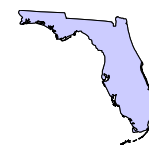


Medicare B Update!

A Newsletter for Florida Medicare Part B Providers



In This Issue...

A Physician's Focus

A Letter From the Carrier Medical Director 3

Administrative

Including Information on the Advance Notice Requirement 4

Claims

Claims and Appeals Submission Requirements and Tips 5

Coverage/Reimbursement

Specific Regulations and Pricing Information 6

Local and Focused Medical Review Policies

Final Policies Including Effective Dates 34

Electronic Media Claims

Information on HIPAA, and EMC Submissions 79

General Information

Fraud and Abuse, Medicare Secondary Payer, and Other Issues 80

Educational Resources

Seminar and Training Information and Order Forms 89

DynCorp Requests Medical Records for Therapy Services

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), has contracted with one of their Program Safeguard Contractors, DynCorp TRP, to perform a number of tasks related to physical therapy, occupational therapy, and speech language pathology services.

Among the tasks is medical review of therapy services to determine the appropriateness of claim processing results. In order to accomplish this, DynCorp is contacting providers to request medical records associated with the 1998, 1999 and 2000 therapy services. CMS is anticipating that providers comply with the medical records requests and appreciates your cooperation.

For more information and education, visit the DynCorp TRP website at www.dynpsc.org.

The Medicare B Update! should be shared with all health care practitioners and managerial members of the provider/supplier staff. Issues published beginning in 1997 are available at no cost from our provider Website, www.floridamedicare.com.

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____
- _____
- _____



TABLE OF CONTENTS

From the Medical Director

A Physician's Focus - "Frequently Asked Questions" 3

Administrative

General Information About the *Medicare B Update!* 4

Advance Notice Requirement 4

Claims

2002 ICD-9-CM Coding Changes 5

Correct Coding Initiative 5

Split Billing 5

Pneumococcal Pneumonia, Hepatitis B,
and Influenza Virus Vaccines 6

Coverage/Reimbursement

Ambulatory Surgical Center

Clarification of Payment and Place of Service

Requirements for ASC Claims 9

Anesthesia

Billing Procedures and Modifiers for CRNA and an

Anesthesiologist in a Single Anesthesia

Procedure 9

CPT Code 01784 Discontinued for 2001—

Correction to Article 9

Drugs and Biologicals

Updated Allowances for Injectable Drugs 9

Durable Medical Equipment, Prosthetics,

Orthotics, and Supplies (DMEPOS)

DMEPOS Items Processed by Local Carriers—

Correction to Article 10

Evaluation and Management Services

Non-Global Preoperative Services 10

Expansion of Medicare Reimbursement for

Telehealth Services 11

Visits to Patients Residing in Various

Places of Service 13

HCPCS

Deletion of HCPCS Codes A9160, A9170, A9190,

and Modifier GX and Replacement with New

Codes and Modifiers; Status Change to

HCPCS Code A9270 14

Laboratory/Pathology

82962—Pricing Revision 15

New CLIA Waived Tests 15

Podiatry

Follow Up from Podiatry Seminars 16

Radiology

New PET Scan Codes—Corrected Allowances 17

Surgery

Clinical Trials on Carotid Stenting with Category B

Investigational Device Exemptions (IDEs) 18

Adult Liver Transplantation—

Expansion of Coverage 18

Cryosurgery of the Prostate Gland Performed as

Salvage Therapy 18

Local and Focused

Medical Review Policies

Focused Medical Review

J9217 – Leuprolide Acetate

(for Depot Suspension), 7.5 mg. 19

Proper Coding for Correction of Trichiasis 20

Local Medical Review Policy

A0430: Air Ambulance Services 20

A9270: The List of Medicare Noncovered Services 23

G0030: Positron Emission Tomography (PET) Scan .. 28

G0104: Colorectal Cancer Screening 34

G0108: Diabetes Outpatient Self-Management

Training 36

J1745: Infliximab (Remicade™) 39

Appropriate Billing of J9219 Leuprolide Acetate

Implant (VIADUR™) 41

00001: Independent Diagnostic Testing Facility

(IDTF) 41

00103: Anesthesia Services (Ocular Procedures) ... 54

Anesthesia for Panniculectomy 57

31231: Diagnostic Nasal Endoscopy 57

55873: Cryosurgical Ablation of the Prostate 59

62310: Epidural/Subarachnoid Injections—

Correction 61

85007: Complete Blood Count 61

88141: Pap Smears 64

90901: Biofeedback 66

92225: Ophthalmoscopy 69

93303: Transthoracic and Doppler

Echocardiography and Doppler Color Flow

Velocity Mapping 71

99183: Hyperbaric Oxygen Therapy (HBO Therapy) .. 73

Electronic Media Claims

HIPAA-AS Standard-Health Care Claim and

Coordination of Benefits (COB) Transactions .. 74

MailBox Migration Deadline 74

General Information

Fraud and Abuse

Undercover Investigation Reveals Unethical Tactics ... 75

DMERC

DMERC Region C Physician Information Sheet

(PHYIS): Respiratory Assist Devices (RAD) 75

Home Health Consolidated Billing

Home Health Prospective Payment System

(HH PPS) Consolidated Billing—Revised Edits 78

Procedures Subject to Home Health Consolidated

Billing—Clarification 78

Coordination of Benefits

COB Contractor Fact Sheet for Providers 79

The Patient Friendly Advisory

Toll-Free Helpline Available to Assist your Patients

with Medicare Questions 80

General Information

Services and Items Furnished to Prisoners 81

The Interactive Voice Response System 81

Educational Resources

Medicare Education and Training Events 84

Medicare Part B Cardiology Seminars for 2001 85

Medicare Part B Beyond the Basics

Workshops for 2001 86

Florida Medicare Education and Training Resource

Manual Order Form 87

Florida Medicare Education and Training Individual

Module Order Form 88

Order Form – 2001 Part B Materials 89

Medicare B Update! Reader Survey 90

Important Addresses, Phone Numbers,

and Websites 91

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A PHYSICIAN'S FOCUS

"Frequently Asked Questions"

As I meet with various physician groups, I get asked many questions about Medicare. I have included some of the most frequently asked in this quarter's update article. The questions come from a fictional provider who has no resemblance to anyone living or dead.



Q. How does Medicare decide which services to cover?

A. The criteria for Medicare coverage decisions goes back to the law that says that Medicare may cover a service if it is considered to be "medically necessary and reasonable."

Q. Well then, what do you mean by "medically necessary and reasonable?"

A. "Medically necessary and reasonable" services are those things that are needed to diagnose and treat illnesses, injuries and deformities.

Q. Prescription drugs are necessary to treat illnesses. Why are they not covered?

A. When Medicare became law, there was not enough tax money to provide everything and prescriptions were a small part of the health care bill. They were therefore excluded as a benefit. Screening services, preventive services and cosmetic surgery were also excluded.

Q. But I thought that Medicare covered some preventive services such as screening tests and immunizations.

A. That's right. Congress has passed special legislation to cover some screening services such as mammograms, Pap tests, prostate cancer tests, and colon cancer tests. Some preventive services such as immunizations for flu and pneumonia have also been added. Others may be added in the future. It also seems probable that Congress will add a prescription drug benefit in the near future.

Q. What is this I hear about the Health Care Financing Administration (HCFA) changing its name?

A. Correct again. HCFA came into being during President Carter's administration. Secretary of Health and Human Services Tommy Thompson has announced that the new name will be the Centers for Medicare and Medicaid Services (CMS).

Q. How do I as a provider know which services are covered by Medicare?

A. Coverage decisions are made nationally by CMS (formerly HCFA) and locally by First Coast Service Options, Inc., the local Carrier. The national decisions are published in the Coverage Issues Manual and are also found on their website, www.hcfa.gov. The local policies are published in the *Medicare Part B Update!* that is mailed to each person billing the Carrier, and are also on our Website, www.floridamedicare.com.

Q. Many of my patients are having a hard time making ends meet. Is it okay if I make up a diagnosis so that Medicare will pay and save my patient the expense?

A. The answer is definitely *no!* Such a practice would be considered fraud. I used to be surprised by that question. But then I read an article that reported a survey that indicated that forty to fifty percent of respondents had used some form of deception in the past year to help patients obtain coverage for services. I would strongly recommend that physicians *not* engage in this type of activity.

Q. What is this Qui Tam I keep hearing about?

A. The Qui Tam Law allows an individual to sue another individual or company in the name of the government to collect funds that were inappropriately billed to and collected from the government. The government will then prosecute the case and the "whistle blower" will be given a percentage of the settlement. Every year the government recovers millions of dollars from these actions.

Q. It is difficult for me to keep up with what Medicare covers and what it does not. Can I just get an Advance Beneficiary Notice (ABN) from all of my Medicare patients and bill them if Medicare fails to pay?

A. No. Such a practice would be abusive and unfair to your patients. The rules for ABNs are much more specific than that and are published in this and every issue of the *Medicare Part B Update!* (see page 4).

Q. Is there anything you would like to say in conclusion.

A. Yes. We at FCSO understand that dealing with Medicare is a complex and sometimes frustrating exercise. We realize that only a small percentage of providers are intentionally abusing the system. All of the others are out there every day, seeing the patients, providing and documenting necessary services, and billing us correctly. FCSO's Value is to "Do the Right Things the Right Way." That translates into paying your claims promptly and correctly the first time and to prevent or recover all inappropriate payments.

It has been a pleasure discussing these issues with you. I hope you find the information useful.

Sincerely,

Sidney R. Sewell, M.D.
Medical Director

ADMINISTRATIVE

General Information About the *Medicare B Update!*

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

Distribution of the *Update!* is limited to individual providers and professional association (PA) groups who bill at least one claim to Florida Medicare Part B for processing during the twelve 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 89).

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 **General Information** (other information for Medicare providers including Fraud and Abuse issues), and **Educational Resources** that includes seminar schedules and reproducible forms, and important addresses, phone numbers and websites.

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

2002 ICD-9-CM Coding Changes

The 2002 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2001. Providers must begin using the updated ICD-9-CM codes for claims submitted on or after October 1, 2001 and the updated diagnostic codes must be used for all services billed on or after January 1, 2002.

A 90-day grace period is provided, during which Florida Medicare will accept both old and new ICD-9-CM codes, for claims received October 1 through December 31, 2001. This grace period is to allow providers sufficient time to obtain and integrate the updated ICD-9-CM codes into their billing systems. *For claims received on or after January 1, 2002, the latest version of the ICD-9-CM codes must be used.*

The latest versions of the ICD-9-CM manuals (as well as a variety of other coding materials) may be obtained from:

HealthCare Consultants of America (800) 253-4945	Medicode Publications (800) 999-4600	St. Anthony's Publishing (800) 632-0123
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ICD-9-CM and other coding materials may also be obtained from local medical publishing and consulting firms.

Source: HCFA Transmittal AB-01-91, CR 1661

Correct Coding Initiative

Version 7.3 of the Correct Coding Initiative (CCI) will be effective October 1, 2001, effective for services rendered on or after October 1, 2001. Version 7.3 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/product/correct-coding.htm

As a reminder, Florida Medicare is not liable for information provided and/or published by AdminaStar Federal and/or NTIS.

Source: HCFA CR1712, transmittal B-01-42

Split Billing

Florida Medicare continues to receive a significant number of claims submitted separately although they are for the same patient, same assignment and same date of service. This is referred to as split billing, and, in many cases, it causes unnecessary delays and denials of payment.

Be sure to submit all services for the same patient (of the same assignment) rendered on the same day or during the same hospitalization (unless hospitalization is extended over a very long period of time) on the same claim.

If your software splits each detail of what should be one claim onto separate claims, contact your software vendor to ensure that you are operating on the most efficient level possible and avoiding unnecessary transmissions.

Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

Flu season is just around the corner! Providers should emphasize to their beneficiaries the importance of immunizations. The following article contains information for providers regarding the billing and processing of claims for pneumococcal, hepatitis B, and influenza virus vaccines.

Pneumococcal, hepatitis B, and influenza virus vaccines fall into the category of drugs and biologicals, therefore, effective for services provided on or after February 1, 2001, the mandatory assignment provision of section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) applies. Additionally, effective for claims with dates of service on or after October 1, 2001, the requirement that Item 32 of Form HCFA-1500 (Name and Address of Facility) be completed will revert to a "non-applicable" entry.

Pneumococcal Pneumonia Vaccinations. The Medicare Part B program covers pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity or individual with a supplier number. This includes revaccination of patients at highest risk of pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons at highest risk. Effective July 1, 2000, Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

An initial vaccine may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years have passed since receipt of a previous dose of pneumococcal vaccine.

Persons at high risk for whom an initial vaccine may be administered include all people age 65 and older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on

the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

Hepatitis B Vaccine. With the enactment of Public Law 98-369, coverage under Part B was extended to hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B.

High-risk groups currently identified include (see exception below):

- End stage renal disease (ESRD) patients;
- Hemophiliacs who receive Factor VIII or IX concentrates;
- Clients of institutions for the mentally retarded;
- Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Coverage of the pneumococcal vaccine (PPV), influenza virus vaccine, and hepatitis B vaccine and their administration is available *only* under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A. Payment is 100 percent of the Medicare allowed amount for PPV and influenza virus vaccine. Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine. Part B deductible and 80 percent coinsurance *do* apply for hepatitis B vaccine. Mandatory assignment applies to pneumococcal vaccine (PPV), influenza virus vaccine, *and* hepatitis B vaccine.

Influenza Virus Vaccine. Influenza virus vaccine and its administration are covered when furnished in compliance with any applicable State law by any provider of service or any entity or individual with a provider or supplier number. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Frequency of Vaccinations

Typically, PPV is administered once in a lifetime. Medicare may pay claims for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

Typically, one influenza vaccination is allowable per flu season. Claims for beneficiaries who have received more than one influenza virus vaccine in a 12 month period will be reviewed to determine whether the service was reasonable and necessary (e.g., a patient receives an influenza injection in January for the current flu season and is vaccinated again in November of the same year for the next flu season.)

Billing for Additional Services

When a provider administers PPV, influenza virus, or hepatitis B vaccines without providing any other additional services during the visit, the provider may only bill for the vaccine and its administration. These services are always separately payable, whether or not other services are also provided during the same encounter. The provider may bill for additional reasonable and necessary services in addition to the administration of PPV, influenza virus, and or hepatitis B vaccines.

Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary but must submit an unassigned claim on the beneficiary's behalf. Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the procedure code for the vaccine, and the physician or supplier (e.g., a drugstore) which actually administers the vaccine may bill separately for the administration, using the procedure code for the administration. This process will result in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine *administration* only, billers should list only code G0008 in block 24D of the HCFA-1500. When billing for the influenza *vaccine* only, billers should list only code 90659 in block 24D of the HCFA-1500. The same applies for PPV and hepatitis B billing using the appropriate PPV and hepatitis B codes.

A preprinted roster bill includes HCPCS codes for both the vaccine and its administration. When billing for influenza vaccine *administration* only, billers should cross out the code for the vaccine. For example, billers should leave HCPCS code G0008 and cross out CPT code 90659. Likewise, when billing for the influenza *vaccine* only, billers should leave CPT code 90659 and cross out HCPCS code G0008. The same rule applies for PPV codes.

CPT/HCPCS Codes

The following CPT codes are used for billing vaccines:

90657	90723	90746
90658	90732	90747
90659	90744	90748

Note: procedure 90669 is not FDA-approved, and is therefore noncovered by Medicare.

These codes are for the vaccines only and do not include their administration. The following HCPCS "G" codes are used to bill for administration of vaccines:

G0009	Administration of pneumococcal vaccine
G0008	Administration of influenza virus vaccine
G0010	Administration of hepatitis B vaccine

Billing Requirements

Physicians and suppliers submit claims on Form HCFA-1500. The Unique Physician Identification Number (UPIN) must be entered in Item 17A of the HCFA-1500 for PPV and hepatitis B vaccines. No UPIN is required in Item 17A of the HCFA-1500 for influenza virus vaccine claims since Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, no UPIN is required in Item 17A of the HCFA-1500 for PPV claims since Medicare will no longer require that the vaccine be administered under a physician's order or supervision.

Diagnosis Codes

The following ICD-9-CM diagnosis codes for PPV and influenza virus and hepatitis B vaccines and their administration should appear in Block 21 of form HCFA-1500:

V03.82	PPV
V04.8	Influenza virus vaccine
V05.3	Hepatitis B vaccine

Reimbursement Guidelines

Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. The allowable charge for the vaccine cannot exceed the lower of the actual charge or 95 percent of the median of all average wholesale prices (AWP).

The administration of PPV, influenza virus, and hepatitis B vaccines, (codes G0009, G0008, and G0010), though not reimbursed directly through the Medicare Physician Fee Schedule Database (MPFSDB), is reimbursed at the same rate as code 90782 on the MPFSDB for the year that corresponds to the date of service of the claim. Limiting charge does not apply to PPV, influenza virus vaccine, or hepatitis B vaccine and their administration. The administration of the influenza virus vaccine is covered in the flu shot benefit, rather than under the physicians' services benefit; therefore, it is not eligible for the ten percent Health Professional Shortage Area (HPSA) incentive payment.

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as public health clinics [PHCs]) may bill Medicare for PPV, hepatitis B, and influenza virus vaccine administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

Simplified Roster Bills

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by PHCs and other entities that bill the Medicare carriers. Medicare has not developed roster billing for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary. Effective November 1, 1996, this simplified claims filing procedure also applies to individuals and entities billing for PPV.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing. However, the rosters should not be used for single patient bills and the date of service for each vaccination administered must be entered.

Entities which submit claims on roster bills (and therefore must accept assignment) may not collect any “donation” or other cost-sharing of any kind from Medicare beneficiaries for PPV or influenza vaccinations. However, the entity may bill Medicare for the amount

which is not subsidized from its own budget. For example, an entity that incurs a cost of \$7.50 per vaccination and pays \$2.50 of the cost from its budget may bill Medicare the \$5.00 cost which is not paid out of its budget.

Provider Enrollment Criteria. All individuals and entities that will submit PPV and influenza benefit claims to Medicare on roster bills must complete the Provider/Supplier Enrollment Application, Form HCFA-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process. Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV and influenza virus vaccinations. Establish an edit to identify individuals and entities that plan to participate in the Medicare program only for the purpose of mass immunizing beneficiaries.

Modified HCFA-1500. If the PHC or other individual or entity qualifies to use the simplified billing process, it may use a preprinted HCFA-1500 that contains standardized information about the entity and the benefit.

Entities submitting roster claims to carriers must complete the following blocks on a single modified HCFA-1500 that serves as the cover document for the roster:

HCFA-1500 Block	Influenza Virus Vaccine Claims	PPV Claims
Block 1	Check “Medicare”	Check “Medicare”
Block 2	See attached roster	See attached roster
Block 11	None	None
Block 17	N/A	Name of ordering physician MUST be entered (One name per claim form)
Block 17a	N/A	UPIN of ordering physician MUST be entered (One UPIN per claim form)
Block 20	No	No
Block 21	V04.8	V03.82
Block 24B	60-Mass Immunization Center	60-Mass Immunization Center
Block 24D (line 1) (line 2)	90657, 90658, or 90659 G0008	90732 G0009
Block 24E (lines 1 AND 2)	1	1
Block 24F	Enter the charge for each listed service.	Enter the charge for each listed service.
Block 27	X in YES block	X in YES block
Block 29	0.00	0.00
Block 31	Entity’s representative must sign	Entity’s representative must sign
Block 32	N/A	N/A
Block 33	Enter the entity’s billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number	Enter the entity’s billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number

Sample rosters and samples of modified Form HCFA -1500s are available to view, print, or download from our provider Website – www.floridamedicare.com – in the “Forms” area.

Sources: HCFA Transmittal 1667, CR 1103
 HCFA Transmittal 1700, CR 1633
 HCFA Transmittal 1711, CR 1700

COVERAGE/REIMBURSEMENT

AMBULATORY SURGICAL CENTER

Clarification of Payment and Place of Service Requirements for ASC Claims

An ambulatory surgical center (ASC) may bill Medicare for a facility fee for a procedure on the Medicare-approved ASC list and performed at the ASC. The current list of ASC approved CPT/HCPCS procedures was published in the 2nd Quarter 2001 *Medicare B Update!* (pages 12-15). Claims for ASC facility fees billed for codes not on the Medicare-approved ASC list will be denied.

However, physicians and qualified nonphysician practitioners may bill Medicare for procedures *not* on the Medicare-approved ASC list but performed in an ASC.

Such claims will be paid at the nonfacility rate according to the physician fee schedule, i.e., using the nonfacility practice expense RVUs, for such procedures when covered by Medicare. The Medicare physician fee schedule payment for procedures not on the ASC list but performed in an ASC includes payment for all practice expenses, and, as noted above, there is no separate payment of an ASC facility fee.

The place of service code for procedures performed in an ASC is 24.

Source: CMS Transmittal B-01-43, CR 1680

ANESTHESIA

Billing Procedures and Modifiers for CRNA and an Anesthesiologist in a Single Anesthesia Procedure

Where a single anesthesia procedure involves both a physician medical direction service and the service of a medically directed certified registered nurse anesthetist (CRNA), and the service is furnished on or after January 1, 1998, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

For dates of service on or after January 1, 1998, where the CRNA and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the service is billed in accordance with the following procedures:

1. For a single medically directed service, the physician will use modifier QY (medical direction one certified registered nurse anesthetist [CRNA] by an anesthesiologist), and

2. For the anesthesia service furnished by the medically directed CRNA, the CRNA will use modifier QX (CRNA service: with medical direction by a physician)

Unusual Circumstances

In unusual circumstances, such as a complicated trauma case, in which it is medically necessary for both a CRNA and an anesthesiologist to be involved completely and fully in a single anesthesia case, Medicare may recognize full payment for the services of each of the two providers. Documentation must be submitted by *both* the CRNA and the anesthesiologist to support payment of the full fee for each of the two providers. In these cases, the physician would report using modifier AA and the CRNA would use modifier QZ (CRNA service: without medical direction by a physician).

Source: HCFA Transmittal 1714, CR 288

CPT Code 01784 Discontinued for 2001—Correction to Article

An article was published in the 1st Quarter 2001 *Medicare B Update!* (page 22) that indicated CPT code 01784 was discontinued for 2001 and replaced with either 01700 or 01780. The 2001 CPT does indicate that 01784 is discontinued; however, procedure code 01700 is invalid. The correct codes to report for anesthesia for procedures on arteries or veins of upper arm or elbow, not otherwise specified, are **01770** (arteries) and 01780 (veins).

DRUGS AND BIOLOGICALS

Updated Allowances for Injectable Drugs

Medicare Part B allowances for certain injectable drugs have been updated, effective for services processed on or after July 2, 2001. The new allowances are on the following page.

CODE	PAR	NONPAR	CODE	PAR	NONPAR	CODE	PAR	NONPAR
90371	649.80	617.31	J1160	2.44	2.32	J3105	2.68	2.55
90659	5.05	5.05*	J1170	1.62	1.54	J3240	531.05	504.50
90740	187.82	187.82*	J1205	10.01	9.51	J3245	436.41	414.59
A9500	120.18	114.17	J1260	16.46	15.64	J3270	IC	IC
A9605	IC	IC	J1325	17.37	16.50	J3280	5.43	5.16
J0120	4.77	4.53	J1327	13.58	12.90	J3310	6.80	6.46
J0150	34.25	32.54	J1362	IC	IC	J3370	7.87	7.48
J0200	18.60	17.67	J1440	177.91	169.01	J3390	IC	IC
J0290	1.58	1.50	J1450	86.55	82.22	J3470	20.58	19.55
J0456	23.97	22.77	J1565	775.51	736.73	J7060	10.88	10.34
J0610	1.34	1.27	J1570	35.23	33.47	J7070	14.18	13.47
J0635	13.67	12.99	J1580	10.55	10.02	J7501	107.91	107.91*
J0695	IC	IC	J1650	5.82	5.53	J7505	777.31	777.31*
J0696	15.24	14.48	J1730	117.03	111.18	J9045	111.11	105.55
J0710	IC	IC	J1745	65.70	62.41	J9050	114.40	108.68
J0735	55.15	52.39	J1790	5.44	5.17	J9060	42.45	40.33
J0740	803.70	763.51	J1960	3.78	3.59	J9201	106.72	101.38
J0743	15.50	14.73	J2500	26.02	24.72	J9208	156.64	148.81
J0835	16.04	15.24	J2640	0.66	0.63	J9209	40.43	38.41
J0895	13.50	12.83	J2910	15.16	14.40	J9219	5399.80	5129.81
J1000	2.61	2.48	J3000	6.56	6.23	J9293	244.19	231.98
J1070	4.31	4.09	J3010	1.95	1.85	J9390	90.73	86.19
J1090	2.16	2.05	J3070	3.21	3.05	Q3013	1458.25	1385.34
J1110	14.58	13.85						

IC= Individual Consideration

* = 5% reduction for nonparticipating providers does not apply

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

DMEPOS Items Processed by Local Carriers—Correction to Article

An error has been noted regarding the effective date in the article that was published in the June 2001 *Medicare B Update! Special Issue* (page 7). The pricing that was published is effective for services **provided on**

or after July 1, 2001 and is **not** retroactive to January 1, 2001 as stated in the article.

Florida Medicare apologizes for any inconvenience this may have caused.

EVALUATION AND MANAGEMENT SERVICES

Non-Global Preoperative Services

Section 15047 (Preoperative Services Paid under the Physician Fee Schedule) is added to the Medicare Carriers Manual (MCM) to clarify payment policy for preoperative evaluations performed *outside* of the global surgical period. These are services and procedures that are **not** part of the global surgical period as defined in MCM sections 4820 and 4821 (i.e., minor surgery – the day of surgery and 10 follow-up days; major surgery – one day prior to the surgery and 90 follow-up days). *Services that are part of the global surgery policy are*

not affected by this change. This change is effective for services rendered on or after January 1, 2001, processed on or after June 30, 2001.

Non-Global Preoperative E/M Examinations

Non-global preoperative E/M examinations are defined as examinations performed by, or at the request of, the attending surgeon that are not included in the global surgical package for the purpose of evaluating a patient's risk of perioperative complications and to optimize perioperative care. Non-

global preoperative examinations are payable if they are medically necessary and meet the documentation and other requirements for the service billed.

Preoperative Diagnostic Tests

Preoperative diagnostic tests are defined as tests performed by, or at the request of, the attending surgeon to determine a patient's perioperative risk and optimize perioperative care. Preoperative diagnostic tests are payable if they are medically necessary and meet any other applicable requirements.

ICD-9-CM Diagnosis Coding Requirements

All preoperative examinations and preoperative diagnostic tests must be billed using one of the following ICD-9-CM codes:

V72.81	Preoperative cardiovascular examination
V72.82	Preoperative respiratory examination
V72.83	Other specified preoperative examination
V72.84	Preoperative examination, unspecified

Additionally, the physician should also report the appropriate ICD-9-CM code for the condition(s) that prompted surgery. Other diagnoses and conditions affecting the patient should be also reported on the claim, if appropriate.

Medical Necessity

Claims containing these ICD-9-CM codes are subject to medical necessity requirements as determined by any applicable national coverage decisions. In instances where there is no national coverage determination, medical necessity is determined by carrier discretion.

HCFA Transmittal 1707, CR 1511

Expansion of Medicare Reimbursement for Telehealth Services

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1834 of the Social Security Act (the Act) to provide for an expansion of Medicare payment for telehealth services. Section 223 of BIPA limits the existing telehealth provision to services furnished before October 1, 2001, and mandates that the expanded benefit be effective for services furnished on or after October 1, 2001.

Expansion of Benefit Summary

Effective for services furnished **on or after October 1, 2001**, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunication system. Eligible geographic areas will be expanded beyond rural health professional shortage areas to include counties not in a metropolitan statistical area (MSA). Additionally, federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location. An interactive telecommunication system is required as a condition of payment; however, BIPA does allow the use of asynchronous 'store and forward' technology in delivering these services when the originating site is a federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specifies that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) will be equal to what would have been paid without the use of telemedicine.

Distant site practitioners include only a physician as described in section 1861(r) and a medical practitioner as described in section 1842(b)(18) (C) of the Act. BIPA also expands payment under Medicare to include a \$20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous, 'store and forward' telecommunication system. BBA 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA requires that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for current teleconsultation provision. The current teleconsultation provision as authorized by section 4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR sections 410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

Eligibility Criteria for Telehealth Services

Beneficiaries eligible for telehealth services. Medicare beneficiaries are eligible for telehealth services only if

- they are presented from an originating site located in either a rural health professional shortage area (HPSA) as defined by section 332(a)(1) (A) of the Public Health Services Act or
- in a county outside of a MSA as defined by section 1886(d)(2)(D) of the Act.

Exception to rural HPSA and non MSA geographic requirements. Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

Originating site defined. An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are:

- The office of a physician or practitioner
- A hospital
- A critical access hospital
- A rural health clinic
- A federally qualified health center.

Coverage of Telehealth

Scope of coverage. The use of a telecommunication system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes as follows:

- Consultations (CPT codes 99241 - 99275)
- Office or other outpatient visits (CPT codes 99201 - 99215)
- Individual psychotherapy (CPT codes 90804 - 90809)
- Pharmacologic management (CPT code 90862)

Conditions of Payment

Technology. For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Exception to the interactive telecommunications requirement. In the case of federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous ‘store and forward technology’, in single or multimedia formats, is used as a substitute for an interactive telecommunication system. The originating site and distant site practitioner must be included within the definition of the demonstration program.

Store and forward defined. For purposes of this instruction, store and forward means the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site. A patient’s medical information may include, but not limited to, video clips, still images, X-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

Note: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis and or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Telepresenters. A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

Payment Methodology for Physician/Practitioner at the Distant Site

Distant site defined. The term “distant site” means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunication system.

Payment amount (professional fee). The payment amount for the professional service provided via a telecommunication system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for an

office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunication system should be made at the same amount as when these services are furnished without the use of a telecommunication system. For Medicare payment to occur, the service must be within a practitioner’s scope of practice under state law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

Medicare practitioners who may receive payment at the distant site (i.e., at a site other than where the beneficiary is). As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law. When the physician or practitioner at the distant site is licensed under state law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunication system.

Medicare practitioners who may bill for covered telehealth services are listed below (subject to state law):

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist*
- Clinical social worker*

*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Originating Site Facility Fee Payment Methodology

Originating site defined. The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunication system occurs. For asynchronous, store and forward telecommunication technologies, an originating site is only a federal telemedicine demonstration program conducted in Alaska or Hawaii.

Facility fee for originating site. For consultation, office or other outpatient visit, psychotherapy and pharmacologic management services delivered via a telecommunication system furnished from October 1, 2001, through December 31, 2002, the originating site fee is the lesser of \$20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated annually by the Medicare Economic Index (MEI).

Payment amount. For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of \$20. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

The originating site facility fee payment methodology for each type of facility is clarified below.

Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system. Payment is not based on current fee schedules or other payment methodologies.

Hospital inpatient. When the originating site is for hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).

Critical access hospitals. When the originating site is a critical access hospital, payment is made as described above, separately from the cost-based reimbursement methodology.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of the actual charge or \$20 regardless of geographic location. The geographic practice cost index (GPCI) will not be applied to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician fee schedule.

Instructions for Submission of Telehealth Claims

Distant site practitioners. Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications systems for dates of service October 1, 2001, and later must be submitted to the carriers that processes claims for the practitioners service area. Submit

such claims with the appropriate *CPT* code for the professional service provided and the telehealth modifier "GT" – "via interactive audio and video telecommunications system." By using the "GT" modifier to bill for the telehealth service, the distant site practitioner verifies that the beneficiary was located at an eligible originating site at the time of the telehealth service. Exception for store and forward (non-interactive) telehealth. In the case of a Federal telemedicine demonstration program conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. When store and forward technologies are used, submit the appropriate *CPT* code and telehealth modifier "GQ", "via asynchronous telecommunications system." (See "Store and forward defined" and "Medical practitioners who may receive payment at the distant site" sections). By using the "GQ" modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Eligibility Criteria" and "Conditions of Payment" sections.)

Originating Site Facility Fee. To receive the facility payment, submit claims with HCPCS code "Q3014, telehealth originating site facility fee" By submitting "Q3014" HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county. The facility fee will be updated yearly based upon the Medicare economic index and will be announced in an annual PM for carriers and intermediaries. Carriers and intermediaries must use these fees to pay the correct amount for this service. The Medicare physician fee schedule database will indicate that this claim is carrier-priced. This process is similar to the process currently used for the payment of certain mammography services. Physicians' and practitioners' offices must bill the appropriate Medicare carrier for the originating site facility fee.

The telehealth professional service payment and originating site facility fee are subject to post payment verification.

Source: HCFA Transmittal AB-01-69, CR 1650

Visits to Patients Residing in Various Places of Service

HCFA-1500 claim filing requirements specify that the two-digit place of service (POS) code must be entered in block 24B (or electronic equivalent). Section 15510 of the Medicare Carriers Manual (MCM) - Home Care and Domiciliary Care Visits – provides specific POS coding requirements depending on the beneficiary's residence.

Evaluation and management (E/M) services provided to patients residing in a Skilled Nursing Facility [(SNF) (*CPT* definition formerly identified as SNFs, intermediate care facilities (ICFs), or long term care facilities (LTCFs))] must be reported using the appropriate level of service code within the range identified for Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care services. *Current Procedural Terminology (CPT)* codes range from **99301** through **99303** for the former and **99311** through **99313** for the latter, and Nursing Facility Discharge Services codes **99315 - 99316**.

These codes are limited to POS **31** (SNF), **32** (Nursing Home/Nursing Facility), **54** (Intermediate Care Facility/Mentally Retarded) and **56** (Psychiatric Residential Treatment Center).

CPT codes **99321** through **99333**, domiciliary, rest home (e.g., boarding home), or custodial care services, are used to report E/M services to residents residing in a facility that provides room, board, and other personal assistance services, generally on a long-term basis. These procedure codes are limited to POS **33** (Custodial Care Facility) and **55** (Residential Substance Abuse Facility). These facilities are often referred to as adult living facilities or assisted living facilities. Physicians and providers furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the range of codes 99321- 99333 to support the service they provide.

CPT codes **99341** through **99350**, home services codes, are used to report E/M services furnished to a patient residing in his or her own private residence and not any type of facility. These codes apply *only* to POS **12** (Patient’s Home). Home services codes, CPT codes 99341 through 99350, may *not* be used for billing for E/M services provided other than in the private residence of an individual.

Effective for services rendered on or after January 1, 2000 processed on or after July 23, 2001, claims for these procedures billed in places of service *other than* those referenced above will be returned as unprocessable. As a reminder, unprocessable claims are not afforded appeal rights; they must be corrected and resubmitted.

The following chart is provided for easy reference:

CODE	VALID POS
99301-99303	31, 32, 54, 56
99311-99313	32, 32, 54, 56
99315-99316	31, 32, 54, 56
99321-99333	33, 55
99341-99350	12

For more information, please refer to the article entitled “Procedure-to-Place of Service Inconsistent” published in the March/April 2000 *Medicare B Update!* (page 7).

Source: HCFA Transmittal 1709, CR 1714

HCPCS

Deletion of HCPCS Codes A9160, A9170, A9190, and Modifier GX and Replacement with New Codes and Modifiers; Status Change to HCPCS Code A9270

To allow providers and suppliers to bill Medicare in order to obtain denials for secondary payers for noncovered items and services, the following changes will become effective **January 01, 2002**:

Deleted Codes

- A9160 Non-covered service by podiatrist
- A9170 Non-covered service by chiropractor
- A9190 Personal comfort item, (non-covered by Medicare statute)

Deleted Modifier

- GX Service not covered by Medicare

Status Changed to “Not Valid for Medicare”

- A9270 Non-covered item or service

Added Codes

- Q3015 Item or service statutorily non-covered, including benefit category exclusion, (used only when no specific code available)
- Q3016 Item or service not reasonable and necessary, (used only when no specific code available)

Added Modifiers

- GY Item or service statutorily non-covered
- GZ Item or service not reasonable and necessary

Coding Instructions

The new codes, Q3015 and Q3016, must be used when there is no specific code currently available to describe the item or service. If a specific code is available, it must be used. “Not Otherwise Classified” codes may not be used in these situations. The new modifiers, GY and GZ, must be used when a specific code is available but the provider or supplier wants to indicate that the item or service is not covered or is not reasonable and necessary. Anytime the codes Q3015 or Q3016 are used, providers and suppliers must include a description of the services or items provided as well as an explanation of why the services or supplies are being

submitted. This information is entered in Item 19 of the HCFA-1500. For the electronic format, providers and suppliers must report this information in the claims level note. If space for additional narrative is needed, the provider or supplier must enter the qualifier “ADD” in NTE01 then enter the additional narrative in NTE02. Anytime the modifiers GY or GZ are used, providers and suppliers must explain why the services or supplies are being submitted. This information is entered in Item 19 of Form HCFA-1500. For the electronic format, providers and suppliers must report this information in the claims level note. If space for additional narrative is needed, the provider or supplier must enter the qualifier “ADD” in NTE01, then enter the additional narrative in NTE02. Examples of explanatory language are, “Claim submitted to receive denial for secondary payer” or “Service performed by family member.”

Items and Services Considered Not Reasonable and Necessary

Medicare may cover certain items and services as reasonable and necessary under particular circumstances. These same items and services may not be covered benefits under other circumstances. When a provider or supplier furnishes either an assigned or unassigned service or item that they believe is not reasonable and necessary according to Medicare policies and regulations, the specific HCPCS code that describes the service or item furnished must be submitted along with the GZ modifier. If there is no specific code available, the provider or supplier may submit the claim using the Q3016 code.

Statutorily Non-Covered Items or Services

Items and services that are statutorily non-covered by Medicare, must be submitted using the specific code with the GY modifier. This includes claims submitted by chiropractors for statutorily non-covered maintenance therapy. If there is no specific code available, the provider or supplier must submit the claim using the Q3015 code.

Use of the GA Modifier with the New Codes and Modifiers

When a service is performed or item supplied that is not reasonable and necessary under the specific circumstances, it is the responsibility of the provider or supplier to notify the beneficiary in writing through the use of the advance beneficiary notice (ABN). The provider or supplier should file the pertinent services or items on the claim with the GA modifier, waiver of liability statement on file. The GA modifier must be used in conjunction with the Q3016 or GZ modifier, not instead or in place of them. Use a GA modifier with all

assigned Part B claims where an ABN is given, and for all unassigned Part B claims for physicians' services where an ABN is given (per section 1842(l) of the Social Security Act ["the Act"]) and for durable medical equipment, prosthetics, orthotics, and supplies when an ABN is given. (See sections 1834(a)(18) and 1834(j)(4) of the Act.) If the service or supply is statutorily excluded, thus resulting in an automatic denial, neither the ABN nor the GA modifier is required. (See sections 7320 and 7330 of the Medicare Carriers Manual for further information on waiver of liability.)

Source: HCFA Transmittal B-01-30, CR1371

LABORATORY/PATHOLOGY

82962—Pricing Revision

The allowance for procedure 82962 was increased from \$1.48 to \$2.58, effective for claims processed on or after May 7, 2001, for services rendered January 1, 2001 and after.

New CLIA Waived Tests

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

- Worldwide Medical Corporation, First Check® Home Drug Test (THC), effective June 29, 2000, *CPT* code 80101QW
- Worldwide Medical Corporation, First Check® Home Drug Test (THC-COC), effective June 29, 2000, *CPT* code: 80101QW
- Roche Diagnostics Coagu Chek S Systems Test (for prothrombin time), effective September 6, 2000, *CPT* code 85610QW
- Wyntek Signify Mono Test, effective September 7, 2000, *CPT* code 86308QW
- Worldwide Medical Corporation, First Check® Home Drug Test Panel 4 (THC-COC-OPI-MET), effective December 6, 2000, *CPT* code 80101QW
- OraSure Technologies Q.E.D. A-150 Saliva Alcohol Test, effective December 19, 2000, *CPT* code 82055QW
- OraSure Technologies Q.E.D. A-350 Saliva Alcohol Test, effective December 19, 2000, *CPT* code 82055QW
- Genua Menopause Monitor Test, effective January 12, 2001, *CPT* code 83001QW
- Bayer Diagnostics/MICROALBUSTIX™ Reagent Strips, effective February 16, 2001, *CPT* code: 82044QW and 82570QW
- Cholestech LDX® Alanine Aminotransferase (ALT) Test, Effective: April 13, 2001, *CPT* code 84460QW.

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

- 83001QW for the Genua Menopause Monitor Test
- 82570QW for creatinine performed by the Bayer Diagnostics/MICROALBUSTIX™ Reagent Strip
- 84460QW for the Cholestech LDX® Alanine Aminotransferase (ALT) Test.

The additional *CPT* code 82570QW has been added to the Bayer Clinitek 50 Urine Analyzer – for microalbumin and creatinine test.

Please refer to the table on the following page for the list of tests approved by the CDC as waived tests under CLIA that have been added as of June 7, 2001.

Source: HCFA transmittal AB-01-95; CR1751

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Worldwide Medical Corporation, Drug Test (THC)	Worldwide Medical Corporation	80101QW	Screening test for the presence/ FirstCheck ® Home detection of cannabinoids (THC) in urine
Worldwide Medical Corporation, First Check ®Home Drug Test (THC-COC),	Worldwide Medical Corporation	80101QW	Screening test for the presence/ detection of cannabinoids (THC) and cocaine metabolites in urine
Roche Diagnostics Coagu Chek S Systems Test (for prothrombin time)	Roche Diagnostics Corporation	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency
Wyntek Signify Mono Test	Wyntek Diagnostics, Inc.	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Worldwide Medical Corporation, First Check ®Home Drug Test Panel 4 (THC- COC- OPI- MET)	Worldwide Medical Corporation	80101QW	Screening test for the presence/ detection of cannabinoids (THC), cocaine metabolites, opiates and methamphetamines in urine
OraSure Technologies Q.E.D.A-150 Saliva Alcohol Test	OraSure Technologies, Inc.	82055QW	Quantitative determination of alcohol (ethanol) in saliva
OraSure Technologies Q.E.D.A-350 Saliva Alcohol Test	OraSure Technologies, Inc.	82055QW	Quantitative determination of alcohol (ethanol) in saliva
Genua Menopause Monitor Test,	Genua I944 Inc.	83001QW	Detects follicle stimulating hormone in urine
Bayer Diagnostics/ MICROALBUSTIX™ Reagent Strip	Bayer Inc.	82044QW 82570QW	Semi- quantitative measurement of microalbumin and creatinine in urine for the detection of patients at risk for developing kidney damage
Cholestech LDX® Alanine Aminotransferase (ALT) Test	CHOLESTECH Corporation	84460QW	Quantitative determination of alanine aminotransferase in whole blood

This list includes updates through 6/7/2001

PODIATRY

Follow Up from Podiatry Seminars

Several podiatry seminars were presented throughout Florida during March, April and May 2001. As a result, several questions and/or situations required follow up. Listed below are the questions and replies to your concerns.

Q. Are debridement of five mycotic nails and cutting of corns and calluses on the bottom of the foot considered bundled? Should I bill modifier 59 if both are performed?

A. Debridement of mycotic nails is bundled with cutting of corns and calluses. Since you are performing debridement of mycotic nails and removing corns and calluses **from the bottom of the foot**, you would meet the criteria of a separate site. In this situation, *CPT* procedure code **modifier 59** should be used with the code for debridement of five mycotic nails.

Q. Are the following situations considered bundled?

- 11719 nails and 11055 plantar
 - G0127 nails and 11055-11056 digit(s)
- Should I bill modifier 59 if both are performed?

A. These are **not** bundled situations and modifier 59 is not required.

Q. Is anesthesia **required** when performing avulsion or

excision of a nail (procedure code 11730 or 11750)?

A. From a Medicare perspective, anesthesia is **not** a requirement when billing for the performance of a nail avulsion. Performing these services without anesthesia may be a quality of care issue. Please contact your specialty society.

Q. Is a culture and sensitivity **required** when billing for an incision and drainage of an abscess?

A. From a Medicare perspective, a culture and sensitivity is **not** a requirement when billing for the performance of an incision and drainage of an abscess. However, not performing a culture may be a quality of care issue. Please contact your specialty association.

Q. The patient had a surgical procedure performed. During the follow-up period, patient went skiing causing a wound dehiscence that had to be repaired. Which of the following modifiers should be billed?

- 58 staged or related procedure (no reduction)
- 78 return to the operating room (reduced)
- 79 unrelated procedure (no reduction)

A. This is a related procedure during the postoperative period and procedure code **modifier 58** should be billed.

Q. In the attempt to save a patients foot, several debridements were performed without success, thus resulting in the amputation of the foot. Which of the following modifiers should be billed?

- 58 staged or related procedure (no reduction)
- 78 return to the operating room (reduced)
- 79 unrelated procedure (no reduction)

A. This is a related procedure during the postoperative period and procedure code **modifier 58** (subsequent procedure that is more extensive) should be billed.

Q. I realize that the name and UPIN of the treating or diagnosing physician is required for routine foot care. My question is do I need an **actual written referral** from the treating or diagnosing physician?

A. **No**, an actual written referral is not necessary. The name of the physician and the date last seen must be documented in the patients record.

Q. I have patients who have been diagnoses with dementia. They are in long term care (LTC) facilities. They have thick deformed nails. Your explanation

makes the need for documenting pain, but some of these patients can't communicate. They are deserving of periodic service offered under your auspices.

A. We would agree that the inability to communicate pain should not mean that a patient would never be entitled to care. We do believe, however, that there are many indicators of pain and that in the absence of the ability to verbally communicate, the provider must document that which makes him or her believe pain is impairing the ability to ambulate. Some indicators might be facial expressions such as flinching, grimacing upon weight bearing or pulling away, or declining ability or willingness to ambulate.

Q. In spite of using the digit modifiers, I continue to receive denials (bundled) for procedure code 28285-T6 (hammertoe) (**second** digit right foot) when performed on the same day as 28296-RT (hallux valgus [bunionectomy] correction).

A. You should bill as follows:
 28296-RT
 28285-59-T6

RADIOLOGY

New PET Scan Codes—Corrected Allowances

Information was published in the 3rd Quarter 2001 *Medicare B Update!* (pages 30-31) concerning expanded coverage and new codes for Positron Emission Tomography (PET) Scans, effective for services provided on or after July 1, 2001. Allowances for these codes were subsequently provided in the June 2001 *Special Issue Update!* entitled *Additional Changes Effective July 1, 2001*.

The allowances published in the special issue were improperly calculated. The correct allowances are as follows:

Code/Mod	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0210	2187.15	2389.98	2527.58	2077.79	2270.48	2401.20	2389.46	2611.05	2761.38
G0210 TC	2110.37	2309.69	2444.43	2004.85	2194.21	2322.21	2305.58	2523.34	2670.54
G0210 26	76.78	80.29	83.15	72.94	76.28	78.99	83.88	87.72	90.84
G0211	2287.51	2390.37	2527.99	2173.13	2270.85	2401.59	2499.10	2611.48	2761.83
G0211 TC	2210.73	2310.08	2444.84	2100.19	2194.58	2322.60	2415.22	2523.76	2670.99
G0211 26	76.78	80.29	83.15	72.94	76.28	78.99	83.88	87.72	90.84
G0212 - G0230	2187.15	2389.98	2527.58	2077.79	2270.48	2401.20	2389.46	2611.05	2761.38
G0212 TC - G0230 TC	2110.37	2309.69	2444.43	2004.85	2194.21	2322.21	2305.58	2523.34	2670.54
G0212 26 - G0230 26	76.78	80.29	83.15	72.94	76.28	78.99	83.88	87.72	90.84

SURGERY

Clinical Trials on Carotid Stenting with Category B Investigational Device Exemptions (IDEs)

Section 50-32 of the Coverage Issues Manual (CIM) has been revised to reflect that **effective for services provided on or after July 1, 2001**, Medicare covers percutaneous transluminal angioplasty (PTA) of the carotid artery concurrent with carotid stent placement when furnished in accordance with the Food and Drug Administration approved protocols governing Category B IDE clinical trials. Performance of PTA in the carotid artery when used to treat obstructive lesions outside of approved protocols governing Category B IDE clinical trials remains a noncovered service. PTA of the vertebral and cerebral arteries remains noncovered.

The billing for the procedure is based upon how the service is delivered. Appropriate procedure codes for the provider to bill when performing this service would be procedure code 35475 for the PTA and procedure code 37205 for the actual stent placement.

These services must be billed on Form HCFA-1500 (or electronic equivalent). Claims for IDEs must be identified with the QA modifier, and the IDE number assigned by the FDA must be entered in block 23.

HCFA Transmittal AB-01-74,
CR 1660

Adult Liver Transplantation—Expansion of Coverage

The Centers for Medicare and Medicaid Services (CMS) - formerly HCFA - has revised section 35-53 of the Medicare Coverage Issues Manual (CIM) to provide for coverage of adult liver transplantation for patients with hepatocellular carcinoma under certain circumstances.

Effective September 1, 2001, Medicare covers adult liver transplantation for hepatocellular carcinoma when the following conditions are met:

1. The patient is not a candidate for subtotal liver resection;
2. The patient's tumor(s) is less than or equal to 5 cm in diameter;
3. There is no macrovascular involvement;
4. There is no identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bone; and
5. The transplant is furnished in a facility which is approved by CMS as meeting institutional coverage criteria for liver transplants.

Adult liver transplantation for other malignancies remains excluded from coverage.

CMS Transmittal 142, CR 1738

Cryosurgery of the Prostate Gland Performed as Salvage Therapy

Effective for claims with dates of service on or after July 1, 2001, Medicare covers cryosurgery of the prostate gland performed as salvage therapy for patients meeting the following requirements:

1. Having recurrent localized prostate cancer;
2. Having failed a trial of radiation therapy as their primary treatment; and
3. Meeting one of the following criteria:
 - (a) Stage T2B or below; or
 - (b) Gleason score less than 9; or
 - (c) PSA less than 8 ng/mL.

NOTE: Medicare does *not* cover cryosurgery of the prostate gland performed as salvage therapy after failure of other therapies as the primary treatment.

For additional information regarding cryosurgery of the prostate gland, please refer to the local medical review policy (LMRP) on pages 59-60 of this issue.

HCFA Transmittal 1710,
CR 1632

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 consistent with the manner in which the carrier reports LMRPs to the Health Care Financing Administration (HCFA).

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

Draft LMRPs and previously published final LMRPs may be obtained by accessing the Florida Medicare provider website at: www.floridamedicare.com

Medical Policy Table of Contents

Focused Medical Review

J9217 – Leuprolide Acetate (for Depot Suspension), 7.5 mg. ...	19
Proper Coding for Correction of Trichiasis	20

Local Medical Review Policy

A0430: Air Ambulance Services	20
A9270: The List of Medicare Noncovered Services	23
G0030: Positron Emission Tomography (PET) Scan	28
G0104: Colorectal Cancer Screening	34
G0108: Diabetes Outpatient Self-Management Training	36
J1745: Infliximab (Remicade™)	39
Appropriate Billing of J9219 Leuprolide Acetate Implant (VIADUR™)	41
00001: Independent Diagnostic Testing Facility (IDTF)	41
00103: Anesthesia Services (Ocular Procedures)	54
Anesthesia for Panniculectomy	57
31231: Diagnostic Nasal Endoscopy	57
55873: Cryosurgical Ablation of the Prostate	59
62310: Epidural/Subarachnoid Injections— Correction	61
85007: Complete Blood Count	61
88141: Pap Smears	64
90901: Biofeedback	66
92225: Ophthalmoscopy	69
93303: Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping	71
99183: Hyperbaric Oxygen Therapy (HBO Therapy)	73

Florida Medicare Program Safeguards - Focused Medical Review

J9217 – Leuprolide Acetate (for Depot Suspension), 7.5 mg.

This procedure code in the Health Care Financing Administration's Common Procedure Coding System (HCPCS) was recently analyzed as part of the focused medical review process that is mandated by the Centers for Medicare and Medicaid Services (CMS - formerly the Health Care Financing Administration, or HCFA). The time period covered by this particular analysis is the first half of 2000.

As a general practice rule, urologists utilize this procedure most often in the office setting (place of service [POS] 11) to treat certain symptoms associated with advanced prostate cancer. This medication is provided in three strengths or formulations: J9217, J9218 (Leuprolide Acetate, per 1 mg.), and J9219 (Leuprolide Acetate Implant, 65 mg.). These drugs may be provided on a monthly, quarterly, every four months, and yearly dosage regimen. HCPCS Code J9219 new code in the 2001 HCPCS and was not analyzed with this group.

A local medical review policy (LMRP) currently in existence states that Leuprolide is covered upon submission of adequate medical necessity documentation. In the absence of medical necessity requiring that the patient receive Leuprolide as opposed to Goserelin Acetate, a chemically equivalent preparation (such as infection, cachexia, or sensitivity to Goserelin Acetate), it is paid at the same rate as Goserelin Acetate (J9202). The LMRP (J1950) in place has been effective since 1995 and was most recently revised in January 2001 as a result of the annual HCPCS update. This revision was published in the 2nd Quarter 2001 *Medicare B Update!* (page 29). The complete LMRP was published in the July/August 2000 *Update!* (pages 33-36). LMRP J1950 is based upon HCFA Payment Policy, MCM Sections 2049, 2050.5D, and 7501.1.

Several items of interest were noted during the analysis of code J9217:

- In the six-month period reviewed, some providers billed in excess of 6 injections in a six-month period. Review of subsequent claims data confirmed that several providers were billing in excess of 13 injections in a 365 day period. Even when considering the individual dose and formulation, the data demonstrated that J9217 was being billed at an excessive rate, whether given monthly, quarterly, or every four months.
- The number of units billed in the units field (block 24 G of Form HCFA-1500 or electronic equivalent) appeared to reflect the *dosage* or milligrams supplied

in some situations. Appropriate billing is based on adjusting the number of units according to the dosage/ regimen prescribed for the patient. Please refer to the LMRP and MCM for billing instructions.

- Under the guidelines for the Part A Skilled Nursing Facility Prospective Payment System (SNF PPS), this service should not be unbundled and billed to Part B as the concept of PC/TC does not apply in this setting and should have been paid by the SNF (refer to HCFA Program Memorandum AB 98-18). Steps may be undertaken to recoup inappropriate payments in this POS (31).
- Also found were a number of these services paid for POS home (12). As a reminder, Medicare does not reimburse for these drugs if self-administered.

Florida Medicare Program Safeguards - Focused Medical Review

Proper Coding for Correction of Trichiasis

The purpose of this article is to serve as a reminder of the coding guidelines outlined in the American Medical Association's (AMA) *Current Procedural Terminology (CPT)* manual and *CPT Assistant*.

During the course of the past year, Florida Medicare analyzed the use of many procedure codes in an effort to identify why Florida providers utilize certain services at a higher rate than in other states. Detailed code level analysis took place, which provided insight as to why this state and its providers stand out in utilization of certain services. Among the codes analyzed were:

- 67820 *Correction of Trichiasis; Eplilation, by forceps only. (Revise Eyelashes)*
- 67825 *Correction of Trichiasis; Eplilation, by other than forceps (e.g. by Electrosurgery, Cryotherapy, Laser Surgery)*

Several reasons were identified; however, the most prevalent was the incorrect use of and/or coding of these procedures. Medicare reimbursement is on a *per procedure* basis, regardless of the number of eyelashes or eyelids involved during the performance of that procedure.

Proper use of these codes as defined by the AMA was published in the *CPT Assistant* Volume 8, Issue 7, July 1998. That issue contained a question & answer article regarding coding of these procedures. Please refer to those coding guidelines when billing for these services.

CPT material may be ordered online from the AMA at www.ama-assn.org/catalog, or by calling 1-800-621-8335.

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FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number

A0430

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Air Ambulance Services

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Medicare Carriers Manual, Sections 2120.1-2124.H, 2125, 3102, 5116, 5215, Program Memorandum, B-00-09 (Change Request 1065)

Program Memorandum, AB-00-88

(Change Request 1281), dated 09/18/2000

Program Memorandum, AB-00-118

(Change Request 1461), dated 11/30/2000

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

09/17/2001

Original Policy Ending Date

N/A

Revision Effective Date

N/A

Revision Ending Date

N/A

LMRP Description

Air ambulance transportation service, either by means of a helicopter or fixed wing aircraft, is a covered service regardless of the State or region in which it is rendered. However, air ambulance transportation is covered only if the patient’s medical condition is such that transportation by either basic or advanced life support land ambulance is not appropriate.

In addition to meeting medical necessity requirements, all other requirements, such as ambulance crew requirements and origin and destination requirements must be met.

Indications and Limitations of Coverage and/or Medical Necessity

Air ambulance transportation services will be considered medically reasonable and necessary when:

- The patient’s medical condition requires immediate and rapid ambulance transportation that could not have been provided by land ambulance; and either
- 1. The point of pick-up is inaccessible by land vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States), or
- 2. Great distances or other obstacles (e.g., heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities. The term “appropriate facilities” refers to units or components of a hospital that are capable of providing the required level and type of care for the patient’s illness and have available the type of physician or physician specialist needed to treat the patient’s condition.

Medical Appropriateness

Medical appropriateness is established when the patient’s condition is such that the time needed to transport a patient by land, or the instability of transportation by land, poses a threat to the patient’s survival or seriously endangers the patient’s health. The following list of conditions are examples of situations which could justify air ambulance transportation. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

- Acute neurological emergencies requiring emergent/time sensitive interventions not available at the sending facility. This includes such conditions as intracerebral hemorrhage, status epilepticus, acute stroke, diffuse cerebral edema, acute hydrocephalus, CNS infection requiring operative intervention, thrombolytics, etc.
- Acute vascular emergencies requiring emergent/time sensitive interventions not available at the sending facility. This includes such conditions as thoracic or abdominal aortic aneurysm with dissection or impending dissection, acute occlusion of major vessels resulting in limb-threatening ischemia, etc.
- Acute surgical emergencies requiring emergent/time sensitive interventions not available at the sending facility.
- Critically ill patients with compromised hemodynamic/respiratory function who require intensive care during transport and whose time of transfer must be minimized during transport.

- Critically ill obstetric patients who require intensive care during transport and whose time of transfer between facilities must be minimized to prevent patient/fetal morbidity. This includes such conditions as a suspected birth weight less than 2000 grams or gestation less than 34 weeks, premature labor with delivery of low birth weight infant, etc.
- Acute cardiac emergencies requiring emergent/time-sensitive intervention not available at the sending facility. This includes such interventions as angioplasty with or without stent placement, cardiac surgery, intra-aortic balloon pump placement, thrombolytics, cardiogenic shock, etc. It is expected that the patients are unstable and the life-saving intervention is needed immediately.
- Critically ill neonatal/pediatric patients with potentially compromised hemodynamic/respiratory function, a metabolic acidosis greater than 2 hours post delivery, sepsis, or meningitis.
- Patients with electrolyte disturbances and toxic exposure requiring immediate life-saving intervention such as hemoperfusion or hemodialysis.
- Transplant patients for which immediate surgical transplantation is needed to enhance successful transplantation of the donor organ(s).
- Patients with life-threatening conditions requiring care in a specialty center. This includes such conditions requiring a hyperbaric oxygen unit, burns requiring treatment in a burn treatment center, potentially life or limb-threatening trauma and/or multiple severe injuries requiring treatment at a trauma center.

Hospital to Hospital Transport

Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness requirements are met, that is, transportation by ground ambulance would endanger the patient’s health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such services include burn units, cardiac care units, and trauma units. A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or his or her family prefer a specific hospital or physician.

NOTE: Air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician’s office or a patient’s home.

CPT/HCPCS Section & Benefit Category

Ambulance

CPT/HCPCS Codes

- A0430
- A0431
- A0435
- A0436

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

N/A

Diagnoses that Support Medical Necessity

N/A

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

Origin and destination modifiers are to be used with codes A0430-A0436. 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

Payment for air ambulance mileage services is based on each loaded mile. The loaded miles flown by an air ambulance is expressed in statute miles, not nautical miles.

Documentation Requirements

All services for air ambulance services are reviewed on a prepayment basis. Medical record documentation submitted with the claim must clearly document that the

patient’s condition requires immediate and rapid ambulance transportation that could not have been provided by land ambulance. This information can be found on the ambulance transport sheet (run sheet), emergency room records, hospital records, and/or progress notes.

For transfers occurring between facilities, it is expected that the person responsible for managing the patient’s care indicate in the records the medical condition of the patient and the need for air ambulance transportation in lieu of ground transportation. In addition to the documentation supporting the need for air transportation, when the transferring facility does not have adequate facilities to provide the medical services needed by the patient, the records must support that the time sensitive medical service needed was utilized immediately. For example, it is not expected that air transportation is needed for a stable myocardial infarction patient being transferred for a cardiac catheterization the following day.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on 02/24/2001.

Start Date of Comment Period

02/16/2001

End Date of Comment Period

04/02/2001

Start Date of Notice Period

08/01/2001

Revision History

Revision Number	Original	PCR B2001-109
Start Date of Comment Period:		02/16/2001
Start Date of Notice Period:		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Original Effective Date		09/17/2001

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

A9270

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

The List of Medicare Noncovered Services

AMA CPT Copyright Statement

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HCFA National Coverage Policy

N/A

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

10/20/1997

Original Policy Ending Date

N/A

Revision Effective Date

07/01/2001

Revision Ending Date

06/30/2001

LMRP Description

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

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

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

Indications and Limitations of Coverage and/or Medical Necessity

A service or procedure on the “national noncoverage list” may be noncovered for a variety of reasons. It may be noncovered based on a specific exclusion contained in the

Medicare law; for example, acupuncture; it may be viewed as not yet proven safe and effective and, therefore, not medically reasonable and necessary; or it may be a procedure that is always considered cosmetic in nature and is denied on that basis. The precise basis for a national decision to noncover a procedure may be found in references cited in this policy. A service or procedure on the “local” list is always denied on the basis that we do not believe it is “medically reasonable and necessary.” Our list of local medical review policy exclusions contains procedures that, for example, are:

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

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

CPT/HCPCS Section & Benefit Category

N/A

CPT/HCPCS Codes

Local Noncoverage Decisions

Laboratory Procedures

- 82016* Acylcarnitines; qualitative, each specimen
- 82017* Acylcarnitines; quantitative, each specimen
- 82172 Apolipoprotein, each
- 82379* Carnitine (total and free), quantitative, each specimen
- 82523* Collagen cross links, any method (Urinary Biochemical Assays for Bone Resorption)
- 83883 Nephelometry, each analyte not elsewhere specified
- 84134 Prealbumin
- 86301* Immunoassay for tumor antigen, quantitative; CA 19-9
- 86316* Immunoassay for tumor antigen; other antigen, quantitative (eg, CA 50, 72-4, 549), each
- 86343* Leukocyte histamine release test (LHR)
- 86618 Antibody; Borrelia burgdorferi (Lyme disease)
- 86628 Antibody; Candida
- 86631 Antibody; Chlamydia
- 86910 Blood typing, for paternity testing, per individual; ABO, Rh, and MN
- 86911 each additional antigen system
- 87081 Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart
- 87084 Infectious agent antigen detection by direct fluorescent antibody technique; Chlamydia trachomatis
- 87270
- 87320 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative multiple step method; Chlamydia trachomatis

87470	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique	90586	tuberculosis, live, for percutaneous use Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
87471	Bartonella henselae and Bartonella quintana, amplified probe technique	90632	Hepatitis A vaccine, adult dosage, for intramuscular use
87472	Bartonella henselae and Bartonella quintana, quantification	90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
87475	Borrelia burgdorferi, direct probe technique	90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
87477	Borrelia burgdorferi, quantification	90645	Hemophilus Influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
87482	Candida species, quantification	90646	Hemophilus Influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
87485	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique	90647	Hemophilus Influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
87487	Chlamydia pneumoniae, quantification	90648	Hemophilus Influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
87492	Chlamydia trachomatis, quantification	90660	Influenza virus vaccine, live, for intranasal use
87511	Gardnerella vaginalis, amplified probe technique	90665	Lyme disease vaccine, adult dosage, for intramuscular use
87512	Gardnerella vaginalis, quantification	90680	Rotavirus vaccine, tetravalent, live, for oral use
87515	hepatitis B virus, direct probe technique	90690	Typhoid vaccine, live, oral
87520	hepatitis C, direct probe technique	90691	Typhoid vaccine, Vi capsular polysaccharide (ViCPS), for intramuscular use
87522*	hepatitis C, quantification	90692	Typhoid vaccine, heat-and phenol-inactivated (H-P), for subcutaneous or intradermal use
87525	hepatitis G, direct probe technique	90693	Typhoid vaccine, Acetone-Killed, Dried (AKD), for subcutaneous or jet injection use (U.S. military)
87526	hepatitis G, amplified probe technique	A9270*	Becaplermin (Regranex)
87527	hepatitis G, quantification	A9270	Muse
87531	Herpes virus-6, direct probe technique	J3520	Edetate disodium, per 150 mg (chemical endarterectomy)
87532	Herpes virus-6, amplified probe technique	J3530	Nasal vaccine inhalation
87533	Herpes virus-6, quantification		
87534	HIV-1, direct probe technique		
87537	HIV-2, direct probe technique		
87538	HIV-2, amplified probe technique		
87539	HIV-2, quantification		
87540	Legionella pneumophila, direct probe technique		
87541	Legionella pneumophila, amplified probe technique		
87542	Legionella pneumophila, quantification		
87557	Mycobacteria tuberculosis, quantification		
87562	Mycobacteria avium-intracellulare, quantification		
87580	Mycoplasma pneumoniae, direct probe technique		
87581	Mycoplasma pneumoniae, amplified probe technique		
87582	Mycoplasma pneumoniae, quantification		
87592	Neisseria gonorrhoeae, quantification		
87620	papillomavirus, human, direct probe technique		
87622	papillomavirus, human, quantification		
88000-88099	Necropsy (autopsy)		
88349	Electron microscopy: scanning		
89250-89261	Culture and fertilization of oocyte(s) and other artificial insemination procedures		
89264	Sperm identification from testis tissue, fresh or cryopreserved		
A9270*	BRCA1 and BRCA2		
A9270	Homocysteine Testing for Cardiovascular Risk Assessment		
A9270*	In Vitro Chemosensitivity and/or Resistance Assays		
A9270*	Neuronal Thread Protein (NTP)		
	Drugs and Biologicals		
90476	Adenovirus vaccine, type 4, live, for oral use	01990	Physiological support for harvesting of organs from brain-dead patients
90477	Adenovirus vaccine, type 7, live, for oral use	01995	Regional I.V. administration of local anesthetic agent or other medication (upper or lower extremity)
90581	Anthrax vaccine, for subcutaneous use	11975	Insertion, implantable contraceptive capsules
90585	Bacillus Calmette-Guerin vaccine (BCG) for	11977	Removal with reinsertion, implantable contraceptive capsules
		11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets underneath the skin)
		15820-15821	Blepharoplasty, lower lid
		15824-15829	Rhytidectomy
		15876-15879	Suction assisted lipectomy
		17380	Electrolysis epilation, each ½ hour
		27599*+	Tidal knee irrigation
		43999*+	Gastric Electrical Stimulation
		58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection) with occlusion of oviducts by device (eg, band, clip, or Falope ring)
		58671	Artificial insemination; intra-cervical
		58321	Artificial insemination; intra-uterine
		58322	Sperm washing for artificial insemination
		58323	
			Procedures

58970 Follicle puncture for oocyte retrieval, any method
 58974 Embryo transfer, intrauterine
 58976 Gamete, zygote, or embryo intrafallopian transfer, any method
 58999+ Pap plus speculoscopy (PPS)
 59012 Cordocentesis (intrauterine), any method
 64999*+ Bretylum Bier Block
 76499*+ MRI for use in measuring the blood flow, spectroscopy imaging of cortical bone and calcification, and procedures involving resolution of bone or calcification
 92548* Computerized dynamic posturography
 92970* Cardioassist-method of circulatory assist; internal
 92971* Cardioassist-method of circulatory assist; external
 92997-92998 Percutaneous transluminal pulmonary artery balloon angioplasty
 93720-93722* Plethysmography, total body
 93740 Temperature gradient studies
 93799*+ Metaiodobenzylguanidine (MIBG) imaging
 94014 Patient initiated spirometric recording per 30 day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation
 94015 Patient initiated spirometric recording per 30 day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)
 94016 Patient initiated spirometric recording per 30 day period of time; physician review and interpretation only
 95806 Sleep Study unattended by a technologist
 95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk, with report
 95832 hand, with or without comparison with normal side
 95833 total evaluation of body, excluding hands
 95834 total evaluation of body, including hands
 95851 Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each truck section (spine)
 95852 hand, with or without comparison with normal side
 95999*+ Biothesiometry
 95999+ Current Perception Threshold Testing (CPT)
 95999*+ Surface electromyography
 97545 Work hardening/conditioning; initial 2 hours
 97546 each additional hour (List separately in addition to code for primary procedure)
 99360 Stand-by anesthesia
 A9270* Abdominal Aorta Transplant from a Cadaver
 A9270* Adoptive Immunotherapy
 A9270* Arthroscopic laser arthrodesis/rhizotomy of the facet joint with cancellous bone allograft and autologous platelet gell patch
 A9270* Balloon Lacrimoplasty
 A9270* Blood Brain Barrier Disruption
 A9270* Cellular Therapy
 A9270 Disposable Pain Control Infusion Pump (PCIP)

A9270* Epiduroscopy/Myeloscropy
 A9270* Epiluminescence microscopy
 A9270* Fetal Tissue Transplantation
 A9270* Gamma Knife for lesions outside the head
 A9270 High Voltage Pulsed Current (HVPC) Therapy
 A9270* Intradiscal electrothermal therapy (intradiscal electrothermal annuloplasty)
 A9270* Lidocaine Intravenous For Chronic Pain
 A9270* Kyphoplasty
 A9270* Large and Small Bowel Transplants
 A9270* Light reflecting rheography
 A9270* Matrix Pro Elect/Matrix Elect DT
 A9270* Meniscal Allograft Transplantation
 A9270* Neocontrol (Magnetic Incontinence Chair)
 A9270* OssaTron treatment
 A9270 Politzer Procedure
 A9270 Quantitative Sensory Testing (QST)
 A9270* Shark Cartilage Injections
 A9270* Silicone Oil Injections
 A9270* SPECT with Altropane for early diagnosis of Parkinson's disease
 A9270* Stenting of the vertebral and cerebral arteries
 A9270* The Canalith Repositioning Procedure
 A9270* Ultrasound Guided Sclerotherapy
 A9270* ZStat flu Influenza Test Kits
 D9248 Non-intravenous conscious sedation
 G0167 Hyperbaric oxygen treatment not requiring physician attendance, per treatment session
 G0193* Endoscopic study of swallowing function (also fiberoptic endoscopic evaluation of swallowing (FEES))
 G0194* Sensory testing during endoscopic study of swallowing (add on code) referred to as fiberoptic endoscopic evaluation of swallowing with sensory testing (FEEST)

National Noncoverage Decisions

Devices

33999*+ Artificial hearts and related devices (CIM 65-15)
 A9270* Intrapulmonary percussive ventilator for home use (CIM 60-21)

Laboratory Procedures

80050 General Health Panel
 86999*+ Cytotoxic leukocyte tests for food allergies (CIM 50-2)
 86910 Blood typing, for paternity testing, per individual; ABO, Rh and MN
 86911 each additional antigen system
 88399*+ Human tumor stem cell drug sensitivity assays (CIM 50-41)

Drugs and Biologicals

90669 Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use
 A4260* Levonorgestral (contraceptive) implants system, including implants and supplies (Statute 1862 [a][1][a])
 A4261 Cervical cap for contraceptive use (Statute 1862[a][1][a])
 A9270 Oral Medication (MCM 2049)
 A9270* Rebetrone (MCM 2049)
 G0192 Intranasal or oral administration; one vaccine (single or combination vaccine/toxoid) (MCM 2049.4)

J3570*	Laetrile (Amygdalin, Vit B17) (CIM 45-10)	95199+	Repository antigen (MCM 2005.2)
J8499+	Prescription drug, oral, nonchemotherapeutic, not otherwise specified (MCM 2049)	95999*+	EEG monitoring during open heart surgery and in immediate post-op period (CIM 35-57.1)
J8499*+	Sublingually administered antigens (CIM 45-28)	97780-97781*	Acupuncture (CIM 35-8)
Q2001	Oral, Cabergoline, 0.5 mg (MCM 2049.5)	98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions (MCM 2251)
Procedures		97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (CIM 65-10)
15775-15776	Punch graft for hair transplant (MCM 2329)	97803	re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes (CIM 65-10)
32491*	Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous), for lung volume reduction, sternal split or transthoracic approach, with or without any pleural procedure (prior to 1/1/97 HCPCS code G0061) (CIM 35-93)	97804	group (2 or more individual(s)), each 30 minutes (CIM 65-10)
35452*	Transluminal balloon angioplasty (PTA) in treatment of obstructive lesions of aortic arch (CIM 50-32.3)	99172	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare)
53899*+	Bladder Stimulator (CIM 65-11)	99173	Screening test of visual acuity, quantitative, bilateral
55970-55980*	Intersex surgery (CIM 35-61)	A9160	Noncovered service by podiatrist (MCM 2020.4)
56805	Clitoroplasty for intersex state (CIM 35-61)	A9170	Noncovered service by chiropractor (MCM 2026.26)
57335	Vaginoplasty for intersex state (CIM 35-61)	A9270	Carbon Dioxide Therapy (CIM 35-29)
59899*+	Ambulatory home monitoring of uterine contractions (MCM 2005.1)	A9270*	Cardiogram (CIG) as an alternative to stress test or thallium stress test (CIM 50-47)
64999*+	Stereotactic cingulotomy as a means of psychosurgery (CIM 35-84)	A9270*	Carotid body resection to relieve pulmonary symptoms, including asthma (CIM 35-7)
65760-65767, 65771*	Refractive keratoplasty to correct refractive error (CIM 35-54)	A9270*	Carotid sinus nerve stimulator for treatment of paroxysmal supraventricular tachycardia (CIM 65-4)
69949*	Cochleostomy with neurovascular transplant for Meniere's Disease (CIM 35-50)	A9270*	Chelation Therapy (EDTA) for treatment of arteriosclerosis (CIM 35-64)
72159	Magnetic resonance angiography, spine canal and contents, with or without contrast material(s) (CIM 50-14)	A9270*	Circulator Boot System (CIM 35-74)
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s) (CIM 50-14)	A9270*	Colonic irrigation (CIM 35-1)
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s) (CIM 50-14)	A9270	Cosmetic surgery (MCM 2329)
78351*	Dual Photon Absorptiometry, one or more sites (CIM 50-44)	A9270*	Diathermy or ultrasound treatments performed for respiratory conditions or diseases (CIM 35-41)
78608*	Brain imaging, positron emission tomography (PET); metabolic evaluation (CIM 50-36)	A9270*	Ear/carbon therapy (CIM 35-29)
78609*	perfusion evaluation (CIM 50-36)	A9270*	Electrical aversion therapy for treatment of alcoholism (CIM 35-23.1)
78810*	Tumor Imaging, Positron Emission Tomography (PET), metabolic evaluation	A9270*	Electrical continence (CIM 65-2)
90760	Routine physical exam (MCM 2320)	A9270*	Electrosleep therapy (CIM 35-18)
90875-90876	Individual psychophysiological therapy incorporating biofeedback (CIM 35-27)	A9270	Electrotherapy for the treatment of facial nerve paralysis (Bell's Palsy) (CIM 35-72)
90899*+	Transcendental meditation (CIM 35-92)	A9270	Eye exam, routine (MCM 2320)
90908 (prior to 1/1/97)	Biofeedback (psychiatric only) (CIM 35-27)	A9270*	Fabric wrapping of abdominal aneurysms (CIM 35-34)
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	A9270*	Gastric balloon for treatment of obesity (CIM 35-86)
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	A9270*	Hair analysis (CIM 50-24)
93668	Peripheral arterial disease (PAD) rehabilitation, per session	A9270*	Hemodialysis for treatment of schizophrenia (CIM 35-51)
93760	Thermogram; cephalic	A9270*	Indirect Calorimetry used to assess nutritional status as a respiratory therapy
93762	peripheral	A9270	Intestinal bypass for obesity (CIM 35-33)
93784-93790*	Ambulatory blood pressure monitoring (CIM 50-42)	A9270*	Intravenous histamine therapy (CIM 35-19)
		A9270*	Investigational IOLS in FDA Core Study or Modified Core Study (MCM 2020.25)
		A9270*	Partial ventriculectomy (also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery) (CIM 35-95)

- A9270* Pelvic floor stimulator (CIM 65-9)
- A9270* Percutaneous transluminal angioplasty (PTA) of the vertebral and cerebral arteries (CIM 50-32)
- A9270* Platelet-derived wound healing formula (Procuren) (CIM 45-26)
- A9270* Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (CIM 35-13)
- A9270 Speech therapy by pathologist/speech therapist (MCM 2206.2)
- A9270* Sweat test as predictor of efficacy of sympathectomy in PVD (CIM 50-3)
- A9270* Thermogenic therapy (CIM 35-6)
- A9270* Tinnitus masking (CIM 35-63)
- A9270* Transfer factor for treatment of multiple sclerosis (CIM 45-17)
- A9270* Transilluminator light scanning or diaphanography (CIM 50-46)
- A9270* Transvenous (catheter) pulmonary embolectomy (CIM 35-55)
- A9270* Treatment of decubitus ulcers by ultraviolet light, low intensity direct current, topical application of oxygen and topical dressings with balsam of Peru in castor oil (CIM 35-31)
- A9270* Treatment of motor function disorders with electrical nerve stimulation (CIM 35-20)
- A9270* Ultrafiltration independent of conventional dialysis (CIM 55-3)
- A9270* Vertebral Axial Decompression (VAX-D) (CIM 35-97)
- A9270 Vitamin B12 injections to strengthen tendons, ligaments of the foot (CIM 45-4)
- G0122 Colorectal cancer screening; barium enema
- G9016 Smoking cessation counseling, individual, in the absence of or in addition to any other evaluation and management service, per session (6-10 minutes) demo project code only
- M0100* Gastric freezing (CIM 35-65)
- V5010 Hearing exam for the purpose of a hearing aid (MCM 2320)

These lists of noncovered services are not inclusive.

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

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

Reason for Denial

See criteria for noncoverage.

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

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

N/A

Documentation Requirements

National noncovered services may not be covered by the local carrier.

In order for noncovered services to be evaluated for coverage, the following documentation must be submitted to the local carrier:

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

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 advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on 02/24/2001.

Start Date of Comment Period

N/A

End of Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	25	PCR B2001-131
Start Date of Comment Period:		N/A
Start Date of Notice Period:		08/01/2001
		4th QTR 2001 <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: Change request 1660 (transmittal AB-01-74) dated 5/03/01, provides coverage of PTA of the carotid artery with concurrent carotid stent placement when furnished in accordance with a FDA approved Category B IDE clinical trial. Therefore, information regarding the noncoverage of stent and PTA of carotid artery was deleted from policy. Also, the existing noncovered codes 97545 and 97546 were added

to the policy. In addition a revision is necessary to reflect the status change based on Change Requests 1638 (Transmittal AB-01-59) and 1708 (Transmittal AB-01-84). Procedure codes 90471 and 90472 were changed from Nationally Noncovered to invalid for Medicare purposes. Based on Change Request 1536, HCPCS code G0121 is a covered service therefore, it was deleted from the policy.

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

G0030

Original Policy Effective Date

10/02/1995

Contractor Name

First Coast Service Options, Inc.

Original Policy Ending Date

N/A

Contractor Number

00590

Revision Effective Date

07/01/2001

Contractor Type

Carrier

Revision Ending Date

06/30/2001

LMRP Title

Positron Emission Tomography (PET) Scan

LMRP Description

PET is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceutical) such as FDG (2-{fluorine-18}-fluoro-2-dexoy-D-glucose) that are usually administered intravenously to the patient. At this time, Medicare only covers FDG PET Scans.

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Indications and Limitations of Coverage and/or Medical Necessity

The following indications may be covered for PET under certain circumstances. Details of Medicare PET coverage are discussed later in this policy. Unless otherwise indicated, the clinical conditions below are covered when PET utilizes FDG as the tracer.

HCFA National Coverage Policy

Coverage Issues Manual, Section 50-36

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

NOTE: All other uses of PET scans not listed in this policy are NOT covered.

Clinical Condition	Effective Date	Coverage
Solitary Pulmonary Nodules (SPNs)	January 1, 1998	Characterization
Lung Cancer (Non Small Cell)	January 1, 1998	Initial Staging
Lung Cancer (Non Small Cell)	July 1, 2001	Diagnosis, staging, and restaging
Esophageal Cancer	July 1, 2001	Diagnosis, staging, and restaging
Colorectal Cancer	July 1, 1999	Determining location of tumors if rising CEA level suggests recurrence
Colorectal Cancer	July 1, 2001	Diagnosis, staging, and restaging
Lymphoma	July 1, 1999	Staging and restaging only when used as an alternative to Gallium scan
Lymphoma	July 1, 2001	Diagnosis, staging, and restaging
Melanoma	July 1, 1999	Evaluating recurrence prior to surgery as an alternative to Gallium scan
Melanoma	July 1, 2001	Diagnosis, staging, and restaging; noncovered for evaluating regional nodes
Refractory Seizures	July 1, 2001	Covered for pre-surgical evaluation only
Perfusion of the heart using Rubidium 82* tracer	March 14, 1995	Covered for noninvasive imaging of the perfusion of the heart
*Not FDG PET		
Head and Neck Cancer	July 1, 2001	Diagnosis, staging, and restaging; noncovered for CNS and thyroid
Myocardial Viability	July 1, 2001	Covered only following an inconclusive SPECT

General Conditions of Coverage

A. Regardless of any other terms or conditions, all uses of PET scans, in order to be covered by the Medicare program, must meet the following general conditions prior to June 30, 2001:

1. Such scans must be performed using a camera that has either been approved or cleared for marketing by the FDA to image radionuclides in the body.
2. Submission of claims for payment must include any information Medicare requires to assure that the PET scans performed: (a) were medically necessary; (b) did not unnecessarily duplicate other covered diagnostic tests; and (c) did not involve investigational drugs or procedures using investigational drugs as determined by the FDA.
3. The PET scan entity submitting claims for payment must keep such patient records as Medicare requires on file for each patient for whom a PET scan claim is made.

B. Regardless of any other terms or conditions, all uses of PET scans, in order to be covered by the Medicare program, must meet the following general conditions as of July 1, 2001:

1. PET scans are covered for those indications otherwise listed in this document. For indications covered beginning July 1, 2001, scans performed with dedicated full-ring scanners will be covered. For those indications covered prior to July 1, 2001, all PET scanners approved or cleared for marketing by the FDA remain covered.
2. The provider should maintain on file the doctor's referral and documentation that the procedure involve only FDA approved drugs and devices, as is normal business practice.
3. The ordering physician is responsible for certifying the medical necessity of the study and that it meets the conditions specified in the instructions. The physician should have documentation in the beneficiary's medical record to support the referral to the PET scan provider.

Covered Indications for PET Scans and Limitations/ Requirements for Usage

For all uses of PET, excluding Rubidium 82 for perfusion of the heart, myocardial viability and refractory seizures the following definitions apply:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare. PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific signs and symptoms of disease).

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Note: PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific symptoms).

Monitoring - Use of PET to monitor tumor response during the planned course of therapy (i.e. when no change in therapy is being contemplated) is NOT covered. Restaging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.

Coverage of PET Scans for Noninvasive Imaging of the Perfusion of the Heart

Effective for services performed on or after March 14, 1995, PET scans done at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb82) are covered, provided the requirements below are met:

The PET scan, whether rest alone or rest with stress, is used in place of, but not in addition to, a single photon emission computed tomography (SPECT); or

The PET scan, whether rest alone or rest with stress, is used following a SPECT that was found inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)

For any PET scan for which Medicare payment is claimed for dates of service prior to July 1, 2001, the claimant must submit additional specified information on the claim form (including proper codes and/or modifiers), to indicate the results of the PET scan. The claimant must also include information on whether the PET scan was done after an inconclusive noninvasive cardiac test. The

information submitted with respect to the previous noninvasive cardiac test must specify the type of test done prior to the PET scan and whether it was inconclusive or unsatisfactory. These codes are in the form of special G codes used for billing PET scans using Rb 82. Beginning July 1, 2001 claims should be submitted with the appropriate codes.

Coverage of FDG PET for Lung Cancer

The coverage for FDG PET for lung cancer, effective January 1, 1998, has been expanded. Beginning July 1, 2001 usage of FDG PET for lung cancer has been expanded to include diagnosis, staging, and restaging of the disease.

A. Effective for services performed on or after January 1, 1998, Medicare covers regional FDG PET chest scans, on any FDA approved scanner, for the characterization of single pulmonary nodules (SPNs). The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient.

Requirements:

There must be evidence of primary tumor. Claims for regional PET chest scans for characterizing SPNs should include evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other detection method, indicating an indeterminate or possible malignant lesion, not exceeding four centimeters (cm) in diameter.

PET scan claims must include the results of concurrent thoracic CT, which is necessary for anatomic information, in order to ensure that the PET scan is properly coordinated with other diagnostic modalities.

In cases of serial evaluation of SPNs using both CT and regional PET chest scanning, such PET scans will not be covered if repeated within 90 days following a negative PET scan.

Note: A tissue sampling procedure is not routinely covered in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. When there has been a negative PET scan, the provider must submit additional information with the claim to support the necessity of a Tissue Sampling Procedure (TSP), for review by the Medicare contractor.

B. Effective for services performed from January 1, 1998 through June 30, 2001, Medicare approved coverage of FDG PET for initial staging of non-small-cell lung carcinoma (NSCLC).

Limitations:

This service is covered only when the primary cancerous lung tumor has been pathologically confirmed; claims for PET must include a statement or other evidence of the detection of such primary lung tumor. The evidence should include, but is not restricted to, a surgical pathology report, which documents the presence of an

NSCLC. Whole body PET scan results and results of concurrent computed tomography (CT) and follow-up lymph node biopsy must be properly coordinated with other diagnostic modalities. Claims must include both:

- The results of a concurrent thoracic CT, necessary for anatomic information, and
- The results of any lymph node biopsy performed to finalize whether the patient will be a surgical candidate. The ordering physician is responsible for providing this biopsy result to the PET facility.

Note: Where the patient is considered a surgical candidate, (given the presumed absence of metastatic NSCLC unless medical review supports a determination of medical necessity of a biopsy) a lymph node biopsy will not be covered in the case of a negative CT and negative PET. A lymph node biopsy will be covered in all other cases, (i.e., positive CT + positive PET; negative CT + positive PET; positive CT + negative PET).

C. Beginning July 1, 2001, Medicare covers FDG PET for diagnosis, staging, and restaging of NSCLC. Documentation should be maintained in the beneficiary's medical file to support the medical necessity of the procedure, as is normal business practice.

Requirements: PET is covered in either/or both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Coverage of FDG PET for Esophageal Cancer

A. Beginning July 1, 2001, Medicare covers FDG PET for the diagnosis, staging, and restaging of esophageal cancer. Medical evidence is present to support the use of FDG PET in pre-surgical staging of esophageal cancer.

Requirements: PET is covered in either/or both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Coverage of FDG PET for Colorectal Cancer

Medicare coverage of FDG PET for colorectal cancer where there is a rising level of carcinoembryonic antigen (CEA) was effective July 1, 1999 through June 30, 2001. Beginning July 1, 2001, usage of FDG PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging of the disease.

A. Effective July 1, 1999, Medicare covers FDG PET for patients with recurrent colorectal carcinomas, which are suggested by rising levels of the biochemical tumor marker CEA.

Frequency Limitations:

Whole body PET scans for assessment of recurrence of colorectal cancer cannot be ordered more frequently than once every 12 months unless medical necessity documentation supports a separate re-elevation of CEA within this period.

Limitations:

Because this service is covered only in those cases in which there has been a recurrence of colorectal tumor, claims for PET should include a statement or other evidence of previous colorectal tumor, through June 30, 2001.

B. Beginning July 1, 2001, Medicare coverage has been expanded for colorectal carcinomas for diagnosis, staging, and restaging. New medical evidence supports the use of FDG PET as a useful tool in determining the presence of hepatic/extrahepatic metastases in the primary staging of colorectal carcinoma, prior to selecting a treatment regimen. Use of FDG PET is also supported in evaluating recurrent colorectal cancer beyond the limited presentation of a rising CEA level where the patient presents with clinical signs or symptoms of recurrence.

Requirements: PET is covered in either/or both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Coverage of FDG PET for Lymphoma

Medicare coverage of FDG PET to stage and re-stage lymphoma as an alternative to a Gallium scan, was effective July 1, 1999. Beginning July 1, 2001, usage of FDG PET for lymphoma has been expanded to include diagnosis, staging, and restaging of the disease.

A. Effective July 1, 1999, FDG PET is covered for the staging and restaging of lymphoma.

Requirements:

FDG PET is covered only for staging or follow-up restaging of lymphoma. Claims must include a statement or other evidence of previous diagnosis of lymphoma when used as an alternative to a Gallium scan.

To ensure that the PET scan is properly coordinated with other diagnostic modalities, claims must include results of concurrent computed tomography (CT) and/or other diagnostic modalities when they are necessary for additional anatomic information.

No PET scan may be covered in cases where it is done within 50 days of a Gallium scan done by the same facility where the patient has remained during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen.

Frequency Limitations for Restaging:

PET scans will be allowed for restaging no sooner than 50 days following the last staging PET scan or Gallium scan, unless the medical necessity documentation supports that the restaging at an earlier date is medically necessary.

- B. Effective for services performed on or after July 1, 2001, the Medicare program has broadened coverage of FDG PET for the diagnosis, staging, and restaging of lymphoma.

Requirements:

PET is covered in either/or both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Coverage of FDG PET for Melanoma

Medicare covered the evaluation of recurrent melanoma prior to surgery when used as an alternative to a Gallium scan, effective July 1, 1999. For services performed on or after July 1, 2001, FDG PET is covered for the diagnosis, staging, and restaging of malignant melanoma. FDG PET is not covered for the use of evaluating regional nodes in melanoma patients.

- A. Effective for services furnished July 1, 1999 through June 30, 2001, in the case of patients with recurrent melanoma prior to surgery, FDG PET (when used as an alternative to a Gallium scan) is covered for tumor evaluation.

Frequency Limitations:

Whole body PET scans cannot be ordered more frequently than once every 12 months, unless medical necessity documentation, maintained in the beneficiary's medical record, supports the specific need for anatomic localization of possible recurrent tumor within this period.

Limitations:

The FDG PET is covered only as an alternative to a Gallium scan. No PET scan may be covered in cases where it is done within 50 days of a Gallium scan done by the same facility where the patient has remained during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen.

- B. Effective for services performed on or after July 1, 2001, FDG PET scan coverage for the diagnosis, staging, and restaging of malignant melanoma (not the evaluation of regional nodes) has been broadened.

Limitations:

PET scans are not covered for the evaluation of regional nodes.

Requirements:

PET is covered in either/or both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and,

(2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Coverage of FDG PET for Head and Neck Cancers (Cancers of the Central Nervous System [CNS] and thyroid are noncovered)

Effective for services performed on or after July 1, 2001, Medicare will provide coverage for cancer of the head and neck, excluding the central nervous system (CNS) and thyroid.

Limitations:

PET scans for head and neck cancers are not covered for CNS or thyroid cancers.

Requirements:

PET is covered in either/or both of the following circumstances:

Diagnosis - PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare.

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

Coverage of FDG PET for Myocardial Viability

Beginning July 1, 2001, Medicare covers FDG PET for the determination of myocardial viability, following an inconclusive SPECT.

Limitations:

In the event that a patient has received a single photon computed tomography test (SPECT) with inconclusive results, a PET scan may be covered.

Coverage of FDG PET for Refractory Seizures

Beginning July 1, 2001, Medicare will cover FDG PET for pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity.

Limitations:

Covered only for pre-surgical evaluation.

CPT/HCPCS Section & and Benefit Category

Radiology/Nuclear Medicine

CPT/HCPCS Codes

G0030	G0040	G0211	G0221
G0031	G0041	G0212	G0222
G0032	G0042	G0213	G0223
G0033	G0043	G0214	G0224
G0034	G0044	G0215	G0225
G0035	G0045	G0216	G0226
G0036	G0046	G0217	G0227
G0037	G0047	G0218	G0228
G0038	G0125	G0219	G0229
G0039	G0210	G0220	G0230

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

The following ICD-9-CM codes are applicable to HCPCS codes G0030-G0047 only:

411.81	414.11
414.00-414.03	414.8

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

Documentation that the required conditions (as indicated in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy) for each of the FDG PET scans performed has been met must be maintained by the referring physician in the beneficiary’s medical record. PET scan facilities must keep patient record information on file for each Medicare patient for whom such a PET scan claim is made. The medical record must include standard information (e.g., age, sex, and height) along with any annotations regarding body size or type which indicate a need for a PET scan to determine the patient’s condition.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	7	PCR B2001-128
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: Transmittals 136 and AB-01-54 expanded coverage of PET scans effective July 1, 2001.

Advance Notice Statement

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

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

G0104

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Colorectal Cancer Screening

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Program Transmittal 1697
(Change Request 1536, dated 02/08/2001)
Medicare Carriers Manual, Section 4180

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

08/17/1998

Original Policy Ending Date

N/A

Revision Effective Date

07/01/2001

Revision Ending Date

06/30/2001

LMRP Description

Cancer screening is a means of detecting disease early, in asymptomatic individuals, with the goal of decreasing morbidity and mortality. Generally, screening examinations, tests, or procedures are not diagnostic of cancer but instead indicate that a cancer may be present. The diagnosis is then made following a workup that generally includes a biopsy and pathologic confirmation. Colorectal cancer screening involves the use of fecal occult blood testing, rigid and flexible sigmoidoscopy, radiographic barium contrast studies, and colonoscopy.

Indications and Limitations of Coverage and/or Medical Necessity

Effective for services furnished on or after January 1, 1998, Medicare will cover colorectal cancer screening test/procedures for the early detection of colorectal cancer. The following are the coverage criteria for these screening services:

- Screening fecal-occult blood tests (code G0107) are covered at a frequency of once every 12 months for beneficiaries who have attained age 50. Screening

fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician.

- Screening flexible sigmoidoscopies (code G0104) are covered at a frequency of once every 48 months for beneficiaries who have attained age 50. If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal (procedure codes 45330-45339) should be billed rather than code G0104.
- Screening colonoscopies (code G0105) are covered at a frequency of once every 24 months for beneficiaries at high risk for colorectal cancer. High risk for colorectal cancer means an individual with one or more of the following:
 - A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
 - A family history of familial adenomatous polyposis;
 - A family history of hereditary nonpolyposis colorectal cancer;
 - A personal history of adenomatous polyps;
 - A personal history of colorectal cancer; or
 - A personal history of inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal (procedure codes 45378-45385) should be billed rather than code G0105. This screening must be performed by a doctor of medicine or osteopathy.

- Screening barium enema examinations (codes G0106 and G0120) are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters specified in the law for screening sigmoidoscopy and screening colonoscopy apply.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual. This screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

It is not expected that these screening services are performed on patients that present with active gastrointestinal symptomatology.

Effective for services furnished on or after July 1, 2001:

- Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (code G0121) is covered unless he or she has had:
 - A screening colonoscopy (code G0121) within the preceding ten years or;
 - A screening flexible sigmoidoscopy (code G0104) within the preceding four years.

If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal (procedure codes 45378-45385) should be billed rather than code G0121. This screening must be performed by a doctor of medicine or osteopathy.

- A screening flexible sigmoidoscopy (code G0104) is allowed once every 48 months unless the beneficiary does not meet the criteria for high risk of developing colorectal cancer *and* he or she has had a screening colonoscopy (code G0121) within the preceding 10 years.

CPT/HCPCS Section & Benefit Category

Digestive System/Surgery

CPT/HCPCS Codes

G0104	G0106	G0120	G0122
G0105	G0107	G0121	

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

The following diagnosis list applies only to procedure codes G0105 (Screening colonoscopy) and G0120 (Barium enema).

555.0-555.9	558.1-558.9	V10.06	V16.0
556.0-556.9	V10.05	V12.72	V18.5

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

Procedure code G0122 should be used when a screening barium enema is performed not as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service will be denied as non-covered because it fails to meet the requirements of the benefit.

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

When billing procedure code G0105 (Screening colonoscopy) or G0120 (Barium enema), submit the applicable ICD-9-CM diagnosis for high risk:

- For patients with a close relative who has had colorectal cancer or a family history of hereditary nonpolyposis colorectal cancer, utilize diagnosis V16.0;
- For patients with a family history of familial adenomatous polyposis, utilize diagnosis V18.5;
- For patients with a personal history of adenomatous polyps, utilize diagnosis V12.72;
- For patients with a personal history of colorectal cancer, utilize diagnosis V10.05 or V10.06;
- For patients with an inflammatory bowel disease utilize diagnosis 555.0-555.9, 556.0-556.9, or 558.1-558.9.

Any time the scheduled colorectal screening service turns into a diagnostic/therapeutic service, the applicable diagnostic/therapeutic procedure code should be billed.

Documentation Requirements

Medical record documentation maintained by the provider must indicate that the service provided was screening in nature. In addition, if procedure code G0105 (Screening colonoscopy) or G0120 (Barium enema) is billed, the documentation should support that the patient is at high risk. This information is usually found in the office/progress notes, history/physical, and/or procedure note.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous specialties.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	1	PCR B2001-139
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: HCFA transmittal 1697 (Change Request 1536, dated 02/08/2001) revises Colorectal Cancer Screening by authorizing coverage for screening colonoscopies beginning July 1, 2001, for all individuals, including those not at high risk (code G0121) who had not received a screening colonoscopy (G0121) within the preceding ten years or a screening flexible sigmoidoscopy (G0104) with the preceding four years.

Advance Notice Statement

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

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

G0108

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Diabetes Outpatient Self-Management Training

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Program Memorandum B-01-40
(Change Request 1455, dated 06/15/2001)
Coverage Issues Manual, Section 80-2

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

04/17/2000

Original Policy Ending Date

N/A

Revision Effective Date

02/27/2001

Revision Ending Date

02/26/2001

LMRP Description

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

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

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

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

Indications and Limitations of Coverage and/or Medical Necessity

Medicare coverage of diabetes outpatient self-management training was based on Section 80-2 of the Coverage Issues Manual prior to July 1, 1998. Effective for services performed on or after July 1, 1998 until February 26, 2001, coverage of diabetic training was based on the criteria identified in Program Memoranda AB-99-46, AB-99-30, AB-98-36, and AB-98-51. Effective for services performed on or after February 27, 2001 expanded coverage of diabetes outpatient self-management training is covered when the following criteria are met.

General Conditions of Coverage

The training must be ordered by the physician or qualified nonphysician practitioner treating the beneficiary's diabetes. The order must be part of a comprehensive plan of care established by the physician or qualified nonphysician practitioner and describe the training that the referring physician or qualified non-physician practitioner is ordering and/or any special concerns such as the need for general training, or insulin-dependence.

- The plan of care must be maintained in the medical record of the ordering provider and document the need for training on an individual basis when group is typically covered.
- The order must include a statement signed by the

physician that the service is needed.

- The provider of the service must maintain documentation in the file that includes the original order from the physician and any special conditions noted by the physician.
- Any change in the training order must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the performing provider's file.
- When a beneficiary has not received initial training meeting the quality standards of this section, they are eligible to receive 10 hours of initial training within a continuous 12-month period. Nine hours of initial training must be provided in a group setting consisting of 2 to 20 individuals unless the ordering physician or nonphysician practitioner certified that a special condition exists that makes it impossible for the beneficiary to attend a group training session. Those conditions include but are not limited to: no group session is available within 2 months of the date the training is ordered; the beneficiary has special needs resulting from problems with hearing, vision, or language limitations or other special conditions identified by the treating physician or nonphysician practitioner; additional insulin instruction is needed.
- The one hour of initial training may be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training. The 10 hours of initial training may be provided in any combination of half-hour increments within the 12-month period and less than 10 hours of initial training may be used in the 12-month period.
- Two hours of follow-up training is covered each year starting with the calendar year following the year in which the beneficiary completes the initial training. The 2 hours of training may be given in any combination of half-hour increments within each calendar year on either an individual or group basis without the certification of the ordering physician or nonphysician practitioner that special conditions exist.

Medical Eligibility for Coverage

Medicare covers initial training for beneficiaries who have the following medical conditions present prior to the physician's or nonphysician practitioner's order for the training.

- New onset diabetes.
- Inadequate glycemic control as evidenced by a glycosylated hemoglobin (HbA1c) level of 8.5% or more on two consecutive HbA1c determinations 3 or more months apart in the year before the beneficiary begins receiving training.
- A change in treatment regimen from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- High risk for complications based on inadequate glycemic control (documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the beneficiary needed emergency room visits or hospitalization).
- High risk based on at least one of the following: lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation; pre-proliferative or proliferative retinopathy or prior laser treatment of the eye; kidney complications related to diabetes, when manifested by albuminuria, without other cause, or elevated creatinine.

Note: Beneficiaries with diabetes, becoming newly eligible for Medicare, can receive diabetes outpatient self-management training in this program.

Quality Standards

The outpatient diabetes self-management training program must be accredited as meeting approved quality standards, except during the first 18-months after February 27, 2001. HCFA will accept recognition of the American Diabetes Association (ADA) as meeting the National Standards for Diabetes Self-Management Training Programs as published in Diabetes Care, volume 23, number 5. Programs without ADA recognition or accreditation by the HCFA-approved national accreditation organization are not covered after February 27, 2001.

CPT/HCPCS Section & Benefit Category

Medicine

CPT/HCPCS Codes

G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

250.00-250.93

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.

Reimbursement for Diabetic Outpatient Self-Management Training is not separately payable when rendered to a beneficiary in the following type of bills: inpatient in a hospital or skilled nursing facility, hospice care, resident in a nursing home, outpatient in a rural health clinic or federally qualified health center.

The beneficiary has previously received initial training from an ADA recognized program.

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

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

Services for diabetes outpatient self-management training must be billed with the appropriate HCPCS code, G0108 or G0109, in 30-minute increments only. The units field on the claim should be adjusted accordingly.

Documentation Requirements

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

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

- The treating physician or qualified nonphysician practitioner must order the diabetic training and describe the training needed for each beneficiary including any special concerns/conditions or rationale for providing individual training versus group training. This order, which includes a statement indicating that the service is needed, must be signed by the ordering or qualified nonphysician practitioner and included as part of a comprehensive plan of care. This plan of care must be maintained in the ordering provider's medical record.
- The provider of the diabetic training must maintain in the beneficiary's medical record the original order from the physician/nonphysician practitioner and any special conditions noted by the ordering provider. Any change in the training order must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the performing provider's file.
- An individualized assessment including relevant medical history, cultural influences, health beliefs and attitudes, diabetes knowledge, self-management skills and behaviors, readiness to learn, cognitive ability, physical limitations, family support, and financial status.
- An individualized mutually agreed upon education plan established by the team (patient, physician, and health care team members) based on the individualized assessment, including but not limited to the problems to be addressed, the educational objectives, and educational modality(ies) used to meet the objectives.
- A periodic individualized reassessment between the beneficiary and instructor(s) that indicates the progress toward the goal(s).
- Attendance sheets documenting that the beneficiary was present during each training session must be part of the beneficiary's file maintained by the provider of the service.

Utilization Guidelines

Initial training encompasses up to 10 hours of training within a continuous 12-month period. Nine of these hours must be provided in a group setting unless a special condition exists as identified in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Follow-up training of up to 2 hours training is covered each year starting with the calendar year following the year in which the beneficiary completes the initial training.

Other Comments

Terms defined:

Certified provider - physicians, individuals or entities that are paid under the physician-fee schedule. This includes the following non-physician practitioners: physician assistants (PAs), nurse practitioner (NPs), nurse midwives (NMs), clinical psychologists (CPs), and clinical social workers (CSWs).

Glycosuria - the presence of glucose in the urine. Traces of sugar, particularly glucose, may occur in normal urine but are not detected by ordinary qualitative methods. In routine urinalyses the presence of a reducing sugar is suspicious of diabetes mellitus.

Sources of Information and Basis for Decision

Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on 08/21/1999.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	2	PCR B2001-136
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Revised Effective Date:		02/27/2001

Explanation of Revision: Change request 1455, dated 06/15/2001 expanded coverage of diabetes outpatient self-management training based on Section 4105 of the Balanced Budget Act of 1997. The effective date was 02/27/2001 however, the change request indicated a 07/17/2001 implementation date.

Advance Notice Statement

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

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

J1745

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Infliximab (Remicade™)

AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 2000 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

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

Original Policy Effective Date

08/21/2000

Original Policy Ending Date

N/A

Revision Effective Date

06/11/2001

Revision Ending Date

06/10/2001

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., corticosteroids, 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 0, 2, & 6. Subsequent treatments will be covered if the patient responds to the initial treatment as demonstrated by a reduction in signs and symptoms.
- When used in combination with methotrexate, to reduce the signs and symptoms and inhibit the progression of structural damage in patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to methotrexate. An adequate trial of methotrexate should last a minimum of three (3) months. Normally, the patient receives an infusion of infliximab for this indication at weeks 0, 2, & 6 and then approximately every eight (8) weeks.

Note: For patients who are unable to tolerate methotrexate or in the rare instance that methotrexate is contraindicated for a patient, treatment with infliximab alone will be covered only if documentation is maintained in the patient’s record that clearly indicates the reason that the patient cannot take methotrexate.

CPT/HCPCS Section & Benefit Category

Drugs and Biologicals

CPT/HCPCS Codes

J1745

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

555.0
555.1
555.2
555.9
565.1
569.81
714.0

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.

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:

- the patient is receiving infliximab in combination with methotrexate; or
- the patient is intolerant of methotrexate; or
- the patient has a medical condition that contraindicates the use of methotrexate.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on 02/19/2000

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	1	PCR B2001-113
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Revised Effective Date:		06/11/2001

Explanation of Revision: Statements regarding infliximab being allowed as monotherapy were added to the Indications and Limitations and Documentation Requirements Sections of the policy.

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.

Appropriate Billing of J9219 Leuprolide Acetate Implant (VIADUR™)

Florida Medicare has received numerous inquiries regarding the appropriate method of billing for J9219 Leuprolide acetate implant, 65 mg (VIADUR™). VIADUR is a leuprolide acetate-filled implant for the palliative treatment of advanced prostate cancer. It is inserted subcutaneously in the inner aspect of the upper arm. The recommended dose of VIADUR is one implant for a 12-month period. VIADUR must be removed after 12 months of therapy. Once removed, another implant may be inserted to continue therapy. The drug should be billed as J9219 and will be reimbursed at 95% of the average wholesale price (AWP). The insertion and/or removal of the implant should be billed as procedure code 17999 (Unlisted procedure, skin, mucous membrane and subcutaneous tissue). Documentation supporting the performance of the insertion and/or removal of the implant is required on a prepayment basis.

FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number

00001

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Independent Diagnostic Testing Facility (IDTF)

AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 2000 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

HCFA National Coverage Policy

Program Memorandum B-01-28 (Change Request 850, 4/19/01)

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

04/19/1999

Original Policy Ending Date

N/A

Revision Effective Date

07/01/2001

Revision Ending Date

06/30/2001

LMRP Description

A new regulation (CFR section 410.33) entitled, "Independent Diagnostic Testing Facility (IDTF)", was published in the Federal Register on October 31, 1997. This regulation established that payment for diagnostic procedures would be made only where the service is provided by a physician, a group of physicians, an

approved portable x-ray supplier, or an IDTF - except in the case of certain specified exceptions. An IDTF is defined as a fixed location, a mobile entity, or an individual nonphysician practitioner. This new entity, which replaces the current Independent Physiological Laboratory (IPL), is independent of a hospital or physician's office. The diagnostic tests in an IDTF must be performed by licensed, certified nonphysician personnel under appropriate physician supervision.

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

Indications and Limitations of Coverage and/or Medical Necessity

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

• Supervising physician

- An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of nonphysician personnel who use the equipment. This level of supervision is the requirement for general supervision.
- The supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. In the case of a procedure requiring the direct or personal supervision of a physician, the IDTF's supervising physician must personally furnish this level of supervision whether the procedure is performed in the IDTF or, in the case of mobile services, at the remote location.

• Nonphysician personnel

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

• **Ordering of tests**

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

• **Multi-state entities**

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

• **Applicability of State law**

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

The nonphysician personnel credentialing requirements listed below cover the following sections: Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology, Nuclear Medicine, Special Ophthalmological Services, Otorhinolaryngologic Services, Cardiology, Echocardiography, Cardiac Catheterization/Electrophysiological Procedures/ Other Vascular Studies, Non-invasive Vascular Diagnostic Studies, Pulmonary, Allergy and Clinical Immunology and Neurology and Neuromuscular. It is required that the nonphysician personnel performing the diagnostic tests, be credentialed as evidenced by state licensure and/or national board certification. The Carrier requires that all IDTF applicants meet the credentialing criteria as outlined in this policy on the date the applicant enrolls as an IDTF.

In addition, the credentialed and/or licensed nonphysician personnel must maintain an active licensure and/or credential status in order for the diagnostic tests to be covered.

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

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

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

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

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

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

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

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

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

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

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

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

Certified Nuclear Medicine Technologist (CNMT).

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

Certified Retinal Angiographer (CRA).

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

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

- The State of Florida offers the following certification:

Emergency Medical Technician (EMT);
 Paramedic.

- The National Board for Respiratory Care (NBRC) offers the following credentials:
 Certified Pulmonary Function Tech (CPFT);
 Registered Pulmonary Function Tech (RPFT);
 Certified Respiratory Therapist (CRT);
 Registered Respiratory Therapist (RRT);
 Perinatal/Pediatric Care Specialist.

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

- Registered Nurse (RN) with active state licensure and proficiency demonstration.
- The American Association of Electrodiagnostic Technologists (AAET) offers the following credentials:
 Registered Electrodiagnostic Technologist (R. EDT.).
- The American Board of Registration of Electroencephalographic and Evoked Potential Technologists, Inc. (ABRET) offers the following credentials:
 Registered Electroencephalographic Technologist (R. EEG T.);
 Registered Evoked Potential Technologist (R. EP T.);
 Certified Neurophysiologic Interoperative Monitoring Technologist (CNIM).
- The Board of Registered Polysomnographic Technologists (BRPT) offers the following credentials:
 Registered Polysomnographic Technologist (RPSGT).
- The National Certification of Diagnostic Medical Sonographers (NCDMS) offers the following credentialing:
 Certified Diagnostic General Sonographers (CDGS);
 Certified Diagnostic Obstetrical/Gynecological Sonographers (CD/OBGYNS);
 Certified Diagnostic Vascular Sonographers (CDVS);
 Certified Diagnostic Cardiac Sonographers (CDCS).

All credentialing examinations is obtained by a combination of physics and instrumentation and one or more of the following: Obstetrics/Gynecology, abdomen and small parts, vascular, and adult echocardiography.

Physician Supervision

Effective for services performed on or after July 1, 2001, the level of physician supervision required for diagnostic tests payable under the Medicare physician fee schedule has been revised. Physician supervision for diagnostic tests is defined under one of three categories: general supervision, direct supervision, or personal supervision (see terms defined in the “Other Comments” Section of the policy).

The levels of physician supervision of diagnostic tests are classified from 1-6. The levels are defined as follows:

1. Procedure must be performed under the general supervision of a physician.
2. Procedure must be performed under the direct supervision of a physician.
3. Procedure must be performed under the personal supervision of a physician.
4. Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.
5. Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.
6. Procedure must be personally performed by a physician OR a physical therapist who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the service under state law.

For certain codes within the range of CPT codes 95860-95937, the following additional criteria apply:

NOTE:

- a All level of supervision standards for the lead number (“6” or “7”) apply; in addition, the PT with ABPTS certification may personally supervise another PT but only the PT with ABPTS certification may bill.
- 66 May be performed only by PTs with ABPTS certification and certification in this specific procedure, or performed personally by the physician.
- 77 PT with ABPTS certification (TC & PC), or direct supervision of physician (TC & PC), or technician with certification and general supervision of physician (TC only; PC physician) procedure.
- 22 May be performed by a technician with on-line real-time contact with physician.
- 21 Procedure may be performed by technician with certification and under general supervision of a physician; otherwise under direct supervision of physician. (TC only; PC always physician).

CPT-4 CODE(S)	CERTIFICATION	PHYSICIAN SUPERVISION
54240	ARDMS: RVT CCI: RVS NCDMS: CDGS	2
70030-70160	State license: CRT-R (General Radiographer) Medical Physicist	1
70190-70330	State license: CRT-R (General Radiographer) Medical Physicist	1
70336	Demonstrates proficiency	2

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

70350-70355	State license: CRT-R (General Radiographer)	1
70360	State license: CRT-R (General Radiographer) Medical Physicist	1
70370-70371	State license: CRT-R (General Radiographer) Medical Physicist	3
70380	State license: CRT-R (General Radiographer) Medical Physicist	1
70450	State license: CRT-R (General Radiographer) Medical Physicist	1
70460-70470	State license: CRT-R (General Radiographer) Medical Physicist	2
70480	State license: CRT-R (General Radiographer) Medical Physicist	1
70481-70482	State license: CRT-R (General Radiographer) Medical Physicist	2
70486	State license: CRT-R (General Radiographer) Medical Physicist	1
70487-70488	State license: CRT-R (General Radiographer) Medical Physicist	2
70490	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
70491-70492	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
70496-70498	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	
70540	Demonstrates proficiency	1
70542	Demonstrates proficiency	2
70543-70549	Demonstrates proficiency	
70551	Demonstrates proficiency	1
70552-70553	Demonstrates proficiency	2
71100-71130	State license: CRT-R (General Radiographer)	1
71250	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
71260-71270	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
71275	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	
71550	Demonstrates proficiency	1
71551-71552	Demonstrates proficiency	
71555	Demonstrates proficiency	2
72010-72120	State license: CRT-R (General Radiographer) Medical Physicist	1
72125-72126	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
72127	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
72128	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

72129-72130	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
72131	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
72132-72133	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
72141	Demonstrates proficiency	1
72142	Demonstrates proficiency	2
72146	Demonstrates proficiency	1
72147	Demonstrates proficiency	2
72148	Demonstrates proficiency	1
72149-72158	Demonstrates proficiency	2
72159	Demonstrates proficiency	
72170-72190	State license: CRT-R (General Radiographer) Medical Physicist	1
72191	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
72192	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	
72193-72194	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
72195	Demonstrates proficiency	
72196	Demonstrates proficiency	1
72197	Demonstrates proficiency	
72198	Demonstrates proficiency	
72200-72220	State license: CRT-R (General Radiographer) Medical Physicist	1
73000-73030	State license: CRT-R (General Radiographer) Medical Physicist	1
73050-73080	State license: CRT-R (General Radiographer) Medical Physicist	1
73120-73140	State license: CRT-R (General Radiographer) Medical Physicist	1
73200	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
73201-73202	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
73206	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	
73218-73219	Demonstrates proficiency	
73720-73721	Demonstrates proficiency	1
73722-73723	Demonstrates proficiency	
73725	Demonstrates proficiency	

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

73500-73520	State license: CRT-R (General Radiographer) Medical Physicist	1
73540-73565	State license: CRT-R (General Radiographer) Medical Physicist	1
73590-73610	State license: CRT-R (General Radiographer) Medical Physicist	1
73620-73660	State license: CRT-R (General Radiographer) Medical Physicist	1
73700	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
73701-73702	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
73706	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	
73718-73719	Demonstrates proficiency	
73720-73721	Demonstrates proficiency	1
73722-73723	Demonstrates proficiency	
73725	Demonstrates proficiency	2
74000-74022	State license: CRT-R (General Radiographer) Medical Physicist	1
74150	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
74160-74170	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	2
74175	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	
74181	Demonstrates proficiency	1
74182-74183	Demonstrates proficiency	
74185	Demonstrates proficiency	2
74210-74249	State license: CRT-R (General Radiographer)	3
74250	State license: CRT-R (General Radiographer)	2
74251	State license: CRT-R (General Radiographer)	3
74260-74283	State license: CRT-R (General Radiographer)	3
74290-74291	State license: CRT-R (General Radiographer)	1
74400-74415	State license: CRT-R (General Radiographer)	2
74420	State license: CRT-R (General Radiographer)	3
74710	State license: CRT-R (General Radiographer) Medical Physicist	1
74775	State license: CRT-R (General Radiographer)	3
75552	Demonstrates proficiency	1
75553	Demonstrates proficiency	2
75554-75555	Demonstrates proficiency	1

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

75556	Demonstrates proficiency	
76003	State license: CRT-R (General Radiographer)	3
76005	State license: CRT-R (General Radiographer)	
76010-76066	State license: CRT-R (General Radiographer) Medical Physicist	1
76070-76076	State license: CRT-R (BMO)	1
76078	State license: CRT-R (General Radiographer)	1
76090-76092	ARRT: CRT-R with advanced credentialing in mammography	
76093-76094	Demonstrates proficiency	1
76098	State license: CRT-R (General Radiographer)	1
76100-76125	State license: CRT-R (General Radiographer)	2
76150	State license: CRT-R (General Radiographer)	1
76350	State license: CRT-R (General Radiographer)	2
76355	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	3
76375-76380	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT Medical Physicist	1
76390	Demonstrates proficiency	
76400	Demonstrates proficiency	1
76499	Dependent on diagnostic procedure performed	
76506	ARDMS: RDMS-Neurosonology	2
76511-76513	ARDMS: RDMS-Ophthalmology JCAHPO: COA, COT, COMT	3
76516-76519	ARDMS: ROUB, RDMS-Ophthalmology JCAHPO: COA, COT, COMT	2
76529	ARDMS: RDMS-Ophthalmology JCAHPO: COA, COT, COMT	2
76536	ARDMS: RDMS-Abdomen NCDMS: CDGS	1
76604	ARDMS: RDMS-Abdomen	1
76645-76778	ARDMS: RDMS-Abdomen NCDMS: CDGS	1
76800	ARDMS: RDMS-Neurosonology	2
76805-76815	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS	2
76816-76818	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS	1
76819	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS	
76825	ARDMS: RDMS-Obstetrics & Gynecology ARDMS: RDCS NCDMS: CD/OBGYNS	2
76826-76828	ARDMS: RDMS-Obstetrics & Gynecology ARDMS: RDCS NCDMS: CD/OBGYNS	1

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

76830-76831	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS	1
76856-76857	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS	1
76870	ARDMS: RDMS-Abdomen NCDMS: CDGS	1
76872	ARDMS: RDMS-Abdomen NCDMS: CDGS	1
76873	ARDMS: RDMS-Abdomen NCDMS: CDGS	
76880	ARDMS: RDMS-Abdomen	1
76885	ARDMS-RDMS	2
76886	ARDMS-RDMS	1
76977	Demonstrates proficiency	1
76999	ARDMS: RDMS-Appropriate credentialing based on body area examining NCDMS: Appropriate credentialing based on body area examining	
77417	State license MDC	1
78000-78018	State license: CRT-N, CNMT	1
78020	State license: CRT-N, CNMT	
78070-78075	State license: CRT-N, CNMT	1
78099	State license: CRT-N, CNMT	
78102-78195	State license: CRT-N, CNMT	1
78199	State license: CRT-N, CNMT	
78201-78291	State license: CRT-N, CNMT	1
78299	State license: CRT-N, CNMT	
78300-78350	State license: CRT-N, CNMT	1
78399	State license: CRT-N, CNMT	
78414-78455	State license: CRT-N, CNMT	1
78456	State license: CRT-N, CNMT	
78457-78458	State license: CRT-N, CNMT	1
78460-78483	State license: CRT-N, CNMT	1
78494-78496	State license: CRT-N, CNMT	1
78499	State license: CRT-N, CNMT	
78580-78596	State license: CRT-N, CNMT	1
78599	State license: CRT-N, CNMT	
78600-78607	State license: CRT-N, CNMT	1
78610-78660	State license: CRT-N, CNMT	1
78699	State license: CRT-N, CNMT	
78700-78761	State license: CRT-N, CNMT	1
78799	State license: CRT-N, CNMT	
78800-78807	State license: CRT-N, CNMT	1
78999	State license: CRT-N, CNMT	

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

92081-92083	JCAHPO: COT, COMT	1
92100-92130	JCAHPO: COA	
92235-92240	JCAHPO: COT, COMT Registered Nurse CRA	2
92250	JCAHPO: COT, COMT CRA	1
92265-92275	JCAHPO: COT, COMT Registered Nurse	3
92283-92284	JCAHPO: COA, COT, COMT	2
92285	JCAHPO: COT, COMT CRA	2
92286	JCAHPO: COT, COMT Registered Nurse CRA	3
92287	JCAHPO: COT, COMT Registered Nurse CRA	
92516	Certified Audiologist	
92520	Speech Pathologist	
92541-92548	Certified Audiologist	5
92552-92557	Licensed Audiologist	5
92561-92584	Licensed Audiologist	5
92585-92586	ABRET: R. EP T., R. EEG T. Audiologist	5
92587-92589	Licensed Audiologist	5
93000-93012	CCI: CCT, RCS Registered Nurse (RN) Paramedic	1
93015-93017	CCI: CCT, RCS Registered Nurse (RN) Paramedic	2
93024	CCI: CCT, RCS Registered Nurse (RN) Paramedic	3
93040-93278	CCI: CCT, RCS Registered Nurse (RN) Paramedic	1
93303-93308	ARDMS: RDCS CCI: RCS NCDMS: CDCS	1
93312	ARDMS: RDCS CCI: RCS NCDMS: CDCS	3
93315	ARDMS: RDCS CCI: RCS NCDMS: CDCS	3
93320	ARDMS: RDCS CCI: RCS NCDMS: CDGS, CD/OBGYNS, CDVS, CDCS	1

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

93321-93325	ARDMS: RDCS, RDMS (Obstetrics & Gynecology) CCI: RCS NCDMS: CDGS, CD/OBGYNS, CDVS, CDCS	1
93350	ARDMS: RDCS CCI: RCS, CCT for stress portion Registered Nurse Paramedic NCDMS: CDCS	1
93501	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse	3
93505	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse	3
93510-93533	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse	3
93555-93572	State license: CRT-R (General Radiographer) CCI: RCIS, RCS Registered Nurse	3
93600-93642	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse	3
93660	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse	3
93724	CCI: CCT Registered Nurse Paramedic	3
93727	CCI: CCT Registered Nurse Paramedic	
93733	CCI: CCT Registered Nurse Paramedic	1
93734-93735	CCI: CCT Registered Nurse Paramedic	2
93736	CCI: CCT Registered Nurse Paramedic	1
93737-93738	CCI: CCT Registered Nurse Paramedic	2
93741-93744	CCI: CCT Registered Nurse Paramedic	
93770	CCI: CCT Registered Nurse Paramedic	1
93799	CCI: CCT Registered Nurse Paramedic	
93875-93882	ARDMS: RVT CCI: RVS NCDMS: CDVS	1

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

93886-93888	ARDMS: RVT CCI: RVS	1
93922-93990	ARDMS: RVT CCI: RVS NCDMS: CDVS	1
94010	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)	1
94060-94070	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)	2
94200-94375	State license: RPFT, RRT, CPFT, CRT	1
94400-94450	State license: RPFT, RRT, CPFT, CRT	2
94620	State license: RPFT, RRT Registered Nurse (RN)	1
94621	State license: RPFT, RRT Registered Nurse (RN)	2
94664-94665	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)	2
94680-94690	State license: RPFT, RRT	2
94720-94750	State license: RPFT, RRT	1
94760-94762	Demonstrates proficiency	1
94770	State license: RPFT, RRT	1
94799	State license: Appropriate credentialing based on service performing	
95004	RN with active state license	2
95024-95056	RN with active state license	2
95805, 95807-95811	ABRET: R. EEG T. BRPT: RPSGT State license: CPFT, RPFT, CRTT, RRT	1
95812-95822, 95827	ABRET: R. EEG T.	1
95900-95904	AAET: R. EDT. ABRET: R. EP T. Qualified Physical Therapist permitted to perform service under state law	77a
95921	AAET: R. EDT	2
95922-95923	AAET: R. EDT	3
95925-95930	ABRET: R. EP T., R. EEG T.	21
95933-95937	AAET: R. EDT. Qualified Physical Therapist permitted to perform service under state law	77a
95950-95953	ABRET: R. EEG T.	1
95954	ABRET: R. EEG T.	3
95956-95957	ABRET: R. EEG T.	1
95958	ABRET: R. EEG T.	3
95999	Appropriate credentialing based on service performing	
G0004-G0015	CCI: CCT Registered Nurse (RN) Paramedic	1

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

G0050	ARDMS: RDMS-Abdomen NCDMS: CDGS	1
G0195-G0196	Speech Pathologist	
G0202-G0207	ARRT: CRT-R with advanced credentialing in mammography	
Q0035	CCI: CCT Registered Nurse (RN) Paramedic	1

CPT/HCPCS Section & Benefit Category

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

CPT/HCPCS Codes

54240	70492	72100	73050	73719	74775	76512	78006
70030	70496	72110	73060	73720	75552	76513	78007
70100	70498	72114	73070	73721	75553	76516	78010
70110	70540	72120	73080	73722	75554	76519	78011
70120	70542	72125	73120	73723	75555	76529	78015
70130	70543	72126	73130	73725	75556	76536	78016
70134	70544	72127	73140	74000	76003	76604	78018
70140	70545	72128	73200	74010	76005	76645	78020
70150	70546	72129	73201	74020	76010	76700	78070
70160	70547	72130	73202	74022	76020	76705	78075
70190	70548	72131	73206	74150	76040	76770	78099
70200	70549	72132	73218	74160	76061	76775	78102
70210	70551	72133	73219	74170	76062	76778	78103
70220	70552	72141	73220	74175	76065	76800	78104
70240	70553	72142	73221	74181	76066	76805	78110
70250	71100	72146	73222	74182	76070	76810	78111
70260	71101	72147	73223	74183	76075	76815	78120
70300	71110	72148	73225	74185	76076	76816	78121
70310	71111	72149	73500	74210	76078	76818	78122
70320	71120	72156	73510	74220	76090	76819	78130
70328	71130	72157	73520	74230	76091	76825	78135
70330	71250	72158	73540	74240	76092	76826	78140
70336	71260	72159	73550	74241	76093	76827	78160
70350	71270	72170	73560	74245	76094	76828	78162
70355	71275	72190	73562	74246	76098	76830	78170
70360	71550	72191	73564	74247	76100	76831	78172
70370	71551	72192	73565	74249	76101	76856	78185
70371	71552	72193	73590	74250	76102	76857	78190
70380	71555	72194	73592	74251	76120	76870	78191
70450	72010	72195	73600	74260	76125	76872	78195
70460	72020	72196	73610	74270	76150	76873	78199
70470	72040	72197	73620	74280	76350	76880	78201
70480	72050	72198	73630	74283	76355	76885	78202
70481	72052	72200	73650	74290	76375	76886	78205
70482	72069	72202	73660	74291	76380	76977	78206
70486	72070	72220	73700	74400	76390	76999	78215
70487	72072	73000	73701	74410	76400	77417	78216
70488	72074	73010	73702	74415	76499	78000	78220
70490	72080	73020	73706	74420	76506	78001	78223
70491	72090	73030	73718	74710	76511	78003	78230

78231	78496	78801	92565	93308	93631	94060	95819
78232	78499	78802	92567	93312	93640	94070	95822
78258	78580	78803	92568	93315	93641	94200	95827
78261	78584	78805	92569	93320	93642	94240	95900
78262	78585	78806	92571	93321	93660	94250	95903
78264	78586	78807	92572	93325	93724	94260	95904
78270	78587	78999	92573	93350	93727	94350	95921
78271	78588	92081	92575	93501	93733	94360	95922
78272	78591	92082	92576	93505	93734	94370	95923
78278	78593	92083	92577	93510	93735	94375	95925
78282	78594	92100	92579	93511	93736	94400	95926
78290	78596	92130	92582	93514	93737	94450	95927
78291	78599	92235	92583	93524	93738	94620	95930
78299	78600	92240	92584	93526	93741	94621	95933
78300	78601	92250	92585	93527	93742	94664	95934
78305	78605	92265	92586	93528	93743	94665	95936
78306	78606	92270	92587	93529	93744	94680	95937
78315	78607	92275	92588	93530	93770	94681	95950
78320	78610	92283	92589	93531	93799	94690	95951
78350	78615	92284	93000	93532	93875	94720	95953
78399	78630	92285	93005	93533	93880	94725	95954
78414	78635	92286	93012	93555	93882	94750	95956
78428	78645	92287	93015	93556	93886	94760	95957
78445	78647	92516	93017	93561	93888	94761	95958
78455	78650	92520	93024	93571	93922	94762	95999
78456	78660	92541	93040	93572	93923	94770	G0004
78457	78699	92542	93041	93600	93924	94799	G0005
78458	78700	92543	93224	93602	93925	95004	G0006
78460	78701	92544	93225	93603	93926	95024	G0015
78461	78704	92545	93226	93607	93930	95027	G0050
78464	78707	92546	93230	93609	93931	95028	G0195
78465	78708	92547	93231	93610	93965	95044	G0196
78466	78709	92548	93232	93612	93970	95052	G0202
78468	78710	92552	93235	93615	93971	95056	G0203
78469	78715	92553	93236	93616	93975	95805	G0204
78472	78725	92555	93268	93618	93976	95807	G0205
78473	78730	92556	93270	93619	93978	95808	G0206
78478	78740	92557	93271	93620	93979	95810	G0207
78480	78760	92561	93278	93621	93980	95811	Q0035
78481	78761	92562	93303	93622	93981	95812	
78483	78799	92563	93304	93623	93990	95813	
78494	78800	92564	93307	93624	94010	95816	

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

N/A

Diagnoses that Support Medical Necessity

N/A

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

When the services are performed for screening purposes.

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

Noncovered ICD-9-CM Code(s)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

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

Effective 1/1/2000, procedure code 93770 is considered a bundled service and therefore, is not separately reimbursable.

Effective 1/1/2000, procedure codes 94760 and 94761 are considered bundled services and therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day.

Documentation Requirements

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

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

In addition, documentation must be available upon request verifying that the technician performing the service(s) meet(s) the credentialing requirements as outlined in this policy.

Also, the IDTF must maintain documentation of sufficient physician resources during all hours of operations to assure that the required physician supervision is furnished. Documentation must be maintained in the IDTF that the personnel performing the diagnostic test(s) have been adequately trained and demonstrates proficiency in the performance of the service(s). This documentation must contain verification by the supervising physician(s).

Utilization Guidelines

N/A

Other Comments

Terms Defined:

General supervision - the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision - the physician must be present in the suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision - a physician must be in attendance in the room during the performance of the procedure.

Sources of Information and Basis for Decision

Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous societies.

Phase I presented at the 11/14/1998 Carrier Advisory Committee Meeting. Phase II presented at the 02/20/1999 Carrier Advisory Committee Meeting.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	10	PCR B2001-114
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4th QTR 2001 <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: Program Memorandum B-01-28 (Change Request 850) dated 4/19/2001 revised the physician supervision requirements for diagnostic tests. Therefore, the policy was revised to add supervision requirements.

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

00103

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Anesthesia Services (Ocular Procedures)

AMA CPT Copyright Statement

CPT codes, descriptions, and other data only are copyright 2000 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

HCFA National Coverage Policy

Medicare Carrier Manual, Sections 2050.2, 2136, 4172, 4830, 15018, and 16003.1

Coverage Issues Manual, Section 35-44B

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

04/20/1998

Original Policy Ending Date

N/A

Revision Effective Date

07/30/2001

Revision Ending Date

07/29/2001

LMRP Description

Anesthesia is defined as the partial or complete loss of sensation, with or without loss of consciousness, as a result of the administration of an anesthetic agent, usually by injection or inhalation.

A variety of types of anesthesia can be used during an ocular procedure. These types are:

- Local Anesthesia : the administration, topical and/or injection, of an anesthetic agent at or around the site at which the procedure is to be performed to effect a regional loss of sensation.
- General Anesthesia: the administration, inhalation and/ or intravenous injection, of an anesthetic agent that results in complete anesthesia, affecting the entire body with loss of consciousness.
- Monitored Anesthesia Care (MAC): the intraoperative monitoring by a physician or other qualified anesthesia personnel of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.

Additionally, these services can be performed under a variety of anesthesia arrangements, such as:

- Personally performed by an anesthesiologist,
- Performed by a medically-directed Certified Registered Nurse Anesthetist (CRNA), and/or
- Performed by the surgeon performing the surgery.

The purpose of this policy is to define the medical necessity of the varying types of anesthesia used during various ocular procedures.

Indications and Limitations of Coverage and/ or Medical Necessity

Anesthesia is covered only when it is determined to be medically necessary and reasonable and the procedure for which it is performed is a covered service (e.g., anesthesia for cosmetic procedures would be noncovered).

General anesthesia and Monitored Anesthesia Care can be covered if the anesthesiologist:

1. Performs a pre-anesthesia examination and evaluation which may include, but is not limited to, medical history of the patient, information related to present illness, social history, allergies, review of systems as applicable and a physical examination of a body area(s) as deemed appropriate by the physician;
2. Prescribes the anesthesia plan, such as Monitored Anesthesia Care, if determined to be necessary;
3. Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence (e.g., in general anesthesia when the patient is anesthetized and/or any emergency such as an arrhythmia, hypotension, hypertension, etc., which the patient may experience during the procedure or immediately following the procedure);
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist such as a medically-directed CRNA;
5. Monitors the course of anesthesia administration at intervals;

6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated post-anesthesia care such as may be required when the patient’s physiological vital signs were abnormal during the procedure. Also, if the patient was under general anesthesia and was intubated, the anesthesiologist may extubate the patient when stable.

While the following CPT codes represent services in which one would not expect to see general anesthesia given or generally would not require Monitored Anesthesia Care, there may be instances in which anesthesia or MAC would be appropriate:

65205	66770	67500	67875
65210	66821	67515	68020
65220	67031	67700	68040
65222	67110	67710	68200
65272	67141	67715	68760
65286	67145	67800	68761
65430	67208	67801	68801
65435	67210	67805	68810
65600	67220	67810	68840
65860	67221	67820	
66761	67227	67825	
66762	67228	67840	

When anesthesia is billed for the above services, documentation must be maintained. Instances for which coverage can be extended include:

- Description of severe patient anxiety,
- Description of a planned, complex procedure,
- Description of patient discomfort under local anesthesia, or
- Description of complications arising during the planned procedure
- Anesthesia performed by the operating surgeon is covered, however, reimbursement is included in the allowance of the surgical procedure.

CPT/HCPCS Section & Benefit Category

Anesthesia/Head

CPT/HCPCS Codes

00103	00142	00145
00140	00144	00147

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

General Anesthesia or MAC for ocular procedures will be denied if determined not to be medically necessary and reasonable.

Anesthesia services performed for procedures not medically necessary and/or reasonable are also considered not medically necessary or reasonable and, therefore, not reimbursable by Medicare.

If the block is administered by the same qualified anesthesia personnel who provides MAC or general anesthesia, only the general anesthesia or MAC service will be allowed.

If qualified anesthesia personnel under the medical direction of the physician administers a block and monitors for immediate but not prolonged effects (e.g., not over 10-15 minutes), only the block (CPT code 67500), and not general anesthesia or MAC, can be billed.

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)

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

When billing MAC procedures, modifier QS must be used.

Consult the correct coding guidelines for applicable special code combinations and reduction in payment due to specific codes billed. An operating surgeon cannot be paid separately for an anesthesia service if he or she also provides the surgical service.

Inpatient or outpatient consultations, (99241-99245, 99251-99255), for anesthesia services for ocular procedures, in lieu of MAC, related to providing pain management with a nerve block (67500), prior to the surgical procedure will be denied as medically unnecessary. Also, subsequent hospital visits for pain management (99231-99233) will be denied as medically unnecessary. This would clearly circumvent what is considered ocular anesthesia as defined in this policy (00140-00147).

These services may be provided in a hospital, outpatient, ASC or in an office setting.

Qualified anesthesia personnel who provide the complete ocular anesthesia service cannot bill separately for the retrobulbar block for the same ophthalmological procedure. If both procedures are billed, only the MAC service will be allowed.

If anesthesia services are billed by a physician, the following modifiers must also be billed:

- AA Anesthesia services performed personally by the anesthesiologist,
- QK Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals,
- AD Medical direction by a physician; more than four concurrent procedures, or
- QS Monitored Anesthesia Care (MAC) service.

In situations where the CRNA and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the following modifier may be used:

- QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

If anesthesia services are billed by a CRNA, the following modifiers must also be billed:

- QX CRNA service with medical direction by a physician,
- QS Monitored Anesthesia Care (MAC) service if MAC was performed,
- QZ CRNA service; without medical direction by a physician.

In unusual circumstances, when it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services for each provider is allowed. Documentation must be submitted by each provider to support payment of the full fee. In these unusual circumstances, the physician would report the service using the “AA” modifier and the CRNA would use the “QZ” modifier.

In addition, the following modifiers may be used to describe the patient’s status if general anesthesia or MAC is administered:

- P1 A normal healthy patient.
- P2 A patient with mild systemic disease.
- P3 A patient with severe systemic disease.
- P4 A patient with severe systemic disease that is a constant threat to life.

MAC will always have 2 different modifiers when billed. For example, if an anesthesia code is billed with a QS modifier indicating MAC, it should also be billed with an AA modifier if the anesthesia was performed personally by the anesthesiologist.

Documentation Requirements

Hospital, outpatient or office records or the anesthesia record should clearly document the medical necessity for performing the MAC. A copy of an appropriate history and physical and the anesthesia record should be provided by the qualified anesthesia personnel who performed the anesthesia service if requested by Florida Medicare.

An anesthesiologist may block more than one patient at a time as long as he/she has arranged for each patient to be monitored by another qualified anesthesia person. The same anesthesiologist can medically direct up to four CRNAs who are involved in concurrent procedures. The CRNA must provide continuous monitoring and other appropriate anesthesia services during the surgical procedure.

If anesthesia is performed for any of the procedure codes listed in the “Indications and Limitations” section of this policy, documentation should be maintained which clearly outlines why general anesthesia or MAC was performed.

Utilization Guidelines

N/A

Other Comments

A CRNA may provide anesthesia services for ocular procedures under the medical direction of an anesthesiologist.

Sources of Information and Basis for Decision

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 advisory groups, which includes representatives from the Florida Society of Anesthesiology and the Florida Society of Ophthalmology.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2001

Revision History

Revision Number: 5 PCR B2001-142
 Start Date of Comment Period N/A
 Start Date of Notice Period 08/01/2001
 4th QTR 2001 *Update!*
 Revised Effective Date: 07/30/2001
 Explanation of Revision: Statement regarding modifier "QZ" was added.

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.

Anesthesia for Panniculectomy

When billing for anesthesia code 00802 (anesthesia for procedures on lower anterior abdominal wall; panniculectomy) associated with CPT code 15831 (excision, excessive skin and subcutaneous tissue [including lipectomy]), documentation that supports medical necessity must be submitted with the claim. This documentation may include history and physical, operative notes, and/or anesthesia notes.

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number
31231

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Diagnostic Nasal Endoscopy

AMA CPT Copyright Statement
CPT codes, descriptions, and other data only are copyright 2000 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply.

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
10/16/2000

Original Policy Ending Date
N/A

Revision Effective Date
07/23/2001

Revision Ending Date
07/22/2001

LMRP Description

A diagnostic nasal endoscopic examination permits visualization of upper airway structures inaccessible to the conventional otoscope or nasal speculum. The endoscopic examination is a safe and rapid (10-15 minutes) procedure used to diagnose nasal and/or sinus pathologic conditions and is performed with a rigid nasal endoscope and/or a flexible endoscope. A nasopharynx examination inspects the posterior nasopharyngeal wall, posterior choanae, fossa of Rosenmueller, eustachian tube orifices, and the superior aspect of the soft palate. The nasal/sinus examination involves the inspection of the above mentioned areas in addition to the sphenoidal recess.

Indications and Limitations of Coverage and/or Medical Necessity

Any symptom that refers to the upper airway may be an indication for endoscopy when routine clinical evaluation including a nasal speculum examination does not provide a satisfactory diagnosis or when the response to medical management is not satisfactory (i.e., the patient condition is not improving or is worsening).

Florida Medicare will consider a nasopharyngoscopy with endoscope (procedure code 92511) medically reasonable and necessary when performed for the following indications:

- To evaluate a patient with suspected adenoid hypertrophy.
- To evaluate a patient presenting with recurrent serous otitis media.
- To evaluate a patient with chronic serous and/or suppurative otitis media.
- To evaluate a patient with suspected eustachian tube dysfunction. This condition is suspected in cases when a patient presents with recurrent otitis after tympanic tube placement.
- To evaluate a patient with a neck mass of unknown etiology.
- To evaluate a patient with nasopharyngeal signs/symptoms in which a physical examination including a nasal speculum exam failed to determine the etiology. These include such symptoms as recurrent epistaxis, throat pain, ear pain/fullness, anosmia (loss of smell), hyposmia (defect in sense of smell), anterior facial pain, nasal crusting, rhinorrhea (thin, watery discharge from the nose), etc.
- To evaluate a patient with known neoplastic disease of the upper airway.
- To evaluate a patient with acute or chronic pharyngitis.

Note: It is not expected that a nasopharyngoscopy will be performed on a patient with a chronic condition such as otitis media at each patient encounter unless the symptoms are not improving or are getting worse.

Florida Medicare will consider a diagnostic nasal endoscopy (procedure codes 31231-31235) medically reasonable and necessary when performed for the following indications:

- To evaluate a patient with nasal polyposis to assess extent of disease and/or evaluate the response to treatment.
- To evaluate a patient with chronic or recurrent rhinosinusitis to determine the source of the purulent material (sphenoid, maxillary, ethmoid ostia). Patients with sinusitis are diagnosed based on a combination of major and minor factors. The major factors are: facial pain/pressure (must accompany another major symptom); facial congestion/fullness; nasal obstruction/blockage; infected nasal drainage (thick and green/yellow); decreased or absent sense of smell; pus in the nose on physical examination, and fever (acute sinusitis only and must accompany another nasal symptom). The minor factors are: headache (must accompany another major symptom); fever; halitosis; fatigue; dental pain; cough; ear pain/pressure/fullness.
- To evaluate a patient with a chronic cough in which an upper airway etiology is suspected.
- To evaluate a patient with persistent nasal obstruction not due to septal deviation and not responding to standard medical therapy (e.g., decongestants, steroids).
- To evaluate a patient presenting with moderate to severe signs and/or symptoms of upper airway abnormalities in which a physical examination including a nasal speculum exam failed to determine etiology. These include but are not limited to anosmia (loss of smell), hyposmia (defect in sense of smell), persistent hoarseness, recurrent epistaxis, serosanguineous nasal discharge, facial pain, odynophagia (pain during swallowing), dysphagia

(difficulty swallowing), tightness in throat, change in voice quality, halitosis, obstructive apnea, etc.

- To evaluate a patient with known or suspected granulomatous disease (e.g., sarcoidosis, Wegener's disease, tuberculosis, syphilis) to rule out upper airway granulomas or ulcerations.
- To evaluate a patient with suspected or known neoplastic disease of the upper airway.
- To postoperatively evaluate the surgical site of the upper airway to determine functional status.
- To evaluate a patient with chronic dacryocystitis (inflammation of the tear sac involving the mucous membrane of the lacrimal sac) to assess the nasolacrimal duct inferior to the inferior turbinate.
- To evaluate a patient with atypical asthma refractory to usual treatment.

Note: It is not expected that a nasal endoscopy be performed on patients with uncomplicated allergic rhinitis or for random screening for nasal polyps in asymptomatic patients or patients with simple allergic rhinitis. In addition, it is not expected that a nasal endoscopy will be performed on a patient with a chronic condition such as sinusitis and nasal congestion unless the symptoms are not improving or are getting worse after undergoing standard medical treatment.

CPT/HCPCS Section & Benefit Category

Respiratory System/Surgery
Medicine/Special Otorhinolaryngologic Services

CPT/HCPCS Codes

31231 31233 31235 92511

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Nasal Endoscopy (31231-31235)

135	461.0-461.9	780.79
146.0-146.9	462	781.1
147.0-147.9	464.0-464.4	782.2
148.0-148.9	465.0	784.0
149.0-149.9	470	784.1
161.0-161.9	471.0-471.8	784.40-784.49
210.5-210.9	472.0-472.2	784.5
212.0	473.0-473.9	784.7
235.1	476.0	784.9
375.42	478.0-478.29	786.2
375.56	493.90-493.91	786.3
381.00-381.9	530.10-530.19	787.2
382.00-382.9	780.50-780.57	925.2
446.4	780.6	V67.00

Nasopharyngoscopy (92511)

146.0-146.9	382.00-382.9	784.0
147.0-147.9	462	784.1
148.0-148.9	472.0-472.2	784.7
149.0-149.9	474.12	784.9
161.0-161.9	478.0-478.29	786.2
210.5-210.9	780.6	786.3
212.0	780.79	787.2
235.1	781.1	
381.00-381.9	782.2	

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

When a nasal endoscopy (31231-31235) is performed, the nasopharyngoscopy (92511) is considered part of the nasal endoscopy. Therefore, procedure code 92511 is included in the basic allowance of the nasal endoscopy when performed on the same day.

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 and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which include representatives from the Florida Society of Allergy, Asthma and Immunology and the Florida Society of Otolaryngology.

Carrier Advisory Committee Meeting held on May 13, 2000.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	1	PCR B2001-130
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Revised Effective Date:	07/23/2001	

Explanation of Revision: Update to allow diagnosis range 161.0-161.9 (Malignant neoplasm of larynx) for procedure code 92511.

Advance Notice Statement

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

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

55873

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Cryosurgical Ablation of the Prostate

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issues Manual, Section 35-96
Medicare Carriers Manual, Section 4174

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

07/01/1999

Original Policy Ending Date

N/A

Revision Effective Date

07/01/2001

Revision Ending Date

06/30/2001

LMRP Description

Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CSAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland.

CSAP can be carried out under general or spinal anesthesia and lasts approximately 2-3 hours. Five to six cryoprobes are placed transperineally under transrectal ultrasound (TRUS). Once the probes are in place, freezing is carried out while observing under TRUS the increasing echoes as the block of frozen prostate tissue approaches the rectal mucosa. Such monitoring minimizes the risk of rectal freezing. The possibility of injury to the urethra is decreased by the use of a warming device which is inserted into the urethra.

Indications and Limitations of Coverage and/or Medical Necessity

Effective for services performed on or after July 1, 1999, Medicare will consider cryosurgery of the prostate medically reasonable and necessary under the following circumstance:

- For primary treatment of patients with clinically localized, stages T1-T3, prostate cancer.

Effective for services performed on or after July 1, 2001, salvage cryosurgery of the prostate for recurrent cancer is medically necessary and appropriate only for those patients with localized disease who:

- Have failed a trial of radiation therapy as their primary treatment; and
- Meet one of the following conditions: Stage T2B or below, Gleason score <9, PSA <8ng/mL.

Note: Cryosurgery as salvage therapy is not covered under Medicare after failure of other therapies as the primary treatment.

CPT/HCPCS Section & Benefit Category

Male Genital System/Surgery

CPT/HCPCS Codes

55873

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

185

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 in the patient's file must demonstrate that the service was performed for the indications identified in this policy. 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 operative report.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - www.floridamedicare.com.

Advisory Committee Notes

N/A

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	2	PCR B2001-132
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: Change request 1632, dated 6/11/01, expanded coverage to include salvage therapy under certain conditions.

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: Epidural/Subarachnoid Injections—Correction

The local medical review policy (LMRP) for Epidural/Subarachnoid Injections was published in the 2nd Quarter 2001 *Medicare B Update!* (pages 56-59). One of the code ranges in the “ICD-9-CM Codes That Support Medical Necessity” section was listed incorrectly. Diagnosis code range 353.0-356.6 should be 353.0-353.6.

Florida Medicare apologizes for any inconvenience this may have caused.

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number
85007

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Complete Blood Count

AMA CPT Copyright Statement
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HCFA National Coverage Policy
Coverage Issues Manual, Section 50-17
Medicare Carriers Manual, Section 4270.2

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
11/18/1996

Original Policy Ending Date
N/A

Revision Effective Date
07/30/2001

Revision Ending Date
07/29/2001

LMRP Description
The complete blood count (CBC) is a series of tests of the peripheral blood that provides a tremendous amount of information about the hematologic system and many other organ systems, prognosis, response to treatment, and recovery. The CBC consists of the following tests that determine number, variety, percentage, concentrations and quality of blood cells: white blood count (WBC), differential white cell count (Diff), red blood count (RBC), hematocrit (HCT), hemoglobin (HGB), red blood cell indices: mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), mean

corpuscular hemoglobin concentration (MCHC), blood smear, and platelet count (PLT).

The major function of the white blood cell (leukocyte) is to fight infection, react against foreign bodies or tissues, and to produce, or at least transport and distribute antibodies in the immune response. The WBC count has two components. One is a count of the total number of WBCs in 1 mm³ of peripheral venous blood. The other component, the differential count, measures the percentage of each type of leukocyte (e.g., neutrophils, lymphocytes, monocytes, eosinophils and basophils) present in the same specimen. An increased total WBC count (leukocytosis) usually indicates infection, inflammation, tissue necrosis, or leukemic neoplasia. Leukopenia (i.e., a decreased WBC count) occurs in many forms of bone marrow failure (e.g., following antineoplastic chemotherapy or radiation therapy, overwhelming infections and autoimmune diseases).

The red blood cell count (erythrocyte) determines the total number of circulating red blood cells in a cubic millimeter of blood. It is an important measurement in the determination of anemia or polycythemia. This test in conjunction with the other red blood cell production tests (HCT and HGB) are closely related. The same underlying conditions will cause an increase/decrease in each of these three tests.

The hematocrit is an important measurement in the determination of anemia or polycythemia. The purpose of this test is to determine the red blood cell mass by measuring space occupied by packed red blood cells. The results are expressed as the percentage of red cells in the volume of whole blood. Normal values range from 42%-52% for men and 37%-47% in women.

Hemoglobin, the main component of erythrocytes, serves as the vehicle for the transportation of oxygen and carbon dioxide. It also serves as an important buffer in the extracellular fluid. HGB is important in the evaluation of anemia. Normal values range from 13.5-18 g/dl in men and 12-16 g/dl in women.

The RBC indices provide information about the size (MCV and RDW), weight (MCH), and hemoglobin concentration (MCHC) of RBCs. Cell size is indicated by the terms normocytic, microcytic and macrocytic. Hemoglobin content is indicated by the terms normochromic, hypochromic, and hyperchromic. Additional information about the RBC size, shape, color, and intracellular structure can be obtained from the blood smear study. The RBC indices are discussed below:

- 1) Mean corpuscular volume
The MCV is a measure of the average volume or size of a single RBC, and is therefore, used in classifying anemias. MCV is derived by dividing the hematocrit by the total RBC count. Normal values vary

according to age and gender. When the MCV value is increased, the RBC is said to be abnormally large, or *macrocytic*. This is most frequently seen in megaloblastic anemias (e.g., vitamin B-12 or folic acid deficiency). When the MCV value is decreased, the RBC is said to be abnormally small, or *microcytic*. This is associated with iron deficiency anemia or thalassemia.

2) Mean corpuscular hemoglobin

The MCH is a measure of the average amount (weight) of hemoglobin within an RBC. MCH is derived by dividing the total hemoglobin concentration by the number of RBCs. Because macrocytic cells generally have more hemoglobin and microcytic cells have less hemoglobin, the causes for these values closely resemble those for the MCV value.

3) Mean corpuscular hemoglobin concentration

The MCHC is a measure of the average concentration or percentage of hemoglobin within a single RBC. MCHC is derived by dividing the total hemoglobin concentration by the hematocrit. When values are decreased, the cell has a deficiency of hemoglobin and is said to be *hypochromic* (frequently seen in iron deficiency anemia and thalassemia). When values are normal, the anemia is said to be normocytic (e.g., hemolytic anemia).

4) Red blood cell distribution width

The RDW is an indication of the variation in RBC size. It is calculated by a machine using the MCV and RBC values. Variations in the width of the RBCs may be helpful when classifying certain types of anemia. The RDW is essentially an indicator of the degree of anisocytosis, a blood condition characterized by RBCs of variable and abnormal size.

The blood smear is the most informative of all hematologic tests. All three hematologic cell lines (RBCs, WBCs, platelets) can be examined. Microscopic examination of the RBCs can reveal variation in RBC size (anisocytosis), shape (poikilocytosis), color, or intracellular content. Classification of RBCs according to these variables is most helpful in identifying the causes of anemia.

The WBCs are examined for total quantity, differential count, and degree of maturity. An increased number of immature WBCs may indicate leukemia. A decreased WBC count indicates failure of marrow to produce WBCs, resulting from drugs, chronic disease, neoplasia, or fibrosis.

The platelet count is an actual count of the number of platelets (thrombocytes) per cubic milliliter of blood. Platelet activity is essential to blood clotting. Counts of 150,000 to 400,000/mm³ are considered normal. Counts less than 100,000/mm³ may indicate thrombocytopenia. Causes of thrombocytopenia include:

- Reduced production of platelets (secondary to bone marrow failure or infiltration of fibrosis, tumor, etc.);
- Sequestration of platelets (secondary to hypersplenism);

- Accelerated destruction of platelets (secondary to antibodies, infections, drugs, prosthetic heart valves);
- Consumption of platelets (secondary to disseminated intravascular coagulation); and/or
- Platelet loss from hemorrhage.

Thrombocytosis is said to exist when platelet counts are greater than 400,000/mm³. This may occur as a compensatory response to severe hemorrhage. Other conditions associated with thrombocytosis include polycythemia vera, leukemia, postsplenectomy syndrome and various malignant disorders.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a complete blood count medically reasonable and necessary for the following conditions:

- Presence of abnormal signs or symptoms such as pallor, weakness, significant tiredness, abnormal bleeding, etc. which may suggest an anemic condition.
- Monitoring of patients with previously diagnosed anemias (e.g., iron deficiency, aplastic, hemolytic).
- Evaluation of patients on medications or treatments that affect blood components (e.g., chemotherapy, radiation therapy, antibiotics, aspirin). Note: there are certain medications especially Gold Salt and penicillamine, used in the rheumatology field that require CBCs every 2-4 weeks during therapy.
- Patients with known acute or chronic diseases (e.g., acute or recurrent peptic disease, renal failure, systemic lupus erythematosus, liver disease, rheumatoid arthritis, eating disorders), injury, leukemia, infections, reaction to inflammation, dehydration if the results can be expected to contribute to the management of the patient.
- Patients with acute or chronic blood loss.
- Patients with splenomegaly (includes post splenectomy).
- Patients undergoing a major surgical procedure (e.g., abdominal, thoracic, carotid, cranial or femoral/popliteal surgery) in which significant blood loss may result.

Platelet counts with a hemogram would be clinically indicated when a condition falls into one of the following categories:

- When signs and symptoms suggest a possible hemorrhagic condition.
- To assess the effects of chemotherapy or radiation therapy on platelet formation.
- To aid in the diagnosis of thrombocytopenia and thrombocytosis.
- To confirm a visual estimate of platelet number and morphology from a previous stained blood film.

A complete blood count can be ordered initially if indications for testing are met. Repeat testing for a CBC or portions thereof will be allowed if it can be expected to provide information for further management or to evaluate a response to therapy (e.g., several days after iron therapy for an iron deficiency anemia). Frequent testing is not expected except under unusual circumstances (e.g., acute bleeding).

CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Hematology and Coagulation

CPT/HCPCS Codes

85007	85014	85022	85025
85008	85018	85023	85027
85009	85021	85024	85031
85013			

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

Complete blood count screening (including routine pre-op) performed on apparent normal and asymptomatic individuals or in the absence of known disease, injury or abnormal signs or symptoms is considered noncovered. Screening CBCs should be billed utilizing diagnosis V72.6 (Special investigations and exam, laboratory).

Noncovered ICD-9-CM Code(s)

V01.9	307.9	702.0-702.8
V07.8-V07.9	331.0	724.00-724.09
V40.0-V40.9	331.1	735.0-735.9
V58.9	331.2	736.00-736.9
V64.0-V64.4	332.0-332.1	737.0-737.9
V67.59	366.00-366.9	739.0-739.9
V67.6	369.00-369.9	743.30-743.39
V67.9	380.4	780.31-780.39
272.0-272.9	401.0-401.9	780.50-780.59
278.00	455.0	780.8
278.1	455.3	780.9
290.0-290.9	455.6	796.2
295.00-295.95	627.3	799.0-799.9
298.0-298.9	700	840.0-848.9
307.80-307.89	701.0-701.9	

Noncovered Diagnoses

N/A

Coding Guidelines

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

CPT codes 85023, 85024, 85025, or 85027 should be billed when a complete blood count with platelet is medically indicated. If there are no clear medical indications for the platelet count, the CPT code will be down coded to 85022 and reimbursed accordingly.

CBCs performed for rheumatoid arthritis patients being treated with the following medications should submit the indicated diagnosis on the claim:

- Diagnosis code E933.1 for patients on antineoplastic and immunosuppressive drugs such as Methotrexate and Imuran;
- Diagnosis code E935.6 (Antirheumatics) for patients on Gold Salts; or
- Diagnosis code E933.8 (Other systemic agents not elsewhere classified) for patients on a penicillamine.

Documentation Requirements

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

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

Certain laboratory tests are included in the composite rate when performed for End Stage Renal Disease (ESRD) beneficiaries within the frequency identified in the Medicare Carriers Manual. The following hematology tests are included in the composite rate at the frequency indicated below:

- Hct and Hgb every month for patients undergoing continuous ambulatory peritoneal dialysis (CAPD).
- Hct and Hgb per treatment; CBC every month, for patients undergoing hemodialysis/hemofiltration, peritoneal dialysis and continuous cyclical peritoneal dialysis.

Certain laboratory tests for CAPD patients are billed separately when performed at independent dialysis facilities. The following hematology tests are not included in the composite rate and are separately billable when performed at the frequency identified in the Medicare Carriers Manual:

- WBC, RBC and platelet count every three months.

Other Comments

Routine testing is not allowed to secure a baseline for minor surgical procedures when performed without associated signs and symptoms or a disease process that demonstrates an anemic condition.

Sources of Information and Basis for Decision

Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number: 9 PCR B2001-134
 Start Date of Comment Period N/A
 Start Date of Notice Period 08/01/2001
 4th QTR 2001 *Update!*
 Revised Effective Date: 07/30/2001

Explanation of Revision: Policy revised to delete information regarding appropriate diagnosis to submit for certain indications.

Advance Notice Statement

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

**FLORIDA MEDICARE PART B
 LOCAL MEDICAL REVIEW POLICY**

Policy Number

88141

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Pap Smears

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Medicare Coverage Issues Manual, Section 50-20 Program Transmittal 1694 (Change Request 1497, dated 02/01/2001)

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

1990

Original Policy Ending Date

N/A

Revision Effective Date

07/01/2001

Revision Ending Date

06/30/2001

LMRP Description

Pap Smear (Papanicolaou Smear/Test) is a cytologic examination of a vaginal smear for early detection of cancer (especially of the cervix and uterus), employing exfoliated cells and a special staining technique which differentiates diseased tissue.

Indications and Limitations of Coverage and/or Medical Necessity

Diagnostic Pap Smear:

Diagnostic Pap smears and related services are covered under Florida Medicare when ordered by a physician under one of the following conditions:

- Previous cancer of the cervix, uterus or vagina that has been or is presently being treated
- Previous abnormal Pap smear
- Abnormal findings of the vagina, cervix, uterus, ovaries or adnexa
- Significant complaint pertaining to the female reproductive system
- Any signs or symptoms that the physician judges to be reasonably related to a gynecologic disorder. The carrier's medical staff determines whether a previous malignancy at another site is an indication for a diagnostic Pap smear or whether the test must be considered a screening Pap smear.

Screening Pap Smear:

For Claims with Dates of Service from January 1, 1998 through June 30, 2001.

Screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioners (e.g., a certified nurse midwife, physician assistant, clinical nurse specialist or nurse practitioner) under one of the following conditions:

- No prior test for the preceding 3 years (use ICD-9-CM code V76.2); or
- There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years, and at least 11 months have passed following the month that the last covered Pap smear was performed (use ICD-9-CM code V15.89); or
- There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical or vaginal cancer, and at least 11 months have passed following the month that the last covered Pap smear was performed (use ICD-9-CM code V15.89).

The high risk factors for cervical cancer include:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease (including HIV infection)
- Fewer than 3 negative or any Pap smears within the previous 7 years

The high risk factors for vaginal cancer include:

- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy

For Claims with Dates Service on or after July 1, 2001

Screening Pap smears are covered every 2 years instead of 3 years unless the women does not qualify for a more frequently performed screening Pap smear (i.e., the women is at high risk or qualifies under the childbearing provision) (See coverage criteria above).

CPT/HCPCS Codes

Diagnostic Pap Smears:

88141	88145	88152	88164
88142	88147	88153	88165
88143	88148	88154	88166
88144	88150	88155	88167

Screening Pap Smears:

G0123	G0143	G0147	P3001
G0124	G0144	G0148	Q0091
G0141	G0145	P3000	

ICD-9-CM Codes that Support Medical Necessity

For Diagnostic Pap Smears:

016.70-016.76	221.0-221.9	622.1
054.10	233.0-233.3	622.7
054.11	233.9	622.8
054.12	236.0-236.3	623.0
078.0	239.5	623.5
078.10-078.19	256.0-256.9	623.7
090.0-099.9	616.0	623.8
112.1	616.10-616.11	624.6
112.2	616.2	624.8
131.00-131.9	616.50-616.51	626.2
170.6	616.8	626.6
171.6	616.9	626.7
179	617.0	626.8
180.0-180.9	617.9	626.9
181	620.0	627.1
182.0-182.8	620.1	627.2
183.0-183.8	620.2	627.3
184.0-184.9	620.8	627.8
198.6	621.0	627.9
198.82	621.1	628.0-628.9
218.0-218.9	621.2	654.10-654.14
219.0-219.9	621.8	795.0
220	622.0	

For Screening Pap Smears:

V15.89	V76.2
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CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Cytopathology

Not Otherwise Classified Codes (NOC)

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

Payment will not be allowed for a diagnostic pap smear (88141-88145; 88147-88148; 88150- 88154; 88164-88167) and a screening pap smear (G0123-G0124; G0141-G0148; P3000-P3001, Q0091) on the same date of service.

Pap smears 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

G0124 and P3001 are professional component only codes effective 1/1/99. Use G0123 or P3000 for the technical components of these screening exams.

For services on or after January 1, 1999, separate payment is allowed under the physician fee schedule for pap smear exams for patients in any setting if the laboratory screening personnel suspect an abnormality, and the physician reviews and interprets the pap smear (G0124, P3001, or 88141).

The pap smear codes are grouped by four code families. Choose the one code that best describes the screening method used. The code families are 88142-88145; 88147-88148; 88150-88154 and 88164-88167.

Code 88142 is not an add-on code. It is not appropriate to report this code in addition to a code from the 88147-88148, 88150-88154 or 88164-88167 series if the only laboratory procedures performed was a pap smear with thin layer preparation.

Code 88155 is listed separately in addition to code(s) for other technical and interpretation services (88142-88145; 88150-88154; 88164-88167).

Documentation Requirements

Documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the diagnostic test. Documentation required for medical review includes history, physical, progress notes and the pathology report. This should be maintained in the patient's permanent record, to be made available in the event of a review request.

Utilization Guidelines

N/A

Other Comments

A woman of childbearing age is one who is premenopausal and has been determined by a physician or other qualified practitioner to be of childbearing age, based on her medical history or other findings.

Sources of Information and Basis for Decision

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 advisory groups, which include representatives from numerous societies.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	10	PCR B2001-143
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: HCFA Transmittal 1694 (Change Request 1497, dated 02/01/2001) revises Screening Pap Smear services by authorizing coverage for Screening Pap Smears beginning July 1, 2001, for beneficiaries that meet specific criteria at a frequency of every two years, instead of every three years.

Advance Notice Statement

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

**FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY**

Policy Number

90901

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Biofeedback

AMA CPT Copyright Statement

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HCFA National Coverage Policy

Coverage Issue Manual, Sections 35-27 and 65-11

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

10/16/1995

Original Policy Ending Date

N/A

Revision Effective Date

07/01/2001

Revision Ending Date

06/30/2001

LMRP Description

Biofeedback therapy provides visual, auditory, or other evidence of the status of certain body functions so that a person can exert voluntary control over an autonomic function and thereby alleviate an abnormal bodily

condition. Biofeedback therapy is based on the learning principle that a desired response is learned by the patient following the reception of some type of information that their action produced the desired physiological response. Biofeedback is not a treatment; it is a tool to help patients learn new tasks.

Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An electromyography device may be used to provide feedback with certain types of biofeedback.

Biofeedback training (90911) evaluates the EMG activity of the levator ani, urinary sphincter and/or anal sphincter by using either intravaginal, intra-anal or surface sensors - Perianal placement (electrodes). The EMG activity is evaluated and provides objective information regarding the muscle activity and provides a basis for pelvic muscle rehabilitation utilizing biofeedback.

Indications and Limitations of Coverage and/or Medical Necessity

Biofeedback training is covered under Medicare when it is reasonable and necessary for:

- muscle re-education of specific muscle groups; or
- treatment of pathological (disease-based) muscle abnormalities of spasticity; or
- incapacitating muscle spasm or weakness and more conventional treatments (e.g., heat, cold, massage, exercise, support) have not been successful.

Biofeedback training specific to the perineal muscles, and/or anorectal or urethral sphincter is considered reasonable and medically necessary by Florida Medicare for:

- the treatment of fecal incontinence when the underlying cause is determined to be an ineffective anal sphincter squeeze function; or
- the treatment of stress, urge, or persistent post-prostatectomy urinary incontinence; and more conventional treatments (e.g., pharmacology, timed voiding, pelvic muscle exercises) have not been successful.

Biofeedback training for the treatment of urinary incontinence performed on or after July 1, 2001 is also subject to the following criteria in accordance with

Medicare’s National coverage determination. Biofeedback training is covered for the treatment of urinary incontinence only after patients have failed a documented trial of pelvic muscle exercise. A failed trial is defined as no clinically significant improvement in urinary incontinence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength. Coverage for biofeedback training applies to services rendered by a practitioner in an office or other facility setting. Home use of biofeedback therapy is not covered.

All patients selected for biofeedback training must have the ability to understand analog or digital signals using auditory or visual display. In addition, these patients must be self-motivated to learn voluntary control through the observation of biofeedback and perform their personalized home exercise prescription usually on a daily basis.

Biofeedback training requires the continuous presence of the physician or qualified non-physician practitioner. Continuous presence requires one-on-one face-to-face involvement between the patient and practitioner during training. Training typically requires 2 to 3 sessions to train, observe progress, reinforce treatment, and follow-up with the patient. It is expected the medical record would document justification for additional sessions.

Biofeedback training with Individual Psychophysiological Therapy:

Coverage Issues Manual 35-27 restricts the use of biofeedback. Florida Medicare does not cover biofeedback for the treatment of psychiatric disorders (90875 and 90876).

CPT/HCPCS Section & Benefit Category

Medicine/Therapeutic, Prophylactic or Diagnostic Injections

CPT/HCPCS Codes

90901	90911	90875	90876
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Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

For 90911:

599.82	787.6	788.32
625.6	788.31	788.33

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.

The use of spinal cord electrical stimulators, rectal electrical stimulators (including the continaid), and the bladder wall stimulators (including the Mentor Bladder Pacemaker) cannot be considered reasonable and necessary and therefore, are noncovered.

Pelvic floor stimulators, whether inserted into the vaginal canal or rectum or implanted in the pelvic area, used as a treatment for urinary incontinence either as a bladder pacer or a retraining mechanism are not covered for the reason that the effectiveness of these devices are unproven. It is inappropriate to bill these services using the biofeedback codes. The appropriate procedure code for the services described is A9270 (non-covered item or service).

Biofeedback therapy is not covered for the treatment of ordinary muscle tension states or for psychosomatic conditions.

Noncovered ICD-9-CM Code(s)

Specific to procedure code 90911: 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

Patient education during a biofeedback session is considered part of the therapeutic session and not reimbursed separately.

HCPCS code G0050 should be used to report post void residual ultrasounds.

Documentation Requirements

Documentation maintained by the performing provider must support that the indication for therapy is reasonable and necessary and that more conventional treatments have not been successful (i.e., heat, cold, massage, exercise, support). This information is usually found in the history and physical, office/progress notes and treatment plan.

Additionally, the documentation needed to support medical necessity for the use of biofeedback training for persons with urinary incontinence would include:

1. A baseline evaluation –
 - A. History -
 - a focused medical, neurologic and genitourinary history. Areas to assess would include duration and characteristics of urinary incontinence (UI); the most bothersome symptom(s) to the patient; frequency, timing and amount of continent voids and incontinent episodes; precipitants of incontinence (cough, laugh, sneeze, new medications, surgery, etc); other urinary tract symptoms; daily fluid intake; bowel habits; alteration in sexual function due to UI; amount and type of perineal pads or protective devices; previous treatments for UI and effects on UI; and expectations of treatment.
 - B. Mental status evaluation -
 - the assessment would include both the cognitive ability and the motivation to self toilet.
 - C. Functional Assessment -
 - areas to assess include manual dexterity, mobility, ability to toilet unaided, uses of physical or chemical restraints.

- D. Evaluation of the individual’s living environment - areas to assess include access and distance to toilets or toilet substitutes as well as ease when rising from beds or chairs.
 - E. Social factors - Areas to assess include living arrangements, the presence of care givers and to what degree care-givers are involved, influence of UI on their socialization.
 - F. Bladder records - most commonly a seven day voiding diary which details the frequency, timing and amount of voids; amount of incontinence episodes; activities associated with UI and type/amount of fluid intake.
2. Physical examination - Guided by the medical history. Areas examined usually include:
- A. General exam for assessment of edema and neurologic abnormalities.
 - B. Abdominal exam.
 - C. Rectal exam to assess perineal sensation, resting and active sphincter tone, fecal impaction, presence of masses and in men, the consistency and contour of the prostate.
 - D. Genital exam in men.
 - E. Pelvic exam in women to assess skin condition, genital atrophy, pelvic organ prolapse, pelvic masses, paravaginal muscle tone and any other abnormalities.

And if needed –

- 3. Direct observation of urine loss by using cough stress test with full bladder; an estimation of post void residual volume; or urinalysis.
- 4. All urinary incontinent patients identified as having reversible conditions that cause or contribute to UI should be managed appropriately. Some conditions are: UTI, atrophic urethritis or vaginitis, stool impaction, use of diuretics or caffeine, use of sedatives may interfere with mobility, anticholinergic agents may enhance urinary frequency, endocrine conditions or fluid volume overload may increase urine production to name a few. The identification and treatment of these reversible conditions will be captured in the medical record. The continued presence of UI following treatment will also be documented.
- 5. The treatment plan will contain the goals of therapy, the exercise prescription, and measurable objectives.
- 6. Individual progress notes will reflect the individualized activity, any instructions given, the patient’s response to the service and their progress toward stated goals of therapy.

Utilization Guidelines

N/A

Other Comments

Terms defined:

Biofeedback: training program designed to develop one’s ability to control the autonomic (involuntary) nervous system.

Stress incontinence: caused by malfunction of the urethral sphincter that causes urine to leak from the bladder when intra-abdominal pressure increases. Symptoms include momentary leakage of urine when sneezing, coughing, laughing, walking, lifting or bending.

Urge incontinence: urine loss associated with a sudden and strong desire (urge) to evacuate the bladder.

Sources of Information and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on 11/14/1998.

Start Date of Comment Period

11/07/1998

End Date of Comment Period

12/22/1998

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	3	PCR B2001-127
Start Date of Comment Period		11/07/1998
Start Date of Notice Period		08/01/2001
		4 th QTR <i>Update!</i>
Revised Effective Date:		07/01/2001

Explanation of Revision: To define the indications and limitations of coverage regarding the use of biofeedback in the treatment of urinary incontinence. Additionally, HCFA’s National coverage determination concerning the use of biofeedback for the treatment of urinary incontinence was incorporated into this Finalized Local Medical Review Policy.

Advance Notice Statement

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

FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number

92225

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Ophthalmoscopy

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HCFA National Coverage Policy

Medicare Carriers Manual, Section 2320

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

12/18/1995

Original Policy Ending Date

N/A

Revision Effective Date

07/30/2001

Revision Ending Date

07/29/2001

LMRP Description

Extended ophthalmoscopy is the inspection of the interior of the eye with the pupil dilated. This inspection is fundamental to diagnosis and permits visualization of the optic disk, arteries, veins, retina, choroid, and media and is directed toward the condition of the vessels, the color of the tissue and the character of the optic nerve. The three methods of viewing the ocular fundus include direct ophthalmoscopy, by which a magnification of about 15X is obtained; indirect ophthalmoscopy, by which a larger field is obtained, but with magnification of 2X to 3X; and biomicroscopy combined with a lens to neutralize corneal refracting power.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider ophthalmoscopy (CPT Codes 92225, 92226) to be medically reasonable and necessary if any one of the following circumstances is present:

- The patient has a malignant neoplasm of the retina or choroid. This may appear as a single, round or oval, slightly elevated, gray or nonpigmented lesion.
- The patient has a retained (old) intraocular foreign body, either magnetic or nonmagnetic. Signs and symptoms may include a statement by the patient that something has hit his/her eye (foreign body sensation), normal or blurred vision, pain or no discomfort, and tearing.
- The patient has retinal hemorrhage, edema, ischemia, exudates and deposits, hereditary retinal dystrophies or peripheral retinal degeneration.
- The patient has retinal detachment with or without retinal defect. The patient may complain of light flashes, dark floating specks, and blurred vision that becomes progressively worse. This may be described by the patient as "a curtain came down over my eyes."
- The patient has retinal defects without retinal detachment.
- The patient has diabetic retinopathy (e.g., background retinopathy or proliferative retinopathy), retinal vascular occlusion, or separation of the retinal layers. This may be evidenced by microaneurysms, cotton wool spots, exudates, hemorrhages, or fibrous proliferation.
- The patient has experienced sudden visual loss or transient visual loss. This may be described as trouble seeing or vision going in and out.
- The patient has chorioretinitis, chorioretinal scars or choroidal degeneration, dystrophies, hemorrhage and rupture, or detachment.
- The patient has Vogt-Koyanagi syndrome. This disease is characterized by bilateral uveitis, dysacusia, meningeal irritation, whitening of patches of hair (poliosis), vitiligo, and retinal detachment. The disease can be initiated by a severe headache, deep orbital pain, vertigo, and nausea.
- The patient has sustained a penetrating wound to the orbit resulting in the retention of a foreign body in the eye.
- The patient has disorders of the vitreous body (e.g., vitreous hemorrhage or posterior vitreous detachment). Spots before the eyes (floaters) and flashing lights (photopsia) can be signs/symptoms of these disorders.
- The patient has posterior scleritis. Signs and symptoms may include severe pain and inflammation, proptosis, limited ocular movements, and a loss of a portion of the visual field.
- The patient has degenerative disorders of the globe.
- The patient has retinoschisis and retinal cysts. Patients may complain of light flashes and floaters.
- The patient has signs and symptoms of endophthalmitis which may include severe pain, redness, photophobia, and profound loss of vision.
- The patient has glaucoma or is a glaucoma suspect. This may be evidenced by increased intraocular pressure or progressive cupping of the optic nerve. The patient's medical record must meet the documentation requirements set forth in this policy (see Documentation Requirements).

CPT/HCPCS Section & Benefit Category

Medicine/Ophthalmology

CPT/HCPCS Codes

92225 92226

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

115.92	362.01-362.02	365.31-365.32
130.2	362.10-362.18	365.41-365.44
190.5	362.21-362.29	365.51-365.59
190.6	362.30-362.37	365.60-365.65
224.5	362.40-362.43	365.81-365.89
224.6	362.50-362.57	365.9
225.1	362.60-362.66	368.11
360.00-360.04	362.70-362.77	368.12
360.11	362.81	368.15
360.12	362.82	376.6
360.13	362.83	377.00
360.19	362.84	377.10-377.16
360.21	363.00-363.08	377.21-377.24
360.23	363.10-363.15	377.30
360.24	363.20	377.33
360.50	363.21	377.34
360.52	363.22	377.41
360.54	363.30-363.35	377.49
360.60	363.40-363.43	379.07
360.64	363.50-363.57	379.21-379.29
360.65	363.61-363.63	379.32
361.00-361.07	363.70-363.72	379.34
361.10-361.19	364.24	743.51-743.59
361.2	365.00-365.04	759.5
361.30-361.33	365.10-365.15	759.6
361.81	365.20-365.24	759.82

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.

An eye examination for the purpose of prescribing, fitting or changing eyeglasses is not covered by the Medicare program.

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

Reimbursement for an ophthalmology; initial (CPT Code 92225) and an ophthalmology; subsequent (CPT Code 92226) will not be made on the same day by the same provider.

Routine ophthalmology is part of an ophthalmologic service and is not reported separately.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity of the ophthalmology exam. The records must document the complaint or symptomatology necessitating the ophthalmology exam and must include the examination results/findings.

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

Documentation in the medical record for a diagnosis of glaucoma (ICD-9-CM Code 365.00-365.9) must include all of the following:

- a detailed drawing of the optic nerve,
- documentation of cupping, disc rim, pallor, and slope, and
- documentation of any surrounding pathology around the optic nerve.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which include representatives from the Ophthalmology and Optometrist Societies.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number:	2	PCR B2001-135
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 Update!
Revised Effective Date:		07/30/2001

Explanation of Revision: Policy revised to add ICD-9-CM code 224.5

Advance Notice Statement

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

FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number

93303

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping

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HCFA National Coverage Policy

Coverage Issues Manual, Section 50-7

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

12/01/1994

Original Policy Ending Date

N/A

Revision Effective Date

07/30/2001

Revision Ending Date

07/29/2001

LMRP Description

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

Indications and Limitations of Coverage and/or Medical Necessity**Transthoracic Echocardiography for Congenital Cardiac Anomalies:**

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

Transthoracic Real Time Echocardiography:

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

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

Echocardiography would be considered appropriate as part of the initial evaluation of a patient with suspected or confirmed chronic ischemic heart disease.

Doppler Echocardiography and Doppler Color Flow Velocity Mapping:

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

- The patient has valvular heart disease or congenital heart disease and echocardiography is needed to define the condition, monitor response to therapy, or to investigate a change in the patient’s clinical condition.
- The patient has a prosthetic heart valve and echocardiography is needed to monitor response to therapy or investigate a change in the patient’s clinical condition.
- The patient has clinical findings which suggest the presence of valvular heart disease (e.g., the patient has a heart murmur which is felt to be clinically significant).
- The patient has proven endocarditis or clinical findings suggestive of endocarditis.
- The patient has clinical findings diagnostic of or suggestive of acute myocardial ischemia or infarction, or the patient has complications of acute myocardial infraction such as valvular incompetency, ventricular septal rupture or aneurysm of heart.
- The patient has a thoracic aortic aneurysm or dissection, or the patient has clinical findings suggestive of aortic dissection or aneurysm.
- The patient has undergone heart transplantation.
- The patient has suspected or confirmed pulmonary hypertension and/or cor pulmonale, and echocardiography is necessary for evaluation and/or follow-up.

Routine performance of resting echocardiography, doppler echocardiography, or doppler color flow velocity mapping on patients with stable chronic coronary artery disease is not considered medically necessary unless the patient has had a change in clinical status which makes repeat procedures necessary. Also, the performance of procedures on patients with simple hypertension without other evidence of heart disease is considered not medically necessary.

CPT/HCPCS Section & Benefit Category

Medicine/Echocardiography

CPT/HCPCS Codes

93303
93304
93307
93308
93320
93321
93325

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

Transthoracic Real Time Echocardiography (procedure codes 93307 and 93308)

164.1	424.90-424.99	746.2
212.7	425.0-425.9	746.3
391.0-391.9	427.0-427.5	746.4
394.0-394.9	427.81	746.5
395.0-395.9	428.0-428.9	746.6
396.0-396.9	429.3	746.7
397.0-397.9	429.4	746.81-746.89
398.91	429.5	746.9
402.00-402.01	429.6	747.0
402.10-402.11	429.71	747.10-747.11
402.90-402.91	429.79	747.3
403.00-403.91	429.81	780.2
404.00-404.93	434.10-434.11	782.3
410.00-410.92	444.21-444.22	785.2
411.0	444.81-444.89	785.3
411.1	453.2	786.02-786.09
411.81	745.0	786.50-786.59
411.89	745.10-745.19	861.00-861.03
412	745.2	861.10-861.13
413.0-413.9	745.3	963.1
414.00-414.05	745.4	996.02
414.10-414.19	745.5	996.03
416.0	745.60-745.69	997.1
416.8	745.7	V42.1
416.9	745.8	V42.2
421.0-421.9	745.9	V43.3
423.0-423.9	746.00-746.09	V58.83
424.0-424.3	746.1	V67.51

Doppler Echocardiography and Doppler Color Flow Velocity Mapping (procedure codes 93320, 93321, and 93325)

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

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

Diagnosis code V58.83 should be used when the 2D echocardiogram is being performed for the evaluation and management of a patient under treatment, or being considered for treatment with a cardiotoxic medication.

Documentation Requirements

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

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

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

Sources of information may be found online under “Medical Policy” in the Part B section on our provider Web site - www.floridamedicare.com.

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 advisory groups, which includes representatives from the Florida Chapter of the American College of Cardiology.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2001

Revision History

Revision Number	11	PCR B2001-133
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2001
		4 th QTR 2001 <i>Update!</i>
Revised Effective Date		07/30/2001

Explanation of Revision: Addition of diagnosis V58.83 for use for patients initiating or receiving treatment with a cardiotoxic medication.

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.

99183: Hyperbaric Oxygen Therapy (HBO Therapy)

National coverage policy for HBO therapy no longer requires that a physician be present during an HBO therapy session. However, Florida Medicare has made a local decision to continue to deny services performed in the absence of a physician (HCPCS code G0167: Hyperbaric oxygen treatment not requiring physician attendance, per treatment session).

ELECTRONIC MEDIA CLAIMS

HIPAA-AS Standard-Health Care Claim and Coordination of Benefits (COB) Transactions

The Health Insurance Portability and Accountability Act—Administrative Simplification (HIPAA-AS) provisions direct the Secretary of Health and Human Services to adopt standards for administrative transactions, code sets, and identifiers, as well as standards for protecting the security and privacy of health data. On August 17, 2000, a final rule designating standards for eight administrative transactions and for medical code sets used in these transactions became effective.

The following information is of importance to providers, third party provider billing agents, provider clearinghouses, and the COB trading partners with whom they interact electronically for Medicare that:

- Medicare will cease acceptance of non-837 version 4010 electronic claims and issuance of version 4010 837 COB transactions as of October 2002.
- The Implementation Guide (IG) and X12N data dictionary may be downloaded without charge from www.wpc-edi.com/HIPAA.
- Medicare will switch to exclusive use of the outbound COB by October 16, 2002.
- Each provider that has elected to submit claims electronically must submit all of their claims in compliance with 837 version 4010 Implementation Guidelines (IG) requirements. Vendors that submit electronic claims for Medicare providers must also comply with these requirements.
- Each trading partner that has elected to exchange COB electronically must accept the 837 version 4010 Implementation Guide claim format, or contract with a clearinghouse to translate their claim data into the 837 version 4010 format. They must furnish that clearinghouse with all data required by the Implementation Guide.
- A provider, provider agent, or trading partner, that elects to use a clearinghouse for translation services is liable for those costs.
- If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for a specific transaction and is using the same program to generate the transaction for all of their clients, then all clients of the vendor/clearinghouse/billing service will not be required to test prior to carrier acceptance of production data.
- EDI submitters should request a testing appointment as soon as possible to be assured they could complete testing and correct any detected system problems prior to October 2002. There is no Medicare charge for this system testing. Appointment slots will be assigned on a first come basis. This carrier will not be able to guarantee testing by the end of September 2002 for any entities that delay scheduling testing until late in the transition period. Specific information regarding testing appointments will be sent directly to our EDI customers.
- COB trading partners must either request system compatibility testing for use of the COB transaction prior to October 2002, or be confident that they have completed system changes as required to accept production COB transactions by October 2002. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with this carrier as soon as possible to assure testing will be completed before October 2002. COB trading partners must have the capability to accept the X12N 4010 837 COB by October 16, 2002. Trading partners must notify contractors that they are ready to accept the X12N 4010 837 COB. No electronic transactions other than X12N 4010 837 will be supported as of 10/16/2002.
- As result of the large number of providers, agents, clearinghouses, and trading partners to be tested and the number of HIPAA standard transactions, it will not be feasible to test each entity during the last quarter of the transition process.

Although Medicare will furnish providers with basic information on HIPAA transaction requirements, Medicare will not furnish in-depth training on the use and interpretation of the standard Implementation Guide. Providers who have questions about their 4010 migration should contact their vendor.

Source: HCFA Transmittal B-01-06, CR 1534

MailBox Migration Deadline

In December 1999, EDI Trading Partners were required to upgrade their electronic protocols in support of Y2K. However, Blue Cross Blue Shield of Florida (BCBSFL) made accommodations for a small number of Trading Partners whose vendors were unable to support Y2K upgrades. BCBSFL has continued to support those customers during the last 18 months. While EDI protocols and standards continue to move forward in today's IT environment, it is no longer feasible or cost effective to continue supporting outdated technology.

Effective January 1, 2002, all electronic submitters currently transmitting data via the Non-Job Entry Subsystem (Non-JES) will be required to begin utilizing the BCBSFL MailBox system. This migration will provide EDI customers with a faster and more efficient service for submission and retrieval of their electronic data.

Medicare EDI will notify all impacted submitters with direct mail-outs in the upcoming months. If you have any questions or concerns in regards to your submitter status, please contact Medicare EDI Transaction Support at (904) 354-5977, option 4.

GENERAL INFORMATION

FRAUD AND ABUSE

Undercover Investigation Reveals Unethical Tactics

A recent Federal undercover investigation of a national consulting firm revealed that it was giving poor advice to its customers—primarily physicians and their staff concerning the Medicare program. The report of the investigation indicated that the consulting firm hosted and conducted seminars in which they furnished inappropriate advice to physicians in filing claims to the Medicare program. Some of the advice consisted of the following:

- How to maximize reimbursements (e.g., upcoding services or unbundling services),
- Not to refund overpaid funds to Medicare, unless Medicare notifies the physician of the overpayment,
- How to ensure payment by using specific diagnosis codes, etc.

Although the consulting firm does not receive payment from the Medicare program, physicians who unwittingly follow their advice assist in the perpetration of fraud against the Medicare program. Unfortunately, healthcare providers who follow poor advice from a consultant or other source risks the possibility of investigation and subsequent prosecution.

Seeking advice on the Medicare program from private organizations is not illegal. However, healthcare providers who do utilize the services of consultants, billing companies, or other entities with respect to filing claims to the Medicare program must consider the validity of their resources.

It is understood that the majority of consulting firms and billing companies as well (as healthcare providers) are honest and attempt to file claims to the Medicare program correctly. Providers need to be aware of those who are not.

DMERC

DMERC Region C Physician Information Sheet (PHYIS): Respiratory Assist Devices (RAD)

The following information is provided by Paul D. Metzger, M.D., Medical Director for the Region C Durable Medical Equipment Regional Carrier:

Dear Physician:

The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC's) Regional Medical Review Policy (RMRP) upon which Medicare bases reimbursement decisions for some of the equipment physicians might order for patients. It describes the equipment, its usual clinical indications, Medicare's coverage criteria for reimbursement, and the adjudication criteria for claims.

The DMERC strongly believes that the physician is still the "Captain of the Ship." Palmetto Government Benefits Administrators (Palmetto GBA) requires a physician's order before reimbursing any item. Sometimes Palmetto GBA requires a Certificate of Medical Necessity (CMN) and extra documentation.

While this may inconvenience physicians with additional paperwork, it is only through physician cooperation that Medicare can provide beneficiaries with the appropriate equipment and supplies they need. Physicians are also helping to protect the Medicare Trust Fund from abusive and fraudulent claims for items that are not medically necessary or physician-ordered. Funds lost to unnecessary utilization of and fraudulent claims for DME come from the same Part B Medicare Fund from which physicians are reimbursed for their own services.

The following Physician Information Sheet (PHYIS) is only a summary of the RMRP published in the DMERC Region C DMEPOS Supplier Manual. The definitive and binding coverage policy will always be the RMRP itself, which reflects national Medicare policy, and upon which actual claims adjudication is based. The Physician Information Sheet is intended only as an effort to educate the physician community on conditions of coverage for items of durable medical equipment, prostheses, orthoses, and supplies when ordered for the care of Medicare beneficiaries.

If more detailed information is desired, the physician is encouraged to obtain a copy of the RMRP from the supplier servicing your patient, or directly from the Region C DMERC office of Professional Relations at (803) 735-1034, ext. 35707 or 35745.

Paul D. Metzger, M.D., Medical Director, Region C DMERC, Palmetto GBA, Columbia SC

Respiratory Assist Devices (RAD)

The Durable Medical Equipment Regional Carrier (DMERC) Respiratory Assist Devices (RAD) medical review policy became effective for dates of service on or after October 1, 1999. It was created after a substantial effort to review all available published literature on the use of these devices, as well as significant input by medical specialty societies and the respiratory care industry. It is somewhat lengthy and complex, and physicians are encouraged to obtain a copy of the policy itself, from the supplier(s) to whom they refer their patients, or to contact the Region C DMERC directly (Palmetto GBA, Columbia, SC) (803) 763-5744 for a copy, or to view it on Palmetto GBA's Web site at www.palmettogba.com.

The RAD policy is separate from the DMERC CPAP medical review policy, and does not change or address in any way, coverage criteria mentioned in the CPAP policy. (Please see below under Obstructive Sleep Apnea for important distinctions between the two policies.)

As with all Physician Information Sheets, this will present a summary of the concepts contained within the DMERC RAD medical policy, with emphasis on matters felt most relevant to treating physicians. Should there be any perceived contradictions between this PHYSIS and the published medical review policy, it is the full policy which is the official document upon which claims adjudications and appeals are based.

Definitions

“Treating Physician:” Because the use of RADs for patients with sleep associated hypoventilation should be prescribed only by physicians who are qualified by virtue of experience and training in non-invasive respiratory assistance, physicians who are not so qualified, but may be treating their patients for other medical conditions, are not considered the treating physician for the prescription (and Medicare coverage) of this therapy.

Noninvasive Positive Pressure Respiratory Assistance (NPPRA): is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy). It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is to be distinguished from the invasive ventilation administered via a securely intubated airway, in a patient for whom interruption or failure of ventilatory support would lead to imminent demise of the patient.

A respiratory assist device (RAD) without backup rate (billing code K0532) delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs (i.e., NPPRA). (An example of such a device would be a bilevel positive airway pressure device.)

A respiratory assist device (RAD) with backup rate (billing code K0533) has exactly the same definition as stated for K0532, except that in addition, it has a timed backup feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur.

Medicare pricing of durable medical equipment is statutorily established; the Health Care Financing Administration must establish fee schedules accordingly. As may be seen above, the main feature distinguishing a K0532 from a K0533 is the availability of a backup rate in the latter. Yet there is a considerable difference in the amounts allowed for these two types of devices:

K0532 has an allowed rental amount of approximately \$240/month for 15 months, after which that amount is allowed twice a year for maintenance.

K0533 has an allowed rental amount of approximately \$550-\$600/month, paid indefinitely, as it is in a different payment category.

For this reason the RAD medical policy establishes not only when a RAD is medically reasonable and necessary, but also distinguishes when it is appropriate to require a backup rate on a RAD.

Coverage and Payment Rules

For a respiratory assist device to be covered, the treating physician must fully document in the patient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

Polysomnographic and blood gas studies may not be performed by the supplier of the RAD. An exception to this rule is hospitals certified to do such tests.

The DMERC RAD medical review policy recognizes four groupings of diseases that may be helped by application of a RAD.

- **Group I: Restrictive Thoracic Disorders:** a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB).
- **Group II: Severe COPD**
- **Group III: Central Sleep Apnea (CSA):** i.e., apnea not due to airway obstruction.
- **Group IV: Obstructive Sleep Apnea (OSA)**

These disease categories are based on available evidence of whether RAD effectiveness has been either well, or only tenuously, established. The type and level of test results required for each disease category similarly reflects those levels of evidence of effectiveness.

As is commonly known, the treatment of sleep-associated hypoventilation is made more difficult by frequently encountered poor patient compliance in acceptance and continued use of the device. Medicare does not pay for equipment that is not being used by the Medicare beneficiary. Because non-compliance is such a concern with this therapy, the medical review policy establishes criteria for initiation of Medicare coverage, and also (at 3 months) for continued coverage.

Initial Coverage (First 3 months)

For Group I Diseases (where COPD disease does not contribute significantly to the patient's pulmonary limitation): In addition to the documented diagnosis itself, the following test is required:

either an awake arterial blood gas (done with the patient breathing their usual FIO₂) with a PaCO₂ > 45 mm Hg,

or a sleep oximetry (done with the patient breathing their usual FIO₂) showing desaturation for at least five continuous minutes < 88%.

or (and only if the disease is a progressive neuromuscular disease) a maximal inspiratory pressure < 60 cm H₂O *or* forced vital capacity < 50% predicted.

Note that only one test (and no polysomnogram) is required.

If patient in this disease group meets a criterion, Medicare will cover either a K0532 or a K0533, depending on the judgment of the physician.

For Group II Disease (Severe COPD): In addition to the documented diagnosis itself, *both* of the following tests are required:

- an awake arterial blood gas (done with the patient breathing their usual FIO₂) with a PaCO₂ > 52 mm Hg, *and*
- a sleep oximetry (done with the patient breathing their usual FIO₂) showing desaturation for at least five continuous minutes < 88%.

While obstructive sleep apnea (and use of CPAP) should be considered and ruled out, a *polysomnogram is not required* to obtain coverage for a RAD for COPD.

If all of the above criteria are met, a K0532 device will be covered for the first three months of NPPRA therapy. A K0533 device will not be covered for a patient with COPD during the first two months, because therapy with a K0532 device with proper adjustments of the device's settings and patient accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. (See below under Continued Coverage for coverage of a K0533 for COPD).

For Group III Disease (Central Sleep Apnea): Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:

- The diagnosis of central sleep apnea (CSA), *and*
- The exclusion of obstructive sleep apnea (OSA) as a primary cause of sleep-associated hypoventilation, *and*
- The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation, *and*
- Oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO₂ (*whichever is higher*), *and*
- Significant improvement of the sleep-associated hypoventilation with the use of a K0532 or K0533 device on the settings that will be prescribed for initial use at home, while breathing the patient's usual FIO₂.

If patient in this disease group meets all the above criteria, Medicare will cover either a K0532 or a K0533, depending on the judgment of the physician.

For Group IV Disease (Obstructive Sleep Apnea):

- A complete facility-based, *attended* polysomnogram, has established the diagnosis of obstructive sleep apnea, *and*
- A single level device (E0601, Continuous Positive Airway Pressure Device) (CPAP) has been tried and proven ineffective.

Important Note about OSA: Please note that the DMERC policy on CPAP is directed by HCFA national policy to specify exactly how many episodes of apnea must be documented within a 6-7 hour period of sleep. That policy is separate from the RAD policy. Note that no specific criteria are explicitly listed for establishing a diagnosis of OSA in the RAD policy, only that a sleep study has been performed. Therefore, for K0532 devices, the use of hypopneic episodes and respiratory distress indices are not precluded from being used to establish a diagnosis of OSA. Furthermore, parameters of the CPAP trial are not specified, nor is it necessary to bill Medicare for a CPAP trial. It is only necessary that a trial be documented in which a CPAP failed to adequately treat the patient's OSA.

By definition, OSA never requires a backup rate. Therefore, a K0533 is never covered for this disease group.

Continued Coverage (Beyond 3 months): Patients covered for the first 3 months of a K0532 or K0533 device must be re-evaluated to establish the medical necessity of continued coverage by Medicare beyond the first three months. While the patient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which Medicare will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy by the treating physician. There must be documentation in the patient's medical record about the progress of relevant symptoms and patient usage of the device up to that time. Failure of the patient to be consistently using the K0532 or K0533 device for an average of 4 hours per 24 hour period by the time of this 61-90 day re-evaluation would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason for Medicare to deny continued coverage as not medically necessary.

Aside from the above documentation in the patient's medical records, the following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months:

- 1) a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the patient is compliantly using the device (an average of 4 hours per 24 hour period) and that the patient is benefiting from its use, *and*
- 2) a Medicare beneficiary statement completed by the patient no sooner than 61 days after initiating use of the device indicating how often the device is being used and whether the patient is inclined to continue using it.

The supplier of the device will request the first statement from the treating physician. The beneficiary statement is the responsibility of the supplier, and not the physician. With only one exception, no further testing is required for continued coverage, just the two statements assuring that the device continues to be used. That exception is, if after treating a patient with severe COPD with a K0532 device for two months, the physician believes that a K0533 device (with backup rate) is needed.

COPD and a K0533: It is necessary to demonstrate that compliant usage of a K0532 has not helped improve the signs and symptoms of hypoventilation secondary to COPD, before a device with a backup rate (K0533) may be covered.

For Group II patients (COPD) who qualified for a K0532 device, if at a time no sooner than 61 days after initial issue and compliant use of a K0532 device, the treating physician believes the patient requires a K0533 device, the K0533 device will be covered if the following criteria are met:

In addition to completion of the two above compliant usage statements (regarding the K0532), there must be obtained:

- an arterial blood gas PaCO₂, repeated no sooner than 61 days after initiation of compliant use of the K0532, done while awake and breathing the patient's usual FIO₂, still remains > 55 mm Hg, **and**
- a sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of a K0532 device, **and while breathing with the K0532 device**, demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO₂ (*whichever is higher*).

Important HCPCS Coding Note: The physician should never sign an order for a ventilator coded K0534 or E0450 as being used for NIPPRA (*non-invasive*), since these codes are only to be used for devices that ventilate patients through tracheostomies.

Documentation

There is no Certificate of Medical Necessity required by this policy.

Patient's Medical Records:

For an item(s) to be considered for coverage and payment by Medicare, the information submitted by the supplier must be corroborated by documentation in the patient's medical records that Medicare coverage criteria have been met. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records or records from other healthcare professionals. This documentation must be available to the DMERC upon request.

Paul D. Metzger, M.D.
Medical Director
Region C DMERC
Palmetto GBA
Columbia, SC

HOME HEALTH CONSOLIDATED BILLING

Home Health Prospective Payment System (HH PPS) Consolidated Billing—Revised Edits

In October 2000, edits were installed in the Medicare Common Working File (CWF) to enforce the consolidated billing of home health services for dates of services falling within an open HH PPS episode of care. These edits apply to Part B for certain outpatient therapy services that were defined in the HH PPS final rule (65 FR 41128), published in the *Federal Register* on July 3, 2000 (please refer to the *Medicare B Update!* May/June 2000 issue, pages 58-59). An updated list of procedures subject to consolidated billing was published in the 2nd Quarter 2001 *Update!* (page 101).

Effective for services processed on or after October 1, 2001, CWF will alter these edits to take the following action. If only a request for anticipated payment (RAP) for the episode of care has been received and the incoming therapy claim contains dates of service within the full 60-day home health episode of care period, CWF will alert the carrier that the service(s) may be subject to consolidated billing. The carrier will forward this alert on to the provider via a new remark code, N88.

N88—This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under an HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

This code will indicate that the services *may be denied and claim payment may be recouped* if later editing or another post-payment recovery process identifies the claim as subject to consolidated billing. This message will be given to the provider only; no message will be displayed to the beneficiary on the Medicare Summary Notice (MSN).

Source: HCFA Transmittal AB-01-70, CR 1644

Procedures Subject to Home Health Consolidated Billing—Clarification

An article providing information concerning procedure codes that are subject to home health consolidated billing was published in the 3rd Quarter 2001 *Medicare B Update!* (pages 87-88). Carriers were recently informed of a change in verbiage that alters the effective dates provided in the article.

The new lists of procedure codes are effective for claims with dates of service January 1, 2001 through December 31, 2001 that are **processed** (not received) by the carrier or intermediary on or after July 1, 2001.

COORDINATION OF BENEFITS

COB Contractor Fact Sheet for Providers

The Health Care Financing Administration (HCFA) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. HCFA awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at the COB contractor. This is no longer the function of your local Medicare intermediary or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or “MSP” when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary’s health care expenses first before Medicare. The table below describes a few of these methods and programs.

Method/Program	Description
Initial Enrollment Questionnaire (IEQ)	Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.
IRS/SSA/HCFA Data Match	Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
MSP Claims Investigation	This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
Voluntary MSP Data Match Agreements	Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between HCFA and employers or various insurers.

Provider Requests and Questions Regarding Claims Payment

Intermediaries and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local intermediary or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor. Questions regarding Medicare claim or service denials and adjustments should continue to be directed to your local intermediary and carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local intermediary or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in HCFA’s Database

The COB Contractor is the sole authority to ensure the accuracy and integrity of the MSP information contained in HCFA’s database (i.e., Common Working File). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse and/or family member changes

in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB Contractor. HCFA also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare program.

Termination and Deletion of MSP Auxiliary Records in HCFA's Database

Intermediaries and carriers will continue to terminate records on the CWF where the provider has received information that MSP no longer applies (e.g. succession of employment, exhaustion of benefits). Termination requests should continue to be directed to your local intermediary or carrier. MSP records on the CWF that you identify as invalid should be reported to the COB Contractor for investigation and deletion.

Contacting the COB Contractor

Effective January 1, 2001, refer all MSP inquiries; including, the reporting of potential MSP situations, invalid MSP auxiliary files, and general MSP questions/ concerns to the COB contractor. Continue to call your local intermediary and/or carrier regarding claims-related and recovery questions. The COB Contractor's Customer Call Center toll free number is 1-800-999-1118 or TDD/TYY 1-800-318-8782. Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, eastern standard time, except holidays. Clip and post this section in a handy place for access by your office and billing staff.

Source: CMS Transmittal AB-01-76, CR1460

THE PATIENT FRIENDLY ADVISORY

Toll-Free Helpline Available to Assist your Patients with Medicare Questions

Patients often look to their doctor's office for advice and information about Medicare and other health insurance concerns. As a trusted information source, you can assist your elder patients by providing resources that will help answer their questions. First Coast Service Options, Inc. would like to provide your facility with the "Patient Friendly Advisory," beginning with this issue of the *Medicare B Update!*. Our mission with this advisory is to provide the medical staff in your facility with quick access to Medicare information to assist you in answering your patients' questions in a timely and efficient manner.

One of the first resources to whom you can refer your patients is the toll-free Medicare Helpline at 1-800-MEDICARE (1-800-633-4227). Established in 1999 by the Centers for Medicare and Medicaid Services (CMS) – formerly the Health Care Financing Administration (HCFA), the helpline is available throughout the United States and is the only national toll-free phone line that provides up-to-date information about Medicare. By calling 1-800-MEDICARE (1-800-633-4227), your patients with Medicare can speak with a customer service representative in English or Spanish to get general information about Medicare, as well as answers questions on:

- Medicare health plan options in the community, including original fee-for-service Medicare and, where available, managed care
- Specific quality and satisfaction information about available managed care plans
- General information about Medicare supplemental insurance (Medigap)
- Telephone numbers for help with a variety of related issues, such as billing questions about Medicare claims, or for help with more complex questions about health insurance.

Callers with access to a teletype-writer (TTY) or telecommunications device for the deaf (TDD) can call 1-877-486-2048.

Customer service representatives are currently available between the hours of 8 a.m. and 4:30 p.m., local time Monday through Friday. Starting October 1, 2001, however, customer service representatives at 1-800-MEDICARE (1-800-633-4227) will be available 24 hours a day, 7 days a week, to respond to questions from beneficiaries and their caregivers. Also, effective October 1, 2001, callers will be able to get immediately by phone information about the choices which best meet their needs and will also be offered the option of receiving a copy of the information in the mail for further discussion and review.

***Please continue to look for
"The Patient Friendly Advisory"
in future issues of the Medicare B Update!***

GENERAL INFORMATION

Services and Items Furnished to Prisoners

Medicare does not pay for items or services paid directly or indirectly by a federal, state or local governmental entity. Generally, no payment is made for services rendered to prisoners, since the state (or other government component which operates the prison) is responsible for the prisoners' medical care and other needs. Exceptions to this exclusion may be overcome only at the initiative of the state or local governmental entity. When an exception is desired, the state or local governmental entity responsible for the prisoners' medical needs must submit to the Medicare contractor documentation establishing that:

- (a) The state or local law requires that individuals in custody repay the cost of the services.
- (b) The state or local governmental entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.
- (c) The state or local entity documents its case with copies of the regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. The state or local governmental entity must produce a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the state or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

For the purpose of the Medicare program the term "prisoner" means a person who is in custody of the police, penal authorities, or other agency of a governmental entity.

The Interactive Voice Response System

Florida Medicare now has two toll-free numbers for Medicare Part B. The number established last fall, (877) 847-4992, should now be used *only* to reach the Interactive Voice Response (IVR) system. A second number, (866) 454-9007, should be used to speak with a Customer Service Representative. By having two toll-free numbers, callers will be able to receive information more quickly.

In order to use the IVR the caller will need the following:

- Touch-tone phone
- Provider Identification Number (PIN)
- Patient Medicare number (Health Insurance Claim or HIC number - optional)

Step 1: Enter the Five-Digit Medicare Provider Number

For instruction on entering alphabetical characters press 0 followed by the pound (#) key. The IVR will give the caller the following instructions.

How to Enter a Letter

To enter a letter, you must press three keys. First, press the star (*) key to indicate you are entering a letter. Second, press the key containing the letter you wish to enter. Third, press the number 1, 2, or 3, depending on the position of the letter on that key. For example: to enter the letter A, press *, 2, 1. To enter letter B, press *, 2, 2. The letter Q and Z do not appear on the telephone keypad. To enter the Q, press *, 1, 1. To enter the letter Z, press *, 1, 2.

After you have entered the alpha letter or letters press the pound (#) key to complete the process.

If there is a number after the letter or letters press that number now.

If there is no number following the letter or letters, press the # key.

If the Medicare number ends in two letters, follow the previous instruction. For example, to enter the suffix TA, you would press *, 8, 1, *, 2, 1, #.

Step 2: Select from One of the Following Options

- Press 1 New legislation and other provider information
- Press 2 Claim information
- Press 3 Eligibility, deductible, and HMO
- Press 4 Pending/finalized claims and year to date amount of file
- Press 5 Check information
- Press 6 Current pricing or verify payable diagnosis for procedure code
- Press 7 To repeat menu
- Press 9 To end this call

Step 3: If Caller Selected Option 2 or 3 the Patient’s Medicare Number is Required

If the number begins with a letter, the patient is normally covered under Railroad Retirement. This information may be verified with the patient or Social Security. Florida Medicare does not process claims for railroad retirees. Claims for these beneficiaries are processed by MetraHealth RRB. Please refer to the address on the inside back cover for the address for MetraHealth.

For all other Medicare numbers, press 1.

The Medicare number consists of nine numbers followed by a letter. Please enter the first nine numbers.

If there are two letters following the number, press 2; otherwise press 1 now.

There is a letter following the number you just entered. If the letter is:

- A, press 1
- B, press 2
- C, press 3
- D, press 4
- M, press 5
- T, press 6
- If any other letters, press 7.

If caller needs instructions for entering alphabetical characters, press the pound (#) key.

If caller would like to enter the suffix and know how to key an alphabetical character, please key the letter or letters now followed by the # key.

IVR Options

A New legislation and other provider information, press 1.

- Press 1 What customer service is all about
- Press 2 Provider customer service hours of operations and best times to call
- Press 3 Medicare Part B Website
- Press 4 Information needed when you call Medicare
- Press 5 What the IVR offers

B Claim information, press 2

To received information from the system, callers will need to have the following information ready:

- Touch-tone phone
- Your 5-digit Medicare provider number (12345)
- The patient’s 9-digit Medicare number (123456789A)
- The date of service (MMDDYY format)

When this choice is made, the caller will be asked to enter the patient’s Medicare number and the date of service of the claim for which the caller is requesting the status. The IVR will respond with the following information on assigned claims:

- Amount allowed
- Amount paid
- Check number
- The date the check was issued
- Date the check was cashed

After this information is provided, the caller will be offered more specific details about the claim. The caller may select option 3 for this information or press any other key. The additional options are as follows:

- Press 1 repeat information about this claim
- Press 2 Information for another claim for this date of service
- Press 4 Different date of service
- Press 5 Different patient Medicare number
- Press 6 Different Provider number

As a reminder, by pressing number 2, the IVR will give the caller the status of another claim for the same date of service. Callers may continue to do this until the IVR states, “There are no more claims for the date you have entered.”

On a non-assigned claim, callers will be advised if we have begun processing the claim. If Florida Medicare has begun processing the claim, the caller will be informed if it has completed processing. (Medicare may release payment information regarding non-assigned claims only to the patient, or to someone after obtaining the patient’s permission.

C Eligibility, deductible, and HMO, press 3

Once the IVR accepts the Medicare number keyed, it will indicate if the patient is currently eligible for Medicare benefits or if he/she is currently enrolled in the Health Maintenance Organization (HMO). It will also indicate if the patient has or has not met his/her deductible.

The information you will receive is the most current information available on the Florida Medicare Part B processing system.

If Social Security's files have been recently changed, or if the patient has had services rendered out of state, the information received may not be the most current.

In this case, the Medicare system in Florida will be updated once a claim is processed for the patient.

D Pending/Finalized claims and year to date amount on file, press 4

Press 1 Pending and finalized claims

Receive the number of pending and finalized claims that are currently on file in the Medicare processing system for the caller's provider number. With this choice, the caller will be informed of the number of claims Medicare is currently processing for him/her, as well as the number of claims that have been completed to date.

Press 2 Month or year-to-date amount

Callers who choose this option will receive the year-to-date amount that Medicare has paid to their provider number.

E Check information, press 5

Press 1 Most recent check on file

Press 2 For status of up to 5 checks

With this choice, callers will be informed the check number, the date it was issued, and the amount of the most recently issued checks.

F Current pricing or verify payable diagnosis of procedure code, press 6

Press 1 Current pricing

Caller will receive current year pricing and site of service pricing.

Press 2 Verify diagnosis code

Caller will need a five digit procedure code and diagnosis code. The IVR will let caller know if the diagnosis is payable for the procedure code or if the procedure is not subject to the diagnosis criteria.

G To repeat this menu, Press 7

The above is the current main menu. When calling, providers do not have to listen to the entire menu if they know which number to press for their choice.

Benefits of the IVR and Hours of Operation

The IVR is available for extended hours. The hours of the IVR are:

7:30a.m. until 5:30p.m. Monday

7:30a.m. until 6:30p.m. Tuesday through Friday

For recorded Medicare information on current issues, the hours of the IVR are:

6:00a.m. until 10:00p.m. Monday through Friday

6:00a.m. until 6:00p.m. Saturday and Sunday

When callers use the IVR, they have 15 minutes in which to obtain data. Callers do not have to wait for the prompts to key their information. All they need do is start by entering the number for the information they wish to receive and then continue with the information as requested by IVR.

Callers may change the provider number during the call, so they may obtain information for multiple providers during a single call. In addition, they are able to change the patient's Medicare numbers on the claim status option. This allows them to receive status information for several claims during the same call.

Florida Medicare Part B is dedicated to ensuring customer satisfaction with our services, and is continually striving for enhancement. We greatly appreciate your feedback, comments, suggestions for improvement, or concerns. Please send them to the following address:

Medicare Part B
P.O. Box 2078
Jacksonville, FL 32231
Attn: Rita Sheppard

EDUCATIONAL RESOURCES

Medicare Education and Training Events

Florida Medicare published information concerning upcoming Medicare educational programs developed for physicians and their billing staff in the 3rd Quarter 2001 *Medicare B Update!* (page 89). Based on the popularity and success of these programs, we are proud to announce the development of additional seminars to be delivered in September. These are:

- **Cardiology Specialty Seminar** – This specialty seminar will discuss Medicare’s coverage issues regarding services rendered by cardiologists, provide opportunities to learn how to troubleshoot claim denials, and promote networking with other billing experts in your own specialty.
- **Medicare Part B Beyond the Basics Interactive Workshop** – This day long practical hands-on learning workshop will provide you opportunities to learn how to troubleshoot claim denials, prepare for the privacy changes implemented as a result of the Health Insurance Portability and Accountability Act (HIPAA), and network with other billing experts. It is a full day of hands-on learning and doing!

For the latest information visit our Website at www.floridamedicare.com, or call our Medicare Seminar Registration Hotline at (904) 791-6422. The seminar registration hotline has information on upcoming events, allows you to choose a location near you, and request a registration form via fax. Another feature of this service is the option to leave a voicemail informing us about other Medicare topics you would like us to make available. We are interested in the provider community’s educational needs and would like to hear from you, especially since we are planning for 2002!

Medicare Educational Materials Available Now!

We have created order forms that providers can use to order the Medicare Part A and B Resource Manuals, and/or individual topics and specialty-specific manuals (e.g., Chiropractor, Podiatry, Radiology, Cardiology, Nephrology, etc.).

The first order form should be used by providers when ordering the comprehensive Medicare Part A and B Resource Manuals. The order form on page 87 contains a description of the manual with a list of topics. These comprehensive and detailed resource manuals are just \$80.00 each.

The second order form should be used by those providers who do *not* wish to order the complete Resource Manual, and are looking only for certain topics or specialty specific information. The order form on page 88 contains a list of each individual topic and specialty-specific manuals. These comprehensive and detailed resource manuals are just \$35.00 each.

Both order forms are also available on our Website.

Order yours today!

MEDICARE PART B CARDIOLOGY SEMINARS FOR 2001

*Presented by First Coast Service Options, Inc.
Your Florida Medicare Contractor*

Four Good Reasons Why You Can't Afford to Miss This Seminar!

- √ You'll receive a comprehensive overview of Medicare's guidelines for services rendered by cardiologists
- √ You'll receive information that clearly defines Medicare policies on diagnostic and interventional cardiology
- √ You'll receive information about evaluation and management services billed by a cardiologist
- √ Your questions will be answered directly by a Medicare expert

Date	Location
September 18, 2001 Tuesday	Embassy Suites Hotel 4350 PGA Blvd. Palm Beach Gardens
September 19, 2001 Wednesday	Radisson Plaza Hotel Orlando 60 South Ivanhoe Blvd. Orlando
September 20, 2001 Thursday	Hilton St. Petersburg 333 1st St. S. St. Petersburg

All sessions are from 8:30 AM to 11:30 AM
Continental breakfast included!

Don't Delay - Register Today – Only \$149.00 Per Person

Early Bird Registration Just \$129 Per Person If Pre-Registered and Paid 20 Days In Advance!

REGISTER IN THREE EASY STEPS...

- Step 1 Complete this form and fax to (904) 791-6292 to pre-register.
 Step 2 Mail this form with your check or money order payable to:
 First Coast Service Options, Inc., Acct. #756240, P.O. Box 45270, Jacksonville, FL 32232
 Step 3 Watch for your confirmation via fax. Bring your confirmation with you to the event.

Date of Cardiology Seminar:	City:
<i>Please list the name(s) of all persons that will be attending the cardiology specialty seminar below.</i>	
1.	3.
2.	4.
Telephone Number:	Amount Enclosed: _____ x \$149 = \$_____
Your E-Mail Address:	Fax Number:
Provider Name:	Billing Provider Number:
Provider Address:	Group Number:
City, State, Zip:	UPIN:
<p>Note: Advance registration and payment is required. Registrations and payments will not be accepted at the event. Refund Policy: Refunds are available if your written refund request is received 7 days prior to the event. There is a \$20 refund processing fee per person. No refunds will be issued for requests received less than 7 days prior to the event. Substitutions: If you are unable to attend, you may send one person in your place. They must bring your confirmation notice with them to the seminar. Questions? Call our Seminar Registration Hotline at (904) 791-6422.</p>	

MEDICARE PART B BEYOND THE BASICS WORKSHOPS FOR 2001

*Presented by First Coast Service Options, Inc.
Your Florida Medicare Contractor*

Five Good Reasons Why You Can't Afford to Miss This Interactive Workshop!

- √ You'll receive information to help you avoid unnecessary claim delays and denials.
- √ You'll receive information regarding Medicare's documentation requirements and tips to help your office remain compliant, including procedure and diagnosis coding.
- √ You'll receive information on Medicare's appeal process and how you can participate in the development of local medical review policy.
- √ You'll receive information on how your practice can prepare for privacy changes implemented as a result of the Health Insurance Portability and Accountability Act (HIPAA).
- √ You'll receive information on how you can protect your practice from becoming a victim of fraud and abuse.

Date	Location
September 11, 2001 Tuesday	Embassy Suites Hotel 4350 PGA Blvd. Palm Beach Gardens
September 13, 2001 Wednesday	Hilton St. Petersburg 333 1st St. S. St. Petersburg
September 14, 2001 Thursday	Radisson Plaza Hotel Orlando 60 South Ivanhoe Blvd. Orlando

All sessions are from 8:30 AM to 4:30 PM and include a continental breakfast and an afternoon snack!

Don't Delay – Register Today – Only \$249 Per Person

Early Bird Registration Just \$229 Per Person If Pre-Registered and Paid 20 Days In Advance

REGISTER IN THREE EASY STEPS...

- Step 1 Complete this form and fax to (904) 791-6292 to pre-register.
 Step 2 Mail this form with your check or money order payable to:
 First Coast Service Options, Inc., Acct. #756240, P.O. Box 45270, Jacksonville, FL 32232
 Step 3 Watch for your confirmation via fax. Bring your confirmation with you to the event.

Date of Workshop:	City:
<i>Please list the name(s) of all persons that will be attending the Beyond the Basics Workshop below.</i>	
1.	3.
2.	4.
Telephone Number:	Amount Enclosed: _____ x \$249 = \$_____
Your E-Mail Address:	Fax Number:
Provider Name:	Billing Provider Number:
Provider Address:	Group Number:
City, State, Zip:	UPIN:
<p>Note: Advance registration and payment is required. Registrations and payments will not be accepted at the event.</p> <p>Refund Policy: Refunds are available if your written refund request is received 7 days prior to the event. There is a \$20 refund processing fee per person. No refunds will be issued for requests received less than 7 days prior to the event.</p> <p>Substitutions: If you are unable to attend, you may send one person in your place. They must bring your confirmation notice with them to the seminar.</p> <p>Questions? Call our Seminar Registration Hotline at (904) 791-6422.</p>	

**FLORIDA MEDICARE EDUCATION AND TRAINING
RESOURCE MANUAL ORDER FORM**

INSTRUCTIONS: Complete all portions of this form and follow the payment instructions outlined in #3 below.


NOTE: Do not include your Medicare provider number.

1. TELL US ABOUT YOURSELF. PLEASE PRINT			
Name			
Title/Position			
Company/Organization			
Address			
City, State, Zip Code			
Phone Number	() -	Extension:	
Fax Number	() -		
E-Mail Address			
2. PLEASE INDICATE THE MATERIALS YOU WOULD LIKE TO PURCHASE.			
QUANTITY	TITLE	PRICE (EA.)	TOTAL
	Medicare Part B Resource Manual Includes our most popular subjects: Advanced Beneficiary Notice; ARNP/PA Guidelines; CPT Coding; Electronic Media Claims; Evaluation and Management Documentation and Coding; Focused Medical Review; Fraud and Abuse; Global Surgery; HCFA-1500 Claims Filing; HIPAA-AS; How to Help Patients Understand Medicare; ICD-9-CM Coding; Inquiries, Appeals, and Overpayments; Medical Review; Medicare Part C; Medicare Secondary Payer; PC-ACE™ for HCFA-1500; Primary Care; Provider Enrollment; and Reimbursement Efficiency	\$80.00	\$
	Medicare Part A Resource Manual Includes our most popular subjects: Direct Data Entry (DDE); Fraud and Abuse; HIPAA; How to Help Patients Understand Medicare; Introduction to Cost Report Auditing; Introduction to Cost Reports; Medical Review; Medicare Part C; Medicare Secondary Payer; PC-ACE™ for UB-92; Provider Enrollment; Provider-Based Regulations; Reconsiderations, Reviews, and Inquiries; Reimbursement Efficiency; and UB-92 Claims Filing	\$80.00	\$
		Sub-Total	\$
		Add 7% Tax	\$
		Total	\$
3. PLEASE SUBMIT YOUR PAYMENT			
SEND YOUR PAYMENT	Submit the completed form with your check or money order: <ul style="list-style-type: none"> ▪ Payable to First Coast Service Options, Inc. #756245 ▪ Mail to Medicare Education and Training, Resource Material Orders, P.O. Box 45270, Jacksonville, FL 32232 Your order will be shipped within four to six weeks.		

**FLORIDA MEDICARE EDUCATION AND TRAINING
INDIVIDUAL MODULE ORDER FORM**

INSTRUCTIONS: Complete all portions of this form and follow the payment instructions outlined in #3 below.

NOTE: Do not include your Medicare provider number.

1. TELL US ABOUT YOURSELF. PLEASE PRINT			
Name			
Title/Position			
Company/Organization			
Address			
City, State, Zip Code			
Phone Number	() -	Extension:	
Fax Number	() -		
E-Mail Address			
2. PLEASE INDICATE WHICH INDIVIDUAL MODULES YOU WANT BY CLEARLY PRINTING THEIR NAMES IN THE LINES PROVIDED BELOW THE LIST. EACH MODULE COSTS \$35.00. (Modules followed by * are included in a resource manual)			
Advanced Beneficiary Notice*	HCFA-1500 Claims Filing*	Pathology	
Ambulance Regulations	HIPAA-AS*	PC-ACE™ for HCFA-1500*	
Anesthesia	How to Help Patients Understand Medicare*	PC-ACE™ for UB-92*	
ARNP/PA Guidelines*	ICD-9-CM Coding*	Podiatry	
Cardiology	Independent Diagnostic Testing Facilities	Primary Care*	
Chiropractic	Inquiries, Appeals, & Overpayments*	Provider Enrollment*	
CPT Coding*	Introduction to Cost Report Auditing*	Provider-Based Regulations*	
Dermatology	Introduction to Cost Reports*	Radiology	
Direct Data Entry (DDE)*	Medical Review*	Reconsiderations, Reviews, & Inquiries*	
Electronic Media Claims (EMC)*	Medicare Part C*	Rehabilitation Services	
E/M Coding*	Medicare Secondary Payer*	Reimbursement Efficiency: Part A*	
E/M Documentation*	Mental Health Services	Reimbursement Efficiency: Part B*	
End Stage Renal Disease (ESRD)	Nephrology	SNF/Consolidated Billing	
Focused Medical Review*	Oncology	UB-92 Claims Filing*	
Fraud and Abuse*	Orthopedics	Vision	
Global Surgery*	Partial Hospitalization Program		
QUANTITY	TITLE		TOTAL
			\$35.00
			Sub-Total \$
			Add 7% Tax
			Total \$
3. PLEASE SUBMIT YOUR PAYMENT			
 SEND YOUR PAYMENT	Submit the completed form with your check or money order: <ul style="list-style-type: none"> ▪ Payable to First Coast Service Options, Inc. #756245 ▪ Mail to Medicare Education and Training, Resource Material Orders, P.O. Box 45270, Jacksonville, FL 32232 Your order will be shipped within four to six weeks.		

ORDER FORM – 2001 PART B MATERIALS

The following materials are available for purchase. 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
<input type="checkbox"/>	Medicare B Update! Subscription – One copy of the <i>Update!</i> is sent free of charge to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the twelvemonths prior to the release of each issue. Non-provider entities or providers who need additional copies at other office locations may purchase an annual subscription. This subscription includes all issues published during calendar year 2001 (back issues sent upon receipt of order).	756245	\$75.00
<input type="checkbox"/>	2001 Fee Schedule – One copy of the <i>Medicare Part B Physician and Non-Physician Practitioner Fee Schedule</i> is sent free of charge in mid-November to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the preceding six months. The Fee Schedule contains calendar year 2001 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2001. These items include the payment rates for injectable drugs, but <i>do not</i> include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the <i>Medicare B Update!</i> Non-provider entities or providers who need additional copies at other office locations may purchase additional copies.	756250	\$20.00
<input type="checkbox"/>	Procedure-to-Diagnosis Relationship Report – This is a listing of the most current file used during claims processing to determine coverage for procedures subject to specific diagnosis criteria. This document is designed to assist providers by outlining diagnosis criteria in order to limit their financial liability for these procedures. Available in single issues or as an annual subscription that includes one update quarterly (annual subscription requests must be received by March 1).	756245	Annual (4 issues) \$60.00 Single Issue \$20.00

Subtotal \$ _____

Tax (7%) \$ _____

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Note: The *Medicare B Update!* and *2001 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* are available **free of charge** online at www.FloridaMedicare.com .

Reader Survey—*Medicare B Update!*

*Please complete the questions below and return your reply to us by September 15, 2001.
Your opinion matters, so we want to hear from you!*

Overall Satisfaction

On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please *circle* the number that best applies.

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Using the same scale, please rate the *Medicare B Update!* in the following areas:

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- 1) “When I read the *Medicare B Update!* I feel comfortable that the information presented is accurate.”

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If you have been to our provider Web site -www.floridamedicare.com- within the last 4 weeks - again using the same scale, how would you rate the site?

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Medicare Part B Participating Providers
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Jacksonville, FL 32231-4117

Chiropractic Claims

Medicare Part B Chiropractic Unit
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Jacksonville, FL 32231-4067

Ambulance Claims

Medicare Part B Ambulance Dept.
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Jacksonville, FL 32231-4099

Medicare Secondary Payer

Medicare Part B Secondary Payer Dept.
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Jacksonville, FL 32231-4078

ESRD Claims

Medicare Part B ESRD Claims
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COMMUNICATIONS

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Jacksonville, FL 32231-0018

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Medicare Part B Fair Hearings
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Jacksonville, FL 32232-5156

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Administrative Law Judge Hearing
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DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
DMERC Operations
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Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries

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Jacksonville, FL 32231-4021

Provider Change of Address:

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Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Provider Education:

For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:

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

For Seminar Registration:

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Jacksonville, FL 32231

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Augusta, GA 30999-0001

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OCR

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WEBSITES

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Florida
www.floridamedicare.com

Health Care Financing Administration
www.hcfa.gov

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