunization
775.0	Syndrome of "infant of a diabetic mother"
775.2	Neonatal myasthenia gravis
775.7	Late metabolic acidosis of newborn
776.2	Disseminated intravascular coagulation in newborn
778.0	Hydrops fetalis not due to isoimmunization
778.2	Cold injury syndrome of newborn
778.5	Other and unspecified edema of newborn
779.0	Convulsions in newborn
779.2	Cerebral depression, coma, and other abnormal cerebral signs
779.5	Drug withdrawal syndrome in newborn

Symptoms, Signs and Ill-defined Conditions

780.01	Coma
780.6	Fever
781.5	Clubbing of fingers
782.5	Cyanosis
783.2	Abnormal loss of weight
785.0-785.3	Symptoms involving cardiovascular system
785.50-785.59	Shock without mention of trauma
786.00-786.9	Symptoms involving respiratory system and other chest symptoms
787.2	Dysphagia
790.91	Abnormal arterial blood gases
793.1-793.2	Nonspecific abnormal findings on radiological and other examination of body structure, lung field and other intrathoracic organ
793.8	Nonspecific abnormal findings on radiological and other examination of body structure, breast
794.2	Nonspecific abnormal results of function studies, pulmonary
794.30-794.39	Nonspecific abnormal results of function studies, cardiovascular
795.5	Nonspecific reaction to tuberculin skin test without active tuberculosis
799.0-779.1	Asphyxia and respiratory arrest

Injury and Poisoning

807.00-807.09	Fracture of rib(s), closed
807.10-807.19	Fracture of rib(s), open
807.2-807.3	Fracture of sternum, open, closed
807.4	Flail chest
807.5	Fracture of larynx and trachea, closed
807.6	Fracture of larynx and trachea, open
810.00-810.03	Fracture of clavicle, closed
810.10-810.13	Fracture of clavicle, open
828.0-828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
839.61	Other, multiple, and ill-defined dislocations, sternum, closed
839.71	Other, multiple, and ill-defined dislocations, sternum, open
847.1	Sprains and strains of other and unspecified parts of back, thoracic
848.3	Other and ill-defined sprains and strains, ribs
848.40-848.49	Other and ill-defined sprains & strains, sternum
860.0-860.5	Traumatic pneumothorax and hemothorax
861.00-861.32	Injury to heart and lung
862.0-862.9	Injury to other and unspecified intrathoracic organs
874.10-874.12	Open wound of larynx and trachea, complicated
875.0-875.1	Open wound of chest (wall)
879.1	Open wound of breast, complicated
879.7	Open wound of other and unspecified parts of trunk, complicated
901.0-901.9	Injury to blood vessels of thorax
903.00-903.02	Injury to axillary blood vessels
905.1	Late effect of fracture of spine and trunk without mention of spinal cord lesion
906.0	Late effect of open wound of head, neck, and trunk
908.0	Late effect of internal injury to chest
908.2	Late effect of internal injury to other internal organs
908.4	Late effect of injury to blood vessel of thorax, abdomen, and pelvis
909.0	Late effect of poisoning due to drug, medicinal or biological substance
909.2-909.5	Late effect of radiation, complications of surgical and medical care, certain other external causes and adverse effect of drug, medicinal or biological substance
922.0-922.1	Contusion of breast and chest wall
926.11	Crushing injury of back
926.8	Crushing injury of multiple sites of trunk
927.01-927.02	Crushing injury of upper limb, scapular region, axillary region
933.0-933.1	Foreign body in pharynx and larynx
934.0-934.9	Foreign body in trachea, bronchus, and lung
935.1-935.2	Foreign body in esophagus and stomach
942.00-942.02	Burn of trunk, unspecified site, breast and chest wall, excluding breast and nipple, unspecified degree
942.04	Burn to back [any part] degree unspecified
942.10-942.12	Erythema [first degree] of trunk, unspecified site, breast and chest wall, excluding breast and nipple
942.14	Erythema [first degree] of back [any part]
942.20-942.22	Blisters, epidermal loss [second degree] burn of trunk unspecified site, breast, chest wall, excluding breast and nipple

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942.24	Blisters, epidermal loss [second degree] burn, back [any part]
942.30-942.32	Full thickness skin loss [third degree NOS] of trunk, unspecified site, breast and chest wall, excluding breast and nipple
942.34	Full thickness skin loss [third degree NOS] back [any part]
942.40-942.42	Deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part of trunk, unspecified site, breast and chest wall, excluding breast and nipple
942.44	Deep necrosis of underlying tissues [deep third degree] without mention of a loss of a body part, back [any part]
942.50-942.52	Deep necrosis of underlying tissues [deep third degree] with loss of a body part of trunk, unspecified site, breast and chest wall, excluding breast and nipple
942.54	Deep necrosis of underlying tissues [deep third degree] with loss of a body part, back [any part]
947.0-947.2	Burn of mouth and pharynx, larynx, trachea, and lung and esophagus
948.10-948.11	Burn involving 10-19% of body surface
948.20-948.22	Burn involving 20-29% of body surface
948.30-948.33	Burn involving 30-39% of body surface
948.40-948.44	Burn involving 40-49% of body surface
948.50-948.55	Burn involving 50-59% of body surface
948.60-948.66	Burn involving 60-69% of body surface
948.70-948.77	Burn involving 70-79% of body surface
948.80-948.88	Burn involving 80-89% of body surface
948.90-948.99	Burn involving 90% or more of body surface
958.0	Air embolism
958.1	Fat embolism
958.2	Secondary and recurrent hemorrhage
958.4	Traumatic shock
958.7	Traumatic subcutaneous emphysema
959.1	Injury, other and unspecified, trunk
972.9	Poisoning, by other and unspecified agents primarily affecting the cardiovascular system
980.3	Toxic effect of fusel oil
981	Toxic effect of petroleum products
983.0-983.9	Toxic effect of corrosive aromatics, acids, and caustic alkalis
986	Toxic effect of carbon monoxide
987.0-987.9	Toxic effect of other gases, fumes, or vapors
991.6	Hypothermia
992.1	Heat syncope
992.3	Heat exhaustion, anhydrotic
993.2-993.9	Effects of air pressure
994.0-994.1	Effects of lightning, drowning and nonfatal submersion
994.7	Asphyxiation and strangulation
995.0-995.2	Certain adverse effects not elsewhere classified
996.00-996.2	Mechanical complication of cardiac, other vascular, or nervous system device, implant and graft
996.60-996.63	Infection and inflammatory reaction due to unspecified, cardiac, other vascular, or nervous system device, implant and graft
996.69	Infection and inflammatory reaction due to other internal prosthetic device, implant and graft
996.71-996.72	Other complications of internal (biological) (synthetic) heart valve prosthesis or other cardiac device, implant and graft
996.74-996.75	Other complications of other internal (biological) (synthetic) other vascular or nervous system device, implant and graft
996.79	Other complications of other internal (biological) (synthetic) prosthetic device, implant and graft
996.83-996.84	Complications of transplanted organ, heart and lung
997.00-997.09	Nervous system complications
997.1-997.3	Cardiac, peripheral vascular, and respiratory complications
998.0	Postoperative shock
998.2	Accidental puncture or laceration during a procedure
998.4	Foreign body accidentally left during a procedure
998.81	Emphysema (subcutaneous) (surgical) resulting from a procedure
999.1	Air embolism
999.2	Other vascular complications
999.3	Other infection
999.4	Anaphylactic shock due to serum

Supplementary Classification of Factors Influencing Health Status and Contact with Health Services

V10.00-V10.09	Personal history of malignant neoplasm, gastrointestinal tract
V10.11-V10.29	Personal history of malignant neoplasm, trachea, bronchus, lung and other respiratory and intrathoracic organs
V10.3	Personal history of malignant neoplasm, breast
V10.40-V10.49	Personal history of malignant neoplasm, genital organs
V10.50-V10.59	Personal history of malignant neoplasm, urinary organs
V10.71-V10.79	Personal history of malignant neoplasm, other lymphatic and hematopoietic neoplasms
V10.82	Personal history of malignant melanoma of skin
V10.87	Personal history of malignant neoplasm, thyroid
V12.01	Personal history of tuberculosis
V41.6	Problems with swallowing and mastication
V42.1-V42.2	Organ or tissue replaced by transplant, heart and heart valve
V42.6	Organ or tissue replaced by transplant, lung
V43.2-V43.3	Organ or tissue replaced by other means, heart and heart valve
V43.81	Other organ or tissue replaced by other means, larynx
V45.00-V45.09	Other postsurgical states, cardiac device in situ
V45.81	Other postsurgical states, aortocoronary bypass status
V47.0-V47.2	Other problems with internal organs
V58.81-V58.89	Other specified procedures and aftercare
V67.1-V67.2	Follow-up examination, following radiotherapy and following chemotherapy
V71.1-V71.2	Observation for suspected malignant neoplasm and suspected tuberculosis

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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
Florida Medicare cannot provide coverage for screening chest X-rays performed with routine physical evaluations. Such services should be submitted with the routine physical examination (health checkup) diagnosis code V70.0. This is a noncovered service.

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
Chest X-rays must be billed with a diagnosis relating to the chest rather than a routine diagnosis or unrelated diagnosis. Diagnoses V58.81-V58.89 should be billed when a CXR is being performed as follow-up to an invasive procedure (e.g., insertion of central line, PICC, etc.).

Documentation Requirements
The medical record documentation must indicate the medical necessity of the test. In addition, documentation that the service was performed, including the test results, should be in the patient's medical records. This information is usually found in the office/progress notes, hospital notes, and/or laboratory results.

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

Utilization Guidelines
N/A

Other Comments
Terms Defined

COPD: chronic obstructive pulmonary disease: generalized airways obstruction, particularly of small airways, associated with varying combinations of chronic bronchitis, asthma, and emphysema.

Congestive Heart Failure (CHF): a common syndrome that may be caused by many different etiologies whose clinical manifestations reflect a fundamental abnormality—a decrease in the myocardial contractile state such that cardiac output is inadequate for the body's needs.

Dyspnea: air hunger resulting in labored or difficult breathing, sometimes accompanied by pain.

Hemoptysis: expectoration of blood arising from hemorrhage of the larynx, trachea, bronchi, or lungs.

Pleural effusion: escape of fluid into the pleural cavity.

Sources of Information
Merck Manual (16th ed.). (1992). Rahway, NJ: Merck & Co, Inc.

Taber's Cyclopedic Medical Dictionary. (17th ed.). (1993). Philadelphia: F. A. Davis Co.

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
07/01/2000

Revision History
Revision Number: 8 (PCR B2000-119)
Start Date of Comment Period: N/A
Start Date of Notice Period: 07/01/2000
Jul/Aug 2000 *Update!*
Revised Effective Date: 07/10/2000
Explanation of Revision: A request from a provider resulted in the expansion of the diagnosis range for hypertensive renal disease (403.00-403.91)

Start Date of Comment Period: N/A
Start Date of Notice Period:
Original Effective Date: 06/01/94
Revision Date/ Number: 10/01/98 7
(PCR 98-145)
('99 ICD-9-CM update)

Start Date of Comment Period: N/A
Start Date of Notice Period: 11/13/98
Nov/Dec '98 *Update!*
Original Effective Date: 06/01/94
Revision Date/ Number: 10/26/98 6
(PCR 98-144)

Start Date of Comment Period:
Start Date of Notice Period:
Original Effective Date: 06/01/94
Revision Date/ Number: 10/01/97 5
(PCR B98-130)
(98 ICD-9-CM update)

Start Date of Comment Period: N/A
Start Date of Notice Period: 09/04/97
Original Effective Date: 06/01/94
Revision Date/Number: 08/05/97 4
(B97-122)

Start Date of Comment Period: N/A
Start Date of Notice Period: 03/12/97
Original Effective Date: 06/01/94
Revision Date/Number: 01/24/97 3
(B96-252B)

Start Date of Comment Period: N/A
Start Date of Notice Period: 01/22/97
Original Effective Date: 06/01/94
Revision Date/Number: 10/16/96/11/04/96 2
(B96-252A)

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Start Date of Comment Period:	07/20/96
Start Date of Notice Period:	10/16/96/11/04/96
Original Effective Date:	06/01/94
Revision Date/Number:	11/18/96/12/16/96 1 (B96-252)
Start Date of Comment Period:	10/23/93
Start Date of Notice Period:	05/01/94
Original Effective Date:	06/01/94 (94-100)

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: 82108

Policy Number
82108

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Aluminum

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual 50-17
Intermediary Manual 3167.3

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
08/18/1997

Revision Effective Date
05/08/2000

Revision Ending Effective Date
05/07/2000

Policy Ending Date
N/A

LMRP Description
Aluminum is the third most prevalent element in the earth's crust. The gastrointestinal tract is virtually impervious to aluminum, absorption being around 2%. Factors regulating aluminum's crossing of the blood-brain barrier are not well understood. Serum aluminum correlates with encephalopathy. Aluminum toxicity has been recognized in many settings where exposure is heavy or prolonged and/or where renal function is limited.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider serum aluminum testing medically necessary for signs and symptoms of aluminum toxicity associated with:

- Infants on parenteral fluids, particularly parenteral nutrition;
- burn patients through administration of intravenous albumin, particularly with coexisting renal failure;
- adult and pediatric patients with chronic renal failure who accumulate aluminum readily from medications and dialysate ;
- adult parenteral nutrition patients;
- patients with industrial exposure; and/or
- patients with prolonged exposure to or excessive doses of such medications as antacids, salicylates, antilipemics, antiatherosclerosis medications, and antipruritics, etc.

One or more of the following signs and symptoms of aluminum toxicity must be present for aluminum testing to be considered medically necessary for the above patients:

- encephalopathy (stuttering, gait disturbance, myoclonic jerks, seizures, coma, abnormal EEG);
- osteomalacia or aplastic bone disease (associated with painful spontaneous fractures, tumorous calcinosis);
- proximal myopathy;
- increased left ventricular mass and decreased myocardial function; and/or,
- microcytic anemia.

Serum aluminum testing is routinely covered once every three months for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries. Services performed more frequently must meet the medical necessity requirements listed above.

HCPCS Section & Benefit Category
Pathology and Laboratory/Chemistry

HCPCS Codes
82108 Aluminum

Not Otherwise Classified Codes (NOC)
N/A

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ICD-9-CM Codes that Support Medical Necessity

268.2	Osteomalacia, unspecified
275.49	Other disorders of calcium metabolism
280.9	Iron deficiency anemia, unspecified [Microcytic (hypochromic) anemia]
284.8	Other specified aplastic anemias [Aplasia, bone marrow (secondary)]
284.9	Aplastic anemia, unspecified [Aplasia, bone marrow (myeloid or idiopathic)]
285.1	Acute posthemorrhagic anemia [Acute microcytic anemia]
294.8	Other specified organic brain syndromes (chronic) [(Encephalopathy] due to dialysis)
348.3	Encephalopathy, unspecified (acute)
359.4*	Toxic myopathy (due to drugs
428.1	Left heart failure
429.3	Cardiomegaly
585	Chronic renal failure
733.10-733.19	Pathologic fracture
965.1	Poisoning by salicylates
972.2	Poisoning by antilipemic and antiarteriosclerotic drugs
973.0	Poisoning by antacids and antigastric secretion drugs
976.1	Poisoning by antipruritics
976.2	Poisoning by local astringents and local detergents
976.3	Poisoning by emollients, demulcents, and protectants
985.9	Toxic effect of unspecified metal (industrial exposure)
E858.3	Accidental poisoning by agents primarily affecting cardiovascular system
E858.4	Accidental poisoning by agents primarily affecting gastrointestinal system
E858.7	Accidental poisoning by agents primarily affecting skin and mucous membrane, ophthalmological, otorhinolaryngological, and dental drugs
E935.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, salicylates
E942.2	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antilipemics and antiarteriosclerotic drugs
E943.0	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, antacids and antigastric secretion drugs
E946.2	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, local astringents and local detergents
E946.3	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, emollients, demulcents, and protectants
E950.0	Suicide and self-inflicted poisoning by analgesics, antipyretics, and antirheumatics
E950.4	Suicide and self-inflicted poisoning by other specified drugs and medicinal substances

* This code must be accompanied by the appropriate "E" diagnosis code to identify the toxic agent.

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

Serum aluminum testing is a separately billable ESRD lab service not included in the ESRD composite rate. Serum aluminum tests performed more frequently than once every three months for specified ESRD beneficiaries are only covered if medically justified. A diagnosis of ESRD alone is not sufficient medical evidence for coverage.

When billing for the indication of toxic myopathy due to drug use, both ICD-9-CM code 359.4 and the appropriate E code identifying the toxic agent must be submitted on the claim form.

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 studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Utilization Guidelines

According to Medicare's national coverage policy, serum aluminum testing is routinely covered once every three months for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries.

Other Comments

None

Sources of Information

Jacobs, D., DeMott, W., Finley, P., Horvat, R., Kasten, B., and Tilzer, L. (eds.). Laboratory Test Handbook (3rd ed.). 1994. Hudson Cleveland: Lexi-Comp, Inc.

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 various specialty societies.

82108 - continued

Start Date of Comment Period
N/A

Start Date of Notice Period
07/01/2000

Revision History
Revision Number: 1 (PCR B2000-089)
Revised Effective Date: 05/08/2000
Start Date of Comment Period: N/A
Start Date of Notice Period: 07/01/2000
Jul/Aug 2000 *Update!*
Explanation of Revision: Several ICD-9 codes were added as a result of comments received through the Intermediary's Draft LMRP notice and comment period. Additionally, Medicare's national coverage policy for routine testing of specified ESRD beneficiaries was added.

Revision Number: Original (PCR B97-078)
Start Date of Comment Period: 04/12/1997
Start Date of Notice Period: 07/01/1997
Original Effective Date: 08/18/1997

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.❖

83735: Magnesium — Correction

The LMRP for magnesium was presented in the May/June 2000 *Medicare B Update!* (pages 42-44). The ICD-9-CM diagnosis code range for excessive vomiting in pregnancy was listed incorrectly. The correct range is 643.10-643.83. ❖

Medical Policy Procedures: 87621

Policy Number
87621

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Human Papillomavirus DNA Assay, Amplified Probe Technique

AMA CPT Copyright Statement

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
08/21/2000

Revision Effective Date
N/A

Revision Ending Effective Date
N/A

Policy Ending Date
N/A

LMRP Description
The human papillomavirus (HPV) DNA Assay is a signal amplified solution hybridization antibody capture assay used to qualitatively detect the presence of eighteen HPV types. HPV viruses are classified into low risk types which are principally associated with low grade squamous intraepithelial lesions, (LGSIL) and high risk types which are typically associated with squamous intraepithelial lesions of all grades, especially high grade squamous intraepithelial lesions (HGSIL) and invasive cancer of the cervix.

HPV infection in the female genital tract is recognized by the majority of health care providers as the major risk factor for development of cervical cancer. It is estimated that infection with high risk HPV types is responsible for 95% of cases of carcinoma of the cervix. However, the most common abnormal pap test result is one of atypical squamous cells of undetermined significance (ASCUS). The management of these equivocal pap test abnormalities is a complex clinical challenge. Each year an estimated two to three million women in the United States have an equivocal ASCUS pap result. On follow-up, approximately 10% of these women will have pre-cancerous high-grade squamous intraepithelial lesions, with some of those having invasive carcinoma. Immediate referral of all ASCUS cases to colposcopy would provide the highest rate of detection. However, due to the frequency of ASCUS and that approximately 90% will turn out to have a benign reactive process, this may not be practical. Current literature supports utilization of the HPV DNA Assay as an additional piece of valuable information to make treatment decisions in patients with abnormal pap smears (ASCUS or above). For example, patients with an ASCUS pap result and "HPV negative" (absence of detectable HPV or only low risk HPV detected) could safely be followed up with repeat testing. Those patients with high risk HPV positive test results are expected to give the highest yield of clinically significant cervical lesions on colposcopy.

87621 - continued

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider the use of HPV DNA Assay testing to be medically reasonable and necessary in the following circumstance:

To assist in the treatment decision in the patient that has had an abnormal pap result of ASCUS or above (e.g., AGUS, LGSIL and HGSIL).

HCPCS Section & Benefit Category

Pathology and Laboratory/Microbiology

HCPCS Codes

87621 Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

795.0 Nonspecific abnormal Papanicolaou smear of cervix

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.

Claims received for HPV DNA testing as a screening test, in the absence of a previous or concurrent abnormal pap smear of ASCUS or above, will be denied.

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 maintained by the performing physician must clearly indicate the medical necessity of the service being billed. Documentation must include a previous or concurrent abnormal pap result (ASCUS or above). 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.

If the provider of the HPV DNA testing is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the test. The physician must state the reason for the HPV DNA testing in his order for the test.

Utilization Guidelines

N/A

Other Comments

If a liquid based pap test is utilized, the HPV DNA test can be performed on the original pap specimen up to 21 days after initial collection. This approach would prevent the patient from having to come in for a second visit to obtain the HPV DNA specimen. Thus, this allows for a patient management decision to be made from a single specimen on a single patient visit.

Sources of Information

American Society for Colposcopy and Cervical Pathology. (1996). ASCCP practice guideline: Management guidelines for follow-up of atypical squamous cells of undetermined significance (ASCUS). The Colposcopist, Winter, 1-9.

Cox, T. (1999). Evaluating the role of HPV testing for women with equivocal papanicolaou test findings. The Journal of the American Medical Association, 281, 1645-1647.

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Ferris, D., Wright, T., Litaker, M., Richart, R., Lorincz, A., Sun, X., & Woodward, L. (1998). Comparison of two tests for detecting carcinogenic HPV in women with papanicolaou smear reports of ASCUS and LSIL. The Journal of Family Practice, 46, 136-141.

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Manos, M., Kinnety, W., Hurley, L., Sherman, M., Shieh-Ngai, J., Kurman, R., Ransley, J., Fetterman, B., Hartinger, J., McIntosh, K., Pawlick, G., & Hiatt, R. (1999). Identifying women with cervical neoplasia: using human papillomavirus DNA testing for equivocal papanicolaou results. The Journal of the American Medical Association, 281, 1605-1610.

Poljak, M., Brencic, A., Seme, K., Vince, A., & Marin, I. (1999). Comparative evaluation of first and second generation Digene hybrid capture assays for detection of human papillomaviruses associated with high or intermediate risk for cervical cancer. Journal of Clinical Microbiology, 37, 796-797.

Reid, R., & Lorincz, A. (1996). New generation of human papillomavirus tests. In Rubin, S., and Hoskins, W. (Eds.), Cervical cancer and preinvasive neoplasia (pp. 27-47). Philadelphia: Lippincott-Ravin.

Richart, R. (1998). Cervical neoplasia: past, present, and future. Contemporary OB/GYN, 117-132.

Wallin, K., Wiklund, F., Angstrom, T., Bergamn, F., Stendahl, U., Wadell, G., Hallmans, G., & Dillner, J. (1999). Type specific persistence of human papillomavirus DNA before the development of invasive cervical cancer. The New England Journal of Medicine, 341, 1633-1637.

87621 - continued

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 Society of Pathologists and the Florida Obstetrics and Gynecologic Society.

Carrier Advisory Committee meeting held on February 19, 2000.

Start Date of Comment Period

02/11/2000

Start Date of Notice Period

07/01/2000

Revision History

Revision Number:	Original (PCR B2000-101)
Start Date of Comment Period:	02/11/2000
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	Jul/Aug 2000 *Update!*
Original Effective Date:	08/21/2000

Advance Notice Statement

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

90804-90809, 90816-90822: Individual Psychotherapy

This policy was last published in the May/June 1996 Medicare B Update! *(pages 41-42). Since that time, the procedure codes for individual psychotherapy have changed due to two different HCPCS updates. Therefore, the policy is being republished in its entirety for clarification of the current HCPCS codes for individual psychotherapy services.*

Psychotherapy is the treatment of mental illness and behavior disturbances in which the physician establishes a professional contact with the patient and through therapeutic communication and techniques, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider individual psychotherapy by a physician **(Codes 90804-90809 and 90816-90822)** to be medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

Individual psychotherapy codes should only be used when the single focus of treatment involves individual therapy and/or continuing medical diagnostic evaluation.

Individual psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnoses.

Individual psychotherapy services are not considered to be medically reasonable and necessary when the patient has an organic brain disorder (dementia or delirium) or other psychiatric or neurologic conditions which have produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist. In these cases, evaluation and management or pharmacologic codes should be used.

Psychotherapy services are not considered to be medically reasonable and necessary when they primarily include the teaching of grooming skills, monitoring activities of daily living, recreational therapy (dance, art, play), or social interaction.

Psychotherapy sessions of approximately 75 to 80 minutes **(Codes 90808-90809, 90821-90822)** should not be routinely used and should be reserved for exceptional circumstance.

Psychotherapy services must be performed by a person licensed by the state of Florida and whose training and scope of practice allows that person to perform such services.

Claims submitted for individual psychotherapy performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable.

HCPCS Codes

90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90805	with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90807	with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90809	with medical evaluation and management services
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
90817	with medical evaluation and management services
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
90819	with medical evaluation and management services
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;
90822	with medical evaluation and management services

90804 - continued

ICD-9-CM Codes That Support Medical Necessity

*290.0-318.1 Mental Disorders

* **ICD-9-CM diagnosis codes for mental disorders must be submitted to the highest specificity for coverage by Florida Medicare for individual psychotherapy services.**

Reasons for Denial

Individual psychotherapy for the patient with profound mental retardation is not considered medically necessary by Florida Medicare.

These services are not medically necessary if a review of medical records indicates that Dementia (Organic Brain Syndrome) and Alzheimer's disease (ICD-9-CM codes 290.0-290.9) have produced a severe enough defect to prevent establishment of a relationship with a therapist.

Noncovered ICD-9-CM Code(s)

318.2 Profound mental retardation

Coding Guidelines

Psychotherapy codes should not be used as generic psychiatric service codes when another code, such as an evaluation and management or pharmacologic management code would be more appropriate.

Individual psychotherapy codes **(Codes 90804-90809 and 90816-90822)** cannot be billed on the same day as an evaluation and management service **(CPT codes 99201- 99350)**, by the same provider or mental health professional group.

Pharmacologic management **(CPT code 90862)** is included in the basic allowance of individual psychotherapy when performed on the same day by the same provider.

Documentation Requirements

Medical record documentation maintained by the provider must indicate the medical necessity of the individual psychotherapy including the following:

- the presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to significantly alter baseline functioning,
- the time spent in the psychotherapy encounter,
- documentation that therapeutic interventions, such as behavior modification, supportive interaction, and discussion of reality were applied to produce therapeutic change,
- the patient's capacity to participate in and benefit from psychotherapy,
- the estimated duration of treatment in terms of number of sessions required, and
- the target symptoms, the goals of therapy and methods of monitoring outcome, and why the chosen therapy is the appropriate treatment modality either in lieu of or in addition to another form of psychiatric treatment.

For an acute problem, there should be documentation that the treatment is expected to improve the health status or function of the patient. For chronic problems there must be documentation indicating that stabilization or maintenance of health status or function is expected.

Other Comments

N/A

Effective Date

This local medical review policy is effective for services processed on or after June 17, 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: 92135

Policy Number

92135

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Scanning Computerized Ophthalmic Diagnostic Imaging

AMA CPT Copyright Statement

HCFA National Coverage Policy

Coverage Issues Manual, Sections 35-39, 35-52, 50-12, and 50-49

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Policy Effective Date

08/21/2000

Revision Effective Date

N/A

Revision Ending Effective Date

N/A

Policy Ending Date

N/A

LMRP Description

Scanning computerized ophthalmic diagnostic imaging allows for early detection of glaucoma damage to the nerve fiber layer or optic nerve of the eye. It is the goal of these diagnostic imaging tests to discriminate among patients with normal intraocular pressures (IOP) who have glaucoma, patients with elevated IOP who have glaucoma, and patients with elevated IOP who do not have glaucoma.

92135 - continued

Two forms of scanning computerized ophthalmic diagnostic imaging tests which currently exist are confocal laser scanning ophthalmoscopy (topography) and scanning laser polarimetry. Although these techniques are different, their objective is the same.

Confocal scanning laser ophthalmoscopy (topography) uses 32 tomographic images to make quantitative topographic measurements of the optic nerve head and surrounding retina.

Scanning laser polarimetry measures change in the linear polarization of light (retardation). It uses a polarimeter, an optical device to measure linear polarization change and a scanning laser ophthalmoscope together to measure the thickness of the nerve fiber layer of the retina.

Indications and Limitations of Coverage and/or Medical Necessity

Scanning computerized ophthalmic diagnostic imaging allows earlier detection of glaucoma and more sophisticated analysis for ongoing management. These tests can distinguish patients with glaucomatous damage irrespective of the status of the IOP. These tests also provide more precise methods of observation of the optic nerve head and can more accurately reveal subtle glaucomatous changes over the course of follow-up exams than visual field and/or disc photos can. This allows earlier and more efficient efforts of treatment toward the disease process.

Florida Medicare will consider scanning computerized ophthalmic diagnostic imaging medically reasonable and necessary under the following circumstances:

1. The patient presents with "mild" glaucomatous damage or "suspect glaucoma" as demonstrated by any of the following:

- Intraocular pressure ≥ 22mmHg as measured by applanation;
- Symmetric or vertically elongated cup enlargement, neural rim intact, cup/disc ratio > 0.4;
- Focal optic disc notch;
- Optic disc hemorrhage or history of optic disc hemorrhage;
- Nasal step peripheral to 20 degrees or small paracentral or arcuate scotoma; or
- Mild constriction of visual field isopters.

Because of the slow disease progression of patients with "suspect glaucoma" or those with "mild" glaucomatous damage, the use of scanning computerized ophthalmic diagnostic imaging at a frequency of > 1/year is not expected.

2. The patient presents with "moderate" glaucomatous damage as demonstrated by any of the following:

- Enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio > 0.5 but < 0.8;
- Definite focal notch with thinning of the neural rim; or
- Definite glaucomatous visual field defect (e.g., arcuate defect, nasal step, paracentral scotoma, or general depression.

Patients with "moderate damage" may be followed with scanning computerized ophthalmic diagnostic imaging and/or visual fields. One or two tests of either per year may be appropriate. If both scanning computerized ophthalmic diagnostic imaging and visual field tests are used, only one of each test would be considered medically necessary, as these tests provide duplicative information.

Scanning computerized ophthalmic diagnostic imaging is *not* considered medically reasonable and necessary for patients with "advanced" glaucomatous damage. Instead, visual field testing should be performed. (Late in the course of glaucoma, when the nerve fiber layer has been extensively damaged, visual fields are more likely to detect small changes than are changes in scanning computerized ophthalmic diagnostic imaging).

The patient with "advanced" glaucomatous damage would demonstrate any of the following:

- Diffuse enlargement of optic nerve cup, with cup to disc ratio > 0.8;
- Wipe-out of all or a portion of the neural retinal rim;
- Severe generalized constriction of isopters (i.e., Goldmann I4e ,< 10 degrees of fixation);
- Absolute visual field defects to within 10 degrees of fixation;
- Severe generalized reduction of retinal sensitivity; or
- Loss of central visual acuity, with temporal island remaining.

In addition, scanning computerized ophthalmic diagnostic imaging is not considered medically reasonable and necessary when performed to provide additional confirmatory information regarding a diagnosis which has already been determined.

HCPCS Section & Benefit Category

Medicine/ Ophthalmology

HCPCS Codes

92135	Scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report, unilateral

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

362.85	Retinal nerve fiber bundle defects
364.22	Glaucomatocyclitic crises
364.53	Pigmentary iris degeneration
364.73	Goniosynechiae
364.74	Adhesions and disruptions of pupillary membranes
364.77	Recession of chamber angle
365.00-365.04	Borderline glaucoma [glaucoma suspect]
365.10-365.15	Open-angle glaucoma
365.20-365.24	Primary angle-closure glaucoma
365.31-365.32	Corticosteroid-induced glaucoma
365.41-365.44	Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes
365.51-365.59	Glaucoma associated with disorders of the lens
365.60-365.65	Glaucoma associated with other ocular disorders
365.81-365.89	Other specified forms of glaucoma
365.9	Unspecified glaucoma
368.40	Visual field defect, unspecified
368.41	Scotoma involving central area
368.42	Scotoma of blind spot area
368.43	Sector or arcuate defects
368.44	Other localized visual field defect
368.45	Generalized contraction or constriction
377.00-377.04	Papilledema
377.9	Unspecified disorder of optic nerve and visual pathways
743.20-743.22	Buphthalmos

92135 - continued

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.

Scanning computerized ophthalmic diagnostic imaging does not have case controlled studies which demonstrate a defined role in making clinical treatment decisions regarding diseases other than those listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy. Until this technology is proven to be as specific and sensitive a method for following other diseases as existing tests, it should not supersede current technologies (e.g., fluorescein angiography).

Scanning computerized ophthalmic diagnostic imaging is not medically necessary when performed solely to provide additional confirmatory information regarding a diagnosis which has already been determined.

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
HCPCS code 92135 is considered a unilateral service. The provider should indicate which eye was treated with either a LT or RT modifier on the HCFA 1500 claim form.

Documentation Requirements
Medical record documentation (e.g., office/progress notes) maintained by the performing physician must indicate the medical necessity of the scanning computerized ophthalmic diagnostic imaging. Additionally, a copy of the test results, computer analysis of the data, and appropriate data storage for future comparison in follow-up exams is required. If both eyes are treated, the documentation maintained by the provider must demonstrate medical need for the performance of the test for each eye.

Utilization Guidelines
N/A

Other Comments
In the United States, glaucoma is the second leading cause of blindness and the most frequent cause among African-Americans. The management of glaucoma includes the early detection and treatment to be able to arrest the loss of vision. Detection depends on the ability to recognize the early clinical manifestations of the various glaucomas.

Glaucoma is not a single disease process. Rather, it is a large group of disorders that are characterized by widely diverse clinical and histopathological manifestations. The common denominator of all the glaucomas is a characteristic optic neuropathy, which derives from various risk factors including increased intraocular pressure (IOP). Although elevated IOP is clearly the most frequent causative risk factor for glaucomatous optic atrophy, attempts to define glaucoma on the basis of ocular tension are no longer advised.

Almost 50% of patents with glaucoma remain undetected. Thirty percent of glaucoma patients are those with normal IOP. Furthermore, there are patients with elevated IOP, that do not necessarily have glaucoma.

Dependence upon visual field tests to separate those patients with glaucoma from those without the disease would still miss a large number of patients. This is because as many as 50% of the one million ganglion cells which enter each optic nerve must be lost before there is glaucomatous visual field defect created. Additionally, some patients cannot perform visual field testing reliably, as it is a subjective test requiring a certain level of alertness and cooperation.

Sources of Information
Chauhan, B., LeBlanc, R., McCormick, T., & Rogers, J. (1994). Test-retest variability of topographic measurements with confocal scanning laser tomography in patients with glaucoma and control subjects. American Journal of Ophthalmology, 118 (1), 9-15.

Shields, M.B. (Ed.). (1998). Textbook of Glaucoma (4th ed.). Baltimore: Williams and Wilkins.

Tjon-Fo-Sang, M., & Lemij, H. (1997). The sensitivity and specificity of nerve fiber layer measurements in glaucoma as determined with scanning laser polarimetry. American Journal of Ophthalmology, 123 (1), 62-69.

Weinreb, R., Shakiba, S. & Zangwill, L. (1995). Scanning laser polarimetry to measure the nerve fiber layer of normal and glaucomatous eyes. American Journal of Ophthalmology, 119 (5), 627-636.

Weinreb, R., Shakiba, S., Sample, P., et. al. (1995). Association between quanitative nerve fiber layer measurement and visual field loss in glaucoma. American Journal of Ophthalmology, 120 (6), 732-738.

Yanoff, M. (Ed.). (1998). Ophthalmic Diagnosis and Treatment. Philadelphia: Current Medicine, Inc.

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 Society of Ophthalmology and the Florida Optometric Association.

Carrier Advisory Committee meeting held on February 20, 1999.

Start Date of Comment Period
04/30/1999

Start Date of Notice Period
07/01/2000

Revision History
Revision Number:	Original (PCR B2000-112)
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Start Date of Notice Period:	07/01/2000 Jul/Aug 2000 *Update!*
Original Effective Date:	08/21/2000

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

Medical Policy Procedures: 93965

Policy Number
93965

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Non-Invasive Evaluation of Extremity Veins

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual 50-6

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
12/01/1994

Revision Effective Date
07/10/2000

Revision Ending Effective Date
07/09/2000

Policy Ending Date
N/A

LMRP Description
Deep venous thrombosis cannot be accurately diagnosed by only clinical assessment. Therefore, several non-invasive tests, including continuous-wave doppler ultrasonography, and various types of venous plethysmography have been used.

The purpose of this policy is to define the conditions for which Florida Medicare will consider non-invasive studies of extremity veins to be medically necessary, and therefore covered.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider non-invasive evaluation of extremity veins to be medically necessary under any of the following circumstances (see covered ICD-9-CM codes):

- The patient has deep venous thrombophlebitis or has clinical findings (otherwise unexplained limb pain, swelling) which suggest the possibility of acute deep venous thrombophlebitis.
- The patient presents with signs and symptoms of pulmonary embolism. The more common symptoms include acute onset of dyspnea, chest pain, apprehension, hemoptysis or syncope.
- The patient has acute pulmonary embolism.
- The patient has symptomatic varicose veins and non-invasive studies are needed to guide management of the patient.
- The patient has chronic venous insufficiency, post phlebitic syndrome, or lymphedema.
- The patient has sustained trauma and injury of the venous system is suspected, making evaluation of the venous system of extremities necessary.

HCPCS Section & Benefit Category
Medicine/Non-Invasive Vascular Diagnostic Studies

HCPCS Codes

93965	Non-invasive physiologic studies of extremity veins, complete bilateral study (e.g., Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	unilateral or limited study

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

415.11	Iatrogenic pulmonary embolism and infarction
415.19	Pulmonary embolism and infarction, other
451.0	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
451.11	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
451.19	Phlebitis and thrombophlebitis of deep vessels of lower extremities, other
451.81	Phlebitis and thrombophlebitis of iliac vein
451.83	Phlebitis and thrombophlebitis of deep veins of upper extremities
451.89	Phlebitis and thrombophlebitis of other sites
453.8	Other venous embolism and thrombosis of other specified veins
454.0	Varicose veins of lower extremities with ulcer
454.1	Varicose veins of lower extremities with inflammation
454.2	Varicose veins of lower extremities with ulcer and inflammation
454.9	Varicose veins of lower extremities without mention of ulcer or inflammation
457.1	Other lymphedema

93965 - continued

459.1	Postphlebitic syndrome
459.81	Venous (peripheral) insufficiency, unspecified
729.5	Pain in limb
729.81	Swelling of limb
757.0	Hereditary edema of legs
786.00-786.59	Symptoms involving respiratory system and other chest symptoms
794.2	Nonspecific abnormal results of pulmonary studies
901.2	Injury to superior vena cava
901.3	Injury to innominate and subclavian veins
902.10	Injury to inferior vena cava, unspecified
902.50	Injury to iliac vessel(s), unspecified
902.87	Injury to multiple blood vessels of abdomen and pelvis
903.00	Injury to axillary vessel(s), unspecified
903.02	Injury to axillary vein
903.1	Injury to brachial blood vessels
903.2	Injury to radial blood vessels
903.3	Injury to ulnar blood vessels
903.5	Injury to digital blood vessels
903.8	Injury to other specified blood vessels of upper extremity
903.9	Injury to unspecified blood vessel of upper extremity
904.2	Injury to femoral veins
904.3	Injury to saphenous veins
904.40	Injury to popliteal vessel(s), unspecified
904.42	Injury to popliteal vein
904.50	Injury to tibial vessel(s), unspecified
904.52	Injury to anterior tibial vein
904.54	Injury to posterior tibial vein
904.6	Injury to deep plantar blood vessels
904.7	Injury to other specified blood vessels of lower extremity
904.8	Injury to unspecified blood vessel of lower extremity
904.9	Injury to blood vessel of lower extremity, unspecified site

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
N/A

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of non-invasive venous studies covered by the Medicare program. Also, the results of non-invasive venous studies covered by the Medicare program must be included in the patient's medical record.

If the provider of non-invasive venous studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information
Goldhaber, S. (1998). Pulmonary thromboembolism. In Fauci, A.S., Braunwald, K., Isselbacher, J., Wilson, J., Martin, J., Kasper, D., Hauser, S., & Longo, D. (Eds.). (1998). Harrison's principles of internal medicine (pp. 1469-1472). New York: McGraw-Hill.

Stauffer, J. (1998). Disorders of the pulmonary circulation. In Tierney, L.M., Jr., McPhee, S.J., Papadakis, M.A. (Eds.). (1998). Current medical diagnosis and treatment (37th ed. pp. 304-311). CT.: 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 numerous societies.

Start Date of Comment Period
N/A

Start Date of Notice Period
07/01/2000

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Explanation of Revision: A revision was made to add ICD-9-CM codes 453.8 and 794.2, to the ICD-9-CM code list based on information we received.

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Original Effective Date: 12/01/94
Revision Date/Number 10/26/98 3 (PCR B98-154)

93965 - continued

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Original Effective Date:	12/01/94 (PCR B94-261)	

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: 98940

Policy Number
98940

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Chiropractic Services

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carrier's Manual 2020.26, 2250, 2251, 4118
Program Memorandum 932B (November 1998)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Policy Effective Date
02/01/1994

Revision Effective Date
04/01/2000

Revision Ending Effective Date
03/31/2000

Policy Ending Date
N/A

LMRP Description
Chiropractic services involve manual manipulation of the spine by a licensed chiropractor to alleviate painful symptomatology due to subluxation of the spine.

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider chiropractic manual manipulation of the spine medically necessary for a beneficiary experiencing a significant neuromusculoskeletal health problem (caused by a spinal subluxation) necessitating manual manipulation by the Chiropractor. In addition, the manipulation must have a direct beneficial therapeutic relationship to the patient's condition. The manipulative service must provide reasonable expectation of recovery or improvement of function.

A licensed chiropractor, who meets national qualifying requirements, is a physician under Medicare Part B for one specific service. Coverage extends *only* to treatment by means of manual manipulation of the spine to correct a subluxation. All other services ordered or furnished by chiropractors are not covered.

In performing manual manipulation of the spine, some chiropractors use manual hand-held devices. The thrust of the force of the device is controlled manually. No additional payment is available for the device's use nor does Medicare recognize an extra charge for the device itself.

Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact. The patient's spinal subluxation, for services processed on April 1, 2000 or after, must be demonstrated by X-ray or physical exam.

Subluxation Demonstrated by X-Ray
For spinal manual manipulation services performed prior to January 1, 2000, the subluxation must be demonstrated by an X-ray taken at a time reasonably proximate to the initiation of the course of treatment. For an acute situation, the documenting X-ray must have been taken no more than twelve (12) months prior or three (3) months following initiation of the course of treatment. In the case of chronic subluxation (e.g., scoliosis) an older X-ray may be accepted provided the beneficiary's health record indicates that the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. Acceptable forms of X-rays include flatplates, magnetic resonance imaging (MRI) studies, and/or computerized tomography (CT) scans. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

Note: Effective for claims with dates of service on or after January 1, 2000, an X-ray is not required to demonstrate the subluxation. However, an X-ray may be used for this purpose if the chiropractor so chooses. Effective for services performed on and after October 1, 2000, the X-ray review process will be reinstituted.

Subluxation Demonstrated by Physical Examination
For spinal manual manipulation services processed April 1, 2000 or after, chiropractors may choose to document the presence of a spinal subluxation through physical examination. To demonstrate the presence of a subluxation, two of the four criteria listed below are required. One of the criteria must be asymmetry/misalignment or range of motion abnormality.

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The evaluation of the musculoskeletal/nervous system must identify:

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

Most spinal joint problems may be categorized as follows:

Acute subluxation - A patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, arrest or retardation of the patient's condition.

Chronic subluxation - A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered.

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

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust. The doctor should discuss the risk with the patient and record this in the chart. However, the presence of several specific health conditions absolutely contraindicates dynamic thrust near the site of the demonstrated subluxation and proposed manipulation. When the medical record supports the presence of an absolute contraindication *near the site of the demonstrated subluxation and proposed manipulation*, the chiropractic manual manipulation will not be considered medically necessary.

The following table itemizes relative and absolute contraindications to dynamic thrust.

Relative Contraindications	Absolute Contraindications
Articular hypermobility and circumstances where the stability of the joint is uncertain	Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation including acute rheumatoid arthritis and ankylosing spondylitis
Severe demineralization of bone	Acute fractures and dislocations or healed fractures and dislocations with signs of instability
Benign bone tumors of the spine	An unstable os odontoideum
Bleeding disorders and anticoagulant therapy	Malignancies that involve the vertebral column
Radiculopathy with progressive neurological signs	Infections of bones or joints of the vertebral column
	Signs and symptoms of myelopathy or cauda equina syndrome
	For cervical spinal manipulations, vertebrobasilar insufficiency syndrome
	A significant major artery aneurysm near the proposed manipulation

Some chiropractors have been identified as using an "intensive care" concept of treatment. Under this approach, multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day unless documentation of the reasonableness and necessity for additional treatment is submitted with the claim.

HCPCS Section & Benefit Category

Chiropractic Manipulative Treatment/Medicine

HCPCS Codes

98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	spinal, three to four regions
98942	spinal, five regions
98943	extraspinal, one or more regions

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

346.00-346.91	Migraine
350.1-350.9	Trigeminal nerve disorders (Neuralgia)
352.0-352.9	Disorders of other cranial nerves
353.0-353.4	Nerve root and plexus disorders
355.0	Lesion of sciatic nerve
355.1	Meralgia paresthetica
356.0	Hereditary peripheral neuropathy
356.1	Peroneal muscular atrophy
356.4	Idiopathic progressive polyneuropathy
356.8	Other specified idiopathic peripheral neuropathy
715.00	Osteoarthrosis, generalized, site unspecified (Degenerative Joint Disease, [DJD])

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715.09	Osteoarthrosis, generalized, multiple sites
715.10	Osteoarthrosis, localized, primary, site unspecified
715.18	Osteoarthrosis, localized, primary, other specified sites
715.20	Osteoarthrosis, localized, secondary, site unspecified
715.28	Osteoarthrosis, localized, secondary, other specified sites
715.30	Osteoarthrosis, localized, not specified whether primary or secondary, site unspecified
715.38	Osteoarthrosis, localized, not specified whether primary or secondary, other specified sites
715.80	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized, site unspecified
715.89	Osteoarthrosis involving, or with mention of more than one site, but not specified as generalized, multiple sites
715.90	Osteoarthrosis, unspecified whether generalized or localized, site unspecified
716.10	Traumatic arthropathy, site unspecified
716.90	Arthropathy, unspecified, site unspecified
720.0	Ankylosing spondylitis
720.1	Spinal enthesopathy
720.2	Sacroiliitis, not elsewhere classified
720.81	Inflammatory spondylopathies in diseases classified elsewhere
720.9	Unspecified inflammatory spondylopathy
721.0-721.91	Spondylosis and allied disorders
722.0	Displacement of cervical intervertebral disc without myelopathy
722.10-722.11	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.30-722.32	Schmorl's nodes
722.4	Degeneration of cervical intervertebral disc
722.51-722.52	Degeneration of thoracic or lumbar intervertebral disc
722.70-722.73	Intervertebral disc disorder with myelopathy
722.80-722.83	Postlaminectomy syndrome
722.90-722.93	Other and unspecified disc disorder
723.0-723.9	Other disorders of cervical region
724.00-724.09	Spinal stenosis, other than cervical
724.1	Pain in thoracic spine
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.6	Disorders of sacrum
724.71-724.79	Disorders of Coccyx
724.8	Other symptoms referable to back
726.5	Enthesopathy of hip region
726.90	Enthesopathy of unspecified site
728.10	Calcification and ossification, unspecified
728.11	Progressive myositis ossificans
728.12	Traumatic myositis ossificans
728.2	Muscular wasting and disuse atrophy, not elsewhere classified
728.3	Other specific muscle disorders
728.4	Laxity of ligament
728.5	Hypermobility syndrome
728.81	Interstitial myositis
728.85	Spasm of muscle
729.0	Rheumatism, unspecified, and fibrositis
729.1	Myalgia and myositis, unspecified
729.2	Neuralgia, neuritis, and radiculitis, unspecified
733.00-733.09	Osteoporosis
737.0	Adolescent postural kyphosis
737.10	Kyphosis (acquired) (postural)
737.12	Kyphosis, postlaminectomy
737.20-737.22	Lordosis (acquired)
737.30	Scoliosis and kyphoscoliosis, idiopathic
737.31	Resolving infantile idiopathic scoliosis
737.32	Progressive infantile idiopathic scoliosis
737.34	Thoracogenic scoliosis
737.8	Other curvatures of spine
738.2	Acquired deformity of neck
738.4	Acquired spondylolisthesis
738.6	Acquired deformity of pelvis
756.11-756.17	Anomalies of spine
756.2	Other congenital musculoskeletal anomalies, cervical rib
784.0	Headache
846.0	Sprains and strains of lumbosacral (joint)(ligament)
847.0-847.4	Sprains and strains of other parts of back
848.3	Other and ill-defined sprains and strains, ribs
848.41	Other and ill-defined sprains and strains, Sternoclavicular (joint)(ligament)
848.42	Other and ill-defined sprains and strains, Chondrosternal (joint)
848.5	Other and ill-defined sprains and strains, Pelvis
905.1	Late effect of fracture of spine and trunk without mention of spinal cord lesion
905.6	Late effect of dislocation
907.3	Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk
953.0-953.5	Injury to nerve root and spinal plexus
954.0	Injury to cervical sympathetic nerve
954.1	Injury to other sympathetic nerve(s)
956.0	Injury to sciatic nerve

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.

Services would not be considered medically reasonable and necessary in the absence of pain or symptomatology resulting from a subluxation of the spine.

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Medicare's coverage for Chiropractic services is limited to manual manipulation of the spine. Any other diagnostic or therapeutic services(s) furnished by a chiropractor or under his or her order will be denied.

All claims submitted for chiropractic manipulative treatment by specialties other than specialty 35 (Chiropractor) will be denied.

Procedure code 98943 is a non-covered service.

Effective January 1, 1999-December 31, 1999:

If the beneficiary refuses to have an X-ray to demonstrate subluxation of the spine, the claim will be denied as a technical denial.

Noncovered ICD-9CM 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

The date of initial treatment or date of exacerbation of the existing condition must be entered in Item 14 of FORM HCFA-1500. This serves as affirmation by the chiropractor that all documentation requirements are being maintained on file by the chiropractor.

If the subluxation is being demonstrated by X-ray for dates of service *prior* to January 1, 2000, enter the X-ray date in Item 19. By completing both items 14 and 19, the chiropractor is certifying that all relevant information requirements are on file along with the appropriate X-ray and all are available for review. It is no longer required to annotate on the claim that the X-rays are available for review. If the subluxation is being demonstrated by X-ray for services on and after October 1, 2000, the above coding guidelines apply.

For acute conditions with the subluxation being demonstrated by an X-ray, add modifier AT (acute treatment) to the chiropractic manipulative treatment HCPCS Code. This modifier will substantiate if the date of the X-ray is reasonably proximate to the initiation of a course of treatment. For chronic conditions or acute exacerbations of a chronic condition in which an older X-ray or diagnostic test is being used to document the subluxation, no modifier is required. It is expected the beneficiary's health record will indicate the condition has existed longer than 12 months and there is reasonable basis for concluding that the condition is permanent.

For services performed January 1, 1999 - December 31, 1999 in which the beneficiary refuses to have an X-ray, the chiropractor must submit one of the appropriate HCPCS codes for chiropractic manipulation in addition to modifier GX (service not covered by Medicare). The claim will be denied as a technical denial.

Procedure codes 98940- 98942 do not represent add-on codes wherein more than one is required to report additional regions. For example, to report CMT of five spinal regions you report only code 98942 as this code includes all five regions.

Documentation Requirements

The following documentation must be maintained in the patient's file. The documentation must be legible and in English.

Initial Visit - The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical exam:

1. History should include the following -
   The symptoms causing the patient to seek treatment;
   The family history if relevant;
   The past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
   The mechanism of trauma;
   The quality and character of symptoms/problem;
   The onset, duration, intensity, frequency, location and radiation of symptoms;
   Aggravating or relieving factors; and
   Prior interventions, treatments, medications, secondary complaints.
2. Description of the present illness including -
   The mechanism of trauma;
   The quality and character of symptoms/problem;
   The onset, duration, intensity, frequency, location, and radiation of symptoms;
   Any aggravating or relieving factors;
   Prior interventions, treatments, medications, secondary complaints; and
   The symptoms causing the patient to seek treatment.

Note: These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i. e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination. The criteria identified under the "Indications and Limitations etc." section must be present.
4. Diagnosis - The primary diagnosis must be subluxation, including the precise level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise

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level of the subluxation may be specified by the exact bones (C5, C6, etc.) or the area may suffice if it implies only certain bones such as occipito-atlantal (occiput & C1[atlas]), lumbo-sacral (L5 and Sacrum) or sacro-iliac (sacrum and ilium).

Examples of acceptable descriptive terms, for the nature of the abnormality/subluxation:

off centered	motion	malpositioning
misalignment	-limited	rotation
lithiasis	-lost	incomplete dislocation
-antero	-restricted	spacing
-postero	-flexion	-abnormal
-retro	-extension	-altered
-lateral	-hypermobility	-decreased
-spondylo	-hypomotility	-increased
	-aberrant	

Other terms may be used if they are *clear* to mean bone/ joint space, position or motion changes of the vertebral elements.

The precise level of subluxation is made in relation to the part of the spine in which the subluxation is identified:

Area of Spine	Names of Vertebrae	Number of Vertebrae	Short Form or Other Name
Neck	Occiput Cervical Atlas Axis	7	Occ, CO Cl thru C7 C1 C2
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1 thru D12 T1 thru T12 R1 thru R12 R1 thru R12
Low Back	Lumbar	5	L1 thru L5
Pelvis	Ilii, right and left		I, Si
Sacral	Sacrum, Coccyx		S, SC

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

5. Treatment Plan - The treatment plan should include the following:

   Recommended level of care (duration and frequency of visits);
   Specific treatment goals; and
   Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment or date of exacerbation of the existing condition.

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

1. History -
   Review of chief complaint;
   Changes since last visit; and
   System review if relevant.

2. Physical exam -
   Exam of area of spine involved in diagnosis;
   Assessment of change in patient condition since last visit; and
   Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

4. Any changes in the treatment plan.

The following documentation requirement applies to subluxations demonstrated by X-ray (required prior to January 1, 2000 and for services performed on and after October 1, 2000):

The X-ray must be in one of the following forms – flat plate, MRI or CT Scan. The X-ray must be dated and demonstrate the precise level of the spinal subluxation.

An X-ray obtained by the chiropractor for his own diagnostic purposes before commencing treatment should suffice for claims documentation purposes. However, when subluxation was for treatment purposes and diagnosed by some other means and X-rays are taken to satisfy Medicare's documentation requirement, carriers should ask chiropractors to cone in on the site of the subluxation in producing X-rays. Such a practice would not only minimize the exposure of the patient but also should result in a film more clearly portraying the subluxation. An X-ray will be considered of acceptable technical quality if any individual trained in the reading of X-rays could recognize a subluxation if present.

The X-ray report, indicated by the date documented on the HCFA Form 1500, must be available for carrier review. The report must demonstrate the existence of the subluxation at the specified level of the spine.

In the event of a medical record review, the X-ray report must be submitted. The actual X-ray films are to be maintained by the chiropractor.

Utilization Guidelines

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of subluxation within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as 3 months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained. Chronic spinal joint condition (e.g., loss of joint mobility or other joint problems) implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Other Comments

Chiropractic or physician consultation should be utilized for the review process, if there is a question as to the validity of medical necessity of the claim.

The following terms are used in this policy:

Ankylosis: immobility and consolidation of a joint due to disease, injury or surgical procedure

Arthritis: rheumatism in which the inflammatory lesions are confined to the joints

Arthrosis: a joint or articulation; a disease of a joint

Atlanto: occipital - region of the spine pertaining to the occiput and the first cervical segment

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Axis: second cervical segment of the spine

Chronic: persisting over a long period of time: designating a disease showing little change or of slow progression; opposite of acute

"C" curve: the normal cervical lordosis

Dorsal: refers to mid-back/thoracic region

Flexion: bending

Intervertebral disc: layers of fibrocartilage between the bodies of adjacent vertebrae, consisting of a fibrous ring enclosing a pulpy center

Kyphosis: "hunchback"; abnormal increase in convexity in the curvature of the thoracic spine

Lordosis: "sway back"; anterior concavity in the curvature of the lumbar and cervical spine as viewed from the side

Manipulation: (adjustment) - skillful treatment or procedure involving the use of hands

Paralysis: loss of motor function

Paresis: weakness or incomplete paralysis

Radicular pain: pain resulting from nerve root irritation

Rotation: the process of turning around an axis

Scoliosis: an appreciable lateral deviation in the normally straight vertical line of the spine

Spondylitis: inflammation of the vertebrae

Subluxation: an incomplete dislocation, off-centering, misalignment fixation or abnormal spacing of the vertebrae anatomically

Vertebrae: any of the 33 bones of the spinal column, comprising the 7 cervical, 12 thoracic, 5 lumbar, 5 sacral and 4 coccygeal vertebrae

Acceptable terminology for spinal manipulation:
- manual adjustment, correction or manipulation
- spinal adjustment, correction or manipulation
- vertebral adjustment, correction or manipulation
- manipulation of spine by chiropractor activator
- spine or spinal adjustment by manual means
- correction equals treatment

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 multiple specialties.

Start Date of Comment Period
N/A

Start Date of Notice Period
01/01/2000

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Start date of notice period: 01/01/2000
Jan/Feb 2000 *Update!*
Revised Effective Date: 04/01/2000
Explanation of Revision: HCFA revised the chiropractic utilization guidelines and documentation requirements. The benefit now allows the subluxation to be demonstrated by X-ray or physical exam.

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(PCR B2000-072)

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HCPCS 2000

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(PCR 99-032)
1999 HCPCS

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(PCR B97-094)
3 (PCR B97-010)
2 (PCR 96-143)
1 (PCR 95-034)
PCR 93-173

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

ELECTRONIC MEDIA CLAIMS

Filing Medicare Claims Electronically

Electronic Media Claims (EMC) filing was created to enable 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 can be used for this purpose. Upgrading your software and purchasing a modem (if necessary) is all it takes.

Service Bureaus, Billing Services, and Clearinghouses - These types of companies 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.

Types of claims that may be submitted electronically 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. ❖

Electronic Funds Transfer

Electronic Funds Transfer (EFT) is a payment option offered to all providers that allows for direct deposit of Medicare Part B payments. There are no requirements to meet in order to have this capability. Payments are deposited within 24-48 hours of the check date (depending on the provider's bank distribution procedures).

Providers who elect EFT still receive the paper remittance data showing payment information (Electronic Remittance Notification, or ERN, allows providers to receive this information electronically as well).

Providers who are interested in this or any other electronic application should contact Provider Electronic Services Marketing at (904) 791-8767. ❖

Electronic Remittance Notification

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/medicare/edi/edi3.htm**

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

Caveat Emptor - Let the Buyer Beware

The Medicare program is the single largest payer of health care benefits in this country. As such, Medicare is big business and has attracted, as big businesses sometimes do, a few unsavory characters. Although the majority of health care providers (e.g., physicians, hospitals, laboratories, medical equipment suppliers, etc.) and other organizations that may be indirectly involved in the Medicare program (billing agencies, medical management firms, consultants, etc.) are honest, those few who are not cause billions of taxpayer dollars to be inappropriately paid each year. Thus, it is important that health care providers and others understand the risks that may be associated with conducting business within the Medicare program.

In some instances, a scam or fraudulent activity may not result in a direct loss to the Medicare program. However, the scam or activity may mislead a health care provider into making unsound business decisions or, as a result, cause improper payments to be made by the Medicare program. The example of such an activity that follows is based on the use of a private billing company or consulting firm, it is not meant as an indictment of those entities.

> An advertisement is sent to health care providers outlining the benefits of hiring a billing company to file their Medicare claims electronically for the provider. This activity in itself is not illegal; Medicare encourages providers to file electronically (please refer to "Electronic Media Claims" on page 67). However, some advertising may include the following kinds of statements:
>
> > The company indicates it is affiliated with either the Health Care Financing Administration (HCFA) or the Medicare contractor(s). *Neither HCFA nor Medicare contractors have any affiliation with private billing companies, consulting firms, or the like.*
> >
> > The company misrepresents or exaggerates the time it takes to process claims filed electronically versus those filed on paper. *While it is true that "clean" claims filed electronically are paid sooner than "clean" paper claims, some advertising leads the readers to believe that paper claims are not even looked at or entered into the claims processing system until the 27th day after they are submitted. This statement is not true—to be more accurate, a "clean" electronic claim is paid on the 14th day after it is submitted and a "clean" paper claim is paid on the 27th day after it is submitted.*
> >
> > The company indicates that electronic claims are paid without question and that paper claims are paid only on a "funds availability" basis. *All covered services reported on a claim (regardless of how it is submitted)* ***must*** *be paid by the Medicare program. There is no "funds availability" policy.*
> >
> > The company indicates that the provider may be at risk of losing their participation status with the Medicare program if they do not file claims electronically, or the company indicates that there is an additional fee or "penalty" associated with filing paper claims to Medicare. *There is no mandate that requires health care providers to file their claims electronically to Medicare. Health care providers are only required to submit claims for qualified Medicare recipients to whom services and items are furnished. The method of submission is the choice of the provider. Again, however, there are benefits to filing claims electronically.*
> >
> > Some companies indicate they can assist the provider "maximize" reimbursements from the Medicare program. *Although health care providers should be paid appropriately for the services and items they furnish, they should exercise caution when attempting to "maximize" their payments as this may lead to improper billing, "upcoding" or even misrepresentation of claims or records. If done willfully and knowingly, this type of activity is considered fraud and is punishable by law.*

To ensure that a health care provider or other organization conducts business appropriately in the Medicare program, several safeguard practices should be considered. Regardless of whether a provider contracts with a private billing company or consulting firm or hires its own employees, here are a few useful suggestions to consider:

- The employees, billing company, or consulting firm should have at least a working knowledge of the Medicare program as it pertains to their particular business. Information regarding the Medicare program, its policies and its guidelines can be obtained from a number of resources such as: seminars or workshops, publications, web sites, health care attorneys, consultants, and, of course, the Medicare contractors.
- The provider or organization may consider implementing a compliance program to ensure that they not only adhere to Medicare regulations, but to ensure that they are engaged in sound, ethical business practices. Note that compliance programs are not required, but have proven to be effective for many health care providers.
- Periodic "self-checks" or audits may be conducted to ensure compliance with regulations and billing guidelines. In addition, the audits may serve as a method for identifying areas for improvement as well as identifying inappropriate practices or payments.
- Ensure that the employees, billing company, or consulting firm maintains the integrity and confidentiality of medical records, patients' health insurance information, and providers' billing numbers.

Billing agencies, medical management firms, and consultants provide services that can be of value to a provider's practice, although these companies do not do anything a provider cannot do for him or herself. Following the guidelines outlined in this article will allow providers to minimize risks while doing business within the Medicare program. ❖

GENERAL INFORMATION

"Do Not Forward" Initiative

The following information was published in the May/June 2000 Medicare B Update! *(page 57). It is being reprinted below as a reminder. Note that Form HCFA-855C is now available online.*

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 department at (904) 634-4994, or log on to our website, **www.floridamedicare.com**. Addresses *cannot* be changed based on telephone calls; written notification as described above is required. ❖

Overpayment Interest Rate

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

Effective May 3, 2000, the interest rate applied to Medicare overpayments is **13.75** percent, based on the new revised PCR rate. The following table lists previous interest rates.

Period	Interest Rate
February 2, 2000 – May 2, 2000	13.50%
October 28, 1999 - February 1, 2000	13.375%
August 4, 1999 - October 27, 1999	13.25%
May 05, 1999 - August 3, 1999	13.375%
February 1, 1999 - May 04, 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%
October 24, 1996 - January 22, 1997	13.375% ❖

MEDICARE REGISTRATION

Applications Available Via Webpage

Enrollment applications [General Enrollment (HCFA-855), Individual Reassignment of Benefits (HCFA-855R) and Change of Information (HCFA-855C)] are now available for downloading from our provider website, **www.floridamedicare.com**. They may also be obtained by contacting Provider Customer Service at (904) 634-4994. ❖

Portable X-Ray and IDTF Provider Numbers

The Health Care Financing Administration (HCFA) has advised that portable X-ray suppliers are to be separately certified when a company provides both Independent Diagnostic Testing Facility (IDTF) and portable X-ray services. This is because portable X-rays are a separate benefit under the law.

If a company provides IDTF and portable X-ray services, the company will be assigned two provider numbers; one for use when billing for IDTF services, and one when billing for portable X-ray services.

IDTF's should obtain enrollment materials by contacting Provider Customer Service at (904) 634-4994 or log on to **www.floridamedicare.com**. Portable X-ray suppliers should obtain enrollment materials by contacting The Agency for Health Care Administration at (850) 487-2717. ❖

Cardiac Catherization Facilities/Clinics

A few facilities/clinics in Florida provide cardiac catherization services. Provider number assignment is dependent on who will be performing the services.

- If all of the physicians performing services are employees of the facility/clinic, a group provider number will be assigned. The facility/clinic would bill globally for services rendered.
- If the facility/clinic allows only physicians that are not employees to utilize their facility, the facility will be assigned a specific provider number that will allow it to bill for the technical component. The physician performing the service would bill for the professional component.
- If the facility/clinic has both employees and non-employees performing services, they will be assigned a group provider number and a specific facility/clinic provider number.

If the facility/clinic contracts with individual physicians and the physicians reassign benefits to the facility/clinic, the facility/clinic may be assigned a group provider number and the contracted individual added as a group member. In this manner, the facility/clinic may bill globally.

When a facility/clinic is planning on performing cardiac catherization services and is requesting enrollment, a cover letter should be attached to the enrollment application indicating that they plan on billing for cardiac catherization services and how their facility/clinic is composed.

Refer to the January/February 2000 *Medicare B Update!* (page 12) for additional billing information. ❖

MEDIGAP CROSSOVER

Crossover Updates

The following updates have been made to the Medicare Part B of Florida Crossover Insurers list. These changes can be viewed on our website at **www.floridamedicare.com** in the Part B Medigap section**.** An updated Understanding Crossover document and Medigap Listing is available on the website as well.

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

Automatic Crossover

- New Crossover Insurer

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

- Updates to Crossover Insurers

  Health Data Management Corporation (HDM)
  Added Plans Administer for:
  GE Capital

  Olympic Health Management (OLHM)
  Added Plans Administer for:
  Combined Insurance Company of America

Medigap Crossover

- Address Change

Number	Insurer Name/Address
48059	London Life Reinsurance PO Box 7777 Lancaster PA 17604
33013	Lutheran Brotherhood PO Box 9482 Minneapolis MN 55440

- Name Change

Number	Former Name	New Name
25002	BCBS of Iowa	Wellmark BCBS of Iowa
47001	BCBS of Oregon	Regence BCBS of Oregon

- Exempt Non-Medigap Insurers

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

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

Number	Insurer Name
45119	American Healthcare
15086	Assn Group Admin
19667	Atlanta Life Insurance
61078	British Embsy
19829	City of Venice
48399	Cuna Mutual Ins Society
19649	DBS
30061	First UNUM Life
19285	HMO Well Care
45133	Huntington National
48374	Ins Co of North America
35053	Investors Life
15130	Kaiser Foundation
42163	Laguardia Medical
31027	Med 65
59045	Mutual Aid
42197	Nat's Maritime Union
20080	NMU Pension Welfare
42209	Norton Company
15134	Occidental Life
53074	Stanford Insurance
19340	Sunbeam Bakeries
45065	Teamsters Local 473
15092	The New England
19384	US Security Ins
59038	Wisconsin Health Ins ❖

EDUCATIONAL RESOURCES

MEDICARE PROVIDER EDUCATION AND TRAINING EVENTS FOR YEAR 2000

MEDIFEST 2000
The Cutting Edge Training Conference

The Tampa/St. Petersburg (July 11&12) and Orlando (August 8&9) MEDIFEST events are sold out!!! Check out the remaining events Medicare Education and Outreach will conduct in 2000:

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

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

FREE!!!

Part A & B:

Jacksonville - July 26, 2000
First Coast Service Options, Inc.
Blue Cross Blue Shield Building
532 Riverside Ave.
(904) 792-8299

8:30 – 11:30 a.m.

❑ Rehabilitative Services

If you have questions for the above seminar please call (904) 791-8299.

Four Easy Steps to Register:

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

OR

STEP 2: Mail this form to:

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 3: 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

Register TODAY!!
Seating is Limited!

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: Mail this form to:

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 3: 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

Register TODAY!!
Seating is Limited!

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: ( ) _____

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

FREE!!!

❑ **July 28, 2000**

Location: First Coast Service Options, Inc.
Blue Cross Blue Shield Building
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: **Mail this form to:**

Seminar Registration
PO Box 45157
Jacksonville, FL 32231

STEP 3: **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**

Register TODAY!!
Seating is Limited!

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.**

FREE!!!

❑ **July 28, 2000**

Location: **First Coast Service Options, Inc.**
Blue Cross Blue Shield Building
532 Riverside Ave.
Jacksonville, FL 32202

Provider Education and Training Advisory Meeting

Medicare Education and Outreach cordially invites you to attend our quarterly Part A and Part B Provider Education and Training Advisory Meeting on September 27, 2000 in Jacksonville.

First Coast Service Options, Inc. is excited about offering a forum to encourage open dialogue between the Medicare contractor and representatives from state medical societies, specialty associations, provider organizations, practitioners, consultants, billing staffs, and others.

During this session the contractor will share important information about Medicare initiatives, trends, aberrancies, other significant issues.

With the help of individuals like you we have proven that partnership works to help us make operational improvements. We are seeking your help to:

- Recommend areas for additional policy clarifications/provider training
- Assist in the improvement of our *Medicare A Bulletin* and *Medicare B Update!*
- Enhance our customer service ARU system
- Recommend topics for special curriculum development
- Evaluate the value and effectiveness of educational sessions attended
- Alert First Coast Service Options to claim processing/system irregularities effecting provider billing

How to prepare for this meeting:

1. Note your recommendations or topics of concern in the space provided below (additional pages are welcome)
2. Fax your registration and comments 10 days prior to the event (September 15, 2000)
3. Be prepared to discuss your ideas in an open and relaxed forum

_____

_____

_____

Please come and spend an exciting and informative half day with us! Your contributions are vital to the success of your carrier/ intermediary. You will not be disappointed.

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.**
Blue Cross Blue Shield Building
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.**

❑ **September 27, 2000**

Please RSVP 10 days prior to the event
Mark your calendar!

www.floridamedicare.com — Florida Medicare's Provider Website

The following outlines information that is available as of June 2000 on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider website.

What's New

Provides a brief introduction to recent additions to specific areas of the site.

Part A

Reason Codes **-** A listing of codes used by Part A to explain actions taken on line items/claims.

Draft and Final LMRPs **-** FCSO's final and draft local and focused medical review policies (LMRPs/FMRPs).

Fraud & Abuse **-** Articles of interest concerning fraud, abuse, and waste in the Medicare program.

Publications **-** *Medicare A Bulletin* [coming soon!]

Part B

Draft and Final LMRPs **-** FCSO's final and draft local and focused medical review policies (LMRPs/FMRPs).

Fraud & Abuse **-** Articles of interest concerning fraud, abuse and waste in the Medicare program.

MEDIGAP Insurer Listing **-** Information about claim crossovers (e.g., list of auto-crossovers, etc.).

Publications **-** *Medicare B Update!* [coming soon!]

Shared

Information common to both Medicare Parts A and B

Education **-** Medicare Educational resources and a "Calendar of Events."

UPIN Directory

MEDPARD Directory

Forms **-** Various enrollment applications and materials order forms.

EDI

Forms **-** Various EDI application enrollment forms such as EMC, ERN, electronic claims status, etc.

Specs **-** Format specification manuals for programmers.

Other **-** EDI Vendor List and other important news and information.

Extra

Guestbook **-** Provide online feedback on the operation of this website.

Site Help

Contact Us **-** Important telephone numbers and addresses for Medicare Part A and Part B and website design comment form (to Webmaster).

Links **-** Informational links to other websites (e.g., HCFA, Medicare Learning Network, etc.).

Search

Enables visitors to search the entire site or individual areas for specific topics or subjects.

Log on Today!!

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-to-Diagnosis Relationship Manual - This manual is no longer available for a fee in hard copy format, effective June 1, 2000. All orders for the Procedure-to-Diagnosis manual received on and after June 1, 2000 will receive a complete payment refund. Recognizing the importance of the manual to providers' practices, Florida Medicare has developed a no-cost alternative for continuing to provide this information. Although Medicare contractors have been temporarily instructed to delay displaying this type of information on websites until approval is received from HCFA, it is anticipated that this manual will be posted to our website at **www.floridamedicare.com** in the near future. Notification will be provided in a future issue of the *Medicare B Update!* once the approval has been issued.		

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

A

B

C

C (continued)

D

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

E

F

G

H

H (continued)

I

L

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

M

M (continued)

N

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

N (continued)

O

P

P (continued)

R

S

T

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

U

V

W

X

Y

Y (continued)

Modifiers

Modifiers (continued)

Procedure Codes

HCPCS Codes

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

HCPCS Codes (continued)

Anesthesia/Surgery, 00100-69979

Anesthesia/Surgery (continued)

Diagnostic Tests 70010-89399

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

Diagnostic Tests (continued)

Medicine, 90281-99199

Medicine (continued)

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

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

WEBSITES

PROVIDER

Florida
www.floridamedicare.com
Health Care Financing Administration
www.hcfa.gov

BENEFICIARY

Florida
www.medicarefla.com
Health Care Financing Administration
www.medicare.gov

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

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

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

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

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

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

PHONE NUMBERS

BENEFICIARY

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

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

PROVIDERS

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

EMC

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

OCR

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

MEDICARE ONLINE BBS

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

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
(803) 735-1034

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

*** ATTENTION BILLING MANAGER***

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