Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

Additional Toll-Free Provider Telephone Number Added

On March 30, 2001, Florida Medicare's Provider Customer Service area implemented a new toll-free telephone number for calls to customer service representatives: **(866) 454-9007**. The existing number, (877) 847-4992, is to be used for calls to the Interactive Voice Response (IVR) line.

Effective May 1, 2001, callers must call the new number to speak to a representative.

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 _____

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HCFA Health Care Financing Administration

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

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

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

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

A PHYSICIAN'S FOCUS

"How Can I Get A Code?"

We frequently get calls and letters from physicians who want to get a "Code" for new procedures or services. When we evaluate the requests, we learn that they are really requesting a "*Current Procedural Terminology*" (*CPT*) code. First Coast Service Options, Inc. (the Florida Medicare Carrier) is not authorized to create new *CPT* codes. These must all be approved by the *CPT* Editorial Panel which is controlled by the American Medical Association (AMA). The Panel is comprised of 16 members, 11 nominated by the AMA and one each from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, HCFA, the American Hospital Association, and the co-chair of the Health Care Professionals Advisory Committee (HCPAC). The AMA's Board of Trustees appoints the Panel members. Each year an annual publication is prepared that makes changes for significant updates in medical technology and practice. The first edition was published in 1966. The most recent edition has over 7,750 codes.

Any interested party may submit materials for consideration by the Editorial Panel. Requests may be made for new codes or to delete or modify old ones. Details for requesting *CPT* code changes can be found in the "Introduction" section of the *CPT* Book or on the AMA's web site, **www.ama-assn.org**. The requester should consider the following questions:

- Is the suggestion included in an existing procedure/service?
- Can the suggested procedure/service be reported by using two or more existing codes?
- Is the suggested procedure/service performed by many physicians/practitioners across the United States?
- Does the suggested procedure/service represent a distinct physician's service?
- Can the suggested procedure/service be represented by a modifier to indicate extraordinary circumstances related to the performance of a procedure/service already included in *CPT*?

If the requester concludes that a new code is needed, the following must be submitted:

- A complete description of the procedure/service (e.g., describe in detail the skill and time involved). If this is a surgical procedure, include an operative report;
- A clinical vignette which describes the typical patient and work provided by the physician/practitioner;
- The diagnosis of patients for whom this procedure/service would be performed;
- A copy(s) of peer-reviewed articles published in US journals indicating the safety and effectiveness of the procedure, as well as the frequency with which the procedure is performed;
- A copy of additional published literature which you feel further explains your request (e.g., practice parameters/ guidelines or policy statements on a particular procedure/service); and
- Evidence of FDA approval of the drug or device used in the procedure/service if required.

These materials will be sent to the members of the HCPAC for comments. The *CPT* Panel members will then review the materials along with the comments. The Panel meets quarterly to consider and vote on the proposals. They can vote to accept, table or reject the proposal. The Executive Committee will review any appeal.

Additional questions concerning *CPT* codes should be addressed to:

CPT Editorial Research & Development
American Medical Association
515 North State Street
Chicago, Illinois 60610

We hope this information is helpful to you in obtaining the appropriate codes to represent your performed services.

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 90).

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.

This issue also contains a pull-out supplement from the Medicare **Financial Services** Department.

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

Additional Development Requests—Correction

An article pertaining to attending or referring provider information was published in the First Quarter 2001 issue of the *Medicare B Update!* (page 5). An error has been noted concerning the HCFA-1500 claim form requirements. Specifically, the article instructs providers to enter the date last seen in block 17, which is incorrect. Date last seen information should be entered in block ***19***. UPIN information should be entered in blocks 17 and 17A.

Florida Medicare apologizes for any inconvenience this may have caused.

Proper Reporting of Bilateral Procedures

A recent review of physician claims indicates that many providers are incorrectly billing claims for bilateral surgical procedures. Claims for bilateral surgical procedures should be billed on a **single** claim detail line with the appropriate procedure code and modifier 50 (Bilateral procedure). This modifier indicates the procedure was performed on both sides of the body. Do not use a number billed of two when billing for bilateral procedures.

For additional information on bilateral procedures, refer to the December 2000 *Medicare B Update! Special Issue (*page 4).

Place of Service Billing for Mixed Nursing Facilities

Florida Medicare has been advised by the Health Care Financing Administration (HCFA) to allow providers rendering services in mixed facilities (i.e., a combination skilled nursing facility and nursing home facility) to bill place of service 32 (as opposed to 31) when the beneficiary is in a Skilled Nursing Facility bed and it can be verified that the patient either does not have or has exhausted their Part A benefits.

Correct Coding Initiative

Version 7.1 of the Correct Coding Initiative (CCI) was implemented on April 1, 2001, effective for services rendered on or after April 1, 2001. Version 7.1 includes all previous versions and updates from January 1996 to the present. Version 7.2 (which also includes all previous versions and updates) will be effective July 1, 2001.

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 **http://www.ntis.gov/product/correct-coding.htm.**

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

COVERAGE/REIMBURSEMENT

AMBULANCE

Ambulance Mileage Codes: A0380, A0390

The Health Care Financing Administration's Common Procedure Coding System (HCPCS) for 2001 lists the above procedure codes as deleted for 2001. Deleted codes, unless otherwise specified, are afforded a 90-day "grace period," during which providers and suppliers may continue to bill such codes.

Because the new Ambulance Fee Schedule has not yet been implemented, suppliers of ambulance services **must** continue to use codes A0380 and A0390 for billing mileage, **until further notice**.

CHIROPRACTIC

Billing Non-Covered Chiropractic Maintenance Therapy – A9170

In an effort to ensure accurate payment for covered services and reduce the risk of payment for chiropractic services that are exclusively non-covered under the Medicare program, the following clarification is provided.

The Medicare Carriers' Manual section 2251.3(B) provides the following definition: "Maintenance Therapy – A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition is not a Medicare benefit. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary."

Currently, billing methods for non-covered maintenance therapy vary depending upon the individual provider office. To ensure consistency in billing, chiropractic physicians must use HCPCS code A9170 (Non-covered service by chiropractor) when performing and billing for non-covered chiropractic maintenance therapy. When billing for maintenance therapy, the patient's condition must meet the criteria described above and the patient's medical record should clearly reflect that the services performed are maintenance in nature.

As with any service that is exclusively a non-covered benefit under the Medicare program, the physician may collect his/her routine fee at the time the service is provided. When billing code A9170, the physician is not required to obtain the patient's signature on an Advance Beneficiary Notice (ABN) form. This is applicable for assigned and non-assigned claims, participating and non-participating physicians, and paper or electronically-submitted claims. This clarification does not affect any other non-covered service (such as office visits, therapy or diagnostic X-ray services) a chiropractic physician may bill using code A9170. As a reminder, when providing services that are exclusively non-covered under the Medicare program, the mandatory claim filing requirement does not apply.

For more information, contact our provider customer service department toll-free at (866) 454-9007.

DMEPOS

DMEPOS Items Processed by Local Carriers

The Durable Medical Equipment Regional Carrier (DMERC) processes most Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS); however, processing jurisdiction for certain services remains with local carriers, or in some case is shared with the DMERC. The following pricing updates are for local carrier jurisdiction codes for services/items furnished on or after January 1, 2001, processed on or after April 2, 2001.

PROC	ALLOWANCE
E0753	1421.30
E0757	4611.66
E0758	4059.30
E0786	6831.93

2001 Jurisdiction List

Below is the updated list of procedure codes for Durable Medical Equipment Regional Carrier (DMERC) and local carrier jurisdictions. Some HCPCS codes have been added to or discontinued from (deleted) the list for this year. Both the DMERCs and the local carriers publish this list to educate providers on which carrier they should be billing for these codes.

Effective for claims with dates of service on or after July 1, 2001, code A4570, previously used to bill for splints, and codes A4580 and A4590, previously used to bill for casting materials, will be invalid for Medicare use (there will be a three-month grace period until September 30, 2001 for these codes). New codes for splints and casts (Q4001 through Q4051) are being added effective for dates of service on or after July 1, 2001. Jurisdiction for splints transfers from the DMERCs to the local carriers at that time. In addition, jurisdiction for slings (A4565) will be jointly maintained by the local carriers for claims submitted by physicians and other practitioners and the DMERCs for claims submitted by suppliers. Additional instructions regarding the new Q codes for splints and casts and payment for these items will be provided in a future publication.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4210	Needle Free Injection Device	DME REGIONAL Carrier
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4253 - A4259	Blood Glucose Test; Lancets; Calibrator Solution	DME REGIONAL Carrier
A4260	Levonorgestrel Implant	Local Carrier
A4261	Cervical Cap for Contraceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier

A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4310 - A4359	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4361 - A4421	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4454 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4460	Elastic Bandage	Local Carrier if incident to a physician's service (not separately payable).If secondary surgical dressing, DME REGIONAL Carrier. (See MCM 2079)
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4464	Joint Supportive Device/Garment	DME REGIONAL Carrier
A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier

A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4561 - A4562	Pessary	DME REGIONAL Carrier
A4565	Slings	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4572	Rib Belt	DME REGIONAL Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME Regional Carrier
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4646	Imaging Agent; Contrast Material	Local Carrier
A4647	Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4650 - A4705	Supplies for ESRD	DME REGIONAL Carrier
A4712	Water, Sterile	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4714 - A4927	Supplies for ESRD	DME REGIONAL Carrier
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier

A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A5500 - A5508	Therapeutic Shoes	DME REGIONAL Carrier
A6020-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A6025	Silicone Gel Sheet	DME REGIONAL Carrier
A6154 - A6406	Surgical Dressing	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
A7000 - A7020	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7501-A7509	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier
A9160 - A9170	Administrative, Miscellaneous, and Investigational	Local Carrier
A9190 - A9270	Noncovered Items or Services	Local Carrier or DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
A9901	Delivery	DME REGIONAL Carrier
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0116	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier
E0176 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0241 - E0246	Bath and Toilet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0298	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier

E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heel Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0480	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier
E0600 - E0606	Suction Pump/Room Vaporizers	DME REGIONAL Carrier
E0607 - E0609	Monitoring Equipment	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0621 - E0635	Patient Lifts	DME REGIONAL Carrier
E0650 - E0673	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0690	Ultraviolet Cabinet	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0753	Implantable Nerve Stimulator Electrodes	Local Carrier
E0755	Reflex Stimulator	DME REGIONAL Carrier
E0756 - E0758	Implantable Nerve Stimulator	Local Carrier
E0760	Ultrasonic Osteogenic Stimulator	DME REGIONAL Carrier
E0765	Nerve Stimulator	DME REGIONAL Carrier
E0776	IV Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier

E0830	Ambulatory Traction Device	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0948	Trapeze Equipment	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier
E1353 - E1390	Additional Oxygen Related Equipment	DME REGIONAL Carrier
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier
E1405 - E1406	Additional Oxygen Equipment	DME REGIONAL Carrier
E1510 - E1699	Artificial Kidney Machines and Accessories	DME REGIONAL Carrier
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1830	Dynamic Flexion Devices	DME REGIONAL Carrier
E1900	Speech Augmentation Communication Devices	DME REGIONAL Carrier
G0001 - G9016	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7190 - J7192	Factor VIII	Local Carrier
J7194	Factor IX	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300	Intrauterine Copper Contraceptive	Local Carrier
J7310	Ganciclovir	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7315 - J7320	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier

J7608 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7799	NOC, Other than Inhalation Drugs through DME	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemo-therapeutic	DME REGIONAL Carrier
J8510 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0112 - K0116	Spinal Orthotics	DME REGIONAL Carrier
K0183 - K0189	Accessories for Positive Airway Pressure Devices	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0268	Humidifier	DME REGIONAL Carrier
K0415 - K0416	Antiemetic Drugs	DME REGIONAL Carrier
K0452	Wheelchair Bearings	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0460 - K0461	Power Add-on Converters for Wheelchairs	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0531	Accessory for Respiratory Assist Device	DME REGIONAL Carrier
K0532 - K0534	Respiratory Assist Device	DME REGIONAL Carrier
K0538 - K0540	Negative Pressure Wound Therapy Pump	DME REGIONAL Carrier
K0541 - K0547	Speech Generating Device	DME REGIONAL Carrier
K0548	Injection, Insulin Lispro	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
K0549 - K0550	Heavy Duty Hospital Beds	DME REGIONAL Carrier
L0100 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of im-planted prosthetic device. If other, DME REGIONAL Carrier
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8490	Prosthetics	DME REGIONAL Carrier

L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME REGIONAL Carrier
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier
M0064 - M0302	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiokymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy	Local Carrier
Q0086	Physical Therapy Evaluation/Treatment	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0136	Injection, Epoetin Alpha	Local Carrier
Q0144	Arithromycin Dihydrate	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
Q0160 - Q0161	Factor IX, Antihemophilic factor	Local Carrier
Q0163 - Q0181	Anti-emetic	DME Regional Carrier
Q0183 - Q0185	Artificial Skin	Local Carrier
Q0187	Factor VIIA	Local Carrier
Q1001 - Q1005	New Technology IOL	Local Carrier
Q2022	Von Willebrand Factor Compex	Local Carrier
Q3013	Verteporfin, per 15 mg	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q9920 - Q9940	Injection of EPO	DME REGIONAL Carrier when self-administered or for Method II beneficiaries, otherwise Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier

V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME REGIONAL Carrier
V2781	Progressive Lens	DME REGIONAL Carrier
V2785	Processing—Corneal Tissue	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2799	Miscellaneous Vision Service	DME REGIONAL Carrier
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME REGIONAL Carrier
V5362 - V5364	Speech Screening	Local Carrier

BIPA Changes to the 2001 Payment Amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

In accordance with the Benefits Improvement and Protection Act (BIPA) of 2000, the fee schedule update factors for 2001 for both DME (BIPA section 425) and prosthetics and orthotics (BIPA section 426) are equal to 3.7 percent (the percentage increase in the consumer price index for all urban consumers for the 12-month period ending with June 2000). Sections 425 and 426 specify that these update factors are to be implemented on July 1, 2001. To account for the timing of the implementation of the 3.7 percent update factors (i.e., July rather than January), BIPA of 2000 provides for temporary increases in the fee schedule amounts for items furnished on or after July 1, 2001, but before January 1, 2002. The temporary increases are 3.28 percent for DME and 2.6 percent for prosthetics and orthotics. For services furnished before July 1, 2001, payment will be based on the 2001 fee schedule amounts in effect prior to enactment of BIPA of 2000.

Based on changes made by BIPA of 2000, the Balanced Budget Refinement Act of 1999, and the Balanced Budget Act of 1997, the DMEPOS pricing updates (percentage increases) for the pricing periods beginning January 2001, July 2001 (where applicable), and January 2002 are as follows:

Category	January 1, 2001	July 1, 2001	January 1, 2002
DME (other than oxygen)	0.3*	3.7 + 3.28*	0.6*
Oxygen and Oxygen Equipment	0.3*	see below *	0.6*
Prosthetics & Orthotics	1.0*	3.7 + 2.6*	1.0
Ostomy/Tracheostomy/Urologicals	0.0	3.7 + 3.28*	0.0
Surgical Dressings	0.0	3.7 + 3.28*	0.0
Therapeutic Shoes	0.3*	3.7 + 3.28*	0.6*
Parenteral & Enteral Nutrition	0.0	n/a	0.0
Reasonable Charge (other than ambulance)	3.7	n/a	CPI-U

* Temporary increase not to be carried over into future periods, except in the case of oxygen and oxygen equipment, where the 0.3 percent increase applies to items furnished on or after January 1, 2001, and before January 1, 2002.

July 2001 DMEPOS Fee Schedule Update

The July 2001 fee schedules for DME, prosthetics and orthotics, and surgical dressings will be released to contractors on May 4, 2001. Fees for local carrier and joint local and DMERC jurisdiction codes will be posted to our provider Website (**www.FloridaMedicare.com**) as soon as they become available, and published in a future issue of the *Medicare B Update!*

DRUGS AND BIOLOGICALS

Mandatory Assignment Required for Drugs and Biologicals

Effective for claims processed on or after **July 1, 2001** for items furnished on or after **February 1, 2001**, under section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA), payment for any drug or biological covered under Medicare Part B may be made only on an assignment-related basis. No charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Part B deductible and coinsurance amounts. This means that nonparticipating providers *may not* bill 115 percent of the allowed amount; limiting charge is no longer applicable since claims for these services are now assigned.

Medicare carriers are required to change the assignment of any unassigned claims received for the above dates. In the event an unassigned claim is received that contains services that are subject to mandatory assignment in addition to those that are not, the services subject to mandatory assignment will be split off and processed as if assignment had been accepted.

CPT and HCPCS codes affected by this requirement include but are not limited to:

A4641	J0670	J1390	J1955	J2790	J7030	J7649	J9170
A4642	J0690	J1410	J1956	J2792	J7040	J7650	J9180
A4644	J0694	J1435	J1960	J2795	J7042	J7651	J9181
A4645	J0695	J1436	J1970	J2800	J7050	J7652	J9182
A4646	J0696	J1438	J1980	J2810	J7051	J7653	J9185
A9500	J0697	J1440	J1990	J2820	J7060	J7654	J9190
A9502	J0698	J1441	J2000	J2860	J7070	J7655	J9200
A9503	J0702	J1450	J2010	J2910	J7100	J7658	J9201
A9505	J0704	J1452	J2060	J2912	J7110	J7659	J9202
A9507	J0710	J1455	J2150	J2915	J7120	J7660	J9206
A9510	J0713	J1460	J2175	J2920	J7130	J7665	J9208
A9600	J0715	J1470	J2180	J2930	J7190	J7668	J9209
A9605	J0720	J1480	J2210	J2950	J7191	J7669	J9211
J0130	J0725	J1490	J2240	J2970	J7192	J7670	J9212
J0150	J0730	J1500	J2250	J2993	J7194	J7672	J9213
J0151	J0735	J1510	J2260	J2994	J7197	J7675	J9214
J0170	J0740	J1520	J2270	J2995	J7198	J7680	J9215
J0190	J0743	J1530	J2271	J2996	J7199	J7681	J9216
J0200	J0745	J1540	J2275	J2997	J7300	J7682	J9217
J0205	J0760	J1550	J2300	J3000	J7310	J7683	J9218
J0207	J0770	J1560	J2310	J3010	J7315	J7684	J9219
J0210	J0780	J1561	J2320	J3030	J7320	J7699	J9230
J0256	J0800	J1562	J2321	J3070	J7330	J7799	J9245
J0270	J0810	J1563	J2322	J3080	J7500	J8499	J9250
J0275	J0835	J1565	J2330	J3105	J7501	J8510	J9260
J0280	J0850	J1570	J2350	J3120	J7502	J8520	J9265
J0282	J0895	J1580	J2352	J3130	J7504	J8521	J9266
J0285	J0900	J1600	J2355	J3140	J7505	J8530	J9268
J0286	J0945	J1610	J2360	J3150	J7506	J8560	J9270
J0290	J0970	J1620	J2370	J3230	J7507	J8600	J9280
J0295	J1000	J1626	J2400	J3240	J7508	J8610	J9290
J0300	J1020	J1630	J2405	J3245	J7509	J8700	J9291
J0330	J1030	J1631	J2410	J3250	J7510	J8999	J9293
J0340	J1040	J1642	J2430	J3260	J7513	J9000	J9310
J0350	J1050	J1644	J2440	J3265	J7515	J9001	J9320
J0360	J1060	J1645	J2460	J3270	J7516	J9015	J9340
J0380	J1070	J1650	J2480	J3280	J7517	J9020	J9350
J0390	J1080	J1670	J2500	J3301	J7520	J9031	J9355
J0395	J1090	J1690	J2510	J3302	J7525	J9040	J9357
J0400	J1095	J1700	J2512	J3303	J7599	J9045	J9360
J0456	J1100	J1710	J2515	J3305	J7608	J9050	J9370
J0460	J1110	J1720	J2540	J3310	J7610	J9060	J9375
J0470	J1120	J1730	J2543	J3320	J7615	J9062	J9380
J0475	J1160	J1739	J2545	J3350	J7618	J9065	J9390
J0476	J1165	J1741	J2550	J3360	J7619	J9070	J9600
J0500	J1170	J1742	J2560	J3364	J7620	J9080	J9999
J0510	J1180	J1745	J2590	J3365	J7625	J9090	Q0136
J0515	J1190	J1750	J2597	J3370	J7627	J9091	Q0144
J0520	J1200	J1785	J2640	J3390	J7628	J9092	Q0156
J0530	J1205	J1790	J2650	J3400	J7629	J9093	Q0157
J0540	J1212	J1800	J2670	J3410	J7630	J9094	Q0160
J0550	J1230	J1810	J2675	J3420	J7631	J9095	Q0161
J0560	J1240	J1820	J2680	J3430	J7635	J9096	Q0163
J0570	J1245	J1825	J2690	J3450	J7636	J9097	Q0183
J0580	J1250	J1830	J2700	J3470	J7637	J9100	Q0184
J0585	J1260	J1840	J2710	J3475	J7638	J9110	Q0185
J0590	J1320	J1850	J2720	J3480	J7639	J9120	Q0186
J0600	J1325	J1885	J2725	J3485	J7640	J9130	Q0187
J0610	J1327	J1890	J2730	J3490	J7642	J9140	Q0188
J0620	J1330	J1910	J2760	J3520	J7643	J9150	Q2001
J0630	J1362	J1930	J2765	J3530	J7644	J9151	Q2002
J0635	J1364	J1940	J2770	J3535	J7645	J9160	Q2003
J0640	J1380	J1950	J2780	J3570	J7648	J9165	Q2004

Q2005	Q3003	Q9929	W4139	90296	90634	90701	90727
Q2006	Q3004	Q9930	W4140	90371	90636	90702	90732
Q2007	Q3005	Q9931	W4141	90375	90645	90703	90733
Q2008	Q3006	Q9932	W4142	90376	90646	90704	90735
Q2009	Q3007	Q9933	W4143	90378	90647	90705	90740
Q2010	Q3008	Q9934	W4144	90379	90648	90706	90742
Q2011	Q3009	Q9935	W4147	90384	90657	90707	90743
Q2012	Q3010	Q9936	W4149	90385	90658	90708	90744
Q2013	Q3011	Q9937	W4150	90386	90659	90709	90745
Q2014	Q3012	Q9938	W4151	90389	90660	90710	90746
Q2015	Q3013	Q9939	W4153	90393	90665	90712	90747
Q2016	Q9920	Q9940	W4156	90396	90669	90713	90748
Q2017	Q9921	W4125	W4158	90399	90675	90716	90749
Q2018	Q9922	W4128	78990	90476	90676	90717	
Q2019	Q9923	W4130	79900	90477	90680	90718	
Q2020	Q9924	W4131	90281	90581	90690	90719	
Q2021	Q9925	W4132	90283	90586	90691	90720	
Q2022	Q9926	W4133	90287	90592	90692	90721	
Q3001	Q9927	W4134	90288	90632	90693	90723	
Q3002	Q9928	W4136	90291	90633	90700	90725	

Allowances for Injectable Drugs

Medicare Part B allowances for certain injectable drugs have been updated, effective for services processed on or after April 2, 2001. Note that limiting change is no longer listed, since assignment is mandatory effective for services processed on or after July 1, 2001 for services provided on or after February 1, 2001.

The new allowances are:

CODE	PAR ALLOW	NONPAR ALLOW
A9500	112.24	106.63
A9502	132.48	125.86
A9505	75.69	71.91
A9600	933.00	886.35
J0150	33.25	31.59
J0210	10.43	9.91
J0270	3.81	3.62
J0280	1.60	1.52
J0282	17.07	16.22
J0290	1.07	1.02
J0360	17.81	16.92
J0390	18.95	18.00
J0460	4.83	4.59
J0475	233.70	222.02
J0530	8.80	8.36
J0570	19.61	18.63
J0704	2.26	2.15
J0720	7.55	7.17
J0745	1.12	1.06
J0780	1.92	1.82
J0945	1.06	1.01
J1000	2.54	2.41
J1030	5.99	5.69
J1040	9.88	9.39
J1070	1.27	1.21
J1080	16.16	15.35
J1090	0.63	0.60
J1095	5.31	5.04
J1165	1.23	1.17
J1212	41.75	39.66
J1245	21.89	20.80
J1320	2.14	2.03
J1441	285.38	271.11
J1580	5.37	5.10
J1730	114.74	109.00
J1800	17.63	16.75
J1850	3.08	2.93
J1910	13.28	12.62
J1940	1.17	1.11
J1950	492.70	468.07
J1980	10.13	9.62
J1990	24.99	23.74
J2270	1.11	1.05
J2271	18.46	17.54
J2275	8.42	8.00
J2321	12.18	11.57
J2410	2.80	2.66
J2545	93.81	89.12
J2560	6.35	6.03
J2597	4.78	4.54
J2725	24.39	23.17
J2730	102.95	97.80
J2760	32.58	30.95
J2770	102.05	96.95
J2790	102.60	97.47
J2912	1.61	1.53
J3000	6.34	6.02
J3010	1.88	1.79
J3230	3.23	3.07
J3301	1.52	1.44
J3303	2.60	2.47
J3305	86.09	81.79
J3310	6.65	6.32
J3320	26.79	25.45
J3350	84.22	80.01
J3370	7.41	7.04
J3430	2.33	2.21
J3450	7.81	7.42
J3485	0.95	0.90
J7040	10.43	9.91
J7042	11.07	10.52
J7050	10.59	10.06
J7051	0.95	0.90
J7120	13.36	12.69
J7192	1.31	1.24
J7516	27.70	26.32
J7517	2.29	2.18
J9015	641.25	609.19
J9080	11.64	11.06
J9160	999.88	949.89
J9170	297.83	282.94
J9185	258.88	245.93
J9201	102.13	97.02
J9206	125.48	119.20
J9212	4.09	3.89
J9217	592.60	562.97
J9245	381.65	362.57
J9268	1654.14	1571.43
J9355	52.84	50.20
J9390	79.28	75.31
Q0157	83.13	78.97
Q0160	1.05	1.05
Q0188	118.75	112.81
90744	22.99	22.99
90746	64.58	61.89

Elimination of Time Limit on Medicare Benefits for Immunosuppressive Drugs

Effective with immunosuppressive drugs furnished on or after December 21, 2000, there is no longer any time limit for Medicare benefits. This instruction supersedes HCFA Program Memorandum AB-99-98, which described the method for determining the former time limit for this benefit that applied to drugs furnished prior to December 21, 2000.

This policy applies to all Medicare entitled beneficiaries who meet all of the other program requirements for coverage under this benefit. Therefore, currently entitled beneficiaries who had been receiving benefits for immunosuppressive drugs in the past, but whose immunosuppressive drug benefit was terminated solely because of the time limit described in PM AB-99-98, would now resume receiving that benefit for immunosuppressive drugs furnished on or after December 21, 2000.

DIAGNOSTIC TESTS

Physician Supervision of Diagnostic Tests

This article provides revised levels of physician supervision required for diagnostic tests payable under the Medicare physician fee schedule, as defined by the Health Care Financing Administration (HCFA).

Section 410.32(b) of the Code of Federal Regulations (CFR), as adopted in the Medicare physician fee schedule final rule of October 31, 1997, requires that diagnostic tests covered under section 1861(s)(3) of the Social Security Act ("the Act") and payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a "physician"(section 1861(r) of the Act) to be considered reasonable and necessary and, therefore, covered under Medicare. The regulation defines these levels of physician supervision for diagnostic tests as follows:

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician 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 in the office setting means the physician must be present in the office 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 means a physician must be in attendance in the room during the performance of the procedure.

The preamble to the final rule of October 31, 1997 assigned a level of physician supervision to most diagnostic tests payable under the physician fee schedule. Implementation of the levels set forth in the final rule was delayed by a memorandum to the HCFA regional offices dated January 28, 1998. The list provides the required level of physician supervision for tests performed under the provisions of 42 CFR 410.32(b).

Effective July 1, 2001, certain codes in the range of CPT 95860 through 95937 will have new supervision levels (either 21, 22, 6a, 66, 77 or 77a). This implementation date will make it possible for physical therapists to acquire the certification required to perform these services without supervision.

Note: Effective July 1, 2001, a physical therapist who is presently certified by the American Board of Physical Therapy Specialties can perform procedures assigned a level of 21, 22, 66, 6a, 77, or 77a without supervision.

Levels of Physician Supervision of Diagnostic Tests

The table on the following pages indicate the required level of physician supervision for specific diagnostic tests, as defined below. Note that the table does not provide an inclusive list of diagnostic tests that require physician supervision. HCFA will provide updates to the table periodically.

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.

Required Level of Physician Supervision of Specific Diagnostic Tests

CODE	LEVEL
URODYNAMICS	
51725 & TC	2
51726 & TC	2
51736 & TC	2
51741 & TC	2
51772 & TC	2
51784 & TC	2
51785 & TC	3
51792 & TC	2
51795 & TC	2
51797 & TC	2
MALE GENITAL SYSTEM	
54240 & TC	2
54250 & TC	1
ANTEPARTUM SERVICES	
59020 & TC	2
59025 & TC	1
RESERVOIR/PUMP IMPLANTATION	
62367 & TC	2
62368 & TC	2
DIAGNOSTIC RADIOLOGY	
HEAD AND NECK	
70010 & TC	3
70015 & TC	3
70030 & TC	1
70100 & TC	1
70110 & TC	1
70120 & TC	1
70130 & TC	1
70134 & TC	1
70140 & TC	1
70150 & TC	1
70160 & TC	1
70170 & TC	3
70190 & TC	1
70200 & TC	1
70210 & TC	1
70220 & TC	1
70240 & TC	1
70250 & TC	1
70260 & TC	1
70300 & TC	1
70310 & TC	1
70320 & TC	1
70328 & TC	1
70330 & TC	1
70332 & TC	3
70336 & TC	2
70350 & TC	1
70355 & TC	1
70360 & TC	1
70370 & TC	3
70371 & TC	3
70373 & TC	3
70380 & TC	1
70390 & TC	3
70450 & TC	1
70460 & TC	2
70470 & TC	2
70480 & TC	1
70481 & TC	2
70482 & TC	2
70486 & TC	1
70487 & TC	2
70488 & TC	2
70490 & TC	1
70491 & TC	2
70492 & TC	2
70540 & TC	1
70541 & TC	2
70551 & TC	1
70552 & TC	2
70553 & TC	2
CHEST	
71010 & TC	1
71015 & TC	1
71020 & TC	1
71021 & TC	1
71022 & TC	1
71023 & TC	3
71030 & TC	1
71034 & TC	3
71035 & TC	1
71036 & TC	3
71040 & TC	3
71060 & TC	3
71090 & TC	3
71100 & TC	1
71101 & TC	1
71110 & TC	1
71111 & TC	1
71120 & TC	1
71130 & TC	1
71250 & TC	1
71260 & TC	2
71270 & TC	2
71550 & TC	1
71555 & TC	2
SPINE AND PELVIS	
72010 & TC	1
72020 & TC	1
72040 & TC	1
72050 & TC	1
72052 & TC	1
72069 & TC	1
72070 & TC	1
72072 & TC	1
72074 & TC	1
72080 & TC	1
72090 & TC	1
72100 & TC	1
72110 & TC	1
72114 & TC	1
72120 & TC	1
72125 & TC	1
72126 & TC	2
72127 & TC	2
72128 & TC	1
72129 & TC	2
72130 & TC	2
72131 & TC	1
72132 & TC	2
72133 & TC	2
72141 & TC	1
72142 & TC	2
72146 & TC	1
72147 & TC	2
72148 & TC	1
72149 & TC	2
72156 & TC	2
72157 & TC	2
72158 & TC	2
72170 & TC	1
72190 & TC	1
72192 & TC	1
72193 & TC	2
72194 & TC	2
72196 & TC	1
72200 & TC	1
72202 & TC	1
72220 & TC	1
72240 & TC	3
72255 & TC	3
72265 & TC	3
72270 & TC	3
72285 & TC	3
72295 & TC	3
UPPER EXTREMITIES	
73000 & TC	1
73010 & TC	1
73020 & TC	1
73030 & TC	1
73040 & TC	3
73050 & TC	1
73060 & TC	1
73070 & TC	1
73080 & TC	1
73085 & TC	3
73090 & TC	1
73092 & TC	1
73100 & TC	1
73110 & TC	1
73115 & TC	3
73120 & TC	1
73130 & TC	1
73140 & TC	1
73200 & TC	1
73201 & TC	2
73202 & TC	2
73220 & TC	1
73221 & TC	1
LOWER EXTREMITIES	
73500 & TC	1
73510 & TC	1
73520 & TC	1
73525 & TC	3
73530 & TC	3
73540 & TC	1
73550 & TC	1
73560 & TC	1
73562 & TC	1
73564 & TC	1
73565 & TC	1
73580 & TC	3
73590 & TC	1
73592 & TC	1
73600 & TC	1
73610 & TC	1
73615 & TC	3
73620 & TC	1
73630 & TC	1
73650 & TC	1
73660 & TC	1
73700 & TC	1
73701 & TC	2
73702 & TC	2
73720 & TC	1
73721 & TC	1
73725 & TC	2
ABDOMEN	
74000 & TC	1
74010 & TC	1
74020 & TC	1
74022 & TC	1
74150 & TC	1
74160 & TC	2
74170 & TC	2
74181 & TC	1
74185 & TC	2
74190 & TC	3
GASTROINTESTINAL TRACT	
74210 & TC	3
74220 & TC	3
74230 & TC	3
74235 & TC	3
74240 & TC	3
74241 & TC	3
74245 & TC	3
74246 & TC	3
74247 & TC	3
74249 & TC	3
74250 & TC	2
74251 & TC	3
74260 & TC	3
74270 & TC	3
74280 & TC	3
74283 & TC	3
74290 & TC	1
74291 & TC	1
74300 & TC	3
74301 & TC	3
74305 & TC	3
74320 & TC	3
74327 & TC	3
74328 & TC	3
74329 & TC	3
74330 & TC	3
74340 & TC	3
74350 & TC	3
74355 & TC	3
74360 & TC	3
74363 & TC	3
URINARY TRACT	
74400 & TC	2
74410 & TC	2
74415 & TC	2
74420 & TC	3
74425 & TC	3
74430 & TC	3
74440 & TC	3
74445 & TC	3
74450 & TC	3
74455 & TC	3

CODE	LEVEL
74470 & TC	3
74475 & TC	3
74480 & TC	3
74485 & TC	3
GYNECOLOGICAL AND OBSTETRICAL	
74710 & TC	1
74740 & TC	3
74742 & TC	3
74775 & TC	3
HEART	
75552 & TC	1
75553 & TC	2
75554 & TC	1
75555 & TC	1
AORTA AND ARTERIES	
75600 & TC	3
75605 & TC	3
75625 & TC	3
75630 & TC	3
75650 & TC	3
75658 & TC	3
75660 & TC	3
75662 & TC	3
75665 & TC	3
75671 & TC	3
75676 & TC	3
75680 & TC	3
75685 & TC	3
75705 & TC	3
75710 & TC	3
75716 & TC	3
75722 & TC	3
75724 & TC	3
75726 & TC	3
75731 & TC	3
75733 & TC	3
75736 & TC	3
75741 & TC	3
75743 & TC	3
75746 & TC	3
75756 & TC	3
75774 & TC	3
75790 & TC	3
VEINS AND LYMPHATICS	
75801 & TC	3
75803 & TC	3
75805 & TC	3
75807 & TC	3
75809 & TC	3
75810 & TC	3
75820 & TC	3
75822 & TC	3
75825 & TC	3
75827 & TC	3
75831 & TC	3
75833 & TC	3
75840 & TC	3
75842 & TC	3
75860 & TC	3
75870 & TC	3
75872 & TC	3
75880 & TC	3

CODE	LEVEL
75885 & TC	3
75887 & TC	3
75889 & TC	3
75891 & TC	3
75893 & TC	3
TRANSCATHETER PROCEDURES	
75894 & TC	3
75896 & TC	3
75898 & TC	3
75900 & TC	3
75940 & TC	3
75945 & TC	3
75946 & TC	3
75960 & TC	3
75961 & TC	3
75962 & TC	3
75964 & TC	3
75966 & TC	3
75968 & TC	3
75970 & TC	3
75978 & TC	3
75980 & TC	3
75982 & TC	3
75984 & TC	3
75989 & TC	3
TRANSLUMINAL ATHERECTOMY	
75992 & TC	3
75993 & TC	3
75994 & TC	3
75995 & TC	3
75996 & TC	3
OTHER PROCEDURES	
76000 & TC	3
76001 & TC	3
76003 & TC	3
76010 & TC	1
76020 & TC	1
76040 & TC	1
76061 & TC	1
76062 & TC	1
76065 & TC	1
76066 & TC	1
76070 & TC	1
76075 & TC	1
76076 & TC	1
76078 & TC	1
76080 & TC	3
76086 & TC	3
76088 & TC	3
76093 & TC	1
76094 & TC	1
76095 & TC	3
76096 & TC	3
76098 & TC	1
76100 & TC	2
76101 & TC	2
76102 & TC	2
76120 & TC	2
76125 & TC	2
76150	1
76350	2
76355 & TC	3
76360 & TC	3
76365 & TC	3

CODE	LEVEL
76370 & TC	2
76375 & TC	1
76380 & TC	1
76400 & TC	1
DIAGNOSTIC ULTRASOUND	
HEAD AND NECK	
76506 & TC	2
76511 & TC	3
76512 & TC	3
76513 & TC	3
76516 & TC	2
76519 & TC	2
76529 & TC	2
76536 & TC	1
CHEST	
76604 & TC	1
76645 & TC	1
ABDOMEN AND RETROPERITONEUM	
76700 & TC	1
76705 & TC	1
76770 & TC	1
76775 & TC	1
76778 & TC	1
SPINAL CANAL	
76800 & TC	2
PELVIS	
76805 & TC	2
76810 & TC	2
76815 & TC	2
76816 & TC	1
76818 & TC	1
76825 & TC	2
76826 & TC	1
76827 & TC	1
76828 & TC	1
76830 & TC	1
76831 & TC	3
76856 & TC	1
76857 & TC	1
76870 & TC	1
76872 & TC	1
EXTREMITIES	
76880 & TC	1
76885 & TC	2
76886 & TC	1
VASCULAR STUDIES	
ULTRASONIC GUIDANCE PROCEDURES	
76930 & TC	3
76932 & TC	3
76934 & TC	3
76936 & TC	3
76938 & TC	3
76941 & TC	3
76942 & TC	3
76945 & TC	3
76946 & TC	3
76948 & TC	3
76950 & TC	3
76960 & TC	3
76965 & TC	3

CODE	LEVEL
OTHER PROCEDURES	
76970 & TC	1
76975 & TC	3
76977 & TC	1
76986 & TC	3
RADIATION ONCOLOGY	
77417	1
DIAGNOSTIC NUCLEAR MEDICINE	
ENDOCRINE SYSTEM	
78000 & TC	1
78001 & TC	1
78003 & TC	1
78006 & TC	1
78007 & TC	1
78010 & TC	1
78011 & TC	1
78015 & TC	1
78016 & TC	1
78018 & TC	1
78070 & TC	1
78075 & TC	1
HEMATOPOIETIC, RETICULOENDOTHELIAL, AND LYMPHATIC SYSTEM	
78102 & TC	1
78103 & TC	1
78104 & TC	1
78110 & TC	1
78111 & TC	1
78120 & TC	1
78121 & TC	1
78122 & TC	1
78130 & TC	1
78135 & TC	1
78140 & TC	1
78160 & TC	1
78162 & TC	1
78170 & TC	1
78172 & TC	1
78185 & TC	1
78190 & TC	1
78191 & TC	1
78195 & TC	1
GASTROINTESTINAL SYSTEM	
78201 & TC	1
78202 & TC	1
78205 & TC	1
78206 & TC	1
78215 & TC	1
78216 & TC	1
78220 & TC	1
78223 & TC	1
78230 & TC	1
78231 & TC	1
78232 & TC	1
78258 & TC	1
78261 & TC	1
78262 & TC	1
78264 & TC	1
78270 & TC	1
78271 & TC	1

CODE	LEVEL
78272 & TC	1
78278 & TC	1
78282 & TC	1
78290 & TC	1
78291 & TC	1
MUSCULOSKELETAL SYSTEM	
78300 & TC	1
78305 & TC	1
78306 & TC	1
78315 & TC	1
78320 & TC	1
78350 & TC	1
CARDIOVASCULAR SYSTEM	
78414 & TC	1
78428 & TC	1
78445 & TC	1
78455 & TC	1
78457 & TC	1
78458 & TC	1
78460 & TC	1
78461 & TC	1
78464 & TC	1
78465 & TC	1
78466 & TC	1
78468 & TC	1
78469 & TC	1
78472 & TC	1
78473 & TC	1
78478 & TC	1
78480 & TC	1
78481 & TC	1
78483 & TC	1
78494 & TC	1
78496 & TC	1
RESPIRATORY SYSTEM	
78580 & TC	1
78584 & TC	1
78585 & TC	1
78586 & TC	1
78587 & TC	1
78588 & TC	1
78591 & TC	1
78593 & TC	1
78594 & TC	1
78596 & TC	1
NERVOUS SYSTEM	
78600 & TC	1
78601 & TC	1
78605 & TC	1
78606 & TC	1
78607 & TC	1
78610 & TC	1
78615 & TC	1
78630 & TC	1
78635 & TC	1
78645 & TC	1
78647 & TC	1
78650 & TC	1
78660 & TC	1

CODE	LEVEL
GENITOURINARY SYSTEM	
78700 & TC	1
78701 & TC	1
78704 & TC	1
78707 & TC	1
78708 & TC	1
78709 & TC	1
78710 & TC	1
78715 & TC	1
78725 & TC	1
78730 & TC	1
78740 & TC	1
78760 & TC	1
78761 & TC	1
OTHER DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES	
78800 & TC	1
78801 & TC	1
78802 & TC	1
78803 & TC	1
78805 & TC	1
78806 & TC	1
78807 & TC	1
78990	1
MEDICINE	
GASTROINTESTINAL	
91000 & TC	3
91010 & TC	3
91011 & TC	3
91012 & TC	3
91020 & TC	3
91030 & TC	3
91032 & TC	3
91033 & TC	3
91052 & TC	3
91055 & TC	3
91060 & TC	3
91065 & TC	1
91122 & TC	3
SPECIAL OPHTHALMOLOGICAL SERVICES	
92060 & TC	1
92065 & TC	1
92081 & TC	1
92082 & TC	1
92083 & TC	1
92135 & TC	1
92235 & TC	2
92240 & TC	2
92250 & TC	1
OTHER SPECIALIZED SERVICES	
92265 & TC	3
92270 & TC	3
92275 & TC	3
92283 & TC	1
92284 & TC	1
92285 & TC	2
92286 & TC	3

CODE	LEVEL
VESTIBULAR FUNCTION TESTS WITH RECORDING	
92541 & TC	5
92542 & TC	5
92543 & TC	5
92544 & TC	5
92545 & TC	5
92546 & TC	5
92547	5
92548 & TC	5
AUDIOLOGIC FUNCTION TESTS	
92552	5
92553	5
92555	5
92556	5
92557	5
92561	5
92562	5
92563	5
92564	5
92565	5
92567	5
92568	5
92569	5
92571	5
92572	5
92573	5
92575	5
92576	5
92577	5
92579	5
92582	5
92583	5
92584	5
92585 & TC	5
92587 & TC	5
92588 & TC	5
92589	5
92596	5
CARDIOGRAPHY	
93000	1
93005	1
93012	1
93015	2
93016	2
93017	2
93024 & TC	3
93040	1
93041	1
93224	1
93225	1
93226	1
93230	1
93231	1
93232	1
93235	1
93236	1
93268	1
93270	1
93271	1
93278 & TC	1

CODE	LEVEL
ECHOCARDIOGRAPHY	
93303 & TC	1
93304 & TC	1
93307 & TC	1
93308 & TC	1
93312 & TC	3
93313	3
93314	3
93315 & TC	3
93316	3
93317	3
93320 & TC	1
93321 & TC	1
93325 & TC	1
93350 & TC	1
CARDIAC CATHETERIZATION	
93501 & TC	3
93505 & TC	3
93508 & TC	3
93510 & TC	3
93511 & TC	3
93514 & TC	3
93524 & TC	3
93526 & TC	3
93527 & TC	3
93528 & TC	3
93529 & TC	3
93530 & TC	3
93531 & TC	3
93532 & TC	3
93533 & TC	3
93555 & TC	3
93556 & TC	3
93561 & TC	3
93562 & TC	3
93571 & TC	3
93572 & TC	3
INTRACARDIAC ELECTROPHYSIOLOGICAL PROCEDURES	
93600 & TC	3
93602 & TC	3
93603 & TC	3
93607 & TC	3
93609 & TC	3
93610 & TC	3
93612 & TC	3
93615 & TC	3
93616 & TC	3
93618 & TC	3
93619 & TC	3
93620 & TC	3
93621 & TC	3
93622 & TC	3
93623 & TC	3
93624 & TC	3
93631 & TC	3
93640 & TC	3
93641 & TC	3
93642 & TC	3
93660 & TC	3

CODE	LEVEL
OTHER VASCULAR STUDIES	
93720	1
93721	1
93724 & TC	3
93731 & TC	2
93732 & TC	2
93733 & TC	1
93734 & TC	2
93735 & TC	2
93736 & TC	1
93737 & TC	2
93738 & TC	2
93740 & TC	1
93770 & TC	1
CEREBROVASCULAR ARTERIAL STUDIES	
93875 & TC	1
93880 & TC	1
93882 & TC	1
93886 & TC	1
93888 & TC	1

CODE	LEVEL
EXTREMITY ARTERIAL STUDIES	
93922 & TC	1
93923 & TC	1
93924 & TC	1
93925 & TC	1
93926 & TC	1
93930 & TC	1
93931 & TC	1
EXTREMITY VENOUS STUDIES	
93965 & TC	1
93970 & TC	1
93971 & TC	1
VISCERAL AND PENILE VASCULAR STUDIES	
93975 & TC	1
93976 & TC	1
93978 & TC	1
93979 & TC	1
93980 & TC	1
93981 & TC	1

CODE	LEVEL
EXTREMITY ARTERIAL-VENOUS STUDIES	
93990 & TC	1
PULMONARY	
94010 & TC	1
94014	1
94015	1
94060 & TC	2
94070 & TC	2
94200 & TC	1
94240 & TC	1
94250 & TC	1
94260 & TC	1
94350 & TC	1
94360 & TC	1
94370 & TC	1
94375 & TC	1
94400 & TC	2
94450 & TC	2
94620 & TC	1
94621 & TC	2
94664	2
94665	2
94680 & TC	2
94681 & TC	2

CODE	LEVEL
94690 & TC	1
94720 & TC	1
94725 & TC	1
94750 & TC	1
94760	1
94761	1
94762	1
94770 & TC	1
94772 & TC	1
ALLERGY	
95004	2
95024	2
95027	2
95028	2
95044	2
95052	2
95056	2
95060	3
95065	3
95070	3
95071	3
95078	3

NEUROLOGY AND NEUROMUSCULAR PROCEDURES

For certain codes within the range of* CPT *95860 through 95937, the following additional criteria apply.

- a All level of supervision standards for the lead number ("6" or "7") apply; in addition, a physical therapist (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).

SLEEP TESTING

CODE	LEVEL
95805 & TC	1
95806 & TC	1
95807 & TC	1
95808 & TC	1
95810 & TC	1
95811 & TC	1
95812 & TC	1
95813 & TC	1
95816 & TC	1
95819 & TC	1
95822 & TC	1
95824 & TC	1
95827 & TC	1
95829 & TC	1
95858 & TC	3
95860 & TC	***6a***
95861 & TC	***6a***
95863 & TC	***6a***
95864 & TC	***6a***
95867 & TC	***6a***
95868 & TC	***6a***
95869 & TC	***6a***
95870 & TC	***6a***
95872 & TC	***66***
95875 & TC	3

CODE	LEVEL
95900 & TC	***77a***
95903 & TC	***77a***
95904 & TC	***77a***
95920 & TC	***22***
95921 & TC	2
95922 & TC	3
95923 & TC	3
95925 & TC	***21***
95926 & TC	***21***
95927 & TC	***21***
95930 & TC	***21***
95933 & TC	***77a***
95934 & TC	***77a***
95936 & TC	***77a***
95937 & TC	***77a***
95950 & TC	1
95951 & TC	1
95953 & TC	1
95954 & TC	3
95955 & TC	2
95956 & TC	1
95957 & TC	1
95958 & TC	3
95961 & TC	3
95962 & TC	3

CODE	LEVEL
CENTRAL NERVOUS SYSTEM ASSESSMENT	
96100	4
96105	4
96110	4
96111	4
96115	4
96117	4
ALPHA-NUMERICS	
G0004	1
G0005	1
G0006	1
G0015	1
G0030 & TC	1
G0031 & TC	1
G0032 & TC	1
G0033 & TC	1
G0034 & TC	1
G0035 & TC	1
G0036 & TC	1
G0037 & TC	1
G0038 & TC	1

CODE	LEVEL
G0039 & TC	1
G0040 & TC	1
G0041 & TC	1
G0042 & TC	1
G0043 & TC	1
G0044 & TC	1
G0045 & TC	1
G0046 & TC	1
G0047 & TC	1
G0050	1
G0106 & TC	3
G0125 & TC	1
G0126 & TC	1
G0130 & TC	1
G0131 & TC	1
G0132 & TC	1
G0163 & TC	1
G0164 & TC	1
G0165 & TC	1
M0302 & TC	1
Q0035 & TC	1
V5362	1
V5363	1
V5364	1

Expanded Coverage for Colorectal Cancer Screening

Effective July 1, 2001, recent legislation expands the colorectal screening benefit to include colonoscopies for Medicare beneficiaries not at high risk for developing colorectal cancer.

Covered Services and HCPCS Codes

Medicare covers colorectal cancer screening test/procedures for the early detection of colorectal cancer for the HCPCS codes indicated.

Effective for Services Furnished on or After January 1, 1998:

G0107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations;
G0104	Colorectal cancer screening; flexible sigmoidoscopy;
G0105	Colorectal cancer screening; colonoscopy on individual at high risk;
G0106	Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy

Effective for Services Furnished on or After July 1, 2001:

G0121	Colorectal screening; colonoscopy on individual not meeting criteria for high risk
NOTE:	The description of this code has been revised to remove the term "noncovered."

Coverage Criteria

The following are the coverage criteria for these screenings:

Screening Fecal-Occult Blood Tests (Code G0107)

Effective for services furnished on or after January 1, 1998, Medicare may pay for screening fecal-occult blood tests (code G0107) for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). 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. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in section 1861(r) (1) of the Social Security Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

Screening Flexible Sigmoidoscopies (code G0104)

Medicare may pay for screening flexible sigmoidoscopies (code G0104) for beneficiaries who have attained age 50 when performed by a doctor of medicine or osteopathy at the following frequencies:

- For services furnished from January 1, 1998, through June 30, 2001, inclusive:
  Once every 48 months (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done).
- For services furnished on or after July 1, 2001:
  Once every 48 months as calculated above unless the beneficiary does not meet the criteria for high risk of developing colorectal cancer and he/she has had a screening colonoscopy (code G0121) within the preceding 10 years. If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (code G0121).

  NOTE: 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 should be billed and paid rather than code G0104.

Screening Colonoscopies For Beneficiaries At High Risk Of Developing Colorectal Cancer (Code G0105)

Medicare may pay for screening colonoscopies (code G0105) when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed). Refer to MCM section 4180.3 for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

NOTE: 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 should be billed and paid rather than code G0105.

Screening Colonoscopies Performed on Individuals Not Meeting the Criteria for Being at High-Risk for Developing Colorectal Cancer (Code G0121)

Effective for services furnished on or after July 1, 2001, Medicare may pay for screening colonoscopies (code G0121) performed under the following conditions:

- On individuals not meeting the criteria for being at high risk for developing colorectal cancer
- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed.)
- If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above (see MCM sections 4180.2.D.1 and .2) **but** has had a covered screening flexible sigmoidoscopy (code G0104), then he or she may have covered a G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

NOTE: 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 should be billed rather than code G0121.

Screening Barium Enema Examinations (codes G0106 and G0120)

Screening barium enema examinations are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters for screening sigmoidoscopies and screening colonoscopies above apply. In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (code G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

For example, a beneficiary received a screening barium enema examination as an alternative to a screening flexible sigmoidoscopy in January 1998. Start your count beginning February 1998. The beneficiary is eligible for another screening barium enema in January 2002.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (code G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed.

For example, a beneficiary at high risk for developing colorectal cancer received a screening barium enema examination (code G0120) as an alternative to a screening colonoscopy (code G0105) in January 1998. Start your count beginning February 1998. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2000.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. 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. The 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.

Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer

Characteristics of the High Risk Individual

An individual at high risk for developing colorectal cancer has 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
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

Partial List of ICD-9-CM Codes Indicating High Risk

Listed below are some examples of diagnoses that meet the high risk criteria for colorectal cancer. This is not an all inclusive list. There may be more instances of conditions which may be coded and could be at the carrier's discretion.

Personal History:

V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Chronic Digestive Disease Condition:

555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified (non-specific PDX on the MCE)

Inflammatory Bowel:

558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified non-infectious gastroenteritis and colitis

Noncovered Services

The following noncovered HCPCS codes are used to allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes for the dates of service indicated:

From January 1, 1998 Through June 30, 2001, Inclusive

Code G0121 (colorectal cancer screening; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does NOT meet the criteria for high risk. This service will be denied as noncovered because it fails to meet the requirements of the benefit for these dates of service. The beneficiary is liable for payment. ***Note that this code is a covered service for dates of service on or after July 1, 2001.***

On or After January 1, 1998

Code G0122 (colorectal cancer screening; barium enema) 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 noncovered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

EVALUATION AND MANAGEMENT (E/M)

Care Plan Oversight in Skilled Nursing Facilities and Hospice

Payment and Coding for Physician Certification/Re-certification of Home Health Services

For 2001, the AMA's *Current Procedural Terminology* (*CPT*) changed the definition of care plan oversight services, CPT codes 99375 and 99378. These new codes are not consistent with Medicare's coverage policy. Therefore, HCFA has established new HCPCS codes G0181 and G0182 (care plan oversight) that are consistent with Medicare's coverage criteria and will no longer recognize CPT 99375 and 99378.

Medicare will now pay separately for the services involved in physician certification/re-certification and development of plan of care for Medicare covered home health services. For this, the Health Care Financing Administration established the following two HCPCS codes for the 2001 physician fee schedule.

G0179 Physician re-certification services for Medicare covered services provided by a participating home health agency (patient not present), including review of subsequent reports of patient status, review of patient's responses to the oasis assessment instrument, contact with the home health agency to ascertain the follow-up implementation plan of care and documentation in the patient's office records, per certification period

(G0179 is to be used for re-certification after a patient has received services for at least 60 days (or one certification period).

G0180 Physician certification services for Medicare covered services provided by a participating home health agency (patient not present), including review of subsequent reports and patient status, review of patient's responses to the oasis assessment instrument, contact with the home health agency to ascertain the initial implementation plan and care, and documentation in the patient's office record, per certification period

(G0180 is to be used when the patient has not received Medicare covered home health services for at least 60 days).

Billing Guidelines

The date of service on the HCFA 1500 claim form should reflect the date the physician signed the home health care's certification form.

Payment and Coding for Care Plan Oversight (CPO) Services (New codes effective January 1, 2001)

G0181 Physician supervision of patient receiving Medicare covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communications (including telephone calls) with the other health care professionals involving in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

G0182 Physician supervision of patient under a Medicare-approved hospice (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communications (including telephone calls) with the other health care professionals involving in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

Separate payment may be made for HCPCS code G0181 or G0182 if the following requirements are met:

1. The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;
2. The CPO services should be furnished during the period in which the beneficiary was receiving Medicare covered HHA or hospice services;
3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
4. The physician furnishes at least 30 minutes of care plan oversight within the calendar month for which payment is claimed. Time spent by a physician's nurse or the time spent consulting with one's nurse is not countable towards the 30 minute threshold. Low intensity services included as part of other evaluation management services are not included as part of the 30 minutes requiring for coverage;
5. The work included in hospital discharge day management (codes 99238-99239) and discharge for observation (code 99217) is not countable towards the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital;
6. The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the first care plan oversight service in the ranges of codes 99201 – 99263 and codes 99281 – 99357 are acceptable prerequisite face-to-face encounters for CPO. EKG, lab, and surgical services are not sufficient face-to-face services for CPO;
7. The care plan oversight billed by the physician was not

routine post-operative care provided in the global surgical period for a surgical procedure billed by the physician;

8. If the beneficiary is receiving home health agency services, the physician did not have a significant financial or contractual interest in the home health agency. CPO services should not be billed by a physician who is an employee of the hospice, including a volunteer medical director. Payment for the services of a physician employed by the hospice are included in payment to the hospice;
9. The care plan oversight services are personally furnished by the physician who bills them;
10. Services provided incident to a physician's service do not qualify as CPO and do not count towards the 30-minute requirement;
11. The physician is not billing for the Medicare ESRD capitation payment for the same beneficiary during the same month; and
12. The physician billing the CPO must document in the patient's record which services were furnished and the date and length of time associated with those services.

Nature of Services

Care plan oversight is the physician supervision of patients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patients status, review of related laboratory and other studies, communication with other health professionals not employed in the same practice who are involved in the patient's care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy.

Services not countable towards the 30 minutes threshold that must be provide in order to bill for CPO include, but are not limited to, time associated with discussions with the patient, his or her family and friends to adjust medication or treatment, time spent by staff getting or filing charts, travel time, and/or physician's time spent telephoning prescriptions in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO services were billed.

Documentation

When a physician bills for HCPCS codes G0181 or G0182, he or she is stating that all the criteria have been met. The physician must maintain documentation that demonstrates that at all of the requirements for billing the code are met, including notations in medical records of the duration of telephone calls. Documentation supplied by home heath agencies or hospices may not be used in lieu of a physician's documentation. Only the physician who has signed the patient's plan of care may be paid for HCPCS codes G0181 and G0182.

Coding Guidelines

The physician must also submit the 6-character Medicare provider number for the home health agency (HHA). For hard paper claims, the 6-character Medicare provider number for the home health agency must be entered in item 23 of the HCFA 1500. For electronic claims submitted using NSF format, the HHA provider number must be entered in Record EAO, field 49, positions 290 through 295. For electronic claim submitted in ANSI-837 format, the HHA provider number must be entered in 2-250NM109(MP). The physician is responsible for obtaining the Medicare provider number for the HHA or hospice. The physician should supply their UPIN number to the HHA or hospice furnishing the service.

Claims submitted for CPO services submitted with a invalid HHA or hospice Medicare provider number will be denied. Claims submitted for CPO services where the Medicare HHA or hospice provider number is missing will be denied with no appeal rights. Claims for CPO services will be denied when review of beneficiary claims history files fails to identify a covered physician service requiring a face-to-face encounter by the same physician during the six months preceding the provision of the first CPO service.

Dates of service entered on the claim must be a first and last date during which documentation care planning services were actually provided during the calendar month, not just the first and last day (30 days of the calendar month for which a claim is submitted). Medical records for those dates must document that 30 minutes or more of time have been spent by the physician for countable care planning activities as well as which services were furnished and the date and length of time associated with those services.

Clarification of Physician Certification Requirements for Medicare Hospice

Section 1814(a)(7) of the Social Security Act ("the Act") contains the requirements for Medicare hospice that a physician certify in writing, at the beginning of a benefit period, that a beneficiary is terminally ill. Section 1861(dd)(3)(A) explains that an individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less. Federal Regulations at 42 CFR 418.3 further clarify that an individual is considered to be terminally ill if they have a medical prognosis of a life expectancy of six months or less *if the illness runs its normal cours*e.

Subtitle C, section 322, of the Benefits Protection and Improvement Act (BIPA) of 2000 amends section 1814(a)(7) of the Act by clarifying that the certification of terminal illness of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." **This clarification is effective for certifications made on or after the date of BIPA enactment, which was December 21, 2000.** The amendment to section 1814(a)(7) of the Act clarifies current policy, that the certification is based on clinical judgment regarding the normal course of illness, and further emphasizes the understanding that making medical prognostication of life expectancy is not always exact.

LABORATORY/PATHOLOGY

Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services to Hospital Patients

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Health Care Financing Administration (HCFA) stated that it would implement a policy to pay only hospitals for the TC of physician pathology services furnished to hospital inpatients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology to a hospital inpatient.

The regulation provided that, for services furnished on or after January, 1, 2001, the carriers would no longer pay claims to the independent laboratory under the physician fee schedule for the TC of physician pathology services for hospital inpatients. Similar treatment was provided under the outpatient prospective payment system for the TC of physician pathology services to hospital outpatients. [The TC of physician pathology services includes the TC of cytopathology and surgical pathology physician services as described in the American Medical Association's (AMA *Current Procedural Terminology* (*CPT*) book.] This change was to take effect for services furnished on or after January 1, 2001.

However, section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA) provides that the Medicare carrier can continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision applies to TC services furnished during the 2-year period beginning on January 1, 2001. The delay is intended to allow independent laboratories and hospitals sufficient time to negotiate arrangements.

For this provision, "covered hospital" means a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients and submitted claims for payment for the TC to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service. The term "fee-for-service Medicare beneficiary" means an individual who:

1. Is entitled to benefits under Part A or enrolled under Part B of title XVIII or both; and
2. Is not enrolled in any of the following:
   a. A Medicare + Choice plan under Part C of such title;
   b. A plan offered by an eligible organization under section 1876 of the Social Security Act ("the Act");
   c. A program of all-inclusive care for the elderly under section1894 of the Act; or
   d. A social health maintenance organization demonstration project established under section 4108(b) of the Omnibus Budget Reconciliation Act of 1987.

In implementing section 542, Medicare will consider as independent laboratories those entities that it has previously recognized and paid as independent laboratories.

The following examples illustrate the application of the statutory provision to arrangements between hospitals and independent laboratories.

> An independent laboratory that has acquired another independent laboratory that had an arrangement on July 22, 1999, with a covered hospital, can bill the TC of physician pathology services for that hospital's inpatients and outpatients under the physician fee schedule.
>
> > Example 1: Prior to July 22, 1999, independent laboratory A had an arrangement with a hospital in which this laboratory billed the carrier for the TC of physician pathology services. In July 2000, independent laboratory B acquires independent laboratory A. Independent laboratory B bills the carrier for the TC of physician pathology services for this hospital's patients in 2001 and 2002.
>
> If a hospital is a covered hospital, any independent laboratory that furnishes the TC of physician pathology services to that hospital's inpatients or outpatients can bill the carrier for these services furnished in 2001 and 2002.
>
> > Example 2: As of July 22, 1999, the hospital had an arrangement with an independent laboratory, laboratory A, under which that laboratory billed the carrier for the TC of physician pathology service to hospital inpatients or outpatients. In 2001, the hospital enters into an arrangement with a different independent laboratory, laboratory B, under which laboratory B wishes to bill its carrier for the TC of physician pathology services to hospital inpatients or outpatients. Because the hospital is a "covered hospital," independent laboratory B can bill the carrier for the TC of physician pathology services to hospital inpatients or outpatients.

If the arrangement between the independent laboratory and the covered hospital limited the provision of TC physician pathology services to certain situations or at particular times, then the independent laboratory can bill the carrier only for these limited services.

An independent laboratory that furnishes the TC of physician pathology services to inpatients or outpatients of a hospital that is **not** a covered hospital may **not** bill the carrier for TC of physician pathology services furnished in 2001 or 2002.

A hospital cannot bill under the outpatient prospective system for the TC of physician pathology services if the independent laboratory that services that hospital outpatients is receiving payment from its carrier under the physician fee schedule.

An independent laboratory that has an arrangement with a covered hospital should forward a copy of this agreement or other documentation to its carrier to confirm that an arrangement was in effect between the hospital and the independent laboratory as of July 22, 1999. This documentation should be furnished for each covered hospital the independent laboratory services. If the laboratory did not have an arrangement with the covered hospital as of July 22, 1999, but has subsequently entered into an arrangement, then it should obtain a copy of the arrangement between the predecessor laboratory and the covered hospital and furnish this to the carrier.

These arrangements must clearly provide the identification of the independent laboratory, including the Provider Identification Number (PIN), and must clearly identify the hospital with which the agreement exists. Send the agreements to:

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

Other than the submission of the agreements as described above, **independent laboratories should not make any changes in their billing procedures for services provided in covered hospitals *at this time***. Providers will be advised in a future issue of the *Medicare B Update!* of additional requirements, as they become available.

Screening Pap Smear and Pelvic Examinations

The Consolidated Appropriations Act of 2001, Public Law 106-554 (enacted on December 21, 2000) changes the frequency limitations from three to two years for screening Pap smears and screening pelvic examinations performed on qualified female beneficiaries, effective for services performed on or after July 1, 2001.

The local medical review policy for Pap smears will be updated to reflect this change and will be published in a future issue of the *Medicare B Update!* and on our provider Website, **www.FloridaMedicare.com.**

New CLIA Waived Tests

Listed below are the latest tests approved by the Centers for Disease Control and Prevention (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.

- Clearplan Easy Fertility Monitor (for luteinizing hormone), effective: July 17, 2000
- Clearplan Easy Fertility Monitor (for estrone 3 glucuronide), effective: July 17, 2000
- Metrika DRx® HbA1c (Professional Use Test System), effective: November 27, 2000
- ZymeTx Zstatflu® Test, effective: December 4, 2000

The following tests are effective for services processed on or after July 1, 2001:

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Clearplan Easy Fertility Monitor (for luteinizing hormone estrone 3 glucuronide)	Unipath Limited	83002QW 82679QW*	Detection of luteinizing hormone and estrone 3 glucuronide in urine to and identify the optimal time for conception
Metrika DRx® HbA1c (Professional Use Test System)	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
ZymeTx Zstatflu® Test	Zymetx, Inc.	87449QW	Qualitative determination of influenza types A and B from throat swab specimens

* This test may not be covered in all instances.

PHYSICAL/OCCUPATIONAL THERAPY

Questions and Answers Regarding Payment for the Services of Therapy Students under Part B of Medicare

The following questions and answers have been provided by HCFA in response to numerous inquiries regarding payment for the services of therapy students under Part B of the Medicare program.

1 Q. Can services provided by a student be reimbursed under Medicare Part B?

A. No, services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners authorized by statute. Students do not meet the definition of practitioners listed in section 1861 of the statute.

2. Q. Can a physical or occupational therapist assistant serve as a clinical instructor (CI) for a physical therapist or occupational therapy assistant student while providing services to a Medicare patient that is within their scope of work, and performed under the direction and supervision of the licensed physical or occupational therapist?

A. Physical therapist assistants and occupational therapy assistants are not precluded from serving as CIs for therapy students while providing services within their scope of work, and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

3. Q. Can services provided by a student with the supervising therapist "in the room" be reimbursed?

A. Only the services of the therapist can be billed to Medicare and paid. However, the fact that the student is "in the room" would not make the service unbillable. Medicare would pay for the services of the therapist.

4. Q. The Current Procedural Terminology (CPT) codes for Therapeutic Procedure state, "Physician or therapist are required to have direct (one-to-one) patient contact." What if the provider has some contact with the patient (e.g., 5 minutes direct patient contact time) and then the student assumes responsibility for treatment under supervision?

A. The therapist can bill for the direct services he/she provides to patients under Medicare Part B. Services performed by the therapy student are not payable under Medicare Part B.

5. Q. Under the Part A Skilled Nursing Facility (SNF) benefit, the SNF Prospective Payment System allows therapy student services to be counted toward rehabilitation minutes if provided under "line of sight" supervision of the therapist.* Does "line of sight" supervision allow Medicare Part B services to be billed for student services?

A. No. "Line of sight" supervision by a therapist does not allow student services to be billed. Services of students are not billable under Medicare Part B.

*Under the SNF Prospective Payment System, payments are based upon the case mix or Resource Utilization Group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determine the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

6. Q. Can student supervision be provided under Medicare as "direct supervision" (e.g., on premises and immediately available) rather than "line of sight," after determining student's readiness by the therapist? This determination is based on the supervisor's evaluation of student competence and safety, patient acuity, patient complexity, patient's functional status and outcomes, and number of visits?

A. No. Services provided by students are not billable under Part B.

7. Q. How can learning experiences be adequately provided for therapy students under Medicare if they must always be "in line of sight" even when:

- The student has been deemed competent in providing therapy or components of care delivery;
- The student is nearing the completion of a clinical experience; and,
- The student is nearing completion of the program and is evaluated as competent as an entry-level clinician.

A. As previously stated, services of students are not billable under Medicare Part B. The Medicare statute does not include a benefit category for students. This policy applies to all physician and practitioner groups under Medicare. You may wish to consult with physician groups about how they structure their training programs.

8. Q. What if a student who is supervised under "line of sight" by the supervising therapist is treating a patient who is under Medicare Part A on Friday. On Monday, the patient's coverage changes to Medicare Part B. How does this affect care provided by the student on Monday?

A. The payment methodologies for Part A and B therapy services rendered by a student are different. Under the physician fee schedule (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B.

Extension of Moratorium on the Application of the $1500 Limitation for Outpatient Rehabilitation Services

An article was published in the March/April 2000 issue of the *Medicare B Update!* concerning a two-year moratorium on the application of the financial limitations (i.e., caps) for outpatient rehabilitation services (page 17). Section 421 of the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act of 2000, (BIPA) extends the moratorium on application of the financial limitation for claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002.

Therefore, the moratorium is now for a three-year period and will apply to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

RADIOLOGY

Expanded Coverage of Positron Emission Tomography (PET) Scans and Related Claims Processing Changes

This article provides notification of expanded Medicare coverage for PET scans, effective for claims with dates of service on or after July 1, 2001. Also effective for claims received on or after July 1, 2001, HCFA will no longer require the designation of the four PET Scan modifiers (N,E,P,S) and has made the determination that no paper documentation needs to be submitted up front with PET scan claims. Documentation requirements such as physician referral and medical necessity determination are to be maintained by the provider as part of the beneficiary's medical record. This information must be made available to carriers upon request of additional documentation to determine appropriate payment of an individual claim.

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-{flourine-18}-fluoro-2-dexoy-D-glucose) that are usually administered intravenously to the patient. At this time, Medicare only covers FDG PET Scans.

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 conditions:

- As of July 1, 2001, 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. In the decision memorandum of December 15, 2000, HCFA had indicated that gamma camera systems with at least a 1-inch thick crystal would be eligible for coverage. However, coverage of PET using camera-based systems is now under further review as a separate national coverage determination. A final decision on what systems other than dedicated PET will be eligible for coverage, if any, will be announced prior to July 1, 2001. For those indications covered prior to July 1, 2001, all PET scanners approved or cleared for marketing by the FDA remain covered.
- The provider must maintain on file the doctor's referral and documentation that the procedure involved: (a) only FDA approved drugs and devices and, (b) did not involve investigational drugs, or procedures using investigational drugs, as determined by the FDA.
- The ordering physician is responsible for certifying the medical necessity of the study according to the conditions. The physician must have documentation in the beneficiary's medical record to support the referral supplied to the PET scan provider.
- All other uses of PET scanners not listed in this instruction are ***NOT*** covered. (See Medicare Coverage Issues Manual (CIM) section 50-36 for specific coverage criteria for PET scans.)

Expansion of Coverage, Effective July 1, 2001

The following is a brief summary of the expanded coverage. Detailed information can be found in CIM section 50-36.

- PET is covered for diagnosis, initial staging and restaging of non-small cell lung cancer (NSCLC).
- Usage of PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging.
- Usage of PET for the initial staging, and restaging of both Hodgkin's and non-Hodgkin's disease.
- Usage of PET for the diagnosis, initial staging, and restaging of melanoma. (PET Scans are NOT covered for the evaluation of regional nodes.)
- Medicare covers PET for the diagnosis, initial staging, and restaging of esophageal cancer.
- Usage of PET for Head and Neck Cancers. (PET scans for head and neck cancer is NOT covered for central nervous system or thyroid cancers.)
- Usage of PET following an inconclusive single photon emission computed tomography (SPECT) only for myocardial viability. In the event that a patient has received a SPECT and the physician finds the results to be inconclusive, only then may a PET scan be ordered utilizing the proper documentation.
- Usage of PET for pre-surgical evaluation for patients with refractory seizures.

Definitions

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

1. **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).

2. **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.
3. **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.

Limitations

For staging and restaging: PET is covered in either/or both of the following circumstances:

1. 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).
2. The 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.

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

Medical Documentation

Additional medical documentation (other than the information needed on the claim form) is no longer required for the submission of PET scan claims. In view of the limitations on this coverage, contractors will conduct periodic analysis of the utilization data for PET scans to identify aberrant providers and conduct post-payment reviews to determine that the use of PET scans is consistent with this instruction.

- PET scanning facilities must keep patient record information on file for each Medicare patient for whom such a PET scan claim is made.
- The medical records can be used in any post-payment review and must include the information necessary to substantiate the need for the PET scan.
- The medical records 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.

HCPCS Codes for PET Scans

Codes G0126, G0163, G0164, and G0165 will be discontinued June 30, 2001; *there will not be a grace period for these codes*. **For dates of service on or after July 1, 2001**, HCFA has established the following new PET Scan codes:

G0210	PET Imaging *whole body;* diagnosis; lung cancer, non-small cell
G0211	PET Imaging *whole body; initial* staging; lung cancer; non-small cell (**replaces G0126**)
G0212	PET Imaging *whole body;* restaging; lung cancer; non-small cell
G0213	PET Imaging *whole body*; diagnosis; colorectal cancer
G0214	PET Imaging *whole body*; *initial* staging; colorectal cancer
G0215	PET Imaging *whole body*; restaging*;* colorectal cancer (**replaces G0163**)
G0216	PET Imaging *whole body*; diagnosis; melanoma
G0217	PET Imaging *whole body*; *initial* staging; melanoma
G0218	PET Imaging *whole body;* restaging; melanoma (**replaces G0165**)
G0219	PET Imaging whole body; melanoma for non-covered indications
G0220	PET Imaging *whole body*; diagnosis; lymphoma
G0221	PET Imaging *whole body; initial* staging; lymphoma (**replaces G0164**)
G0222	PET Imaging *whole body;* restaging; lymphoma (**replaces G0164**)
G0223	PET Imaging *whole body or regiona*l; diagnosis; head and neck cancer; excluding thyroid and CNS cancers
G0224	PET Imaging *whole body or regiona*l; *initial* staging; head and neck cancer; excluding thyroid and CNS cancers
G0225	PET Imaging *whole body or regiona*l; restaging; head and neck cancer, excluding thyroid and CNS cancers
G0226	PET Imaging *whole body*; diagnosis; esophageal cancer
G0227	PET Imaging *whole body; initial* staging; esophageal cancer
G0228	PET Imaging *whole body;* restaging; esophageal cancer
G0229	PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures
G0230	PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study

Additionally, code G0125 has a definition change: "PET imaging regional or whole body; single pulmonary nodule."

Allowances for the new codes will be posted to our provider Website (**www.FloridaMedicare.com**) as soon as they become available, and published in a future issue of the *Medicare B Update!*

SURGERY

Intestinal and Multi-Visceral Transplantation

An article based on HCFA Program Memorandum (PM) AB-00-130, Change Request (CR) 1436, was published in the Second Quarter 2001 *Medicare B Update!* (page 20) concerning intestinal transplantation. The following provides information based on PM AB-01-58, CR 1629, which replaces PM AB-00-130, CR 1436. PM AB-00-130 is superseded by PM AB-01-58 and may be discarded.

Coverage

The coverage section of this article is a national coverage decision (NCD) made under section 1862(a)(1) of the Social Security Act ("the Act"). NCDs are binding on all Medicare carriers, Medicare fiscal intermediaries (FIs), peer review organizations, and other contractors. Under 42 CFR 422.256(b) an NCD that expands coverage is also binding on a Medicare+Choice organization. In addition, an administrative law judge may not disregard, set aside, or otherwise review a NCD issued under section 1862(a)(1). (See 42 CFR 405.732 and 405.860.)

Effective April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe, primary gastrointestinal disease or surgically-induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with mortality and profound morbidity. Multi-visceral transplantation includes organs in the digestive system (i.e., stomach, duodenum, pancreas, liver, intestine and colon).

This procedure is covered only when performed for patients who have failed total parenteral nutrition (TPN) and only when performed in facilities that meet approval criteria. TPN delivers nutrients intravenously, avoiding the need for absorption through the small bowel. Failed TPN for liver failure, thrombosis, frequency of infection, and dehydration are indicated in the following clinical situations:

- Impending or overt liver failure due to TPN induced liver injury. The clinical manifestations include elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulopathy, stomal bleeding or hepatic fibrosis/cirrhosis.
- Thrombosis of the major central venous channels; jugular, subclavian, and femoral veins. Thrombosis of two or more of these vessels is considered a life threatening complication and failure of TPN therapy. The sequelae of central venous thrombosis is a lack of access for TPN infusion, fatal sepsis due to infected thrombi, pulmonary embolism, superior vena cava syndrome, or chronic venous insufficiency.
- Frequent line infection and sepsis. The development of two or more episodes of systemic sepsis secondary to line infection per year that requires hospitalization indicates failure of TPN therapy. A single episode of line related fungemia, septic shock and/or acute respiratory distress syndrome are considered indicators of TPN failure.
- Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN. Under certain medical conditions such as secretory diarrhea and non-constructable gastrointestinal tract, the loss of the gastrointestinal and pancreatobiliary secretions exceeds the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system. Frequent episodes of dehydration are deleterious to all body organs, particularly kidneys and the central nervous system with the development of multiple kidney stones, renal failure, and permanent brain damage.

Aged patients and those with significant co-morbidities, such as cardiopulmonary disease and systemic malignancies, generally do not survive as long as younger and healthier patients receiving intestinal transplantation. Nonetheless, some older patients who are free from other contraindications have received the procedure and are progressing well. The NCD does not include specific exclusions from coverage for advanced age or co-morbidities. Carriers will base claim determinations regarding medical necessity considering the clinical condition of the individual patients.

There is no national coverage policy in effect for services furnished prior to April 1, 2001. In the absence of a national policy, local carriers have discretion to make individual determinations regarding coverage on claims for intestinal transplantation services.

Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. A list of approved transplant facilities can be found at the following website: **www.hcfa.gov/medicare/intstnlist.htm**.

Payment

Immunosuppressive therapy for intestinal transplantation is covered. There is no specific ICD-9-CM diagnosis code for intestinal failure. Although diagnosis codes exist to capture the causes of intestinal failure, some examples of intestinal failure include, but are not limited to:

- Volvulus 560.2,
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,
- Volvulus gastroschisis 569.89, other specified disorders of intestine,
- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,
- Inflammatory bowel disease 569.9, unspecified disorder of intestine,
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and
- Radiation enteritis 558.1.

Physicians will be paid for the transplant procedure using the fee schedule for CPT code 44135, intestinal transplantation from cadaver donor. The national coverage policy is silent with regard to coverage of living donor intestinal transplantation. Therefore, contractors have the discretion to determine coverage on CPT code 44136, intestinal allotransplantation from living donor.

For acquisition of organs for intestinal and multivisceral transplantation, physicians should report one of the following CPT codes for the donor enterectomy as appropriate: 44132, open with preparation and maintenance of allograft from cadaver donor, or 44133, partial from living donor. These codes will be paid under the physician fee schedule until such time as the regulatory definition of "organ" is revised, which would allow payment to be made on a reasonable cost basis.

Coding Guidlines

In block 24D of Form HCFA-1500 or equivalent portions of the electronic claims, physicians should enter one of the following CPT codes for intestinal transplantation:

44135 *Intestinal allotransplantation; from cadaver donor, or*
44136 *Intestinal allotransplantation; from living.*

Physicians excising donor intestines for transplantation should billed one of the following CPT codes as appropriate:

44132 *donor enterectomy from cadaver donor, or*
44133 *donor enterectomy, partial, from living donor.*

Donor services should be billed with the *recipient's* health insurance number.

VISION

Billing for Optical Coherence Biometry (OCB)

Optical Coherence Biometry (OCB) is a new ophthalmic diagnostic test to perform ophthalmic biometry and intraocular lens (IOL) calculation without ultrasound. The instrument utilized is a non-invasive, non-contact device that measures axial length, corneal curvature, and anterior chamber depth. All measurements are stored in a computer, as well as automatically transferred to the IOL calculation program, which allows the surgeon immediate and individualized computation of IOL implant options for his/her patient. The method takes about one minute per eye.

Because this instrument employs partial coherence interferometry to determine the axial length of the eye, rather than ultrasound, it is not appropriate to bill procedure code 76519 (*Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation*) for this device. Claims for optical coherence biometry should be submitted as procedure code 92499 (*Unlisted ophthalmological service or procedure*).

For electronic claim submission, place the word "Interferometry" in the narrative record. For paper claim submission, place the word "Interferometry" in Block 19. Procedure code 76519 may not be paid in addition to optical coherence biometry.

Verteporfin — Billing Clarification

Information was provided in the 1st Quarter 2001 issue of the *Medicare B Update!* (page 16) concerning billing for vertepofin in conjunction with ocular photodynamic therapy (OPT). Since then, Florida Medicare has received clarification from the Health Care Financing Administration (HCFA) regarding billing for the supply of verteporfin during the period of **July 1 through July 17, 2000**.

In the above referenced article, it was indicated that during this period verteporfin was not billable to the carrier and should instead be billed by the facility (hospital) to the intermediary. Since many services for OPT are/were not done in a facility, this interpretation resulted in providers being unable to recover the cost for the supply of verteporfin that were used during this timeframe. Providers who performed OPT during this period may bill the carrier for verteporfin as a supply, using procedure code J3490 (unclassified drugs) and indicating the name, strength, and dosage of the drug. If a claim for the drug was previously submitted and denied, the provider should request a review and provide supporting documentation. However, if the surgical procedure for OPT (67299 or 67220 depending upon which was billed) was not allowed, payment for the drug will continue to be denied.

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**

Please refer to the Table of Contents on page 2 for this issue's list of Local and Focused Medical Review articles

Local Medical Review Policy Development Changes

Several changes have occurred in the Local Medical Review Policy (LMRP) development process. These changes are very positive and will make the development of LMRP's more open to comment and discussion prior to their finalization and implementation. The new procedures will not replace any of the longstanding Health Care Financing Administration (HCFA)-directed procedures of circulating draft LMRPs to all of the Carrier Advisory Committee (CAC) members, their peers, associations, and societies, as well as interested parties throughout the state. This will also not change the CAC Meetings or ongoing schedules. What will occur is:

1. All draft LMRPs will be posted on our Internet Web site (**www.FloridaMedicare.com**) approximately one month before the CAC meetings, in conjunction with our mailing of draft LMRPs to all CAC members and interested parties.
2. Our Web site also instructs readers on how to provide written comments pertaining to the draft LMRPs. Providers have 45 days from the start date of the comment period in which to provide comments. All written comments and supporting documentation can be sent to the Medical Policy and Procedures Department at P.O. Box 2078, Jacksonville, Florida 32231-0048 or, emailed to Medical.Policy@FCSO.com
3. Before each CAC meeting, an open public meeting will be held, whereby interested parties will have the opportunity to present scientific evidence regarding draft LMRPs to First Coast Service Options, Inc. The CAC members will also receive invitations to these open meetings, however, CAC member attendance is not mandatory, and these meetings will not replace current CAC meetings or format. Interested parties must notify us in advance of their attendance and the designated topic that they will be addressing. Interested parties should contact the Medical Policy and Procedures Department at (904) 791-8292 to request a time for their presentation.
4. The same interested parties should summarize their comments, issues, or clinical information in a one-page summary to First Coast Service Options, Inc., which will be forwarded to all CAC members before the scheduled CAC meetings.
5. Posted on our Web site is a summary of the comments received on each new draft LMRP with the contractor's response.
6. Also posted on our Web site is a draft LMRP status page. The purpose of this page is to inform providers at what stage a particular draft LMRP is in (e.g., the draft is under development, the draft has been released for comment, the comment period has ended and comments are now being considered, or the final LMRP has been issued).
7. Providers without access to the Web site can request a hard copy of draft, final, or retired LMRPs by contacting the Medical Policy and Procedures Department at P.O. Box 2078, Jacksonville, Florida 32231-0048, or by emailing your request to Medical.Policy@FCSO.com

These are some of the recent additions to our LMRP development process. We strongly believe that these new changes will make our LMRP process more open for discussion and comment, while continuing our current objectives of maintaining a sound, evidenced-based clinical focus, preserving integrity, and satisfying all HCFA directives.

Progressive Corrective Action (PCA)

What It Is

Medical Review Progressive Corrective Action (PCA) is a concept designed by the Health Care Financing Administration (HCFA) for Medicare contractors to use when deploying resources and tools to conduct medical reviews. PCA ensures that medical review activities are targeted at identified problem areas and that corrective actions imposed are appropriate for the severity of the infraction of Medicare rules and regulations. There are four types of corrective actions that can result from aberrancy evaluations: education, policy development, prepayment review, and postpayment review.

How It Works

The decision to conduct medical review will be driven by data analysis. Data analysis is the starting point in PCA to determine aberrancies in billing patterns that might suggest improper billing or payment. The data analysis may be general surveillance, or may be specific in response to fraud alerts, complaints, or reports from various agencies.

Validating the hypothesis of the data analysis is the next step. Before assigning significant resources to examine claims identified as potential problems, probe reviews will be conducted. A probe review generally will not exceed 20-40 claims per provider for provider-specific problems, and will not exceed 100 claims distributed among the identified provider universe for general, widespread problems. All providers subject to a probe review will be notified in writing that a probe review is being conducted, and will also be notified in writing of the results of the review. Providers or facilities will be asked to provide any and all medical documentation applicable to the claims in question.

The chart below provides a high-level flow exhibit of the PCA Process.

What It Accomplishes

Classification of the problem, if applicable, is the result of the probe review. The three classification levels are minor, moderate, or major. Provider-specific error rate (number of claims paid in error), dollar amount improperly paid, and past billing history are examples of items used to determine classification level.

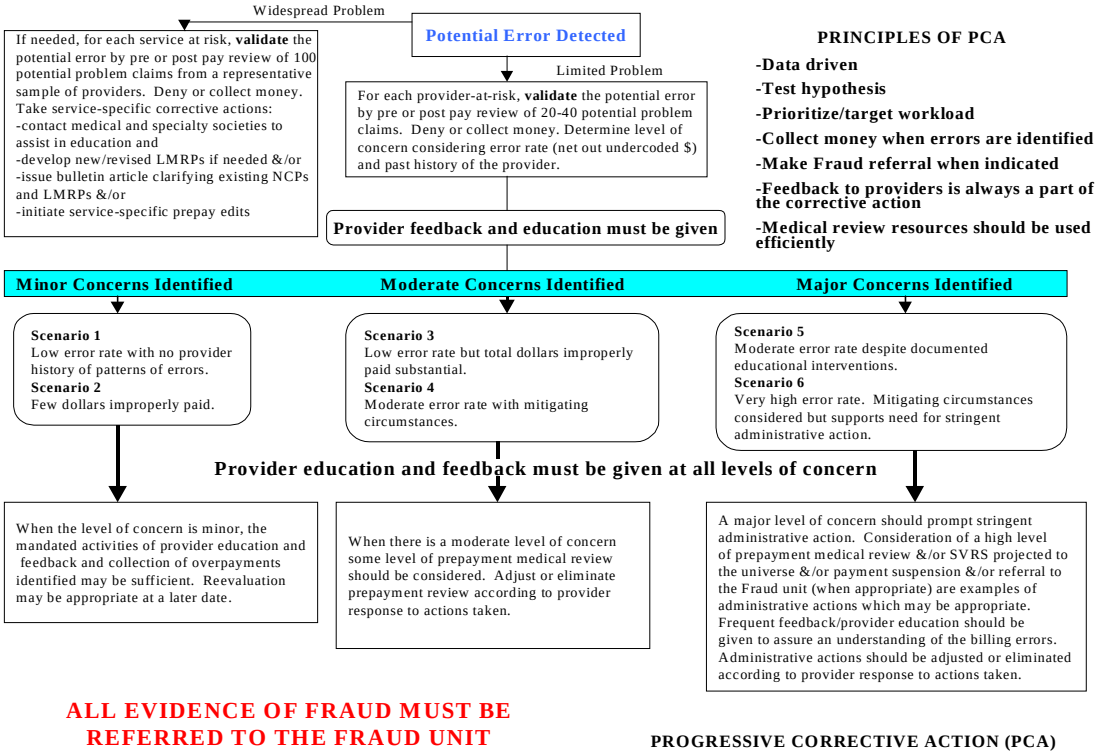
If a minor problem is detected, First Coast Service Options, Inc. (FCSO) will educate the provider on appropriate billing procedures, will collect the money on claims paid in error, and will conduct further analysis at a later date to ensure the problem was corrected.

If a moderate problem is detected, FCSO will educate the provider on appropriate billing procedures, will collect the money on the claims paid in error, and will initiate some level of prepayment medical review until the provider has demonstrated correction of his/her billing procedures.

If a major problem is detected, FCSO will educate the provider on appropriate billing procedures, will collect the money on the claims paid in error, will initiate a high level of prepayment medical review and/or a statistically valid random sample, payment suspension, and/or referral to the Fraud Department (if and when appropriate).

Provider Education and Feedback

Along with the planned medical review activities, provider feedback and education around the review findings is an essential part of the PCA process. When individual reviews are conducted, focused provider education is carried out. This means direct contact between First Coast Service Options (FCSO) and the provider through telephone contact, letter and/or face to face meeting. The overall goal of providing feedback and education is to ensure proper billing practices so that claims will be submitted and paid correctly.



PROGRESSIVE CORRECTIVE ACTION (PCA)

Chemotherapy Administration—Clarification

An article was published in the First Quarter 2001 *Medicare B Update!* that summarized the findings of Florida Medicare's 1999-2000 focused medical review (FMR) activities (pages 78-80). Some confusion has been noted by our providers relating to the direction given on coding "secondary chemotherapy" medications. This article is to provide clarification on how providers should code the diagnosis portion of the claim when administering medications used to prevent many of the side effects caused by the administration of the chemotherapy medications. During our review of many of the preventative and supportive medications used in conjunction with chemotherapy treatments, physicians were noted to bill claims using the primary cancer diagnoses, and were instructed to bill the diagnosis reflective of the disorder being treated (i.e., nausea and vomiting). This instruction created the confusion.

When a patient presents for chemotherapy and undergoes the administration of anti-nausea (e.g., zofran/anzemet), anti-inflammatory/corticosteroid (e.g., decadron), and hydration services as a preventative measure, these drugs should be submitted with ICD-9-CM diagnosis code V58.1 [Encounter for other and unspecified procedures and aftercare; Chemotherapy (e.g. encounter or admission for chemotherapy)], as it appears to be the most appropriate. The provider can then tie the chemotherapy medications to the malignant/cancer diagnosis. This will provide the carrier with a clearer picture of what actually occurred for the patient on that date of service.

Erythropoietin for Anemia of Chronic Disease

Anemia of chronic disease (ACD) is a condition that accompanies chronic inflammatory, infectious, or neoplastic disorders. ACD is associated with an underproduction of red cells, a decrease in iron utilization, and failure of the bone marrow to respond to increased erythropoietin (EPO) levels (blunted EPO response). Laboratory values of patients experiencing ACD usually include a low hemoglobin, reticulocyte count, serum iron with normal or increased iron stores (ferritin level).

Florida Medicare has received several articles from the manufacturer, dating back as far as 1990. Many of these articles focused on patients with rheumatoid arthritis, the critically ill, and a few on patients with neoplastic disease. The articles pertaining to the critically ill encompassed a minimal number of patients in the ICU setting in which phlebotomy, inflammation, nutritional deficiencies, and blood loss contribute significantly to the development of anemia. The majority of these patients required immediate correction of anemia via blood transfusions and their anemia are not associated with ACD. Procrit® is not indicated for patients who require immediate correction of anemia. No studies were received regarding the use of Procrit® in infection and other inflammatory diseases with the exception of rheumatoid arthritis. Many additional studies were reviewed and some of them revealed that use of erythropoietin in anemic patients with cancer demonstrated some benefit but recommended further investigation.

Based on review of the medical literature, there currently is not enough peer-reviewed literature to support the use of Procrit® for patients with anemia of chronic disease. The latest recommendation for patients with ACD is to treat the underlying cause. Further studies are needed to support the use of Procrit® in this population. Therefore, based on this review, erythropoietin given for ACD will remain a noncovered indication.

A9270: The List of Medicare Noncovered Services

The following changes have been made to the list of services that are noncovered by Florida Medicare:

Additions to Local Noncoverage

A9270* Kyphoplasty (effective for services processed on or after June 18, 2001)

A9270* Stenting of the carotid, vertebral, and cerebral arteries (effective for services processed on or after June 18, 2001)

Deletions from Local Noncoverage

Proton Beam Treatment Delivery - Florida Medicare has recently received numerous requests to reconsider our position regarding the inclusion of proton beam therapy on our list of locally noncovered Medicare services. Proton beam therapy is a radiation treatment modality that delivers high dose radiation to a localized site. After a review of the literature and other information, it has been determined that there are certain selected conditions for which proton beam therapy has demonstrated long-term, high disease-control and survival rates, and low or absent morbidity rates. Therefore, Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) has been removed from local medical review policy effective for services processed on or after June 18, 2001. A LMRP may be implemented in the future when the technology becomes available in Florida.

Additions to National Noncoverage

A9270* Percutaneous transluminal angioplasty (PTA) of the carotid, vertebral, and cerebral arteries (Coverage Issues Manual 50-32).

Deletions from National Noncoverage

Intestinal Transplantation - CPT codes 44132, 44133, 44135, and 44136 for intestinal transplantation were new effective January 1 2001, and were subsequently added to the list of procedures that are nationally noncovered. This information was provided in the 2nd Quarter 2001 *Medicare B Update!* (page 24). Also in that issue is an article that provides the national coverage decision (NCD) that is effective for services rendered on or after April 1, 2001 (page 20). Since then, HCFA has provided clarification regarding local contractor medical review decisions for services rendered *prior to* April 1, 2001.

This clarification reiterates the policy that previously existed for these services. The local contractor has discretionary authority in making coverage determinations for intestinal transplantation until national coverage becomes effective on April 1, 2001. Therefore, Florida Medicare will process claims for intestinal transplantation for services performed prior to April 1, 2001 on an individual consideration basis. Note that prior to January 1, 2001, unlisted codes must be used for these services.

When billing for intestinal transplantation, documentation should be submitted with the claim including but not limited to operative report, office records, and/or progress notes.

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

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
J0207

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Amifostine (Ethyol®)

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
11/18/1996

Original Policy Ending Date
N/A

Revision Effective Date
06/18/2001

Revision Ending Date
06/17/2001

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

Indications and Limitations of Coverage and/ or Medical Necessity
Florida Medicare will consider Amifostine (Ethyol®) medically reasonable and necessary under any of the following conditons:

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

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

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

CPT/HCPCS Section & Benefit Category
Drugs Administered Other Than Oral Method

CPT/HCPCS Codes
J0207

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
990 E933.1

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

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

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.

The Carrier Advisory Committee Meeting was held on November 11, 2000.

Start Date of Comment Period
11/03/2000

End Date of Comment Period
12/18/2000

Start Date of Notice Period
05/01/2001

Revision History

Revision Number	4	PCR B2001-071
Start Date of Comment Period		11/03/2000
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date		06/18/2001

Explanation of Revision: Based on the analysis performed through the FMR process, it was determined that Amifostine was being billed with diagnoses that did not support medical necessity. Therefore, a revision was needed to add a covered diagnosis list.

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
J1561

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Intravenous Immune Globulin

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
08/01/1994

Original Policy Ending Date
N/A

Revision Effective Date
06/18/2001

Revision Ending Date
06/17/2001

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

Indications and Limitations of Coverage and/or Medical Necessity
The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them. Florida Medicare will provide coverage for intravenous immune globulin when it is used in treatment of the following conditions:

1. Immunodeficiency Disorders

a) Primary Humoral Immunodeficiency Syndromes

IVIG is indicated for the treatment of patients with primary immunodeficiency syndromes such as common variable immunodeficiency (CVID), congenital agammaglobulinemia (X-linked agammaglobulinemia), severe combined immunodeficiency (SCID), X-linked immunodeficiency with hyperimmunoglobulin M (IgM), and Wiskott-Aldrich syndrome to replace or boost immunoglobulin G (IgG).

- Common variable immunodeficiency (CVID) (also known as acquired hypogammaglobulinemia, adult-onset hypogammaglobulinemia, and dysgammaglobulinemia) is characterized by reduced serum immunoglobulins, impaired antibody responses, and heterogenous clinical features. It is a rare syndrome, affecting one in 50,000 to one in 200,000 people. In most

patients, the onset is in the second or third decade of life. The most common clinical presentation of CVID is an increased susceptibility to infection. Most patients experience severe recurrent and/or chronic sinopulmonary infections such as bronchitis, pneumonia, or bronchiectasis. Patients with CVID can also develop a variety of autoimmune and inflammatory disorders and are also at risk for inflammatory bowel disease.

Once the diagnosis of CVID is suspected based on clinical presentation, laboratory confirmation should be made. A low serum IgG level is the most consistent laboratory abnormality in CVID, with most patients having concurrent deficiencies of IgA and IgM. However, there are rare instances when a patient will have normal IgG levels. Therefore, the serum immunoglobulin measurement alone does not establish a diagnosis of CVID. A definitive diagnosis of CVID is established when a patient does not demonstrate an antibody response to immunization with protein antigens (e.g., tetanus) or carbohydrate antigens (e.g., pneumococcal capsular polysaccharides such as pneumovax).

Therefore, Florida Medicare requires the following diagnostic evidence to support a diagnosis of CVID:

- Laboratory reports demonstrating a normal to low IgG level for the assay utilized;
- Radiological or Computerized Tomography (CT) reports demonstrating severe recurrent and/ or chronic sinopulmonary infections such as bronchitis, pneumonia, bronchiectasis or sinusitis; and
- Laboratory reports demonstrating a lack of ability to produce an antibody response to protein or carbohydrate antigens (e.g., tetanus, pneumococcal capsular polysaccharides such as pneumovax).

Florida Medicare will not provide reimbursement for the initiation or continuation of intravenous immune globulin therapy based solely on a low IgG value, or for patients with mild sinopulmonary disease, or for those that do not demonstrate a lack of ability to produce an antibody to protein or carbohydrate antigens. IVIG therapy for patients with normal humoral immunity but recurrent infections, particularly upper respiratory infections, has no scientific rationale.

The dosing regimen for patients with CVID is not standardized, but is based primarily on the clinical response. Trough levels of IgG and functional antibody levels should also be taken into consideration in the management of the IVIG therapy. A patient will generally receive initial IVIG doses of 200-400 mg/kg/3 to 4 weeks. IVIG replacement in these patients is usually life-long.

- Congenital agammaglobulinemia (X-linked agammaglobulinemia) is an inherited deficiency that appears in the first 3 years of life and occurs in one out of 10,000 people. Quantitative immunoglobulins show marked deficits or absence of all five immunoglobulin classes. Peripheral blood B-lymphocytes are usually absent.
- Severe combined immunodeficiency (SCID) is a rare and fatal inherited syndrome that has an incidence of approximately one in 1,000,000 people. The typical case involves an infant less than one year of age. The lymphocyte counts are significantly below normal, the levels of B- and T-lymphocytes are absent or below normal, the lymphocyte response to mitogen is absent or below normal, and the quantitative measurements of IgG, IgA, and IgM show marked deficits.
- X-linked immunodeficiency with hyperimmunoglobulin M (IgM) is similar to X-linked agammaglobulinemia, however, these patients sometimes have lymphoid hyperplasia. The concentrations of serum IgG, IgA, and IgE are very low, whereas the serum IgM concentration is either normal or, more frequently, greatly elevated and polyclonal.
- Wiskott-Aldrich syndrome is an X-linked recessive syndrome characterized by eczema, thrombocytopenia purpura with normal-appearing megakaryocytes but small defective platelets, and undue susceptibility to infection. Patients usually present during infancy. Survival beyond the teens is rare.

b) Idiopathic Thrombocytopenic Purpura (ITP)

Idiopathic thrombocytopenic purpura (ITP) is a decrease in the circulating number of platelets in absence of toxic exposure or other disease associated with a low platelet count. It occurs as an effect of peripheral platelet destruction. Acute ITP is a disease of childhood which usually follows an acute infection and has spontaneous resolution within 2 months. Chronic ITP is a disease which persists after 6 months without a specific cause. It is usually seen in adults and persists for months to years.

Patients with platelet counts >50,000 should not be given IVIG. IVIG is also inappropriate for patients with platelet counts >30,000 who are asymptomatic or have only minor purpura.

IVIG is indicated for ITP under the following circumstances:

- When administered preoperatively for patients undergoing elective splenectomy, who have platelet counts <20,000.
- For patients with platelet counts <30,000 who have active bleeding.
- For pregnant women with platelet counts <10,000 in the third trimester.
- For pregnant women with platelet counts 10,000-30,000 who are bleeding.

The duration of treatment is generally a short course of 3 to 5 days.

c) Pediatric Human Immunodeficiency Virus (HIV) Infection

IVIG is indicated for use in HIV-infected children (less than 13 years of age) with a CD-4 lymphocyte count of greater than or equal to 200/mm3 to reduce the risk of serious bacterial infections. Laboratory reports must demonstrate an IgG level that is below the normal age-related ranges for the assay utilized. There must also be evidence of a lack of ability to produce an antibody response to immunization with protein antigens (e.g., tetanus) or carbohydrate antigens (e.g., pneumococcal capsular polysaccharides such as pheumovax). IVIG is *not* indicated for use in adult HIV patients (13 years of age and older).

2. Neurological Disorders

IVIG is indicated for the treatment of patients with neurological disorders such as Guillain-Barre' syndrome, relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. However, it is noted that not all patients with these diagnoses require treatment with IVIG.

For each of these diseases, the diagnosis of the disorder must be unequivocal. There must be clinical (history, quantitative examination), electrophysiological motor-sensory nerve conductions, electromyography (EMG), cerebrospinal fluid (CSF), and when necessary biopsy (muscle-nerve) data to support the diagnosis.

IVIG therapy will only be considered medically reasonable and necessary for the following neurological diseases when there is evidence of rapid progression of the disease or relapse.

Once treatment is initiated, we expect meticulous documentation of progress. If there is initial improvement, and continued treatment is necessary, then some type of quantitative assessment to monitor the progress is required (e.g., ADL measurements). Changes in these measures must be clearly documented. **Subjective or experiential improvement alone is insufficient to either continue IVIG or to expect coverage.**

There must be an attempt made to wean the dosage when improvement has occurred. There must be an attempt to stop the IVIG infusion if improvement is sustained with dosage reduction. If improvement does not occur with IVIG, then infusion should not continue.

- Guillain-Barre' syndrome is an acute, frequently severe, and fulminant polyneuropathy that occurs at a rate of approximately one case in a million per month. An infection generally precedes the onset of neuropathy by 1 to 3 weeks. A small proportion occur within 1 to 4 weeks of a surgical procedure. The clinical features include ascending paralysis, areflexia (absence of reflexes), possibly ascending sensory loss, and high spinal fluid protein levels. Intravenous administration of high-dose immunoglobulin given over 5 days has been proven effective.
- Multiple Sclerosis that is relapsing-remitting is characterized by unpredictable recurrent attacks of neurological dysfunction. Attacks generally evolve over days to weeks and may be followed by complete, partial, or no recovery. Patients with a relapsing-remitting course experience no progression of neurological impairment between attacks. The age of onset is generally between 15 and 60 years.
- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) includes a group of chronic progressive or relapsing, inflammatory demyelinating peripheral neuropathies that are manifested by physiological abnormalities such as slowed nerve conduction velocities or dispersion of compound muscle action potentials. Clinical features include chronic progressive or relapsing weakness with sensory loss and high spinal fluid protein levels.
- Myasthenia gravis is a disorder of neuromuscular transmission characterized by fluctuating weakness and fatigability. It is attributed to blockage of the acetylcholine receptor at the neuromuscular end-plates by anti-acetylcholine receptor autoantibodies.

The diagnosis of myasthenia gravis is confirmed by a positive Tensilon test. Anticholinesterase drugs or thymectomy are generally the first treatments for this condition.

IVIG is indicated in those patients with myasthenia gravis who are either refractory to corticosteroids over a 6 week period; have been unable to successfully taper corticosteroids below moderately high doses; or develop severe side effects due to steroid therapy; and have also failed at least one immunosuppressive agent (e.g., azathiprime, Methotrexate, cyclophosphamide, cyclosperine). Length of treatment with IVIG will vary due to the remittent and recurrent nature of this condition.

- Polymyositis and dermatomyositis are conditions in which the skeletal muscle is damaged by a nonsuppurative inflammatory process dominated by lymphocytic infiltration. Polymyositis begins acutely or insidiously with muscle weakness, tenderness, and discomfort. It affects proximal muscles more often than distal muscles. Dermatomyositis involves characteristic skin changes that may precede or follow the muscle syndrome and include a localized or diffuse erythema, maculopapular eruption, scaling eczematoid dermatitis, or rarely, an exfoliative dermatitis. The classic lilac-colored (heliotrope) rash is on the eyelids, bridge of the nose, cheeks (butterfly distribution), forehead, chest, elbows, knees and knuckles, and around the nailbeds. Periorbital edema is frequent.

Diagnostic studies to support a diagnosis of polymyositis or dermatomyositis include an elevated creatine phosphokivase (CPK), an abnormal electromyography (EMG), and/or an abnormal muscle biopsy.

IVIG is indicated in those patients with polymyositis or dermatomyositis who are either refractory to corticosteroids over a 6 week period; have been unable to successfully taper corticosteroids below moderately high doses; or develop severe side effects due to steroid therapy; and have also failed at least one immunosuppressive agent (e.g., azathioprime, Methotrexate, cyclophosphamide, cyclosperine). Length of treatment with IVIG will vary due to the remittent and recurrent nature of these conditions. The need for continuation of IVIG must be documented and would be demonstrated by continued decreased muscle strength, elevated CPKs, and/or EMG abnormalities.

3. Other Disorders

a) Chronic Lymphocytic Leukemia

Chronic lymphocytic leukemia is a disorder of accumulation of mature-appearing lymphocytes in blood marrow and other organs. The symptoms usually develop gradually and include fatigue, shortness of breath with activity, weight loss, or frequent infections of the skin, lungs, kidneys, or other sites. Recurrent infections are a frequent complication.

IVIG is indicated for the prevention of recurrent bacterial infections in patients with hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia (CLL) in order to help correct the patient's immunity deficiency.

b) Bone Marrow Transplantation (BMT)

IVIG is indicated to prevent the risk of acute graft-versus-host disease, associated interstitial pneumonia (infectious or idiopathic) and infections (e.g., cytomegalovirus infections [CMV], varicella-zoster virus infection, and recurrent bacterial infection) after BMT in patients 20 years of age or older in the first 100 days after transplantation. It is not indicated in BMT patients younger than 20 years of age, nor is it recommended for autologous transplants.

c) Kawasaki Disease (mucocutaneous Lymph Node Syndrome)

Kawasaki disease is an acute childhood vasculitis, the diagnosis of which is made based on clinical criteria. These criteria include fever of at least 5 days duration and at least 4 of the following: (1) polymorphic exanthem, (2) changes in the oropharynx such as fissured lips and strawberry tongue without discrete lesions, (3) changes in the extremities such as edema of the hands and feet and erythema of the palms and soles, (4) bilateral conjunctival infection without exudate, and (5) cervical lymphadenopathy, often singular and unilateral. IVIG is indicated for the treatment of Kawasaki disease when used in conjunction with aspirin.

d) Autoimmune Hemolytic Anemia

Autoimmune hemolytic anemia is an acquired anemia induced by binding of autoantibodies and/or complement to the red cells. Signs and symptoms may include, but are not limited to, weakness, fatigue, exertional dyspnea, pallor, jaundice, tachycardia, splenomegaly, hepatomegaly, and anemia. In the majority of patients, this disease is controlled by steroid therapy alone, by splenectomy, or by a combination.

Intravenous immune globulin is indicated only for those patients who have failed to respond to other forms of therapy and/or require rapid cessation of hemolysis due to severe or life threatening manifestatons of this condition. Duration of treatment is generally a short course of 3-5 weeks.

e) Autoimmune Neutropenia

Autoimune neutropenia is a hematologic disorder in which there is a decreased number of neutrophilic leukocytes in the blood due to an autoimmune mechanism. The disease is usually benign and self-limiting, and does not require treatment with IVIG. Occasionally, however, it is marked by repeated infection. IVIG may be recommended for the treatment of an absolute neutrophil count less than 800mm; with recurrent bacterial infections.

CPT/HCPCS Section & Benefit Category
Drugs and Biologicals

CPT/HCPCS Codes
J1561
J1563

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

042	279.2	357.8
204.10-204.11	283.0	358.0
279.04	287.3	446.1
279.05	288.0	710.3
279.06	340	710.4
279.12	357.0	996.85

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

The number of units of J1561 that can be claimed on a single day of service is limited to the number for which the Medicare allowance is less than or equal to the Medicare allowance for one unit of J1563. Code J1561 should never be reported with a number of units greater than 1.

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

- history and physical;
- office/progress note(s);
- applicable test results with written interpretation;
- an accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/dosage; and
- prior treatment therapies (where appropriate or referenced by this policy).

In addition, medical record documentation maintained by the treating physician for claims billed with a diagnosis of CVID must include the following: the initial presenting IgG levels, sinus or chest radiological or computerized tomography reports to support the presence of severe sinus infections, frequent bronchitits, pneumonia, or bronchiectasis, and evidence that the patient has been vaccinated with pneumovax and has had pre-and post-vaccine pneumococcal antibody titers performed to demonstrate the lack of ability to produce an antibody response to protein or carbohydrate antigens.

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 includes representatives from numerous societies.

Start Date of Comment Period
05/05/2000

End Date of Comment Period
06/19/2000

Start Date of Notice Period
05/01/2001

Revision History

Revision Number:	8	PCR B2001-084
Start Date of Comment Period		05/05/2000
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		06/18/2001

Explanation of Revision: Policy revised to provide clarification regarding diagnostic criteria for conditions, as well as to revise the list of approved indications for IVIG.

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.

Levulan® Kerastick™ (Aminolevulinic Acid HCl) plus BLU-U™ Blue Light Photodynamic Therapy

Levulan® Kerastick™ (aminolevulinic acid HCl for topical solution 20%) was FDA approved for the treatment of non-hyperkeratotic actinic keratosis lesions of the face or scalp on December 6, 1999. The Levulan® PDT System is a two-stage process that involves the topical application of the Levulan® Kerastick™ (aminolevulinic acid HCl for Topical Solution, 20%) directly to the individual lesions, followed 14-18 hours later by irradiation for 16 minutes and 40 seconds with the Blue Light Photodynamic Therapy Illuminator.

Claims for the Levulan® Kerastick™ should be submitted under HCPCS code J3490 (Unclassified drugs). The name of the drug and the dosage should be reported in block 19 of the HCFA 1500 claim form. The irradiation with the BLU-U™ Blue Light Photodynamic Therapy Illuminator should be submitted with CPT code 96999 (Unlisted special dermatological service or procedure). Documentation supporting that the service was provided for the FDA approved indication is required prior to reimbursement. This information may be found in the history and physical, office/progress notes, or procedure note.

J9212: Interferon

The local medical review policy (LMRP) for Interferon was published in the January/February 1999 *Medicare B Update!* (pages 16-17). It has been determined that ICD-9-CM diagnosis code 259.2 (Carcinoid syndrome) should be added to the policy as a covered indication for procedure codes J9213, J9214, and J9215. Therefore, diagnosis code 259.2 has been added to the "ICD-9-CM Codes That Support Medical Necessity" section of the policy for procedure codes J9213, J9214, and J9215. This change is effective for claims processed on or after February 5, 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

Mitoxantrone Hydrochloride (HCPCS code J9293) has been removed from the LMRP for Antineoplastic Drugs (Policy number J9999) because a new non-cancer indication has been added, multiple sclerosis. Refer to the 2nd Quarter 2001 Medicare B Update! *for the LMRP for Antineoplastic Drugs (pages 29-34). Additional changes to LMRP J9999 may be found on page 44 of this issue.*

Policy Number
J9293

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Mitoxantrone Hydrochloride

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Sections, 4630, and 15400

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
03/05/2001

Revision Ending Date
03/04/2001

LMRP Description
Mitoxantrone hydrochloride (Novantrone®) is an anthracenedione, which inhibits DNA and RNA synthesis.

Indications and Limitations of Coverage and/or Medical Necessity
Mitoxantrone hydrochloride is FDA approved for treatment of the following:

- Advanced symptomatic prostate carcinoma,
- Acute non-lymphocytic leukemia, and
- Secondary (chronic) progressive, progressive relapsing, or worsening relapsing-remitting multiple sclerosis.

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

- Breast carcinoma
- Acute lymphocytic lukemia
- Non-Hodgkin's lmphoma
- Hepatoma

CPT/HCPCS Section & Benefit Category
Chemotherapy Drugs

CPT/HCPCS Codes
J9293

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

155.0-155.2	200.00-200.88	206.00-206.01
174.0-174.9	202.00-202.98	207.00-207.01
175.0-175.9	204.00-204.01	340
185	205.00-205.01	

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
Chemotherapy administration codes 96400-96450, & 96542 are to be used when Mitoxantrone is being infused for the treatment of a patient with a cancer diagnosis. Infusion codes 90780-90784 should be used when this drug is being given for the treatment of Multiple Sclerosis (ICD-9-CM code 340).

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

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

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.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History

Revision Number	1	PCR B2001-096
Start Date of Comment Period:		N/A
Start Date of Notice Period:		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		03/05/2001

Explanation of Revision: Mitoxantrone J9293 was removed from J9999, Antineoplastic policy because a new non-cancer indication was added, multiple sclerosis.

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

J9999: Antineoplastic Drugs

The local medical review policy (LMRP) for Antineoplastic Drugs (J9999) was published in the 2nd Quarter 2001 *Medicare B Update!* (pages 29-34). Included in this policy is Doxorubicin HCL (J9000). Since that publication, the following changes have been made to the indications for Doxorubicin HCL:

- AIDS related Kaposi's sarcoma has been moved from an off-labeled indication to a labeled indication
- Vaginal and Testicular carcinoma have been added as off-labeled indications

For the complete LMRP for Antineoplastic Drugs, refer to the 2nd Quarter 2001 *Update!* (pages 29-34).

FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number
Q0185

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Apligraf® (Graftskin)

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
06/18/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

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

Apligraf® should be applied to a clean, debrided, thoroughly irrigated wound. Oozing or bleeding should be stopped through the use of gentle pressure. With sterile gloved hands, Apligraf® is placed dermal side down in direct contact with the wound surface. Apligraf® is trimmed to cover the wound bed with 1/8-1/4" margins. The package insert recommends securing Apligraf® with a three-layer dressing to assure contact to the wound bed.

The wound should be inspected and the dressing changed at weekly intervals. Highly exudative wounds may require more frequent dressing changes. Additional applications of Apligraf® may be necessary. Non-adherent remnants should be gently removed, the wound bed cleansed, and additional applications applied. Additional applications should not be placed over adherent areas. Healing tissue or adherent Apligraf® should not be disrupted.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Apligraf® reasonable and medically necessary for the following two indications:

When used with standard therapeutic compression for the treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency that have not adequately responded to conventional venous insufficiency ulcer therapy; or

When used with standard diabetic foot ulcer care for the treatment of non-infected full-thickness neuropathic diabetic foot ulcers that have not adequately responded to conventional diabetic foot ulcer therapy.

Coverage for Apligraf® for venous insufficiency ulcers will be considered when ALL of the following conditions are met:

- The venous stasis ulcer has been present for a minimum of three months duration.
- The venous stasis ulcer must have failed to respond to documented conservative measures of at least eight weeks duration. Conservative measures include debridement of necrotic tissue to promote healing. Debridement can take the form of wet-to-dry dressings, the use of enzymatic debridement (e.g., Elase, Travase), the application of dressings that enhance leukocyte migration for shallow wounds, or surgical debridement. A moist wound-healing environment must be provided. Excess wound exudate must be removed at each dressing change. Clinical infections must be eradicated. Graduated venous compression must be applied to eliminate edema. Possible choices for compression include elastic stockings with at lease 35 mm of compression, Zinc oxide bandages changed weekly, multilayer elastic wraps, and intermittent mechanical compression. Adequate circulation and oxygenation to the wound bed must be maintained. Prior to Apligraf® application, it is expected the medical record documentation will contain evidence that the conservative measures have failed as evidenced by an ulcer that has increased in size and depth or that there has been no change in baseline size or depth with no sign of improvement or no indication that improvement is likely (lack of granulation or progress toward closing).
- The venous stasis ulcer is confirmed as being either partial or full thickness and free of infection. The ulcer must be free of cellulitis, eschar or obvious necrotic material as this will interfere with the device adherence and wound healing.
- The patient must have adequate arterial blood supply to support tissue growth.
- The patient is competent or has the support system required to participate in follow-up care associated with treatment of the wound with Apligraf®.

Coverage for Apligraf® for neuropathic diabetic foot ulcers will be considered when ALL of the following conditions are met:

- The type 1 or type 2 diabetic is under current medical management.
- The full thickness neuropathic diabetic foot ulcer has been present for a minimum of four weeks duration.
- The neuropathic diabetic foot ulcer must have failed to respond to documented conservative measures of at least four weeks duration. Conservative measures include aggressive sharp or surgical debridement of necrotic tissue, saline moistened dressings and a non-weight-bearing regime. Clinical infections must be eradicated. Prior to Apligraf® application, it is expected the medical record documentation will contain evidence that the conservative measures have failed as evidenced by an ulcer that has increased in size and depth or that there has been no change in baseline size or depth with no sign of improvement or no indication that improvement is likely (lack of granulation or progress toward closing).
- The ulcer is located on the plantar, medial, or lateral surface of the foot excluding the heel and free of infection, tunnels, and tracts. Additionally, the ulcer must be free of cellulitis, eschar, or obvious necrotic material as this will interfere with the device adherence and wound healing.
- The extremity must be free of active Charcot's arthropathy.

- The patient must have adequate arterial blood supply to support tissue growth.
- The patient is competent or has the support system required to participate in follow-up care associated with treatment of the wound with Apligraf®.

Apligraf® is contraindicated:

For use on clinically infected wounds;

In patients with known allergies to bovine collagen; or

In patients with known hypersensitivity to the components of the Apligraf® agarose shipping medium (which contains agarose, L-glutamine, hydrocortisone/bovine serum albumin, bovine insulin, human transferrin, triiodothyronine, ethanolamine, O-phosphorylethanolamine, adenine, seleniuos acid, DMEM powder, HAM's F-12 powder, sodium bicarbonate, calcium chloride, and water for injection).

In vitro and *in vivo* histology studies have shown that Apligraf® either degrades or its cell viability is reduced when the device is exposed to the following cytotoxic agents: Dakin's solution, Mafenide acetate, Scarlet red dressing, Tincoban, Zinc sulfate, Povodine-iodine solution, Chlorhexidine, or Polymixin/Nystatin. The use of Apligraf® with these solutions will be considered not reasonable and necessary and will result in denial of reimbursement.

The safety and effectiveness of Apligraf® have not been established for patients receiving more than five device applications.

CPT/HCPCS Section & Benefit Category
Drugs and Biologicals

CPT/HCPCS Codes
Q0185

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
250.80-250.81
454.0

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
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
Providers utilize CPT codes 15000, 15342 and, if applicable, 15343 to represent the work involved with preparing the ulcer site and applying Apligraf®. The Apligraf® device itself is identified by utilizing Q0185. Apligraf is supplied in a 45 square centimeter single use package. Medicare will reimburse for the entire 45 square centimeter biological because the wastage cannot be preserved for later use/used on another patient. Since the coding is based on a per centimeter basis, the units field on the HCFA 1500 form should reflect increments of 45 for each package used. For example, Apligraf is applied to a 25 square centimeter wound. Approximately 20 square centimeters are trimmed from the edges per application protocol. Enter '45' in the units field on the HCFA 1500 claim form (or electronic equivalent). On the other hand, if 60 square centimeters were used, the number billed should reflect 90.

Documentation Requirements
Medical record documentation maintained by the treating provider must substantiate the medical necessity for the use of Apligraf®. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the history and physical, office/progress notes, hospital notes, and/or procedure report.

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

The record must identify the duration of the ulcer's presence with a description of the conservative treatment measures taken. The medical record must contain a description of the wound at baseline (prior to beginning conservative treatment) relative to size, location, stage and presence of infection. The documentation must provide an updated description of the wound prior to Apligraf® application in terms of response to treatment (i.e., ulcer measurement and progress toward healing). Following Apligraf® application, continue to document the changes in the ulcer in terms of complete wound closure. Any additional applications must also be noted.

The diabetic's managing physician must be identified in the medical record if different from the physician managing the wound care.

Utilization Guidelines
N/A

Other Comments
Venous insufficiency is caused by venous hypertension. The underlying pathology is most commonly valvular insufficiency resulting in edema and ultimately tissue breakdown. Venous stasis ulcers most often appear on the medial aspect of the lower legs above the malleolus. The accepted standard of care for venous ulcers is moist wound healing under graduated compression bandages.

Diabetic neuropathy may present with foot pain and is occasionally associated with diminished pulses and trophic skin changes. Loss of light touch and decreased vibratory senses are distinguishing characteristics.

Partial thickness skin ulcer- wound base is visible and the ulcer does not extend through the dermis.

Full thickness skin ulcer- wound base is visible and the ulcer extends through the dermis but not into the subcutaneous tissue to fascia, muscle or bone.

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 various specialties.

Carrier Advisory Committee Meeting held on August 19, 2000.

Start Date of Comment Period

08/11/2000

End Date of Comment Period

09/25/2000

Start Date of Notice Period

05/01/2001

Revision History

Revision Number:	Original PCR B2001-070
Start Date of Comment Period:	08/11/2000
Start Date of Notice Period:	05/01/2001 3rd QTR 2001 *Update!*
Original Effective Date	06/18/2001

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

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

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

04/19/1999

Original Policy Ending Date

N/A

Revision Effective Date

04/01/2001

Revision Ending Date

03/31/2001

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 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.

CPT-4 CODE(S)	CERTIFICATION
54240	ARDMS: RVT, CCI: RVS, NCDMS: CDGS
70030-70160	State license: CRT-R (General Radiographer), Medical Physicist
70190-70330	State license: CRT-R (General Radiographer), Medical Physicist
70336	Demonstrates proficiency
70350-70355	State license: CRT-R (General Radiographer)
70360-70370	State license: CRT-R (General Radiographer), Medical Physicist
70371	State license: CRT-R (General Radiographer)
70380	State license: CRT-R (General Radiographer), Medical Physicist
70450-70488	State license: CRT-R (General Radiographer) Medical Physicist
70490-70498	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
70540-70553	Demonstrates proficiency
71100-71130	State license: CRT-R (General Radiographer)
71250-71275	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
71550-71555	Demonstrates proficiency
72010-72120	State license: CRT-R (General Radiographer), Medical Physicist

72125-72133	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
72141-72159	Demonstrates proficiency
72170-72190	State license: CRT-R (General Radiographer), Medical Physicist
72191-72194	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
72195-72198	Demonstrates proficiency
72200-72220	State license: CRT-R (General Radiographer), Medical Physicist
73000-73030	State license: CRT-R (General Radiographer), Medical Physicist
73050-73080	State license: CRT-R (General Radiographer), Medical Physicist
73120-73140	State license: CRT-R (General Radiographer), Medical Physicist
73200-73206	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
73218-73225	Demonstrates proficiency
73500-73520	State license: CRT-R (General Radiographer), Medical Physicist
73540-73565	State license: CRT-R (General Radiographer), Medical Physicist
73590-73610	State license: CRT-R (General Radiographer), Medical Physicist
73620-73660	State license: CRT-R (General Radiographer), Medical Physicist

73700-73706	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
73718-73725	Demonstrates proficiency
74000-74022	State license: CRT-R (General Radiographer), Medical Physicist
74150-74175	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
74181-74185	Demonstrates proficiency
74210-74249	State license: CRT-R (General Radiographer)
74260-74291	State license: CRT-R (General Radiographer)
74400-74420	State license: CRT-R (General Radiographer)
74710	State license: CRT-R (General Radiographer), Medical Physicist
74775	State license: CRT-R (General Radiographer)
75552-75556	Demonstrates proficiency
76003-76005	State license: CRT-R (General Radiographer)
76010-76066	State license: CRT-R (General Radiographer), Medical Physicist
76070-76076	State license: CRT-R (BMO)
76078	State license: CRT-R (General Radiographer)
76090-76092	ARRT: CRT-R with advanced credentialing in mammography
76093-76094	Demonstrates proficiency
76098	State license: CRT-R (General Radiographer)
76100-76350	State license: CRT-R (General Radiographer)

76355	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
76375-76380	ARRT: Computerized Tomography Technologist, State license with documented training and experience in CT, Medical Physicist
76390-76400	Demonstrates proficiency
76499	Dependent on diagnostic procedure performed
76506	ARDMS: RDMS-Neurosonology
76511-76513, 76529	ARDMS: RDMS-Opthalmology, JCAHPO: COA, COT, COMT
76516-76519	ARDMS: ROUB, RDMS-Opthalmology, JCAHPO: COA, COT, COMT
76536	ARDMS: RDMS-Abdomen, NCDMS: CDGS
76604	ARDMS: RDMS-Abdomen
76645-76778	ARDMS: RDMS-Abdomen, NCDMS: CDGS
76800	ARDMS: RDMS-Neurosonology
76805-76819	ARDMS: RDMS-` Obstetrics & Gynecology NCDMS: CD/OBGYNS
76825-76828	ARDMS: RDMS-Obstetrics & Gynecology ARDMS: RDCS NCDMS: CD/OBGYNS
76830-76831	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS
76856-76857	ARDMS: RDMS-Obstetrics & Gynecology NCDMS: CD/OBGYNS
76870	ARDMS: RDMS-Abdomen. NCDMS: CDGS
76872-76873	ARDMS: RDMS-Abdomen, NCDMS: CDGS
76880	ARDMS: RDMS-Abdomen
76885-76886	ARDMS-RDMS
76977	Demonstrates proficiency
76999	ARDMS: RDMS-Appropriate credentialing based on body area examining, NCDMS: Appropriate credentialing based on body area examining
77417	State license, MDC
78000-78099	State license: CRT-N, CNMT
78102-78199	State license: CRT-N, CNMT
78201-78299	State license: CRT-N, CNMT
78300-78350	State license: CRT-N, CNMT
78399	State license: CRT-N, CNMT
78414-78458	State license: CRT-N, CNMT
78460-78483	State license: CRT-N, CNMT
78494-78499	State license: CRT-N, CNMT
78580-78599	State license: CRT-N, CNMT
78600-78607	State license: CRT-N, CNMT
78610-78699	State license: CRT-N, CNMT
78700-78799	State license: CRT-N, CNMT
78800-78807	State license: CRT-N, CNMT
78999	State license: CRT-N, CNMT
92081-92083	JCAHPO: COT, COMT
92100-92130	JCAHPO: COA
92235-92240	JCAHPO: COT, COMT; Registered Nurse, CRA
92250	JCAHPO: COT, COMT; CRA
92265-92275	JCAHPO: COT, COMT; Registered Nurse

92283-92284	JCAHPO: COA, COT, COMT
92285	JCAHPO: COT, COMT; CRA
92286-92287	JCAHPO: COT, COMT; Registered Nurse, CRA
92516	Certified Audiologist
92520	Speech Pathologist
92541-92548	Certified Audiologist
92552-92557	Licensed Audiologist
92561-92584	Licensed Audiologist
92585-92586	ABRET: R. EP T., R. EEG T.; Audiologist
92587-92589	Licensed Audiologist
93000-93278	CCI: CCT, RCS; Registered Nurse (RN), Paramedic
93303-93308	ARDMS: RDCS CCI: RCS NCDMS: CDCS
93312	ARDMS: RDCS CCI: RCS NCDMS: CDCS
93315	ARDMS: RDCS CCI: RCS NCDMS: CDCS
93320	ARDMS: RDCS CCI: RCS NCDMS: CDGS, CD/ OBGYNS, CDVS, CDCS
93325	ARDMS: RDCS, RDMS (Obstetrics & Gynecology) CCI: RCS NCDMS: CDGS, CD/ OBGYNS, CDVS, CDCS
93350	ARDMS: RDCS CCI: RCS, CCT for stress portion; Registered Nurse Paramedic NCDMS: CDCS
93501	State license: CRT-R (General Radiographer), CCI: RCIS, RCS Registered Nurse
93505	State license: CRT-R (General Radiographer), CCI: RCIS, RCS Registered Nurse
93510-93533	State license: CRT-R (General Radiographer), CCI: RCIS, RCS Registered Nurse
93555-93572	State license: CRT-R (General Radiographer),. CCI: RCIS, RCS Registered Nurse
93600-93642	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse
93660	CCI: CCT, RCIS, RCS ARDMS: RDCS Registered Nurse
93724	CCI: CCT Registered Nurse Paramedic
93727-93738	CCI: CCT Registered Nurse Paramedic
93741-93744	CCI: CCT Registered Nurse Paramedic
93770	CCI: CCT Registered Nurse Paramedic
93799	CCI: CCT Registered Nurse Paramedic
93875-93882	ARDMS: RVT CCI: RVS NCDMS: CDVS
93886-93888	ARDMS: RVT CCI: RVS
93922-93990	ARDMS: RVT CCI: RVS NCDMS: CDVS
94010, 94060-94070	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)
94200-94450	State license: RPFT, RRT, CPFT, CRT
94620-94621	State license: RPFT, RRT Registered Nurse (RN)
94664-94665	State license: CPFT, RPFT, CRT, RRT Registered Nurse (RN)

94680-94750	State license: RPFT, RRT
94760-94762	Demonstrates proficiency
94770	State license: RPFT, RRT
94799	State license: Appropriate credentialing based on service performing
95004	RN with active state license
95024-95056	RN with active state license
95805, 95807-95811	ABRET: R. EEG T. BRPT: RPSGT State license: CPFT, RPFT, CRTT, RRT
95812-95822, 95827	ABRET: R. EEG T.
95900-95904	AAET: R. EDT. ABRET: R. EP T. Qualified Physical Therapist permitted to perform service under state law
95921-95923	AAET: R. EDT
95925-95930	ABRET: R. EP T., R. EEG T.
95933-95937	AAET: R. EDT. Qualified Physical Therapist permitted to perform service under state law
95950-95953	ABRET: R. EEG T.
95954	ABRET: R. EEG T.
95956-95957	ABRET: R. EEG T.
95958	ABRET: R. EEG T.
95999	Appropriate credentialing based on service performing
G0004-G0015	CCI: CCT Registered Nurse (RN) Paramedic
G0050	ARDMS: RDMS-Abdomen, NCDMS: CDGS
G0195-G0196	Speech Pathologist
G0202-G0207	ARRT: CRT-R with advanced credentialing in mammography
Q0035	CCI: CCT Registered Nurse (RN) Paramedic

CPT/HCPCS Section & Benefit Category

Diagnostic Ultrasound/Radiology
Non-ivasive 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	70547	72130	73221
70030	70548	72131	73222
70100	70549	72132	73223
70110	70551	72133	73225
70120	70552	72141	73500
70130	70553	72142	73510
70134	71010	72146	73520
70140	71015	72147	73540
70150	71020	72148	73550
70160	71021	72149	73560
70190	71022	72156	73562
70200	71023	72157	73564
70210	71030	72158	73565
70220	71034	72159	73590
70240	71035	72170	73592
70250	71100	72190	73600
70260	71101	72191	73610
70300	71110	72192	73620
70310	71111	72193	73630
70320	71120	72194	73650
70328	71130	72195	73660
70330	71250	72196	73700
70336	71260	72197	73701
70350	71270	72198	73702
70355	71275	72200	73706
70360	71550	72202	73718
70370	71551	72220	73719
70371	71552	73000	73720
70380	71555	73010	73721
70450	72010	73020	73722
70460	72020	73030	73723
70470	72040	73050	73725
70480	72050	73060	74000
70481	72052	73070	74010
70482	72069	73080	74020
70486	72070	73090	74022
70487	72072	73092	74150
70488	72074	73100	74160
70490	72080	73110	74170
70491	72090	73120	74175
70492	72100	73130	74181
70496	72110	73140	74182
70498	72114	73200	74183
70540	72120	73201	74185
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Not Otherwise Classified Codes (NOC)

N/A

ICD-9 Codes that Support Medical Necessity

N/A

Diagnosis that Support Medical Necessity

N/A

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

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

Noncovered Diagnosis
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.

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
05/01/2001

Revision History

Revision Number:	9	PCR B2001-094
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		04/01/2001

Explanation of Revision: BIPA 2000 provided for new payment methodologies for diagnostic and screening mammograms performed with new technologies. In addition, a new credentialing body for ultrasound was identified, therefore, the credentialing chart was updated to include the appropriate credentials given out by NCDMS.

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
29540

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Strapping

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
06/18/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Strapping of the ankle and/or toe(s) consists of the application of nonmedicated, adhesive gauze dressings, applied by overlapping wraps of gauze to exert pressure and hold a structure in place for the purpose of providing structural support, immobilization or compression for the ankle, foot and/or toe(s).

Unna boot is a paste bandage which consists of gauze that has been impregnated with zinc oxide, gelatin, glycerin, and sometimes calamine. The bandage is applied to the leg from the toe to the knee by overlapping wraps of impregnated gauze. The Unna boot forms a semirigid soft cast which should be left in place for 4 to 7 days.

The Unna boot bandage restricts the volume of the leg, controls edema, and encourages more normal prograde venous blood flow with reduction in the subcutaneous blood pressure. The net effect is improved healing of venous stasis ulcers of the lower extremities.

Indications and Limitations of Coverage and/or Medical Necessity

Strapping (Procedure codes 29540 and 29550)

Florida Medicare will consider Strapping of the ankle and/or toe(s) medically reasonable and necessary for the following symptomatic conditions:

- Strains, sprains, dislocations, tendinitis and certain fractures not accompanied by ulceration. It is not generally expected that strapping of the ankle and/or toe(s) would be done more often than weekly. However, there are circumstances that warrant application of straps several times per week, such as, whirlpool treatments which require removal and reapplication of the straps.

Unna boot (Procedure code 29580)

Florida Medicare will consider the use of the Unna boot bandage medically reasonable and necessary for the following indications:

- To treat venous vascular insufficiency;
- For the treatment of ulcers with and without inflammation of the lower extremities which are caused by increased venous pressure, venous insufficiency or capillary dysfunction; and
- For the management of sprains, strains, dislocations and minor fractures.

It is not expected that Unna boot application would be done more often than once or twice per seven days. Unna boot application is not indicated for use with ulcers resulting from arterial disease or diabetes.

CPT/HCPCS Section & Benefit Category
Surgery/Musculoskeletal System

CPT/HCPCS Codes
29540
29550
29580

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

For CPT codes **29540** and **29550**, the following diagnoses are considered medically reasonable and necessary:

718.37	734	825.0
718.87	735.0	825.20-825.29
719.27	735.1	826.0
726.70	735.3	837.0
726.71	735.4	838.00-838.09
726.72	735.5	845.00-845.19
726.73	735.8	924.20-924.21
726.79	736.79	924.3
727.06	824.0	
728.71	824.2	

For CPT code **29580**, the following diagnoses are considered medically reasonable and necessary:

451.0-451.2	824.0-824.9	837.0-837.1
454.0	825.0	838.00-838.19
454.1	825.20-825.29	845.00-845.19
454.2	826.0	

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

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

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the 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 includes representatives from numerous specialties.

Carrier Advisory Committee Meeting held on November 11, 2000.

Start Date of Comment Period
11/03/2000

End Date of Comment Period
12/18/2000

Start Date of Notice Period
05/01/2001

Revision History
Revision Number:	Original PCR B2001-098
Start Date of Comment Period:	11/03/2000
Start Date of Notice Period:	05/01/2001
	3rd QTR 2001 *Update!*
Original Effective Date:	06/18/2001

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
32851

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Lung Transplantation

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Sections 2050, 4471, and 5249
Program Memorandum, AB-01-10 (Change Request 1513, dated 01/24/2001)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
01/01/1994

Original Policy Ending Date
N/A

Revision Effective Date
04/01/2001

Revision Ending Date
03/31/2001

LMRP Description
Lung transplantation of one or both lungs (32851-32854) is performed for treatment of selected patients where other standard therapies have failed or where no other treatment option exists. Life expectancy for lung transplant candidates is between 12-18 months.

Indications and Limitations of Coverage and/or Medical Necessity
Lung transplantation procedures are covered services of Medicare for selected patients with progressive end-stage pulmonary or cardiopulmonary disease when performed in a HCFA-approved lung transplant facility by a physician practicing within the scope of licensure. Examples of such disorders would be severe emphysema, pulmonary fibrosis, cystic fibrosis, bronchiectasis, and pulmonary hypertension related to arterial or venous vascular disease or congenital heart defects.

CPT/HCPCS Section & Benefit Category
Surgery/Respiratory System

CPT/HCPCS Codes
32851
32852
32853
32854

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
Donor pneumonectomy(ies) (32850) is a noncovered service under Medicare Part B.

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

Noncovered Diagnoses
N/A

Coding Guidelines
Lung transplantations (32851-32854) are considered medically necessary and will be considered on an individual basis, when the following conditions are met:

- diagnosis of irreversible end-stage pulmonary or cardiopulmonary disease with a life expectancy of 18 months
- prognosis is good for both survival and full rehabilitation potential
- all other therapies have been tried or considered
- candidate is 65 years of age or under
- no coincidental life-threatening conditions exist, such as:
    - hepatic or renal dysfunction
    - previous thoracic or cardiac surgery
    - cardiac dysfunction
    - other systemic or multi-system disease
    - obesity
    - psychiatric illness with indications of non-compliance or suicidal ideation
    - continued cigarette smoking
    - malnutrition

Lung transplant services will be reviewed for reimbursement on an individual basis.

Lung transplantation procedures are subject to the surgery global period of 90 days.

Documentation Requirements
The following documentation is required in support of medical necessity for lung transplantation:

- complete history and physical
- operative report
- the name of the lung transplant facility where the procedure was performed

Utilization Guidelines
N/A

Other Comments
Terms Defined:

Bronchiectasis: chronic dilatation of the bronchi marked by unpleasant breath and paroxysmal coughing with expectoration of mucopurulent matter
Cystic fibrosis: a generalized autosomal recessive disorder, characterized by signs of chronic pulmonary disease due to excess mucous production in the respiratory tract in addition to other pathological abnormalities
Dyspnea: difficult or labored breathing
Emphysema: an abnormal permanent enlargement of the air spaces distal to the terminal bronchioles accompanied by destruction of their walls and without obvious fibrosis
End-Stage Pulmonary Disease: irreversibility of severe anatomic changes in the lungs leading to incapacitating clinical manifestations and eventual respiratory failure
Pneumonectomy: the excision of lung tissue, especially of an entire lung
Pulmonary Fibrosis: chronic inflammation and progressive fibrosis of the pulmonary alveolar walls with steadily increasing dyspnea, resulting in death from lack of oxygen or right heart failure

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 Pulmonary, Thoracic, Cardiovascular, and Vasular Surgery Specialties.

Carrier Advisory Committee Meeting held on February 5, 1994.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History
Revision Number:	4	PCR B2001-080
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001 3rd QTR 2001 *Update!*
Revised Effective Date:		04/01/2001

Explanation of Revision: Removed the time limitation for coverage of Immunosuppressive drugs per Change Request 1513.

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
48554

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Pancreas Transplantation

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 35-82
Medicare Carriers Manual, Sections 4176, 4176.1, 4471, and 5249
Program Memorandum, AB-01-10 (Change Request 1513, dated 01/24/2001)

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
04/01/2001

Revision Ending Date
03/31/2001

LMRP Description
Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Indications and Limitations of Coverage and/or Medical Necessity
Effective July 1, 1999, Medicare will consider performance of a whole organ pancreas transplantation medically reasonable and necessary under the following circumstances:

> When it is performed in a licensed facility simultaneously with or after a kidney transplantation (HCPCS code 50360 or 50365).

Pancreas transplantation for diabetic patients who have not experienced end stage renal failure secondary to diabetes continues to be excluded from Medicare coverage. Medicare also excludes coverage of transplantation of partial pancreatic tissue or islet cells.

CPT/HCPCS Section & Benefit Category
Surgery/Digestive System

CPT/HCPCS Codes
48554

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
250.00-250.93	404.03	585
403.01	404.12	V42.0
403.11	404.13	V43.89
403.91	404.92	
404.02	404.93	

Note: The billing of pancreas transplantation requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9-CM codes 250.00-250.93 ***and*** 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 585, V42.0, or V43.89 to report the approved indication for 48554.

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
Providers must use ICD-9-CM codes 250.00-250.93 ***and*** 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 585, V42.0, or V43.89 to report the approved indication for 48554.

If the kidney and pancreas transplants are performed simultaneously, a diabetes diagnosis code ***and*** a renal failure code ***or*** one of the hypertensive renal failure diagnosis codes should be billed.

If a patient has had a kidney transplant that was successful, the patient no longer has chronic renal failure; therefore, it would be inappropriate to bill diagnosis code 585 for such a patient. In these cases, a diabetes diagnosis ***and*** V42.0 ***or*** V43.89 should be billed.

Documentation Requirements
Medical record documentation (e.g., history and physical, office/progress notes, etc.) maintained by the ordering/referring physician must indicate the medical necessity for performing a pancreatic transplant. Additionally, a copy of the operative report should be maintained in the medical records.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information and Basis for Decision
N/A

Advisory Committee Notes
N/A

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History

Revision Number:	4	PCR B2001-081
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		04/01/2001

Explanation of Revision: Based on HCFA transmittal AB-01-10 (Change Request 1513), the limitation of coverage for immunosuppressant drug therapy has been removed.

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
67221

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Ocular Photodynamic Therapy (OPT) with Verteporfin

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Sections 35-100 and 45-30
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
03/19/2001

Original Policy Ending Date
N/A

Revision Effective Date
07/01/2001

Revision Ending Date
06/30/2001

LMRP Description
Ocular photodynamic therapy (OPT) is a form of treatment for the "wet" or exudative form of age-related macular degeneration. The wet form of macular degeneration involves the growth of abnormal blood vessels called choroidal neovascularization (CNV) beneath the retina resulting in leakage and bleeding. Without treatment, the majority of patients eventually develop scar tissue beneath the macula, which results in loss of central vision. The concept of OPT is to selectively close the abnormal blood vessels, eliminate the bleeding and leakage, and stabilize or improve the vision.

OPT is similar to traditional laser ablation in that abnormal blood vessels are destroyed; however, it is unique in that the low intensity laser activation of the drug verteporfin (Visudyne™) preserves the surrounding structures from destruction that is an unfortunate side effect of traditional thermal laser. This feature allows use of this treatment for preservation of vision when the CNV occurs close to the center of the macula.

OPT is a two-step process. In the first step, the patient receives an intravenous injection of verteporfin. The verteporfin circulates through the body and adheres to the walls of the abnormal blood vessels beneath the macula. A laser is then used to shine light into the back of the eye. When this light beam activates the verteporfin, there is closure of the blood vessel. Over time, the body is able to absorb the blood and fluid, which results in stabilization or improvement of visual function.

Over the course of 1-3 months, the blood vessels that have been treated with OPT typically open again and leakage may recur. Treatment is performed at three-month intervals if there is evidence of continued leakage from the blood vessels.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for the following indication:

For the treatment of age-related macular degeneration in patients with predominantly classic subfoveal CNV lesions (where the area of classic CNV occupies = 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram.

Prior to verteporfin OPT retreatment, documentation of the patient's condition must include fluorescein angiographic evidence of current leakage from CNV.

Florida Medicare will not consider the performance of OPT with verteporfin medically reasonable and necessary when any of the following circumstances exist:

- Inability to obtain photographs and an adequate, legible fluorescein angiogram to document CNV (including difficulty with venous access) unless there is a documented history of fluorescein allergy; and
- There is no evidence of CNV leakage (as determined by fluorescein angiography).

CPT/HCPCS Section & Benefit Category
Surgery/ Eye and Ocular Adnexa

CPT/HCPCS Codes
67221 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
G0184 Destruction of localized lesion of choroid (for example, neovascularization); ocular photodynamic therapy (includes intravenous infusion), other eye
Q3013 Injection, verteporfin, 15 mg (Effective 07/01/2001)

Not Otherwise Classified Codes (NOC)
J3490 Unclassified drugs (verteporfin [VisudyneÔ]) (Effective 07/18/2000 – 06/30/2001)

ICD-9-CM Codes that Support Medical Necessity
362.52 Exudative senile macular degeneration

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
362.50 Macular degeneration (senile), unspecified
362.51 Nonexudative senile macular degeneration

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 verteporfin with laser activation is the only form of OPT that is FDA-approved. Other drugs for OPT remain experimental, and therefore noncovered by Medicare.

Effective July 1, 2001, Verteporfin (Q3013) that is not used in conjunction with OPT and furnished intravenously incident to a physician's service will be denied.

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

Noncovered Diagnoses
N/A

Coding Guidelines
CPT code 67221 must be used for claims for OPT and includes the infusion of verteporfin and all other services required to perform OPT.

CPT code G0184 should only be billed when performing OPT on a second eye at the same session as the first eye.

CPT code J3490 must be used for the drug verteporfin (Visudyne ™) for services performed 07/18/2000-06/30/2001.

CPT code Q3013 must be used for the drug verteporfin (Visudyne ™) for services performed on or after 07/01/2001.

Claims submitted for OPT performed on both eyes on the same day will only receive a single reimbursement rate for verteporfin, as a single infusion is adequate for treatment of both eyes.

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/operative report.

The documentation maintained by the performing physician should include the following:

- Evaluation and management exam including the name and total calculated drug dose (mg) of the photodynamic therapy drug administered and the patient's body surface area on which the dose of the drug is based.
- Fluorescein angiography report, which should include the description of the lesion (e.g., predominantly classic, minimally classic, no classic).

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 includes representatives from the Florida Society of Ophthalmology.

Carrier Advisory Committee Meeting held on August 19, 2000.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History

Revision Number:	1	PCR B2001-097
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		07/01/2001

Explanation of Revision: Transmittal AB-01-19 provides a new temporary code for verteporfin (Q3013) effective 07/01/2001. Transmittal 135 provides coverage information for photodynamic therapy and photosensitive drugs effective 07/01/2001. Transmittal AB-01-37 provides processing instructions for services related to the drug verteporfin effective 07/01/2001. These changes have been incorporated into 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.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
76090

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Diagnostic Mammography

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-21
42 Code of Federal Regulation, Section 410.34
Program Memorandum, Transmittal AB-01-20

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
04/01/2001

Revision Ending Date
03/31/2001

LMRP Description
The word "diagnostic" in diagnostic mammography denotes the identifying of a disease from its signs and symptoms, using both ionizing and non-ionizing radiations. Diagnostic mammography involves obtaining exposures of the breast to provide specific analytical information to be used in problem solving for a suspected

breast disease. A radiologist is available at the time of the study to review the images and request immediate additional evaluation if necessary.

As of January 1, 1996, the definition of diagnostic mammography has been expanded to include as candidates for this service men or women with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. Previously, only symptomatic men or women were candidates for diagnostic mammography.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare covers diagnostic mammograms when the beneficiary:

- presents signs, symptoms or physical findings suggestive of breast disease (e.g., lump, pain, nipple discharge or retraction, or skin changes such as dimpling, skin thickening or orange peel skin, radiologic evidence of breast abnormality);
- has been or is being treated for breast cancer;
- has a personal history of biopsy-proven benign breast disease; or
- is still at the facility for a screening exam, has a screening mammogram exam interpreted by the radiologist as nonspecific abnormal finding requiring additional films.

Diagnostic mammograms are covered as often as is medically necessary. A physician's order is required for coverage of a diagnostic mammogram. The physician may be the treating physician, or in the case of a screening mammogram converted to a diagnostic mammogram, the interpreting radiologist.

CPT/HCPCS Section & Benefit Category

Radiology/Diagnostic Radiology

CPT/HCPCS Codes

76090	G0204	G0206
76091	G0205	G0207

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

174.0-174.8	238.3	996.54
175.0-175.9	610.0-610.8	V10.3
198.2	611.0-611.8	V15.89
198.81	793.8	V71.1
217	879.0	
233.0	879.1	

Diagnoses that Support Medical Necessity

N/A

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Services performed by a non-certified center will be denied.

Services performed by a facility whose certificate is suspended or revoked will be denied.

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnoses

N/A

Coding Guidelines

As a reminder, effective April 1, 1995, all mammography facilities (both diagnostic and screening) require a certification number. The certification number should be placed in FAO record, field 31, field positions 142-151 (electronic claim submissions—National Standard Format) or Block 32 of the HCFA-1500 form (paper claim submissions).

Radiologists who interpret screening mammographies are allowed, per Balanced Budget Act-97, to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. Where a radiologist's interpretation results in the need for additional films, the mammography is no longer considered a screening exam for payment purposes. When this occurs, the claim will be paid as a diagnostic mammogram instead of a screening mammogram. In this instance, the claim must be prepared utilizing HCPCS Codes 76090, 76091, G0204, G0205, G0206 or G0207 with modifier GH. The treating physician's UPIN is to be used to represent the ordering physician. It is expected that the radiologist will refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient.

Documentation Requirements

If you **REFER** a patient for mammography, include the following information in your order:

- the ICD-9-CM diagnosis code that reflects the reason for the test; and
- the type of test (diagnostic); and
- maintain on file records which support medical necessity such as history and physical and progress notes.

If you **PERFORM** the mammography test, obtain the following information:

- A physician's order that specifically prescribes a diagnostic mammogram as well as the medical reason for the test; and
- Maintain on file the radiology report.

Utilization Guidelines

N/A

Other Comments
Medicare will pay for mammography services in an Ambulatory Surgery Center (ASC) if the ASC has a FDA 6-digit mammography certification number.

Asymptomatic women without medical record documentation to support a personal history of breast cancer, biopsy-proven benign breast disease, or radiologic evidence of breast abnormality are candidates for screening mammography.

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 Radiological Society.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History

Revision Number	2	PCR B2001-090
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date		04/01/2001

Explanation of Revision: BIPA 2000 provided for new payment methodologies for diagnostic and screening mammograms performed with new technologies.

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
76092

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Screening Mammograms

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 4601
42 Code of Federal Regulation, Sections 410.32 and 410.34
Program Memorandum, Transmittal AB-01-20

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
07/22/1996

Original Policy Ending Date
N/A

Revision Effective Date
04/01/2001

Revision Ending Date
03/31/2001

LMRP Description
Screening mammography is a radiologic procedure for women for the early detection of breast cancer. They are conducted for preventative purposes, when there are no clinical indications or symptoms. Screening mammographies include a physician's interpretation of the results.

A screening mammogram, at a minimum, is a 2 view exposure (cranio-caudal and a medial lateral oblique view) of each breast. On occasion, supplementary views may be required to visualize breast tissue optimally (eg, augmented breast, large breast, patient with depressed sternum or pronounced ribs).

Indications and Limitations of Coverage and/or Medical Necessity
A physician's order is not required for coverage of a screening mammogram. Age and statutory frequency parameters are used to determine if payment can be made for a screening mammogram.

Age	Screening Period
35-39	Baseline (only one allowed for this age group)
Over age 39	Annual (11 full months must have elapsed following the month of the last screening)

Counting Screening Periods:
Count months between mammographies beginning the month ***after*** the date of the examination.

Example: The beneficiary received a screening mammography in January 1997. Start your count beginning with February 1997.

Limitation of Liability for Screening Mammograms: Limitation of liability provisions pertain to items and services denied as "not reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Screening mammograms denied as being performed more frequently than allowed under Medicare law, or because they were not performed at a Medicare-approved screening center, fall under limitation of liability regulations as well.

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology

CPT/HCPCS Codes
76092 G0202 G0203

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
V76.12

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
Not within the screening period designated in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Services performed by a non-certified center will be denied.

Services performed by a facility whose certificate is suspended or revoked will be denied.

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

Noncovered Diagnoses
N/A

Coding Guidelines
As a reminder, all mammography facilities (both diagnostic and screening) require a certification number. The certification number should be placed in FAO record, field 31, field positions 142-151 (electronic claim submissions—National Standard Format) or Block 32 of the HCFA-1500 form (paper claim submissions).

Interpretation of screening mammograms are to be performed only by physicians who are certified under the certification number of the screening center. The two exceptions are when the beneficiary requests a transfer of the films from one facility to another for a second opinion, or because the patient has moved to another part of the country where the next screening mammography will be performed.

Effective January 1, 1998, every screening mammography claim must contain CPT Code 76092 and diagnosis code V76.12. Effective April 1, 2001, HCPCS codes G0202 and G0203 may also be utilized with diagnosis code V76.12.

Radiologists who interpret screening mammographies are allowed, per Balanced Budget Act-97, to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. Where a radiologist's interpretation results in the need for additional films, the mammography is no longer considered a screening exam for payment purposes. When this occurs, the claim will be paid as a diagnostic mammogram instead of a screening mammogram. In this instance, the claim must be prepared utilizing CPT Code 76090, 76091, G0204, G0205, G0206 or G0207 with modifier GH. The treating physician's UPIN is to be used to represent the ordering physician. It is expected that the radiologist will refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient.

Documentation Requirements
If you **REFER** a patient for screening mammography, include the following information in your order:

- the type of test (screening);
- the date of the last screening mammogram.

If you **PERFORM** the mammography test, obtain the following information:

- an order that specifically prescribes a screening mammogram, if the test is referred by a physician;
- the date of the last screening mammogram, if a screening mammogram has been ordered by the physician;
- the date of the last screening mammogram, if the beneficiary has no physician's order; and
- maintain on file the radiology report.
- if the interpreting physician is not certified under the certification of the screening center, the documentation must clearly contain information to support the exception when billing the Medicare program.

Utilization Guidelines
Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39.

Other Comments
The substance of the present definition of screening mammography has been retained so that women with a personal history of breast cancer or a personal history of biopsy-proven benign breast disease can be considered candidates for a screening mammogram if the patient's attending physician determines it is appropriate.

Breast cancer is the most commonly diagnosed cancer, and the second leading cause of death among women.

Florida Medicare will pay for mammography services in an Ambulatory Surgery Center (ASC) if the ASC has a FDA 6-digit mammography certification number.

The need to do supplemental views in order to visualize the breast tissue optimally (more than two views each breast) does not have any effect on the payment amount because payment is prescribed by statute.

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 Radiological Society.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History
Revision Number:	8	PCR B2001-091
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		04/01/2001

Explanation of Revision: BIPA 2000 provided for new payment methodologies for diagnostic and screenig mammograms performed with new technologies.

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.

80048: Automated Multichannel Tests

The complete local medical review policy (LMRP) for Automated Multichannel Tests was published in the September/ October 2000 Medicare B Update! *(pages 32-50). Since then, the following changes have been made to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections of the policy:*

Calcium; total (Procedure Code 82310):
Calcium is a predominantly extracellular cation. It is of great importance in blood coagulation; it gives firmness and rigidity to bones and teeth; it is important in acid-base balance; it is essential for lactation; it is important in activating enzymes; it is essential for the function of nerves and muscles, including the myocardium; and for maintaining the permeability of membranes. Over 98% of body's calcium is found in the bones and teeth. The serum calcium test is used to evaluate parathyroid function and calcium metabolism by directly measuring the total amount of calcium in the blood. About 50% of blood calcium is ionized; the rest is protein bound (with albumin). The serum calcium level is a measurement of both. The normal calcium is 8.5-10.5 mg/dl.

Florida Medicare will consider a calcium test medically reasonable and necessary for the following conditions:

Evaluation of patients with clinical signs and symptoms of hypercalcemia. Signs and symptoms of hypercalcemia include, but are not limited to**,** the following:

nausea and vomiting	prominent skeletal muscle weakness
anorexia	polyuria, nocturia, polydipsia
constipation	stupor
abdominal pain	coma
dehydration	ECG changes/prolongation of QT interval
lethargy	death
confusion	flank pain due to renal calculi

Conditions in which a serum calcium test may be medically reasonable and necessary for hypercalcemia include, but are not limited to, the following: hyperparathyroidism; malignancies; adrenal insufficiency; acromegaly; hypervitaminosis D; immobilization; and drugs (e.g., thiazide diuretics, calcium salts, etc.).

Evaluation of patients with clinical signs and symptoms of hypocalcemia. Signs and symptoms of hypocalcemia include, but are not limited to, the following:

arrhythmias	anxiety
bronchospasm	malaise
muscle cramping	tetany
seizure activity	dysphagia
diplopia and photophobia	muscle twitching

Trousseau's sign (carpopedal spasm)
Chvostek's sign (facial muscle spasm)
ECG changes/shortened QT interval
unexplained dementia, depression, psychosis
circumforal and peripheral numbness and tingling

Conditions in which a serum calcium test may be medically reasonable and necessary for hypocalcemia include, but are not limited to, the following: hypoparathyroidism; hypoalbuminemia; renal failure; pancreatitis; vitamin D deficiency; severe malnutrition and malabsorption; septic shock; and drugs (e.g., anticonvulsants, heparin, laxatives, loop diuretics, magnesium salts, and etc.).

Even though a patient has a condition stated above, it is not expected that a serum calcium test be performed frequently for stable chronic symptoms that are associated with that disease.

Disorders of calcium metabolism are initially evaluated with measurements of serum phosphorus, albumin, chloride, magnesium, potassium, total protein, parathyroid hormone levels, and often a 24-hour urine calcium level.

In accordance with national Medicare coverage policy, serum calcium laboratory tests are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

Chloride, blood (Procedure Code 82435):
Chloride is an anion that exists primarily in the extracellular spaces as part of sodium chloride or hydrochloric acid. Chloride maintains cellular integrity

through its influence on osmotic pressure and acid-base and water balance. Chloride concentration increases or decreases in response to concentrations of other anions.

Measurement of chloride is usually done for inferential value and is helpful in diagnosing disorders of acid-base and water balance. The normal adult serum chloride leve is 96-106 mEq/L.

Florida Medicare will consider a serum chloride test medically reasonable and necessary when performed for the following conditions:

Evaluation of patients with signs and symptoms of hypochloremia. Signs and symptoms of hypochloremia include, but are not limited to, the following:

hyperexcitability of the nervous system and muscles
shallow breathing
hypotension
tetany

Conditions in which serum chloride may be medically reasonable and necessary include, but are not limited to, the following which are related to hypochloremia:

severe vomiting
severe diarrhea
excessive sweating
gastric suction
chronic respiratory acidosis
burns
metabolic alkalosis
congestive heart failure
addison's disease
primary aldosteronism
syndrome of inappropriate antidiuretic hormone (SIADH)
overhydration or water intoxication
acute intermittent porphyria

Evaluation of patients with signs and symptoms of hyperchloremia. Signs and symptoms of hyperchloremia can include, but are not limited to, the following:

lethargy
weakness
deep breathing

Conditions in which serum chloride may be medically reasonable and necessary include, but are not limited to, the following which are related to hyperchloremia:

dehydration
cushing's syndrome
hyperventilation which causes respiratory alkalosis
metabolic acidosis with prolonged diarrhea
hyperparathyroidism
renal tubular acidosis
diabetes insipidus
salicylate intoxication
head injury with hypothalmic damage
multiple myeloma
acute or chronic renal failure
excessive infusion of sodium chloride
hyperchloremic acidosis resulting from gastrointestinal
bicarbonate loss caused by drugs (e.g., calcium chloride, magnesium sulfate, and cholestyramine)
hyperchloremic acidosis resulting from drug induced
hyperkalemia with renal insufficiency (e.g., potassium sparing diuretics, trimethoprim, pentamidine, angiotensin-converting enzyme inhibitors, nonsteroidal anti-inflammatory drugs, and cyclosporine)

Even though a patient has a condition stated above, it is not expected that a serum chloride test be performed frequently for stable chronic symptoms that are associated with that disease.

Interpretation of chloride usually requires clinical information and other electrolytes such as sodium, potassium, and carbon dioxide to assess electrolyte, acid-base, and water balance.

In accordance with national Medicare coverage policy, serum chloride laboratory tests are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

Phosphorus (inorganic phosphate); (Procedure Code 84100):
Phosphorus is a non-metal chemical element. Most of the body's phosphorus is combined with calcium within the skeleton, however, approximately 15% of the phosphorus exits in the blood as a phosphate salt. Phosphates help store and utilize body energy, and help regulate calcium levels, carbohydrate and lipid metabolism, and acid-base balance. Vitamin D is important in the absorption and metabolism of phosphorus. Phosphorus levels are determined by calcium metablolism, parathormone, and to a lesser degree by intestinal absorption. Normal serum phosphorus is 2.5-4.5 mg/dl. Serum phosphate levels help to detect endocrine, skeletal, and calcium disorders, and aid in the diagnosis of renal disorders and acid-base imbalance.

Florida Medicare will consider a phosphorus test medically necessary under either of the following circumstances:

Evaluate patients with signs and symptoms of hypophosphatemia. Patients with mild hypophosphatemia usually have no clinical manifestations. Clinical findings below usually occur when the phosphate deficit is severe:

anorexia
nausea
muscle weakness and soreness
bone pain
apprehension
confusion
paresthesias
mental obtundation
hypercalciuria
osteomalacia
rhabdomyolysis
encephalopathy
seizures
hemolysis
platelet dysfunction
thrombocytopenia

Conditions in which serum phosphorus test may be medically reasonable and necessary include, but are not limited to, the following which are related to hypophosphatemia:

Decreased phosphate ingestion or absorption:

malnutrition: alcoholism, starvation
vitamin D deficiency
malabsorption syndromes
hyperalimentation without phosphate supplements

Increased utilization or consequence of metabolism:

pregnancy
recovery from malnutrition or diabetic ketoacidosis: insulin and glucose therapy
respiratory alkalosis: salicylate poisoning; gram-negative bacteremia
lactate, sodium bicarbonate, or sodium chloride infusions
absorption by bone following parathyroidectomy

Excess losses of phosphate:

dialysis
diuretic therapy
primary hyperparathyroidism
renal tubular defects: congenital, after renal transplant, toxic, and diuretic phase following acute renal failure or burns
oral antacid therapy
hypomagnesemia

\Evaluate patients with hyperphosphatemia. Patients with hyperphosphatemia usually have no clinical symptoms per se. Symptoms may arise, however, from underlying conditions. Some signs of hyperphosphatemia can include, but are not limited to, the following:

serum phosphorus level greater than 4.5 mg/dl on two fasting blood levels
skeletal lesions on X-ray
elevation of serum creatinine and alkaline phosphatase

Conditions in which serum phosphate test may be medically reasonable and necessary include, but are not limited to, the following which are related to hyperphosphatemia:

Excess phosphate from exogenous sources:

ingestion of dairy products
ingestion of phosphate salts or use of phosphate enemas in patients with renal disease
hypervitaminosis D
sarcoidosis

Excess phosphate from endogenous sources:

metabolic or respiratory acidosis
skeletal lesion, local: myeloma, Padget's disease, metastatic carcinoma
skeletal lesion, diffuse: prolonged skeletal immobilization, severe hyperparathyroidism secondary to renal disease
phosphate release from tissue destruction or ischemia
irradiation or chemotherapy
hemolysis
lactic acidosis

Impaired excretion of phosphate: renal disease, hypoparathyroidism

Even though a patient has a condition stated above, it is not expected that a serum phosphorus test be performed frequently for stable chronic symptoms that are associated with that disease.

Tests useful in the differential diagnosis include repeat serum phosphorus, alkaline phosphatase, calcium, parathyroid hormone, and skeletal X-ray.

In accordance with national Medicare coverage policy, serum phosphate laboratory tests are routinely covered at a frequency of once per month for hemodialysis intermittent peritoneal dialysis, continuous cycling peritioneal dialysis, and hemofiltration beneficiaries. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

Utilization Guidelines

Routine serum calcium, serum chloride, and serum phosphate laboratory tests, those performed at a frequency of once per month for hemodialysis, intermittent peritioneal dialysis, continuous cycling peritoneal dialysis, and hemofiltration beneficiaries, are included in the renal facility's composite rate and may not be billed separately to the Medicare program. Services performed at a greater frequency than specified are separately billable if medically necessary. A diagnosis of ESRD (ICD-9-CM code 585) alone is not sufficient medical evidence to warrant coverage of additional tests.

Revision History

Revision Number:	13	PCR B2001-092
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		03/19/2001

Explanation of Revision: Three (3) of the enclosed chemistry tests (82310, 82435, and 84100) were further defined in individual Local Medical Review Policies. This policy is being revised to incorporate the language in the specific LMRPs to ensure consistency.

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.

80061: Lipid Profile/Cholesterol Testing

Florida Medicare recently received a request to add diabetes mellitus to the list of covered indications in our Local Medical Review Policy (LMRP) 80061 (Lipid Profile/Cholesterol Testing) for the performance of a lipid panel (80061). After reviewing the literature, it has been determined that an annual fasting lipid panel is a recognized test utilized in the management of diabetes mellitus. Therefore, effective for services processed on or after May 1, 2001, Florida Medicare will consider the performance of an annual fasting lipid panel (80061) medically reasonable and necessary for patients with diabetes mellitus (ICD-9-CM codes 250.00-250.93). If the lipid panel demonstrates dyslipidemia requiring dietary treatment, subsequent lipid panels should be billed utilizing ICD-9-CM codes 272.0-272.9. If the patient requires drug therapy due to the dyslipidemia, subsequent lipid panels should be billed utilizing ICD-9-CM code E942.2.

82728: Ferritin

The LMRP for Ferritin was published in the September/October 2000 *Medicare B Update!* (pages 51-52). In order to clarify the last bullet in the "Indications" section of the policy, the following statement, "Use ICD-9-CM codes 280.0-280.9 for these indications" has been added. If a patient has a suspected deficiency of iron due to a history of a prior gastrectomy, the appropriate ICD-9-CM code to use would be 280.9.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
82947

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Blood Glucose Testing

AMA CPT Copyright Statement

HCFA National Coverage Policy
Transmittals AB-00-99, AB-00-108, and AB-00-109

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
08/25/1997

Original Policy Ending Date
N/A

Revision Effective Date
06/18/2001

Revision Ending Date
06/17/2001

LMRP Description
Glucose, the body's main source of cellular energy, is formed from the digestion of carbohydrates and the conversion of glycogen by the liver. Glucose is essential for brain and erythrocyte function. Excess glucose is stored as glycogen in the liver and muscle cells. Hormones which influence glucose metabolism include insulin, glucagon, thyroxine, somatostatin, cortisol, and epinephrine. Glucagon accelerates glycogen breakdown in the liver and causes the blood glucose to rise. Insulin increases cell membrane permeability to glucose, transports glucose into cells for metabolism, stimulates glycogen formation, and reduces blood glucose levels.

Blood glucose testing is used to aid in the diagnosis, treatment, and follow-up of carbohydrate metabolism disorders.

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

In the presence of signs and symptoms of hyperglycemia, which can include the following:

-polyuria
-polydipsia
-weight loss, in spite of normal or excessive dietary intake
-candidal vaginitis in women

Conditions related to hyperglycemia include, but are not limited to, the following:

-diabetes mellitus
-acute stress response (e.g., myocardial infarction, severe infection)
-Cushing's disease
-pheochromocytoma
-hyperparathyroidism
-adenoma of the pancreas
-pancreatitis
-pituitary adenoma
-glucagonoma
-chronic liver disease
-chronic renal disease
-acromegaly

In the presence of signs and symptoms of hypoglycemia, which can include the following:

-diaphoresis
-tremulousness
-hunger
-faintness
-palpitations
-confusion
-inappropriate behavior
-visual disturbances
-coma
-seizures

Conditions related to hypoglycemia include, but are not limited to, the following:

-insulinoma
-hypothyroidism
-hypopituitarism
-Addison's disease
-extensive liver disease
-extrapancreatic neoplasm
-drug-induced hypoglycemia (eg, sulfonylurea, insulin, ethanol, salicylates)
-enzyme deficiency diseases (eg, galactosemia, inherited maple syrup disease)
-starvation

For the purpose of managing insulin therapy (shots, medication, diet).

For a laboratory service to be considered reasonable and necessary, it must not only be ordered by the physician, but the ordering physician must also use the result in the management of the beneficiary's medical condition. Implicitly, the blood glucose result must be reported to the physician promptly so that the physician can use the result and instruct continuation or modification of patient care.

If home use glucose monitoring devices are utilized by a home health employee during a home health visit, the service must be performed in accordance with laboratory coverage criteria to qualify for separate payment under the Medicare laboratory benefit. The home health agency must receive a supplier number and be registered for CLIA testing even if only a certificate of waiver is issued. Services performed for patients who maintain home-use glucose monitoring devices are not eligible for payment under Medicare's laboratory benefit.

CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

CPT/HCPCS Codes

82947 82948 82962

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

112.0	253.2	780.01
112.1	253.7	780.1
112.2	255.0	780.2
157.0-157.8	255.4	780.31-780.39
194.0	276.5	780.4
211.6	356.8	780.8
211.7	357.8	783.21
227.0	571.0	783.5
250.00-250.93	571.2	783.6
251.0	571.49	788.41
251.1	571.5	788.42
251.3	571.6	790.2
251.4	571.8	790.6
251.8	577.0	791.5
252.0	577.1	V67.51
253.0	648.80-648.84	

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 billing for the diagnosis of elevated blood sugar, use ICD-9-CM code 790.6 (other abnormal blood chemistry). ICD-9-CM code 790.6 is indicated for other abnormal blood chemistry; however, for blood glucose testing it is only covered when the test is being performed for an elevated blood sugar.

Bill the service with CPT procedure code **82947** for glucose; quantitative, blood, (except reagent strip)], and CPT procedure code **82948** for blood glucose, reagent strip. Include the appropriate ICD-9-CM code which describes the symptom or condition. CPT code **82947** should not be billed on the same day as a Basic-Metabolic Panel (**80048**), a General Health Panel (**80050**), or a Comprehensive Metabolic Panel (**80053**), unless the blood is obtained at different encounters.

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

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test, including:

- office/progress notes
- laboratory results

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

Utilization Guidelines

N/A

Other Comments

Terms-

Glucose quantitative method: a complex assay performed after blood is clotted and separated. The serum or plasma is assayed in a laboratory device generally designed for multiple sequential assays.

Glucose reagent strip method: a drop of whole blood is placed on the glucose oxidase strip, blotted at a prescribed interval, and the resulting color is compared against a color chart on the side of the vial which contains unused reagent strips.

Glucose monitoring device method: a drop of whole blood is obtained (usually by finger stick device) and assayed by glucose oxidase, hexokinase, or electrochemical methods and spectrophotometry using a small portable device designed, and approved by the FDA, for home blood glucose monitoring use.

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
05/01/2001

Revision History
Revision Number:	8	PCR B2001-089
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		06/18/2001

Explanation of Revision: HCFA released three Transmittals describing blood glucose monitoring services.

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
86353

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Lymphocyte Transformation

AMA CPT Copyright Statement

HCFA National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
06/18/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Lymphocyte transformation tests evaluate lymphocyte competence using in vitro tests to assess the ability of the lymphocytes to proliferate and to recognize and respond to antigens. Two types of lymphocyte transformation tests, mitogen assay and antigen assay, are discussed in this policy.

The mitogen assay, performed using nonspecific plant lectins, evaluates the mitotic response of T and B lymphocytes to a foreign antigen. In the mitogen assay, a purified culture of lymphocytes from the patient's blood is incubated with a nonspecific mitogen for 72 hours. The culture is then pulse-labeled with tritiated thymidine, which is incorporated in the newly formed DNA of dividing cells. The uptake of radioactive thymidine can be measured by a liquid scintillation spectrophotometer in counts per minute, which parallels the rate of mitosis. Lymphocyte responsiveness, or the extent of mitosis, is then reported as a stimulation index, determined by dividing the counts per minute of the stimulated culture by the counts per minute of a control culture.

The antigen assay uses specific antigens, such as purified protein derivative (PPD), Candida, mumps, tetanus toxoid, and streptokinase, to stimulate lymphocyte transformation. After incubation of 4 ½ to 7 days, transformation is measured by the same method used in the mitogen assay.

In the mitogen and antigen assays, a low stimulation index or unresponsiveness indicates a suppressed or defective immune system.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider a lymphocyte transformation test medically reasonable and necessary when performed for the following indications:

- To assess and monitor genetic and acquired immunodeficiency states (e.g., caused by marrow failure, certain drugs, etc.); and
- To monitor immunosuppressive or immunoenhancing therapy.

Note: This test is only covered when the patient has a suspected or known genetic or acquired immunologic disorder as demonstrated by the patient's history and physical. It is not covered as a screening test. In addition, it is expected that the results of this test will be used in the management of the patient.

CPT/HCPCS Section & Benefit Category
Immunology/Pathology and Laboratory

CPT/HCPCS Codes
86353

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
042
279.00-279.9
E933.1

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

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

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

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the performing provider 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 laboratory results.

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 includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on August 19, 2000.

Start Date of Comment Period
08/11/2000

End Date of Comment Period
09/25/2000

Start Date of Notice Period
05/01/2001

Revision History

Revision Number:	Original PCR B2001-093
Start Date of Comment Period	08/11/2000
Start Date of Notice Period	05/01/2001
	3rd QTR 2001 *Update!*
Original Effective Date:	06/18/2001

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
93922

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Sections 50-6, 50-7, 35-10

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
012/01/1994

Original Policy Ending Date
N/A

Revision Effective Date
06/18/2001

Revision Ending Date
06/17/2001

LMRP Description
Noninvasive physiologic studies are functional measurement procedures that include Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurements, or plethysmography. These studies are useful to confirm and document arterial insufficiency.

The purpose of this policy is to define the circumstances for which Florida Medicare will consider noninvasive physiologic studies of upper or lower extremity arteries to be medically necessary and, therefore, covered.

Indications and Limitations of Coverage and/ or Medical Necessity
Florida Medicare will consider noninvasive physiologic studies of the upper or lower extremity arteries to be medically necessary under any of the following circumstances:

- Claudication of less than one block or of such severity that it interferes significantly with the patient's occupation or lifestyle. The diabetic patient with absent or diminished pulses with or without neuropathies may have no symptoms of claudication due to their neuropathy type symptoms. Slowing down of their gait patterns, also, may not cause claudication symptomatology.
- Rest pain (typically including the forefoot), usually associated with absent pulses, which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position.
- Tissue loss defined as gangrene or pregangrenous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses.
- Aneurysmal disease.
- Evidence of thromboembolic events.
- Evidence of compression/occlusion of the vascular structures supplying the upper extremity.
- Blunt or penetrating trauma (including complications of diagnostic and/or therapeutic procedures).
- Transcutaneous oxygen tension measurements (TpO_2) are utilized in conditions for which hyperbaric oxygen therapy (HBO) is being considered, as well as for monitoring the course of HBO therapy. Medicare has identified on a national level, the medical conditions covered for HBO therapy. The following conditions are considered medically indicated uses for TpO_2 testing prior to, and during the course of, HBO therapy: acute traumatic peripheral ischemia, crush injuries and suturing of severed limbs, progressive necrotizing infections, acute peripheral arterial insufficiency, preparation and preservaton of compromised skin grafts, and soft tissue radionecrosis as an adjunct to conventional treatment.
- Transcutaneous oxygen tension measurements (TpO_2) used to determine a line of demarcation between viable and non-viable tissue when surgery or amputation is anticipated.

A routine history and physical examination, which includes Ankle/Brachial Indices (ABIs), can readily document the presence or absence of ischemic disease in a majority of cases. It is not medically necessary to proceed beyond the physical examination for minor signs and symptoms such as hair loss, absence of a single pulse, relative coolness of a foot, shiny thin skin, or lack of toe nail growth unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention. Examples of additional signs and symptoms that do not indicate medical necessity include:

- Continuous burning of the feet is considered to be a neurologic symptom.
- "Leg pain, nonspecific" and "Pain in limb" as single diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.
- Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.
- Absence of relatively minor pulses (e.g., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.

While the HBO Society has not published a practice parameter regarding the use of TpO_2 to monitor the response to HBO therapy, literature supports repeating the TpO_2 value after 20 treatments. Comparison is made with the baseline study to determine the response to therapy.

In general, noninvasive studies of the arterial system are to be utilized when invasive correction is contemplated, but not to follow noninvasive medical treatment regimens (e.g., to evaluate pharmacologic intervention). The latter may be followed with physical findings and/or progression or relief of signs and/or symptoms.

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

CPT/HCPCS Codes
93922
93923
93924

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

440.0	444.81-444.89	903.5
440.20-440.24	447.0	903.8
440.30-440.32	447.1	904.0
441.00-441.03	447.2	904.1
442.0	707.10-707.19	904.41
442.3	707.8	904.51
443.0	785.4	904.53
443.1	903.00	904.6
443.81	903.02	904.7
443.9	903.1	996.1
444.0	903.2	996.70-996.79
444.1	903.3	998.11-998.13
444.21-444.22	903.4	998.2

Medical conditions covered by Coverage Issues Manual, Section 35-10 for HBO therapy with associated transcutaneous oxygen tension measurements (TpO_2):

444.21-444.22	927.00-927.09	928.3
444.81	927.10-927.11	928.8-928.9
728.86	927.20-927.21	929.0-929.9
902.53	927.8	990
903.01	927.9	996.52
903.1	928.00-928.01	996.90-996.99
904.0	928.10-928.11	
904.41	928.20-928.21	

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
Duplex scanning (93925, 93926, 93930, and 93931) and physiologic studies (93922, 93923, and 93924) are reimbursed during the same encounter if the physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurysmal disease. Medical record documentation must demonstrate the medical necessity of performing both duplex scanning and physiologic studies on the same date of service.

For evaluation of dialysis access, see Local Medical Review Policy 93990.

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of non-invasive physiologic studies of the upper or lower extremity arteries. Also, the results of arterial studies must be included in the patient's medical record. If performing procedure code 93924, documentation must include results of resting studies *and* after treadmill stress testing studies. This information is normally found in the office/progress notes and test results.

If the provider of noninvasive physiologic studies of arteries of the upper or lower extremity 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 arterial studies from another provider, the ordering/referring physician must state the reason for the studies in his order for the tests.

Vascular testing that is billed excessively may be considered medically necessary when there is a change in the patient's symptoms (acceptable ICD-9-CM code) or there is the presence of a new condition (acceptable ICD-9-CM code).

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 Vascular Society.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History

Revision Number	6	PCR B2001-088
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2001
		3rd QTR 2001 *Update!*
Revised Effective Date		06/18/2001

Explanation of Revision: HCFA released Transmittal 129 modifying national coverage for Hyperbaric Oxygen (HBO) therapy.

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.

95115: Allergen Immunotherapy

The local medical review policy (LMRP) for allergen immunotherapy services was published in the September/October 2000 *Medicare B Update!* (pages 69-70). It has been brought to Florida Medicare's attention that the "Coding Guidelines" section of the policy currently identifies evaluation and management (E/M) service codes 99201-99215 as being allowed in addition to 95115 or 95117 only when separately identifiable services are provided at the same time. However, ***any*** E/M service is allowed in addition to 95115 or 95117 when separately identifiable services are provided at the same time. Therefore, the reference to the specific E/M codes in the "Coding Guidelines" section of the policy has been removed. All other references in the policy as published continue to be in effect, including the advance beneficiary notice statement.

FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number
99183

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Hyperbaric Oxygen Therapy (HBO Therapy)

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual , Section 35-10
HCFA letter July 13, 1998 DHPP:CJ

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
05/01/2001

Revision Ending Date
05/06/2001

LMRP Description
Hyperbaric Oxygen Therapy is a medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O_2) at greater than one atmosphere (atm) pressure. Either a monoplace chamber pressurized with pure O_2 or a larger multiplace chamber pressurized with compressed air where the patient receives pure O_2 by mask, head tent, or endotracheal tube may be used.

In order to receive Medicare reimbursement for HBO therapy, the physician must be personally in constant attendance in the hyperbaric department (unit) when the patient is receiving hyperbaric oxygen therapy. This is a professional activity that cannot be delegated in that it requires independent medical judgment by the physician. The physician must be present, carefully monitoring the patient during the hyperbaric oxygen session and be immediately available should a complication occur.

Indications and Limitations of Coverage and/or Medical Necessity
HBO therapy is covered by Medicare for the following conditions:

1. **Acute carbon monoxide intoxication** induces hypoxic stress. The cardiac and central nervous systems are the most susceptible to injury from carbon monoxide. The administration of supplemental oxygen is essential treatment. Hyperbaric oxygen causes a higher rate of dissociation of carbon monoxide from hemoglobin than can occur breathing pure air at sea level pressure. The chamber compressions should be between 2.5 and 3.0 atm abs. It is not uncommon in patients with persistent neurological dysfunction to require subsequent treatments within six to eight hours, continuing once or twice daily until there is no further improvement in cognitive functioning.
2. **Decompression illness** arises from the formation of gas bubbles in tissue or blood in volumes sufficient enough to interfere with the function of an organ or to cause alteration in sensation. The cause of this enucleated gas is rapid decompression during ascent. The clinical manifestations range from skin eruptions to shock and death. The circulating gas emboli may be heard with a Doppler device. Treatment of choice for decompression illness is HBO with mixed gases. The result is immediate reduction in the volume of bubbles. The treatment prescription is highly variable and case specific. The depths could range between 60 to 165 feet of sea water for durations of 1.5 to over 14 hours. The patient may or may not require repeat dives.
3. **Gas embolism** occurs when gases enter the venous or arterial vasculature embolizing in a large enough volume to compromise the function of an organ or body part. This occlusive process results in ischemia to the affected areas. Air emboli may occur as a result of surgical procedures (e.g., cardiovascular surgery, intra-aortic balloons, arthroplasties, or endoscopies), use of monitoring devices (e.g., Swan-Ganz introducer,

infusion pumps), in nonsurgical patients (e.g., diving, ruptured lung in respirator-dependent patient, injection of fluids into tissue space), or traumatic injuries (e.g., gunshot wounds, penetrating chest injuries). Hyperbaric oxygen therapy is the treatment of choice. It is most effective when initiated early. Therapy is directed toward reducing the volume of gas bubbles and increasing the diffusion gradient of the embolized gas. Treatment modalities range from high pressure to low pressure mixed gas dives.

4. **Gas gangrene** is an infection caused by the clostridium bacillus, the most common being clostridium perfringens. Clostridial myositis and myonecrosis (gas gangrene) is an acute, rapidly growing invasive infection of the muscle. It is characterized by profound toxemia, extensive edema, massive death of tissue and variable degree of gas production. The most prevalent toxin is the alpha-toxin which in itself is hemolytic, tissue-necrotizing and lethal. The diagnosis of gas gangrene is based on clinical data supported by a positive gram-stained smear obtained from tissue fluids. X-ray radiographs, if obtained, can visualize tissue gas.

   The onset of gangrene can occur one to six hours after injury and presents with severe and sudden pain at the infected area. The skin overlying the wound progresses from shiny and tense, to dusky, then bronze in color. The infection can progress as rapidly as six inches per hour. Hemorrhagic vesicles may be noted. A thin, sweet-odored exudate is present. Swelling and edema occur. The noncontractile muscles progress to dark red to black in color.

   The acute problem in gas gangrene is to stop the rapidly advancing infection caused by alpha-toxin. Medical treatment is aimed at stopping the production of alpha-toxin and to continue treatment until the advancement of the disease process has been arrested. The goal of HBO therapy is to stop alpha-toxin production thereby inhibiting further bacterial growth at which point the body can use its own host defense mechanisms. HBO treatment starts as soon as the clinical picture presents ***and*** is supported by a positive gram-stained smear. A treatment approach utilizing HBO, is adjunct to antibiotic therapy and surgery. Initial surgery may be limited to opening the wound. Debridement of necrotic tissue can be performed between HBO treatments when clear demarcation between dead and viable tissue is evident. The usual treatment consists of oxygen administered at 3.0 atm abs pressure for 90 minutes three times in the first 24 hours. Over the next four to five days, treatment sessions twice a day are usual. The sooner HBO treatment is initiated, the better the outcome in terms of life, limb and tissue saving.

5. **Crush injuries** and **suturing of severed limbs, acute traumatic peripheral ischemia** (ATI), and **acute peripheral arterial insufficiency:** Acute traumatic ischemia is the result of injury by external force or violence compromising circulation to an extremity. The extremity is then at risk for necrosis or amputation. Secondary complications are frequently seen: infection, non-healing wounds, and non-united fractures.

   The goal of HBO therapy is to enhance oxygen at the tissue level to support viability. When tissue oxygen tensions fall below 30mmHg., the body's ability to respond to infection and wound repair is compromised. Using HBO at 2-2.4 atm, the tissue oxygen tension is raised to a level such that the body's responses can become functional again. The benefits of HBO therapy for this indication are enhanced tissue oxygenation, edema reduction and increased oxygen delivery per unit of blood flow thereby reducing the complication rates for infection, nonunion and amputation.

   The usual treatment schedule is three 1.5 hour treatment periods daily for the first 48 hours. Additionally, two 1.5 hour treatment sessions daily for the next 48 hours may be required. On the fifth and sixth days of treatment, one 1.5 hour session would typically be utilized. At this point in treatment, outcomes of restored perfusion, edema reduction and either demarcation or recovery would be sufficient to guide discontinuing further treatments.

   For acute traumatic peripheral ischemia, crush injuries and suturing of severed limbs, Hyperbaric Oxygen Therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened. Arterial insufficiency ulcers may be treated by HBO therapy if they are persistent after reconstructive surgery has restored large vessel function.

6. The principal treatment for **progressive necrotizing infections** (necrotizing fasciitis) is surgical debridement and systemic antibiotics. HBO therapy is recommended as an adjunct only in those settings where mortality and morbidity are expected to be high despite aggressive standard treatment. Progressive necrotizing fasciitis is a relatively rare infection. It is usually a result of a group A streptococcal infection beginning with severe or extensive cellulitis that spreads to involve the superficial and deep fascia, producing thrombosis of the subcutaneous vessels and gangrene of the underlying tissues. A cutaneous lesion usually serves as a portal of entry for the infection, but sometimes no such lesion is found.

7. **Preparation and preservation of compromised skin grafts** utilizes HBO therapy for graft or flap salvage in cases where hypoxia or decreased perfusion have compromised viability. This indication is not for primary management of wounds. HBO therapy enhances flap survival. Treatments are given at a pressure of 2.0 to 2.5 atm abs lasting from 90-120 minutes. It is not unusual to receive treatments twice a day. When the graft or flap appears stable, treatments are reduced to daily. Should a graft or flap fail, HBO therapy may be used to prepare the already compromised recipient site for a new graft or flap. It does not apply to the initial preparation of the body site for a graft. HBO therapy is not necessary for normal, uncompromised skin grafts or flaps. Medicare's coverage does not apply to artificial skin grafts.

8. **Chronic refractory osteomyelitis** persists or recurs following appropriate interventions. These interventions include the use of antibiotics, aspiration of the abscess, immobilization of the affected extremity, and surgery. HBO therapy is an adjunctive therapy used with the appropriate antibiotics. Antibiotics are chosen on the basis of bone culture and sensitivity studies. HBO therapy can elevate the oxygen tensions found in infected bone to normal or above normal levels. This mechanism enhances healing and the body's antimicrobial defenses. It is believed that HBO therapy augments the efficacy of certain antibiotics (gentamicin, tobramycin, and amikacin). Finally, the body's osteoclast function of removing necrotic bone is dependent on a proper oxygen tension environment. HBO therapy provides this environment. HBO treatments are delivered at a pressure of 2.0 to 2.5 atm abs for a duration of 90-120 minutes. It is not unusual to receive daily treatments following major debridement surgery. The number of treatments required vary on an individual basis. Medicare can cover the use of HBO therapy for chronic refractory osteomyelitis that has been demonstrated to be unresponsive to conventional medical ***and*** surgical management.
9. HBO's use in the treatment of **osteoradionecrosis** and **soft tissue radionecrosis** is one part of an overall plan of care. Also included in this plan of care are debridement or resection of nonviable tissues in conjunction with antibiotic therapy. Soft tissue flap reconstruction and bone grafting may also be indicated. HBO treatment can be indicated both preoperatively and postoperatively.

   The patients who suffer from soft tissue damage or bone necrosis present with disabling, progressive, painful tissue breakdown. They may present with wound dehiscence, infection, tissue loss and graft or flap loss. The goal of HBO treatment is to increase the oxygen tension in both hypoxic bone and tissue to stimulate growth in functioning capillaries, fibroblastic proliferation and collagen synthesis. The recommended daily treatments last 90-120 minutes at 2.0 to 2.5 atm abs. The duration of HBO therapy is highly individualized.
10. **Cyanide poisoning** carries a high risk of mortality. Victims of smoke inhalation frequently suffer from both carbon monoxide and cyanide poisoning. The traditional antidote for cyanide poisoning is the infusion of sodium nitrite. This treatment can potentially impair the oxygen carrying capacity of hemoglobin. Using HBO therapy as an adjunct therapy adds the benefit of increased plasma dissolved oxygen. HBO's benefit for the pulmonary injury related to smoke inhalation remains experimental. The HBO treatment protocol is to administer oxygen at 2.5 to 3.0 atm abs for up to 120 minutes during the initial treatment. Most patients with combination cyanide and carbon monoxide poisoning will receive only one treatment.
11. **Actinomycosis** is a bacterial infection caused by Actinomyces israelii. Its symptoms include slow growing granulomas that later breakdown, discharging viscid pus containing minute yellowish granules. The treatment includes prolonged administration of antibiotics (penicillin and tetracycline). Surgical incision and draining of accessible lesions is also helpful. Only after the disease process has shown refractory to antibiotics and surgery, could HBO therapy be covered by Medicare. HBO therapy must be utilized adjunct to conventional therapy.

Prior to the initiation of HBO therapy, it is expected in most cases that the diagnosis will be established by the referring or treating physician.

Indications of effective treatment outcomes for HBO include:

- Improvement or healing of wounds.
- Improvement of tissue perfusion.
- New epithelial tissue growth and granulation.
- Tissue PO_2 of at least 30 mmHg of oxygen is necessary for oxidative function to occur.
- Mechanical reduction in the bubble size of air emboli alleviates decompression sickness and gas/ air emboli.
- Tissue PO_2 of 40 or greater defines resolved hypoxia. The body can now resume host functions of wound healing and anti-microbial defenses without the need of HBO therapy.

HBO therapy should not be a replacement for other standard successful therapeutic measures; however, it is the treatment of choice and standard of care for decompression sickness and arterial gas embolism. Traumatic or spontaneous pneumothorax constitute contraindications to adjunctive HBO therapy only if untreated. Pregnancy is considered a contraindication to HBO therapy except in the case of carbon monoxide poisoning where it is specifically indicated.

CPT/HCPCS Section & Benefit Category
Medicine/Other Services and Procedures

CPT/HCPCS Codes
99183
G0167

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

039.0-039.9	904.41	929.0-929.9
040.0	927.00-927.09	958.0
444.21-444.22	927.10-927.11	986
444.81	927.20-927.21	987.7
526.89	927.8	989.0
728.86	927.9	990
730.10-730.19	928.00-928.01	993.2
902.53	928.10-928.11	993.3
903.01	928.20-928.21	996.52
903.1	928.3	996.90-996.99
904.0	928.8-928.9	999.1

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.

Topical application of oxygen (Topox) does not meet the definition of HBO therapy. Also, its clinical efficacy has not been established; therefore, no reimbursement may be made.

Local coverage policy for HBO therapy requires that a physician be present during an HBO therapy session. Services performed in the absence of a physician will not be reimbursed (G0167).

No program payment may be made for HBO in the treatment of the following conditions (per CIM 35-10):

- Cutaneous, decubitus and stasis ulcers
- Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell anemia
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome (Pick's disease Alzheimer's disease Korsakoff's disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic diseases
- Acute cerebral edema

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

Evaluation and management services and/or procedures (e.g., wound debridement, transcutaneous PO_2 determinations) provided in a hyperbaric oxygen treatment facility in conjunction with a hyperbaric oxygen therapy session may be reported separately.

This code reflects a per session descriptor, therefore, regardless of the time HBO therapy is performed (e.g., 1 hour, 2 hours) during each session, each unit billed equals one session.

For each of the fourteen covered conditions, the following diagnosis should be utilized:

1. Acute carbon monoxide intoxication - Diagnosis 986
2. Decompression illness - Diagnosis 993.2, or 993.3
3. Gas embolism - Diagnosis 958.0, or 999.1
4. Gas gangrene - Diagnosis 040.0
5. Acute traumatic peripheral ischemia - Diagnosis 902.53, 903.01, 903.1, 904.0 or 904.41
6. Crush injuries and suturing of severed limbs - Diagnosis 927.00-927.09, 927.10-927.11, 927.20-927.21, 927.8, 927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0-929.9, or 996.90-996.99
7. Progressive necrotizing infections:(necrotizing fasciitis) - Diagnosis 728.86
8. Acute peripheral arterial insufficiency - Diagnosis 444.21, 444.22, 444.81
9. Preparation and preservation of compromised skin grafts (flaps) - Diagnosis 996.52
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management - Diagnosis 730.10-730.19
11. Osteoradionecrosis as an adjunct to conventional treatment - Diagnosis 526.89
12. Soft tissue radionecrosis as an adjunct to conventional treatment - Diagnosis 990
13. Cyanide poisoning - Diagnosis 987.7 or 989.0
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment. - Diagnosis 039.0-039.9

Documentation Requirements

There must be medical documentation to support the condition for which HBO therapy is being given. Documentation for all services should be maintained on file (e.g., progress notes and treatment record) to substantiate medical necessity for HBO treatment.

This medical documentation must include:

1. An initial assessment which will include a medical history detailing the condition requiring HBO therapy. The medical history should list prior treatments and their results including antibiotic therapy and surgical interventions. This assessment should also contain information about adjunctive treatment currently being rendered.
2. Physician progress notes.
3. Any communication between physicians detailing past or future (proposed) treatments.
4. Positive gram-stain smear is required to support the diagnosis of gas gangrene.
5. Definitive radiographic evidence and bone culture with sensitivity studies are required to confirm the diagnosis of osteomyelitis.
6. HBO treatment records describing the physical findings, the treatment rendered and the effect of the treatment upon the established goals for therapy.

Utilization Guidelines
Payment will be made for HBO therapy when it is clinically practical. HBO therapy should not be a replacement for other standard successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than 1 week to several months duration, the average being 2 to 4 weeks. The use of hyperbaric oxygen for more than 2 months, regardless of the condition of the patient, will be reviewed for medical necessity before further reimbursement is made.

Other Comments
N/A

Sources of Information
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 Florida College of Emergency Physicians and Florida Orthopaedic Society.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2001

Revision History

Revision Number:	13	PCR B2001-087
Start Date of Comment Period		N/A
Start Date of Notice Period		05/07/2001
		3rd QTR 2001 *Update!*
Revised Effective Date:		05/07/2001

Explanation of Revision: HCFA released Transmittal No. 129 modifying national coverage for Hyperbaric Oxygen (HBO) Therapy which was published in the 1st Quarter 2001 *Update!*. Multiple provider issues clarified.

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.

Additional Change to the List of Medicare Noncovered Services (A9270)

As this issue goes to print, an additional change has been made to the list of services that are noncovered by Florida Medicare.

The following service has been deleted from Local Noncoverage:

84999* Lymphocyte mitogen response assays used to monitor the treatment of cancer.

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

This change is effective for services processed on or after June 18, 2001. Please refer to the new local medical review policy for lymphocyte transformation (LMRP number 86353) on pages 71-72 of this issue. The remainder of the changes to the List of Medicare Noncovered Services for this quarter may be found on page 36.

ELECTRONIC MEDIA CLAIMS

Elimination of HCFA Free Billing Software Beginning October 1, 2003

Since the late 1980s, the Health Care Financing Administration (HCFA) has required Medicare contractors, such as First Coast Service Options, Inc., (FCSO), to offer free (or "at cost") electronic billing software to our providers upon request. These generally simple pieces of software allowed our providers to submit electronic claims to Medicare, using Medicare specific electronic data interchange formats, either the National Standard Format, the UB-92, or the X12N 837 format. FCSO was required to offer this software in order to increase electronic claim submissions. The software gave our providers an opportunity to try electronic billing at low cost, with the expectation that providers would experience the benefits and procure or develop more sophisticated practice management or billing software that would do additional functions. Additionally, use of this software reduced processing costs to the Medicare program as providers switch from paper to electronic claims.

With the advent of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, there will no longer be Medicare specific electronic formats. The same format will be used by providers to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for providers, and should encourage more providers to use electronic transactions. These changes have prompted HCFA to assess whether or not to continue offering the free billing software in the post-HIPAA environment. HCFA will require FCSO to begin phasing out the free billing software requirement effective fiscal year (FY) 2004, approximately one year after HIPAA standards are implemented. This will give providers enough time to find substitute software that can work with all payers. Providers, suppliers, and vendors will be notified when the transition period will begin to phase out the free billing software.

GENERAL INFORMATION

FRAUD AND ABUSE

Fraud and Abuse in the Medicare Program

This article is intended to inform Medicare providers and health care organizations about the situations they may encounter concerning potential fraud and abuse of the Medicare program.

Fraud and abuse in the Medicare program accounts for a substantial percentage of Medicare's annual spending. In recent years, the estimated cost for fraud and abuse in the Medicare program was as high as $23 billion. However, as a result of the federal government's commitment to combating it as well as the public's growing awareness, this amount was reduced through efforts focused on prevention, education, detection, and enforcement. As of 1999, it was estimated that $12.6 billion could be attributed to fraud and abuse; and in 2000, that estimate was $11.9 billion.

Although these figures appear large, they must be put into perspective — that is; they actually represent a fraction of the Medicare program's total expenditures. For example, the $12.6 billion lost in 1999 represents 7.1 percent of all payments made and the $11.9 billion in 2000 represents 6.8 percent. Thus, it is understood that most health care providers and Medicare recipients are honest. However, those who are intentionally attempting to defraud the Medicare program are doing it well.

The taxpayer dollars lost to health care fraud and abuse are the financial resources that should be used to pay for services and items that keep Medicare recipients in good health. The federal government, its agencies and contractors are aggressively working in dealing with these issues. In addition, many health care providers and Medicare recipients are taking active roles in ensuring the integrity of the Medicare program.

What Is Fraud?

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. Some of the most common examples of fraud are listed below:

- Billing for services or items not actually furnished.
- Soliciting, offering, or receiving a kickback, bribe, or rebate in return for the referral of patients or to induce the performance of a service.
- Falsifying information on medical records, claims, applications, or cost reports in order to increase reimbursement or to receive payment that is not due.
- Misrepresenting services or items that would otherwise be considered not covered as covered services.
- Falsely billing for services or items either furnished to or by a person or entity not authorized under the Medicare program.

What Is Abuse?

Abuse may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid programs, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Although many types of inappropriate practices may be considered abusive, they may evolve into fraud.

What Happens When Fraud or Abuse Is Suspected?

The Health Care Financing Administration and its contractors not only administer the Medicare program, they have a responsibility in ensuring that the tax dollars used to pay medical benefits are used appropriately. They accomplish this through efforts in prevention, detection, and recovery.

It cannot be assumed that all inappropriate payments are the result of some type of fraudulent activity. The investigation and subsequent prosecution of cases of fraud are reserved for those instances when the fraudulent activity is substantiated and documented by repeated patterns of abuse. Therefore, health benefit payers must be prudent in their actions as their decisions could adversely affect individuals or organizations.

For those instances when fraud is not substantiated, there are a variety of remedies that may used to further prevent or recover inappropriate payments:

- Education – Potentially inappropriate activities may be addressed through education such as letters, personal contacts, and/or corrective action plans.
- Review – Claim payments may be reviewed on a pre-payment or retrospective basis. In these instances, inappropriate payments may be identified and denied before they are made or they may be identified and recovered after payment.
- Refunds – Inappropriate payments may be identified by either Medicare or by the recipient of payment. In these cases, the Medicare program may request a refund with or without further punitive action.

- Suspension of payments – In cases where fraud is suspected and it is determined that an individual or entity has received payment inappropriately, the Medicare contractor, through the authority of the Health Care Financing Administration, may suspend a health care provider's payments. That is, the contractor will continue to accept and process the provider's claims, but will withhold all payments.

For those instances when fraud is substantiated and documented through repeated patterns of abuse, Medicare contractors will initiate an investigation and refer the case to federal law enforcement agencies (i.e., the Office of the Inspector General, the Federal Bureau of Investigation, the United States Attorney' Office) for prosecution. In these instances, substantial criminal fines/restitution, incarceration and/or civil penalties may be imposed. In addition, the Department of Health and Human Services may exclude a health care provider from participating in any federally funded health benefit program if the provider is prosecuted for health care fraud.

How Can Health Care Providers Help?

The Medicare program has become big business and has attracted – as big businesses sometimes do – a few unsavory characters. As such, health care providers, although honest, must treat their organization as a business and protect it from any potentially inappropriate activities. Here are a few simple suggestions that health care providers may use in ensuring that they do not fall victim to potentially fraudulent activities:

- Stay informed of and follow Medicare regulations, policies, and guidelines as they relate to their particular type of organization. It has been demonstrated that many inappropriate activities could have been avoided if a provider would have understood the Medicare regulations that apply to their organization.
- Understand and monitor the terms of employment or contracts to ensure that they are not in violation of any law or regulation governing the Medicare program.
- Ensure that those individuals or entities authorized to bill and/or receive payment on behalf of the health care provider have the appropriate knowledge and expertise in dealing with the Medicare program.
- Ensure that there are no violations of laws or regulations when conducting business with individuals or entities outside of the provider's organization.
- Ensure that any document filed to the Medicare program is accurate and meets the appropriate standards (e.g., claims, medical records, cost reports, applications, etc.).
- If a health care provider suspects any type of fraudulent activity, report it to the Medicare contractor or federal law enforcement agency.

GENERAL INFORMATION

If You Experience Problems When Dialing New Toll-Free Number

The Health Care Financing Administration (HCFA) has received a few reports of providers experiencing some problems when calling the new "866 or 877" provider toll-free numbers (Florida Medicare's Part B provider toll-free numbers are 1-866-454-9007 to speak with a Customer Service Representative and 1-877-847-4992 to reach the Interactive Voice Response (IVR) system). The following scenarios may help callers to better understand why they are experiencing difficulties, and who to call to resolve the problem.

Caller on a Telephone Line Behind a Private Branch Exchange (PBX) or an Automated Call Distributor (ACD)

The caller attempts to place a call by dialing an access code, "usually 9" then dials 1-866-NXX-XXXX or 1-877-NXX-XXXX. If the call does not ring through or the caller receives an intercept message the caller should:

1. Contact the PBX or ACD system administrator and advise them that "866 and 877" need to be added to the system to allow calls to these toll-free numbers.
2. If the problem is not in the PBX or ACD, the system administrator should call the local telephone company and report a trouble.

Caller on a Home Telephone

The caller attempts to place a call by dialing 1-866-NXX-XXXX or 1-877-NXX-XXXX. If the call does not ring through or the caller receives an intercept message the caller should:

1. Call his or her local telephone company repair service and request that toll-free exchanges "866 and 877" be made available for calls from his or her home telephone number.

Caller on a Cellular Phone

The caller attempts the call by dialing 1-866-NXX-XXXX or 1-877-NXX-XXXX. If the call does not ring through or the caller receives an intercept message the caller should:

1. Call his or her cellular service provider and request the addition of "866 and 877" to his or her dialing capabilities.

Bulletin and Newsletter Registration Delayed

Notice was provided in the 2nd Quarter 2001 issue of the *Medicare B Update!* that Medicare contractors were going to be required to register providers and suppliers who wanted to continue receiving hard copy Medicare publications. Since release of that information, the Health Care Financing Administration (HCFA) has advised contractors to temporarily suspend their registration efforts. Although such registration remains HCFA's intention, for the immediate future providers and suppliers will see no changes in the way they receive communications from Medicare contractors.

In the meantime, to see what is available online, providers and suppliers are invited to log on to our Website, **www.FloridaMedicare.com.**

The Medicare Fee Schedule Calculation Process

The majority of the services covered under Medicare Part B are reimbursed using a national fee schedule based on the cost physicians incur in rendering a service. There is no payment differential based on the specialty of the provider or the number of years the provider has been in practice under the Medicare program. The Medicare Part B Fee Schedule is calculated based on guidelines set forth by the Health Care Financing Administration (HCFA) that may be found in section 15000 of the Medicare Carriers Manual (MCM). Fee Schedule calculations are performed and provided by HCFA to carriers. The fee schedule is mailed from carriers to providers in mid-November of each calendar year. Additional updates may be made to the fee schedule on a quarterly basis as deemed appropriate by HCFA.

The elements used to calculate the fee schedule amounts are:

- **Resource Based Relative Value Units (RBRVU):** This factor takes into consideration the physician work required for the service, practice expenses, and the malpractice insurance premium. This rate is established annually at a national level and does not vary among Medicare carriers.
- **Geographic Practice Cost Index (GPCI):** This factor represents the variations in practice costs, which exist in different geographic areas. Three geographical areas (localities) exist in Florida. The GPCI is established for each RBRVU component (work, overhead, and malpractice) in each pricing locality for a given state.
- **Conversion Factor (CF):** This factor is a single number set annually at a national level and is used by all carriers in calculating the final fee schedule amounts.

  For each fee schedule service, there are three RBRVUs:
  - A relative value for physician work (RVUw),
  - A relative value for practice expense (RVUpe), and
  - A relative value for malpractice (RVUm).

  For each payment locality, there are three GPCIs:
  - A GPCI for physician work (GPCIw),
  - A GPCI for practice expense (GPCIpe), and
  - A GPCI for malpractice (GPCIm).

The formula for calculating the payment allowance for a given service under the fee schedule is:

Fee Schedule Amount = [(RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm)] x CF

The RBRVUs, GPCIs, and the conversion factor are published in a Final Rule in the *Federal Register* on or near November 1 of each year. Remember that these calculations do not take into account any reductions based on fee schedule payment policies (e.g., pre- post- and intra-operative percentages, professional and technical components, multiple surgery, bilateral surgery, assistant-at-surgery, co-surgery, team surgery, or facility pricing rules). For more information regarding fee schedule payment policies, please refer to the December, 2000 *Medicare B Update! Special Issue* (pages 2-50).

Payment of Physician and Nonphysician Services in Certain Indian Providers

The Indian Health Service (IHS) is the primary health care provider to the American Indian/Alaska Native (AI/AN) Medicare population. The Indian health care system, consisting of tribal, urban, and federally-operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries, via a network of hospitals, clinics, and other entities. While sections 1814(c)and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, an exception is provided for IHS facilities under section 1880. Prior to the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. Effective July 1, 2001, section 432 of BIPA extends payment to services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics.

TrailBlazer Health Enterprises, LLC has been selected as the Part B specialty carrier to enroll IHS, tribe and tribal organization facilities and process IHS physician and non-physician practitioner claims. TrailBlazer Health Enterprises, LLC is currently the fiscal intermediary for IHS hospitals and skilled nursing facilities. All enrollment requests and questions regarding hospitals or free-standing ambulatory care clinics, whether operated by the IHS or by an Indian tribe, or tribal organization, facilities, or any practitioners practicing therein to:

TrailBlazer Health Enterprises, LLC
Provider Enrollment Department
P.O. Box 660159
Dallas, TX 75266-0159

Promoting Colorectal Cancer Screening

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. The estimates for new cases and deaths from CRC in 2001 are 135,400 and 56,700 respectively. However, CRC is one of the most preventable cancers, as well as one of the most curable cancers when detected at an early stage.

Despite the advantages of CRC screening and the fact that Medicare covers CRC screening tests, utilization of this benefit is low. When testifying before the Special Committee on Aging in March 2000, the General Accounting Office (GAO) reported that in 1999, only 14.1 percent of Medicare beneficiaries had one or more of the covered CRC services for screening or diagnostic purposes. The utilization rate had changed little from the 1995 rate of 13.6 percent. While GAO noted numerous reasons for the low rates, including patient, physician, and delivery system issues, its report of the testimony states that there is "substantial room for better outreach and education." Participation from carriers and intermediaries in this effort is needed to increase the utilization of this important benefit.

Since implementation of Medicare's CRC screening benefit, HCFA has partnered with the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI) to increase CRC screening within the Medicare population. Together CDC, HCFA, and NCI carry out the *Screen for Life* (SFL) campaign, which informs men and women aged 50 years and older—the group most at risk—about the importance of CRC screening for early detection and prevention of the disease.

Providers are encouraged to discuss CRC screening with their patients. Research conducted to support the National CRC Awareness Month Campaign found that nearly half of survey respondents who were 50 years of age or older reported that their doctors did not discuss CRC screening with them. However, 9 out of 10 survey respondents reported that they underwent the CRC screening tests that were recommended by their physicians.

Distribution of CRC Materials

Materials that can be ordered free of charge or can be downloaded from the Internet include:

- "Good News" Poster (4 versions) targeting Caucasian, African-American, Asian-American, and Hispanic audiences, with tear-off cards that beneficiaries can take on visits to their doctors (stresses the importance of screening, mentions Medicare coverage);
- "No Symptoms" poster (points out that CRC often starts with no symptoms);
- "Let's Break the Silence" CRC brochures (English and Spanish versions);
- "Colorectal Cancer – Facts on Screening" (for patients); and
- "Colorectal Cancer – Health Professionals Facts on Screening."

In addition, other types of materials such as camera-ready slicks, television public service announcements (PSAs), and radio PSAs are available. Copies may be ordered from the CDC Internet site.

COLORECTAL CANCER (CRC) SCREENING PUBLICATIONS

TO ORDER COPIES FROM HCFA — FAX, E-MAIL, OR TELEPHONE:

Orders For 1-99 copies:
- Fax: 410-786-4786
- E-Mail: LBeasley@HCFA.gov
- Phone: Larry Beasley (410-786-7843)

Orders for 100 or more copies:
- Fax: 410-786-1905
- E-Mail: STaylor@HCFA.gov
- Phone: Susie Taylor (410-786-7849)

Note: Please order publications via fax or e-mail when possible. Because of the large volume of requests, you may not receive an acknowledgment return call for orders placed on voice mail.

TO ORDER OR DOWNLOAD PUBLICATIONS FROM HCFA'S INTERNET SITE:

- See information from the chart that follows for ordering or downloading "Let's Break the Silence" brochures from the HCFA Internet site.

TO ORDER OR DOWNLOAD PUBLICATIONS FROM CDC:

- Visit the Internet site at: **http://www.cdc.gov./cancer/screenforlife,**
- Call **1-888-842-6355,** or
- Write cancerinfo@cdc.gov.
- In addition, other types of materials such as camera ready slicks, television PSAs, and radio PSAs, which are not listed on the table that follows, can be ordered from the CDC Internet site.

TO VIEW MATERIALS BEFORE ORDERING:

- Visit the CDC Internet site at: http://www.cdc.gov./cancer/screenforlife

COLORECTAL CANCER SCREENING CAMPAIGN PRINT MATERIALS

Campaign Print Material	Version	HCFA – CDC Pub No.	Additional Information
Poster	"Medicare Good News" (Caucasian Audience)	HCFA #10122	Order packets of tear-off cards (HCFA #10140 – English) to attach to poster. Order from HCFA.
Poster	"Medicare Good News" (African-Amer. Audience)	HCFA #10124	Order packets of tear-off cards (HCFA #10140 – English) to attach to poster. Order from HCFA.
Poster	"Medicare Good News" (Asian-Amer. Audience)	HCFA #10125	Order packets of tear-off cards (HCFA #10140 – English) to attach to poster. Order from HCFA.
Poster	"Medicare Good News" (Hispanic Audience)	HCFA #10142	Order packets of tear-off cards (HCFA #10141 – Spanish) to attach to poster. Order from HCFA.
Poster–***NEW***	"No Symptoms"	HCFA #10183 CDC #099-6478	Posterboard backing. Order from HCFA.
Tear-off cards For Medicare "Good News" Poster	English	HCFA #10140	Packet of English language tear-off information cards, which attaches to "Good News" poster. Provides info on eligibility for CRC screening under Medicare, Medicare coverage of CRC screening, and risk for CRC. Order from HCFA.
Tear-off cards for Medicare "Good News" Poster	Spanish	HCFA #10141	Packet of Spanish language tear-off information cards, which attaches to Hispanic version of "Good News" poster. Provides information on eligibility for CRC screening under Medicare, Medicare coverage of CRC screening, and risk for CRC. Order from HCFA.
Brochure	*"Let's Break the Silence"* - English	HCFA #95173 CDC #099-6010	Also can be viewed or downloaded from the HCFA or CDC Internet sites. (The HCFA site is located at: http://www.medicare.gov/Publications/coloeng.pdf.) NOTE: The English version of the brochure has an incorrect HCFA Pub No. listed on the back--#10126.)
Brochure	*"Let's Break the Silence"* - Spanish	HCFA #10158 CDC #099-6198	Also can be viewed or downloaded from the HCFA or CDC Internet sites. (The HCFA site is located at: http://www.medicare.gov/Publications/colspan.pdf.) NOTE: The Spanish brochure has an incorrect CDC Pub No. listed on the back--#099-6010.
Fact Sheet – ***NEW***	CRC Facts on Screening (Patients)	CDC #099-6486	A limited number of fact sheets currently are available. They may be ordered or downloaded from CDC's *Screen for Life* Internet Site. *(See instructions on page 1.)*
Fact Sheet – ***NEW***	CRC Health Professionals Facts on Screening	CDC #099-6487	A limited number of fact sheets currently are available. They may be ordered or downloaded from CDC's *Screen for Life* Internet Site. *(See instructions on page 1.)*

Reprintable Beneficiary Poster

In addition to the materials listed above, the information on the following page could be placed in beneficiaries' view:

Some Important Facts You Should Know about Colorectal Cancer!

- Colorectal cancer is the second leading cause of cancer related deaths for men and women in the United States. Colorectal cancer (cancer of the colon or rectum) is second only to lung cancer in causing cancer-related deaths in the U.S. An estimated 135,400 new cases and 56,700 deaths from colorectal cancer are expected in 2001.
- More than one-third of colorectal cancer deaths could be avoided if people over 50 had regular screening tests.
- Most colorectal cancers begin as polyps. (Polyps are growths on the inner wall of the colon or rectum.)
- Colorectal cancer starts with no symptoms. Screening tests are so important because they can find colorectal cancer early, when treatment works best. When colorectal cancer is detected in the earliest stage of the disease (Stage 1), the survival rate is 96 percent.
- Colorectal cancer is one of the most preventable cancers. Screening tests can help prevent colorectal cancer by finding pre-cancerous polyps so they can be removed before they turn into cancer.
- Risk increases as we age. The risk of developing colorectal cancer increases with age. In fact, most cases occur in people 50 and older.
- Both men and women are at risk. Some people think that women are not at risk for colorectal cancer. However, both sexes may develop this cancer.
- African-Americans are more likely than whites to be diagnosed with colorectal cancer at a more advanced stage and more likely to die of it once diagnosed.
- Medicare helps pay for colorectal cancer screening tests. People with Medicare Part B coverage who are age 50 or older are eligible for colorectal cancer screenings. However, in the case of colonoscopy, there is no age limit. The following screening tests are covered by Medicare:
    - Fecal Occult Blood Test (done at home) – Covered once per year. You pay no coinsurance and no Part B deductible.
    - Flexible Sigmoidoscopy – Covered once every 4 years. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible.
    - Colonoscopy
      High Risk Individuals - If you are at high risk for colorectal cancer, Medicare covers a colonoscopy or a barium enema every 2 years. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible. (Your risk is greater if you have a history of inflammatory bowel disease, colorectal cancer, or polyps, and if you have a family history of colorectal cancer or polyps, or have certain hereditary syndromes.)
      Average Risk Individuals – Beginning July 1, 2001, if you are at average risk (i.e., not at high risk) for colorectal cancer, Medicare will cover a colonoscopy every 10 years. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible. However, if you are at average risk and have had a covered flexible sigmoidoscopy, you must wait 4 years to be eligible for Medicare coverage of a colonoscopy.
    - Barium Enema – This test can substitute for a flexible sigmoidoscopy or for a colonoscopy. You pay 20 percent of the Medicare approved amount after the yearly Part B deductible.

Steps You Can Take Now To Protect Your Health

- If you are 50 years old and have never been screened, talk to your doctor about having a screening test for colorectal cancer. Discuss the screening options that are right for you. Do not wait for symptoms.
- If you have any of the following symptoms, discuss them with your doctor. Only he or she can determine if cancer or other conditions are causing the symptoms. The symptoms are:
- Blood in or on the stool,
- A change in bowel habits,
- Stools that are narrower than usual,
- General stomach discomfort, - Frequent gas pains, and
- Unexplained weight loss.
- Visit the Federal Government's *Screen for Life* website at: **www.cdc.gov/cancer/ScreenforLife** for more information about colorectal cancer screening tests.
- Call the Centers for Disease Control and Prevention's toll-free line at 1-888-842-6355 to order a copy of a helpful fact sheet called **Colorectal Cancer Facts on Screening.** It also can be downloaded from the *Screen for Life* website. The fact sheet can help you decide on which screening test(s) is right for you. It gives important information about colorectal cancer and describes the screening tests. It also includes a chart describing each test with information on the purpose of the test, important things to consider when choosing a test, how often to have the test, the cost, and insurance/Medicare coverage.
- Call the National Cancer Institute's Cancer Information Service on 1-800-4-CANCER (TTY 1-800-332-9615) for more information about colorectal cancer or any other cancer.
- When you visit the doctor, keep the following tips in mind so that you get the most from your visit.
- Do not feel uncomfortable about asking questions. Bring a list of questions with you, and have it handy when you talk to the doctor.
- Ask about colorectal cancer screening, even if your doctor does not mention it.
- If you do not understand everything your doctor tells you, let him or her know.
- Bring a notepad and write down notes to help you remember important points.
- Ask your doctor for materials on colorectal cancer and other topics that you can read after you leave the office.

Centralized Influenza and Pneumococcal Vaccination Billing

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

In order to centrally bill for the 2001-2002 season that begins on October 1, 2001, multi-state mass immunizers interested in centralized billing must contact HCFA central office (CO), in writing, at the following address by June 1, 2001.

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

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for Centralized Billing

1. To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims.
2. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given.
3. Multi-state mass immunizers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries can not be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.
4. The carrier assigned to process the claims for centralized billing will be chosen at the discretion of HCFA based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance.
5. The payment rates for the administration of the vaccinations will be based on the MPFS for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, the multi-state mass immunizer must be willing to accept that payments received may vary based on the geographic locality where the service was performed.
6. The payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals which is based on the lower of cost, or 95 percent of the AWP.
7. Multi-state mass immunizers must agree to submit their claims in an electronic media claims standard format using either the National Standard Format (NSF) or American National Standards Institute (ANSI) X12.837 format. Paper claims will not be accepted.
8. In addition to the roster billing instructions found in the Medicare Carriers Manual, section 4480.6, Simplified Roster Bills, multi-state mass immunizers must complete on the electronic format the area that corresponds to Item 32, (Name and Address of Facility, including zip code) on Form HCFA-1500, in order for the carrier to be able to pay correctly by geographic locality. For electronic claims, report the name and address of the facility in: The National Standard Format, record EA0, field 39 (facility/lab name) and record EA1, fields 6 through 10 (facility/lab address, city, state and zip code), The ANSI X12N 837 (version (3051): Claim level loop 2310, 2-250-NM1, with a value of “61” (Performed at the Facility where work was performed) in NM101, a value of “FA” (Facility ID) or “ZZ” (NPI - when implemented) in NM108, and the Provider Number in NM109. Report the address in N3 and N4, The HIPAA ANSI X12N 837(version 4010): Claim level loop 2310D, 2-250-NM1, with a qualifier value of “FA” (Facility) in NM101, a value of “XX” (NPI) - when implemented) in NM108, and the Provider Number ID in NM109. Prior to NPI, enter the Provider Number in loop 2310D position 2-271-REF using “1C” (Medicare Provider Number) in REF01 and the facility ID in REF02. Report the address in N3 and N4.
9. Multi-state mass immunizers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. The assigned Medicare carrier must be contacted prior to the season for exact requirements. The responsibility lies with the multi-state mass immunizer to submit correct beneficiary Medicare information (including the beneficiary’s Medicare Health Insurance Claim Number) as the carrier will not be able to process incomplete or incorrect claims.
10. Multi-state mass immunizers must obtain an address for each beneficiary so that an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an EOMB or MSN from a carrier other than the carrier that normally processes their claims, which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, multi-state mass immunizers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the carrier selected by HCFA. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

11. Multi-state mass immunizers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. The Medicare carrier selected to process the claims can provide this information.
12. Though multi-state mass immunizers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the carrier selected by HCFA to process the flu and PPV claims. This can be done by completing Form HCFA-855 (Provider Enrollment Application) which can be obtained from that carrier.
13. If a multi-state mass immunizer's request for centralized billing is approved, the approval is limited to the upcoming flu season. It is the responsibility of the multi-state mass immunizers to reapply to HCFA CO for approval each year by June 1 for the year prior to the beginning of the flu season for which they wish to bill. Claims submitted without approval will be denied.
14. Each year the multi-state mass immunizers must contact the assigned carrier to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
15. The multi-state mass immunizer will be responsible for providing the beneficiary with a record of the PPV vaccination. The information requested in items 1 through 6 below must be included with the multi-state mass immunizer's annual request to participate in centralized billing:

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

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

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

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

Procedures Subject to Home Health Consolidated Billing

The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary in under a home health plan of care authorized by a physician. The Health Care Financing Administration (HCFA) has revised the previously released listing of procedures that were subject to home health consolidated billing effective October 1, 2000.

Services affected by the home health consolidated billing when billed by various types of providers submitting claims to either Medicare intermediaries or carriers at the same time as a home health episode are subject to denial because payment is provided to the home health agency creating the episode.

The services affected are:

- Non-routine supply
- Therapy codes

The new lists of procedures are effective for claims with dates of service January 1, 2001 through December 31, 2001 that are submitted to the carrier or intermediary July 1, 2001 and later.

Yearly updates to this list of procedures will be issued in conjunction with the release of the HCFA Common Procedure Coding System (HCPCS) annual update.

Non-Routine Supply Codes Affected

A4212	A4327	A4352	A4371	A4387	A4421	A5062	A5123
A4310	A4328	A4353	A4372	A4388	A4455	A5063	A5126
A4311	A4329	A4354	A4373	A4389	A4460	A5071	A5131
A4312	A4330	A4355	A4374	A4390	A4462	A5072	A6020
A4313	A4331	A4356	A4375	A4391	A4481	A5073	A6021
A4314	A4332	A4357	A4376	A4392	A4622	A5081	A6022
A4315	A4333	A4358	A4377	A4393	A4623	A5082	A6023
A4316	A4334	A4359	A4378	A4394	A4625	A5093	A6024
A4319	A4335	A4361	A4379	A4395	A4626	A5102	A6154
A4320	A4338	A4362	A4380	A4396	A4649	A5105	A6196
A4321	A4340	A4364	A4381	A4397	A5051	A5112	A6197
A4322	A4344	A4365	A4382	A4398	A5052	A5113	A6198
A4323	A4346	A4367	A4383	A4399	A5053	A5114	A6199
A4324	A4347	A4368	A4384	A4400	A5054	A5119	A6200
A4325	A4348	A4369	A4385	A4402	A5055	A5121	A6201
A4326	A4351	A4370	A4386	A4404	A5061	A5122	A6202

A6203	A6212	A6224	A6236	A6245	A6256	A6404	A7507
A6204	A6213	A6228	A6237	A6246	A6257	A6405	A7508
A6205	A6214	A6229	A6238	A6247	A6258	A6406	A7509
A6206	A6215	A6230	A6239	A6248	A6259	A7501	
A6207	A6219	A6231	A6240	A6251	A6261	A7502	
A6208	A6220	A6232	A6241	A6252	A6262	A7503	
A6209	A6221	A6233	A6242	A6253	A6266	A7504	
A6210	A6222	A6234	A6243	A6254	A6402	A7505	
A6211	A6223	A6235	A6244	A6255	A6403	A7506	

Therapy Codes Affected

G0193	64550	92597	97001	97022	97039	97504	97546
G0194	90901	92598	97002	97024	97110	97520	97601
G0195	90911	95831	97003	97026	97112	97530	97602
G0196	92506	95832	97004	97028	97113	97532	97703
G0197	92507	95833	97012	97032	97116	97533	97750
G0198	92508	95834	97014	97033	97124	97535	97799
G0199	92510	95851	97016	97034	97139	97537	
G0200	92525	95852	97018	97035	97140	97542	
G0201	92526	96105	97020	97036	97150	97545	

Overpayment Interest Rate

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

Effective April 26, 2001, the interest rate applied to Medicare overpayments is **13.75** percent, based on the new revised PCR rate. Previous interest rates may be found in past issues of the *Medicare B Update!* on our provider website, **www.floridamedicare.com**.

EDUCATIONAL RESOURCES

Medicare Education and Training Events

In the 2nd Quarter 2001 edition of the *Medicare B Update!* we informed you about HCFA's revised fee policy for Provider Education and Training. We also advised you that our education department was developing enhanced and supplemental programs to support improved Medicare education. We are pleased to announce the availability of the following Medicare educational programs for physicians and their billing staff:

- **Medicare – Beyond the Basics Interactive Workshop**
  This day-long practical, hands-on learning workshop will provide you opportunities to learn how to troubleshoot claim denials and talk to your patients to get the most accurate eligibility information, and network with other billing experts. It is a full day of learning and doing!

For dates, locations, and registration fees for these events, please visit the Education and Training section of our Website at **www.FloridaMedicare.com** or call our Medicare Seminar Registration Hotline at:

(904) 791-6422

Other specialty seminars are being developed and will be available soon. Topics being developed include ophthalmology, radiology, cardiology, and mental health.

For the latest information, call our Medicare Seminar Registration Hotline. You can hear about upcoming events, choose a location near you, and request a registration form via fax. Another feature of this service allows you to leave a voicemail to tell us about other Medicare topics you would like us to make available. We are interested in the needs of the provider community and would like to hear from you. Please call us and tell us what topics would be of interest to your practice!

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
❑	***Medicare B Update!*** **Subscription –** One copy of the *Update!*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
❑	**2001 Fee Schedule –** One copy of the *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* 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 *do not* include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Non-provider entities or providers who need additional copies at other office locations may purchase additional copies.	756250	$20.00
❑	**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%) $ _____

Total $ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

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

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** .

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

ELECTRONIC MEDIA CLAIMS (EMC)

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

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

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

MISCELLANEOUS

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

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

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Education and Outreach
P. O. Box 2078
Jacksonville, FL 32231-0048
For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32231

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048
For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

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

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

PHONE NUMBERS

BENEFICIARY

Toll-Free:
(800) 333-7586
Hearing Impaired:
(800) 754-7820

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

PROVIDERS

Toll-Free
Customer Service:
(877) 847-4992
Interactive Voice Response (IVR):
(866) 454-9007

EMC

Format Issues & Testing:
(904) 354-5977
Start-Up & Front-End Edits/Rejects:
(904) 791-8767
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Help Desk
(Confirmation/Transmission):
(904) 905-9880

OCR

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

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
(803) 735-1034

MEDICARE PART A

Toll-Free:
(877) 602-8816

WEBSITES

PROVIDER

Florida
www.floridamedicare.com

Health Care Financing Administration
www.hcfa.gov

BENEFICIARY

Florida
www.medicarefla.com

Health Care Financing Administration
www.medicare.gov

MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC. P.O. BOX 2078 JACKSONVILLE, FL 32231-0048

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*** ATTENTION BILLING MANAGER***

Medicare B Financial Services Department

Medicare Part B Financial Services Department

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

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

Refund: Medicare Part B funds returned due to an overpayment.

Forgery: An alleged fraudulent endorsement of a Medicare Part B check.

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

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

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

Written Inquiry: Any questions related to an overpayment and/or other debt collection.

Medicare Part B Financial Services Physician/Supplier Service Request Form

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

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

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

Note: Physician/suppliers who relocate must timely notify the Medicare Registration Department by using form HCFA-855C, Change of Information Form (a copy of the occupational license must be included) to ensure Medicare checks and correspondence are mailed to the correct address the first time. The form must be mailed to:

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

For general questions and other information, physicians/suppliers can call Provider Customer Service at (866) 454-9007, or write to the Customer Service Department at the address below:

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

What is an Overpayment?

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

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

HCFA
Health Care Financing Administration

FIRST COAST
SERVICE OPTIONS, INC.

How are Overpayments Detected?

Overpayments are detected in many ways:

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

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

How to Refund Overpayments

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

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

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

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

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

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

If you receive an overpayment letter:

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

If you do not make a timely refund:

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

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

Interest will accrue at an annual rate specified by law on the outstanding balance. In accordance with the provisions of Section 1833 (j) of the Tax Equity and Fiscal Responsibility Act and 42 CFR 405.378. First Coast Service Options, Inc., is required to charge interest on the account. You will not be assessed any interest if payment is received within 30 days. After this 30-day period, interest will be assessed for the first 30-day period and an additional 30 day period. Interest will continue to accrue for each 30-day period or portion thereof for which no payment is received. When money is offset (withheld) from your paid claims, it is applied to the accrued interest first and then to the principal.

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

Disagreements with Overpayment Refund Requests

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

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

If the amount of the refund is $100 or more, a hearing may be requested. You may combine other refund requests to meet the $100 or more limit.

The address for requesting a hearing is:

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

How to Track Offset Claims

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

Extended Repayment Schedules for Overpayments

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

Repayment Schedules for 12 Months or Less

Medicare Part B Financial Services may approve repayment schedules up to a period of 12 months.

Documentation for this repayment schedule includes:

- A detailed explanation of the problems preventing a lump sum repayment.
- A statement of how much the physician/supplier can pay for each installment and the number of months.
- A Financial Statement of Debtor form (HCFA-379). All blocks on Form HCFA-379 must be completed or must indicate "N/A"' (not applicable).
- A copy of the physician/ supplier's most recent federal income tax return.

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

Repayment Schedules for Longer Than 12 Months

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

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

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

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

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

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

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

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

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

Certification by Officer/Owner of Debtor(s):

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

_____

_____

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

Signed

_____
Officer or Owner of Debtor(s)

_____
Title

_____
Date

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

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

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

We hope this information is helpful to you.

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

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

See reverse for instructions for completing this form and documentation requirements

1. PHYSICIAN / SUPPLIER INFORMATION

Physician / Supplier Name: _____ Physician / Supplier Number: _____

Address : _____ Phone Number: _____

_____ Contact Person: _____

_____

_____

2. OVERPAYMENT REFUNDS

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

This form, or a similar document containing the following information, should accompany every voluntary refund so the receipt of check is properly recorded and applied. If specific patient/Health Insurance Claim Number/Internal Claim Number/Claim Amount data are not available for all claims due to Statistical Sampling, please indicate the methodology and formula used to determine the amount and reason for the overpayment.

For each claim, provide the following:

Medicare Patient's Name _____ Health Insurance Claim Number _____

Internal Claim Number (ICN) from the Medicare Remittance Notice _____ Date(s) of Service in Question _____

Amount Refunded $ _____

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

Reason for overpayment (Please check one):

Billing/Clerical Error
- Duplicate Payment
- Not Our Patient
- Billed in Error
- Corrected Date of Service
  - Provide the Correct Date _____
- Corrected CPT-IV Code
  - Provide the Correct Code _____
- Modifier Added/Removed
  - Provide the Modifier _____

MSP/Other Payer Involvement
- MSP Group Health Plan Insurance
- MSP No Fault Insurance
- MSP Liability Insurance
- MSP Worker's Compensation
- MSP Black Lung
- Veterans' Administration

Miscellaneous
- Insufficient Documentation
- Patient Enrolled in an HMO
- Services Not Rendered
- Medical Necessity
- Other (please specify)

_____

_____

_____

_____

3. OTHER TYPES OF REQUESTS

☐ Overpayment Review Request (Please attach a copy of the refund request letter along with a detailed explanation of why you believe the refund was requested in error.)

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

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

4. OFFICE OF THE INSPECTOR GENERAL (OIG) REPORTING REQUIREMENTS:

Do you have a Corporate Integrity Agreement with OIG? ____ YES ____ NO

INSTRUCTIONS FOR COMPLETING THE PHYSICIAN / SUPPLIER SERVICE REQUEST FORM

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

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

We encourage you to make a voluntary refund if you know the amount of the refund due Medicare. Sending a voluntary refund will help you avoid any chance of being charged interest, as required by the Health Care Financing Administration if a refund is not received within 30 days from the date of the overpayment letter.

Proper documentation indicating the specific claim being refunded and the reason for the refund is required in order to properly apply your refund. If this information is not received, the refund could be applied to the wrong account. If you are sending a refund for more than one claim, complete this form and send a complete explanation of the reason for the overpaid amount. Please also send a copy of the Provider Remittance Notice (PRN) or a detailed listing that includes the Health Insurance Claim Number, date of service, and the amount of refund, explaining the claims in which the overpayment applies.

If you have received a request from our office for a refund, you should include a copy of the refund request letter with your refund payment.

SECTION 3: Complete this section if:

a) you have received an overpayment letter and disagree with the information in the letter; or,
b) you suspect a Medicare B check has been forged; or,
c) you believe you qualify to refund your overpayment in installments.

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

You may contact us toll-free at 1-866-454-9007 for assistance on completing this form or for information about account balances and questions regarding the Financial Services Area.

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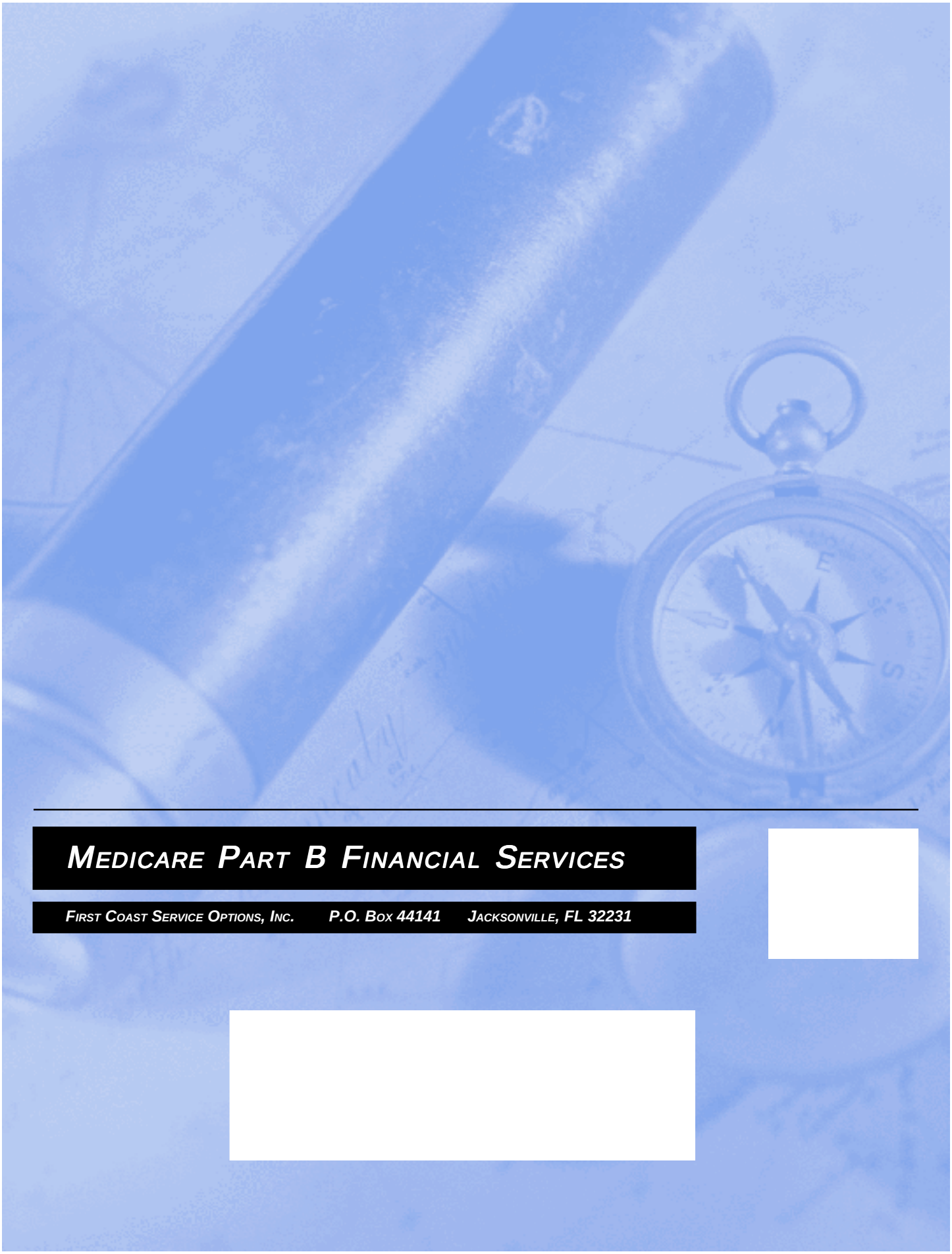

MEDICARE PART B FINANCIAL SERVICES

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