Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Special Issue

Additional Changes Effective July 1, 2001

This Special Issue *Medicare B Update!* provides notice of changes that are effective July 1, 2001 (or other date, where specified). These changes are in addition to those provided in the 3rd Quarter 2001 regular issue *Update!*

Changes featured in this issue include:

- *The Second Update to the Medicare Physician Fee Schedule Database (MPFSDB)*
- *New Temporary "Q" Codes for Casting Supplies and Splints*
- *Additional Codes and Payments for Ambulatory Surgical Centers (ASCs)*
- *Updated Allowances for Local Carrier or Joint Jurisdiction Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)*
- *Payment for Services Furnished by Audiologists*
- *Billing for Audiologic Function Tests for Beneficiaries Who Are Patients of a Skilled Nursing Facility (SNF)*
- *Coverage of Biofeedback Training for the Treatment of Urinary Incontinence*
- *Six New or Revised Local Medical Review Policies (LMRPs)*

Procedures Subject to Home Health Consolidated Billing—Clarification

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

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

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

Routing Suggestions:

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

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:

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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.

COVERAGE/REIMBURSEMENT

MEDICARE PHYSICIAN FEE SCHEDULE

Second Update to the 2001 Medicare Physician Fee Schedule Database

The following changes to the Medicare Physician Fee Schedule Database (MPFSDB) are effective for services processed on or after July 1, 2001. Note that references are made in this document to MPFSDB indicators. The complete definitions of these may be found on pages 2-5 of the December 2000 *Medicare B Update! Special Issue*. **Unless otherwise noted, these changes are effective for services performed on or after January 1, 2001.**

MPFSDB Payment Policy Indicator Changes and New HCPCS Codes

The procedure code status for HCPCS codes **A4570**, **A4580**, **A4590, L2102, L2104, L2122,** and **L2124,** and CPT codes **90471** and **90472** has been changed to "I".

HCPCS code **G0121** (Colorectal screening; colonscopy on individual not meeting criteria for high risk) is **effective for dates of service on or after July 1, 2001**. Applicable MPFSDB indicators are:

Status = A	PC/TC = 0	Facility = 1
Multiple surgery = 2	Bilateral surgery = 0	Assistant surgery = 1
Co-surgery = 0	Team surgery = 0	BMS = 1

The multiple surgery indicator for code **G0184** has been changed to "1".

New HCPCS codes for Positron Emission Tomography (**PET**) Scans have been established and are **effective for services rendered on or after July 1, 2001** (HCPCS codes **G0210 through G0230**). Information regarding the expansion of coverage for PET scans was published in the 3rd Quarter 2001 *Medicare B Update!* (pages 30-31). MPFSDB indicators applicable to these new codes are:

Component:	global	professional (modifier 26)	technical (modifier TC)
Status:	C	A	C
PC/TC:	1	1	1
Facility:	1	1	1
Global:	XXX	XXX	XXX
Multiple surgery:	0	0	0
Bilateral surgery:	0	0	0
Assistant surgery:	0	0	0
Co-surgery:	0	0	0
Team surgery:	0	0	0
BMS	0	0	0

The assistant surgery indicator for CPT codes **22122** and **22222** has been changed to "2".

CPT codes **31623** and **31624** have been classified as related codes for code **31622** (special rules for multiple endoscopic procedures apply).

The code status for CPT code **44132** has been changes to "R".

The code status for CPT codes **63043** and **63044** has been changed from status "B" to "C". Applicable MPFSDB indicators are:

PC/TC = 0	Facility = 1	Multiple surgery = 0
Bilateral surgery = 1	Assistant surgery = 2	Co-surgery = 2
Team surgery = 0	BMS = 0	

The PC/TC indicator for CPT code **76000** has been changed to "2". Therefore, codes **76000-26** and **76000-TC** have been deleted (code status "H").

A 90 day global period has been established for CPT code **77776** (global, professional, and technical components).

Fee Allowance Changes

In addition to the changes described above, the following allowances are **effective for services processed on or after July 1, 2001**. Unless otherwise noted, the new allowances are **effective for services rendered on or after January 1, 2001**.

	PAR			NONPAR			Limiting Charge		
Code/Mod	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04
G0121	367.11	391.56	408.65	348.75	371.98	388.22	401.07	427.78	446.45
	233.41	247.29	258.45	221.74	234.93	245.53	255.00	270.16	282.36*
G0210	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0210 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0211	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0211 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0212	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0212 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0213	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0213 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0214	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0214 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0215	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0215 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0216	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0216 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0217	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0217 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0218	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0218 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0219	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0219 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0220	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0220 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0221	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0221 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0222	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0222 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0223	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0223 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0224	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0224 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0225	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0225 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0226	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0226 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0227	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0227 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0228	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0228 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0229	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0229 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
G0230	191.95	200.73	207.88	182.35	190.69	197.49	209.71	219.30	227.11
G0230 TC	115.17	120.44	124.73	109.41	114.42	118.49	125.82	131.58	136.27
62310	208.25	222.38	232.14	197.84	211.26	220.53	227.51	242.95	253.61
	93.40	98.44	103.10	88.73	93.52	97.95	102.04	107.55	112.64*
62311	203.60	227.31	217.83	193.42	215.94	206.94	222.43	248.34	237.98
	80.59	84.43	76.43	76.56	80.21	72.61	88.04	92.24	83.50*
62318	216.14	230.77	240.95	205.33	219.23	228.90	236.13	252.12	263.24
	100.20	105.65	110.69	95.19	100.37	105.16	109.47	115.42	120.93*
62319	190.09	202.87	211.86	180.59	192.73	201.27	207.67	221.64	231.46
	90.46	95.35	99.92	85.94	90.58	94.92	98.83	104.17	109.16*
63043	IC	IC	IC	IC	IC	IC	IC	IC	IC
63044	IC	IC	IC	IC	IC	IC	IC	IC	IC
76000	9.01	9.52	9.98	8.56	9.04	9.48	9.84	10.40	10.90

* these amounts apply when performed in a facility setting
IC = Individual consideration

New Temporary "Q" Codes for Splints and Casts Used for Reduction of Fractures and Dislocations—Effective July 1, 2001

In the Medicare physician fee schedule beginning in 2001, the casting supplies were removed from the practice expenses for all HCPCS codes, including the CPT codes for fracture management and for casts and splints. Thus, for settings in which CPT codes are used to pay for services which include the provision of a cast or splint, new temporary codes are being established to pay physicians and other practitioners for the supplies used in creating casts. The work and practice expenses involved with the creation of the cast or splint should continue to be coded using the appropriate CPT code. The use of the new temporary codes described below will replace less specific coding for the casting and splinting supplies.

The following temporary "Q" codes have been established for the supplies used by physicians and other practitioners to create splints and casts used for reduction of fractures and dislocations:

CODE	DESCRIPTION	FEE
Q4001	Cast supplies, body cast adult, with or without head, plaster	34.78
Q4002	Cast supplies, body cast adult, with or without head, fiberglass	131.44
Q4003	Cast supplies, application of shoulder cast, adult (11 years +), plaster	24.98
Q4004	Cast supplies, application of shoulder cast, adult (11 years +), fiberglass	86.48
Q4005	Cast supplies, long arm cast, adult (11 years +), plaster	9.21
Q4006	Cast supplies, long arm cast, adult (11 years +), fiberglass	20.76
Q4007	Cast supplies, long arm cast, pediatric (0-10 years), plaster	4.61
Q4008	Cast supplies, long arm cast, pediatric (0-10 years), fiberglass	10.38
Q4009	Cast supplies, short arm cast, adult (11 years +), plaster	6.14
Q4010	Cast supplies, short arm cast, adult (11 years +), fiberglass	13.84
Q4011	Cast supplies, short arm cast, pediatric (0-10 years), plaster	3.07
Q4012	Cast supplies, short arm cast, pediatric (0-10 years), fiberglass	6.92
Q4013	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster	11.18
Q4014	Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), fiberglass	18.88
Q4015	Cast supplies, gauntlet cast (includes lower forearm and hand, pediatric (0-10 years), plaster	5.59
Q4016	Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0-10 years), fiberglass	9.44
Q4017	Cast supplies, long arm splint, adult (11 years +), plaster	6.47
Q4018	Cast supplies, long arm splint, adult (11 years +), fiberglass	10.32
Q4019	Cast supplies, long arm splint, pediatric (0-10 years), plaster	3.24
Q4020	Cast supplies, long arm splint, pediatric (0-10 years), fiberglass	5.16
Q4021	Cast supplies, short arm splint, adult (11 years +), plaster	4.79
Q4022	Cast supplies, short arm splint, adult (11 years +), fiberglass	8.64
Q4023	Cast supplies, short arm splint, pediatric (0-10 years), plaster	2.40
Q4024	Cast supplies, short arm splint, pediatric (0-10 years), fiberglass	4.32
Q4025	Cast supplies, hip spica (one or both legs), adult (11 years +), plaster	26.86
Q4026	Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass	83.85
Q4027	Cast supplies, hip spica (one or both legs), pediatric (0-10 years), plaster	13.43
Q4028	Cast supplies, hip spica (one or both legs), pediatric (0-10 years), fiberglass	41.93
Q4029	Cast supplies, long leg cast, adult (11 years +), plaster	20.53
Q4030	Cast supplies, long leg cast, adult (11 years +), fiberglass	54.05
Q4031	Cast supplies, long leg cast, pediatric (0-10 years), plaster	10.27
Q4032	Cast supplies, long leg cast, pediatric (0-10 years), fiberglass	27.03
Q4033	Cast supplies, long leg cylinder cast, adult (11 years +), plaster	19.15
Q4034	Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass	47.65
Q4035	Cast supplies, long leg cylinder cast, pediatric (0-10 years), plaster	9.58
Q4036	Cast supplies, long leg cylinder cast, pediatric (0-10 years), fiberglass	23.83
Q4037	Cast supplies, short leg cast, adult (11 years +), plaster	11.69
Q4038	Cast supplies, short leg cast, adult (11 years +), fiberglass	29.27
Q4039	Cast supplies, short leg cast, pediatric (0-10 years), plaster	5.85
Q4040	Cast supplies, short leg cast, pediatric (0-10 years), fiberglass	14.65
Q4041	Cast supplies, long leg splint, adult (11 years +), plaster	14.21
Q4042	Cast supplies, long leg splint, adult (11 years +), fiberglass	24.25
Q4043	Cast supplies, long leg splint, pediatric (0-10 years), plaster	7.10
Q4044	Cast supplies, long leg splint, pediatric (0-10 years), fiberglass	12.13
Q4045	Cast supplies, short leg splint, adult (11 years +), plaster	8.25
Q4046	Cast supplies, short leg splint, adult (11 years +), fiberglass	13.27
Q4047	Cast supplies, short leg splint, pediatric (0-10 years), plaster	4.12
Q4048	Cast supplies, short leg splint, pediatric (0-10 years), fiberglass	6.64
Q4049	Finger splint, static	1.50
Q4050	Cast supplies, for unlisted types and material of casts	IC
Q4051	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	IC

IC = Individual consideration

The code status for these procedures is "X" (statutorily excluded from the Medicare Physician Fee Schedule). The payment indicators are identical for all codes in this range. The concepts of PC/TC, facility pricing, multiple surgery, bilateral surgery, assistant surgery, co-surgery, and team surgery do not apply.

Codes A4570, A4580, A4590, L2102, L2104, L2122, and L2124, which were previously used for billing of splints and casts, are invalid for Medicare use effective July 1, 2001. A three-month grace period (July 1, 2001 through September 30, 2001) will be afforded for use of these codes while transitioning to the new Q codes for splints and casts.

For claims with dates of service on or after July 1, 2001, jurisdiction for processing claims for splints (previously billed using A4570) will transfer from the Durable Medical Equipment Regional Carriers (DMERCs) to the local carriers. The local carriers have jurisdiction for processing claims for the new Q codes for splints and casts, which includes codes for splints that may have previously been billed to the DMERCs under code A4570. In addition, for claims with dates of service on or after July 1, 2001, jurisdiction for slings (A4565) will be jointly maintained by the local carriers (for physician claims) and the DMERCs (for supplier claims). The fee allowance for A4565 is changed to $6.10, also effective for claims with dates of service on or after July 1, 2001.

To assist physicians and practitioners with selecting the correct code for the cast and splinting supplies, the following crosswalk provides guidance as to which supply codes are applicable for the various types of casts described by Level I or CPT codes.

Level I	Level II
29000	Q4001 or Q4002
29010	Q4001 or Q4002
29015	Q4001 or Q4002
29020	Q4001 or Q4002
29025	Q4001 or Q4002
29035	Q4001 or Q4002
29040	Q4001 or Q4002
29044	Q4001 or Q4002
29046	Q4001 or Q4002
29049	Q4050
29055	Q4003 or Q4004
29058	Q4003
29065	Q4005 through Q4008
29075	Q4009 through Q4012
29085	Q4013 through Q4016
29105	Q4017 through Q4020
29125	Q4021 through Q4024
29126	Q4021 through Q4024
29130	Q4049
29131	Q4051
29305	Q4025 through Q4028
29325	Q4025 through Q4028
29345	Q4029 through Q4032
29355	Q4029 through Q4032
29365	Q4033 through Q4036
29405	Q4037 through Q4040
29425	Q4037 through Q4040
29435	Q4037 through Q4040
29440	Q4050
29445	Q4037 through Q4040
29450	Q4035, Q4036, Q4039, or Q4040
29505	Q4041 through Q4044
29515	Q4045 through Q4048

AMBULATORY SURGICAL CENTER

Additional Codes and Payments for Ambulatory Surgical Centers (ASCs)

This outlines some additional procedure codes for which the Medicare program provides a facility fee payment when they are performed in Medicare-certified ASCs. In keeping with the Health Care Financing Administration's (HCFA's) practice of providing continued coverage and payment for procedures or services performed in ASCs that the American Medical Association Common Physician's *Current Procedural Terminology* (*CPT*) revises in its annual coding revisions, this lists changes that became effective in CPT, January 1, 2001.

- Medicare will provide a facility payment for breast biopsy codes that were further refined by *CPT* from one single covered ASC code that included imaging guidance into two new codes.
- A covered laparoscopy procedure was also refined.
- A new eye cataract service previously covered in an ASC under a different code (66984) has been further refined by *CPT* into a new code.

Effective for services performed on or after January 1, 2001, the following codes are payable as an ASC facility payment:

CPT Code	ASC Payment Group
19102	2
19103	2
58353	4
66982	8

In addition, section 103 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000) requires Medicare to provide coverage for screening colonoscopy for individuals not at high risk for colorectal cancer. Therefore, HCPCS code G0121 (Screening colonoscopy for individuals not at high risk) is added to the ASC list effective July 1, 2001.

Effective for services performed on or after July 1, 2001, the following code is payable as an ASC facility payment:

HCPCS Code	ASC Payment Group
G0121	2

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 cases is shared with the DMERC. The following pricing updates are for local carrier and joint jurisdiction codes for services/items **provided on or after July 1, 2001.**

Code/Mod	Allowance
E0751	6042.11
E0753	1497.24
E0756	6799.41
E0757	4858.05
E0758	4276.18
E0781 RR	247.69
E0782 NU	3950.46
E0782 RR	395.06
E0782 UE	2962.85
E0783 NU	7532.94
E0783 RR	753.30
E0783 UE	5649.72
E0785	434.76
E0786 NU	7295.21
E0786 RR	729.52
E0786 UE	5471.41
L8600	503.18
L8603	353.40
L8606	185.50
L8610	516.14
L8612	544.38
L8613	243.73
L8614	15427.00
L8619	6617.61
L8630	271.48
L8641	294.65
L8642	241.86
L8658	252.78
L8670	448.55

AUDIOLOGY

Payment for Services Furnished by Audiologists

This article is based on HCFA Program Memorandum (PM) B-01-34, the purpose of which is to make the medical coverage determinations for audiology tests similar and comparable to ophthalmology tests as outlined in section 2320 of the Medicare Carriers Manual. The effective date for this information is May 29, 2001.

Diagnostic testing, including hearing and balance assessment services, performed by a qualified audiologist is paid for as "other diagnostic tests" under section 1861(s)(3) of the Social Security Act ("the Act"). This type of testing is paid for when a physician orders testing to obtain information as part of his/her diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. Services are excluded under section 1862(a)(7) of the Act when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of a hearing aid.

Diagnostic services performed by a qualified audiologist and meeting the above requirements are payable as "other diagnostic tests." The payment for these services is determined by the reason the tests were performed, rather than the diagnosis or the patient's condition. Payment for these services is based on the physician fee schedule amount. The entity billing for the audiologist's services may accept assignment under the usual procedure or, if not accepting assignment, may charge the patient and submit a non-assigned claim on their behalf.

If a physician refers a beneficiary to an audiologist for evaluation of signs or symptoms associated with hearing loss or ear injury, the audiologist's diagnostic services should be covered, even if the only outcome is the prescription of a hearing aid. If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician referral, then these tests are not covered, even if the audiologist discovers a pathologic condition.

As provided in 1861(ll)(3) of the Act, a qualified audiologist is an individual with a master's or doctoral degree in audiology and who:

A. Is licensed as an audiologist by the state in which the individual furnishes such services; or
B. In the case of an individual who furnishes services in a state which does not license audiologists, has:
    1. Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience),
    2. Performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and
    3. Successfully completed a national examination in audiology approved by the Secretary of HHS.

To determine whether a particular audiologist qualifies under the above definition, the carrier will check individual qualifications. A source for determining an audiologist's professional qualifications is the American Speech-Language-Hearing Association's national directory. This directory lists certified individuals and lists other directories available from state speech and hearing associations. In addition, in states that have statutory licensure or certification requirements, the carrier will obtain a current listing of audiologists holding the required credentials in the state.

NOTE: There is no provision for direct payment to audiologists for therapeutic services.

Billing for Audiologic Function Tests For Beneficiaries Who Are Patients of a Skilled Nursing Facility (SNF)

This provides new billing requirements for audiologic function tests. Some previous instuctions inadvertently included audiologic function testing with speech therapy services which are subject to SNF Part B consolidated billing requirements that must be billed by the SNF when furnished to beneficiaries in Part B SNF stays. However, audiologic function tests furnished to Part B beneficiaries are separately payable under the physician fee schedule.

Audiologic function tests will generally be billed to the carrier by the provider of service. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component to the intermediary, but is not required to bill the service. The audiologic function test codes are listed below. All codes listed below have a technical component. Only the two codes identified with an asterisk (*) beside them have a professional component.

Audiologic Function Tests

92552, 92553, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92569, 92571, 92572, 92573, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587*, 92588*, 92589, 92596, V5299

Payment to SNFs for audiologic function tests are bundled into the PPS payment amount for beneficiaries in a covered SNF Part A stay, whether provided directly by the SNF or under arrangements by an independent provider based on a contract with the SNF. Independent audiologists may bill the carrier directly for services rendered to beneficiaries not in a SNF Part A covered stay. Payment is made based on the physician fee schedule, whether by the carrier or the intermediary. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic function tests are payable under Part B when billed by the SNF as type of bill 22x, or when billed directly to the carrier by the provider of the service. Since audiologic function tests are not bundled with speech therapy services, payment is made to the provider of service or to the SNF where the services are provided under arrangements with the SNF. **This change is effective for services rendered on and after April 1, 2001.**

EVALUATION AND MANAGEMENT

Biofeedback Training for the Treatment of Urinary Incontinence

This article provides information concerning HCFA Program Memorandum (PM) AB-01-79, which revises the Coverage Issues Manual (CIM) by adding section 35-27.1. In 35-27.1, biofeedback for the treatment of urinary incontinence is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength. Home use of biofeedback therapy is not covered.

This revision to the CIM is a national coverage decision made under section1862 (a)(1) of the Social Security Act. National coverage determinations (NCDs) are binding on all Medicare carriers, intermediaries, peer review organizations, and other contractors. Under 42 CFR 422.256 (b) a NCD that expands coverage is also binding on a Medicare+Choice organization. Billing and coding instructions are not included in the national coverage decision.

The following claim instructions apply for **dates of service on or after July 1, 2001**. Claims for biofeedback training are to be submitted on health insurance claim Form HCFA-1500 or electronic equivalent. These services are reimbursed based on the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

The following existing CPT codes should be used when billing for biofeedback therapy:

90901	Biofeedback training by any modality
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

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**

FLORIDA MEDICARE PART B LOCAL MEDICAL REVIEW POLICY

Policy Number
J9212

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Interferon

AMA CPT Copyright Statement

HCFA National Coverage Policy
Medicare Carriers Manual, Section 2049.5

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
01/01/1993

Original Policy Ending Date
N/A

Revision Effective Date
07/30/2001

Revision Ending Date
07/29/2001

LMRP Description
Interferons are naturally occurring small proteins with both antiviral and antiproliferative properties. Interferons exert their cellular effects by binding to specific membrane receptors on the cell surface and subsequently initiate a complex sequence of intracellular events.

Interferon alfacon-1 is a recombinant non-naturally occurring type-1 interferon. Interferon alfa-2A and alfa-2B are sterile protein products produced by recombinant DNA techniques. The exact mechanism of action is unknown, but appears to involve direct antiproliferative action against tumor cells or viral cells to inhibit replication, modulation of the host immune response by enhancing the phagocytic activity of macrophages, and augmentation of specific cytotoxicity of lymphocytes for target cells.

Alfa-N3 is a naturally occurring antiviral agent derived from human leukocytes. It attaches to membrane receptors and causes cellular changes, including increased protein synthesis. Gamma-1B, a biological response modifier, is a single-chain polypeptide containing 140 amino acids.

Indications and Limitations of Coverage and/or Medical Necessity

Interferon Alfacon-1 (J9212)
Florida Medicare will consider the administration of **Interferon alfacon-1** medically reasonable and necessary for the following indications: chronic hepatitis C and hairy cell leukemia.

Interferon alfa-2A (J9213) or Interferon alfa-2B (J9214)
Florida Medicare will consider the administration of **Interferon alfa-2A or Interferon alfa-2B** medically reasonable and necessary for the following indications: acute or chronic hepatitis C, chronic hepatitis B, condylomata acuminata, hairy cell leukemia, malignant melanoma, AIDS-related Kaposi's sarcoma, head and neck cancer, bladder cancer, brain cancer, carcinoid syndrome, chronic lymphocytic leukemia, chronic myelocytic leukemia, cutaneous T-cell lymphoma, esophageal cancer, renal cancer, multiple myeloma, non-Hodgkin's lymphoma, mycosis fungoides, essential thrombocytosis, osteosarcoma, ovarian cancer, pancreatic cancer, skin cancer, colorectal cancer, polycythemia vera, and laryngeal papillomatosis.

Interferon alfa-N3 (J9215)
Florida Medicare will consider the administration of **Interferon alfa-N3** medically reasonable and necessary for the following indications: chronic hepatitis C, condylomata acuminata, hairy cell leukemia, malignant melanoma, AIDS-related Kaposi's sarcoma, bladder cancer, carcinoid syndrome, chronic myelocytic leukemia, renal cancer, multiple myeloma, non-Hodgkin's lymphoma, mycosis fungoides, essential thrombocytosis, ovarian cancer, and laryngeal papillomatosis.

Interferon gamma-1B (J9216)
Florida Medicare will consider the administration of **Interferon gamma-1B** medically reasonable and necessary for the following indication: chronic granulomatous disease.

*Please note the following limitations regarding Interferons:

The self-administration of Interferons alfacon-1, alfa-2A, alfa-2B, alfa-N3, and gamma-1B are noncovered by Medicare.

The following Interferons are considered self-administered and noncovered by Florida Medicare: J1825 (beta-1a) and J1830 (beta-1b). Please refer to Local Medical Review Policy J0001 (Self-Administered Drugs).

The Interferon alfa-2B recombinant and ribavirin combination (Rebetron) is considered noncovered by Florida Medicare and should be billed utilizing code A9270. Please refer to Local Medical Review Policy A9270 (The List of Medicare Noncovered Services).

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

CPT/HCPCS Codes
J9212	J9214	J9216
J9213	J9215	

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
For J9212 (Interferon alfacon-1):

070.54	202.40-202.48

For J9213 (Interferon alfa-2A) or J9214 (Interferon alfa-2B):

070.41	157.4	191.0-191.9
070.44	161.0-161.9	200.00-200.88
070.51	170.0-170.9	202.00-202.98
070.54	172.0-172.9	203.00-203.81
070.59	173.0-173.9	204.10
078.11	176.0-176.9	205.10
140.0-149.9	183.0-183.9	238.4
150.0-150.9	188.0-188.9	259.2
153.0-153.9	189.0	289.9
154.0-154.8	189.1	

For J9215 (Interferon alfa-N3):

070.54	183.0-183.9	202.00-202.98
078.11	188.0-188.9	203.00-203.81
161.0-161.9	189.0	205.10
172.0-172.9	189.1	259.2
176.0-176.9	200.00-200.88	289.9

For J9216 (Interferon gamma-1B):
205.10

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

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

The self-administration of Interferons alfacon-1, alfa-2A, alfa-2B, alfa-N3, and gamma-1B.

The following Interferons are considered self-administered and noncovered by Florida Medicare: J1825 (beta-1a) and J1830 (beta-1b). Please refer to Local Medical Review Policy J0001 (Self-Administered Drugs).

The Interferon alfa-2B recombinant and ribavirin combination (Rebetron) is considered noncovered by Florida Medicare and should be billed utilizing code A9270. Please refer to Local Medical Review Policy A9270 (The List of Medicare Noncovered Services).

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

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the ordering/referring physician must substantiate the medical necessity for the use of the specific Interferon by indicating the condition for which it is being administered. The drug name, dosage, and route of administration must also be recorded. This information is normally found in the office/progress notes or medication administration record.

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 February 24, 2001.

Start Date of Comment Period
02/16/2001

End of Date of Comment Period
04/02/2001

Start Date of Notice Period
06/01/2001

Revision History
Revision Number	9	PCR B2001- 117
Start Date of Comment Period:		02/16/2001
Start Date of Notice Period:		06/01/2001
		June 2001 Special *Update!*
Revised Effective Date		07/30/2001

Explanation of Revision: The policy revision was required to ensure the appropriateness of the indications for each of the Interferons. The existing original policy has been deleted.

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 2 for details concerning ABNs.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
10060

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures

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
07/30/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
An abscess is a cavity containing pus surrounded by inflamed tissue. This cavity is formed as a result of the production and exudation of pus in a localized infection. It is generally associated with pain, swelling and erythema. An abscess often requires incision and drainage to remove the purulent material in order for healing to occur.

Procedure codes 10060 and 10061 represent incision and drainage of an abscess involving the skin, subcutaneous and/or accessory structures. This includes the following types of abscess: furuncle, carbuncle, suppurative hidradenitis, an abscessed cyst, an abscessed paronychia, and/or other abscess involving the cutaneous and/or subcutaneous structures.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the use of incision and drainage of an abscess of the skin, subcutaneous and/or

accessory structures to be medically reasonable and necessary for the treatment of an actively infected abscess involving these structures. This includes the incision and drainage of the following types of abscess:

furuncle;

carbuncle;

suppurative hidradenitis;

an abscessed cyst;

an abscessed paronychia; and/or

other abscess of cutaneous and/or subcutaneous structures.

It would not generally be expected to see incision and drainage of an abscess of the skin, subcutaneous and/or accessory structures to be repeated frequently and/or multiple times. If frequent repeated incision and drainage is required, the medical record must reflect the reason for persistent/recurrent abscess formation, as well as any measures taken to prevent reoccurence.

CPT/HCPCS Section & Benefit Category
Integumentary System/Surgery

CPT/HCPCS Codes
10060
10061

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

528.5	680.0-680.9	705.83
607.2	681.10-681.11	
611.0	682.0-682.9	

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

Reason for Denial
When performed for indications other that 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
Procedure codes 10060 and 10061 represent incision and drainage of an abscess involving the skin, subcutaneous and/or accessory structures. Therefore, the medical necessity diagnosis code must represent an abscess, not the underlying condition causing the abscess. For example, the ICD-9-CM code for sebaceous cyst (706.2) would not meet medical necessity for procedure codes 10060 or 10061. If the patient had an abscess of a sebaceous cyst then it would be appropriate to code the applicable ICD-9-CM code for the abscess (depending upon the anatomical location of the abscess).

Similarly, if billing a covered diagnosis, the medical record must demonstrate that an abscess was present. For example, if billing the diagnosis code for paronychia of the toe (ICD-9-CM code 681.11), the medical record must clearly demonstrate that an abscessed paronychia was present and that incision and drainage of the purulent material occurred, in order to bill procedure code 10060 or 10061. If a nail avulsion occurred and the medical record documentation does not demonstrate that an abscess was present and incision and drainage of purulent material occurred, then the appropriate nail avulsion procedure code (11730 or 11732) should be billed, not procedure codes 10060 or 10061.

Furthermore, there are many other anatomical sites of abscess that are not addressed in this policy. There are numerous incision and drainage procedure codes that are specific to the incisions and drainage of an abscess in various anatomical sites. Therefore, it would be appropriate to bill these more specific incision and drainage codes. For example: an abscess of the eyelid should be billed with procedure code 67700 (Blepharotomy, drainage of abscess, eyelid); a perirectal abscess should be billed with procedure code 46040 (Incision and drainage of ischiorectal and/or perirectal abscess); an abscess of the finger should be billed with procedure codes 26010-26011 (Drainage of finger abscess).

Documentation Requirements
Medical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed. As stated in the "Coding Guidelines" section, the medical record must clearly indicate that an abscess was present. This should include the location, size, and appearance of the abscess.

In addition, documentation that the service was performed (incision and drainage of purulent material from an abscess) 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.

Furthermore, the medical record must clearly document the medical necessity for repeated incision and drainage of an abscess. If frequent incision and drainage is required, the medical record must reflect the reason for persistent/recurrent abscess formation, as well as any measures taken to prevent reoccurence. For example, for repeated incision and drainage of an abscessed paronychia, the medical record should document any additional measures taken to prevent reoccurence and/or the reason for not performing more definitive treatment (e.g., the patient refuses and/or is not a candidate for permanent, partial or complete nail and nail matrix removal).

Utilization Guidelines
N/A

Other Comments

Terms Defined

Furuncle – a boil that begins as an infected and inflamed gland and/or hair follicle but progresses to form an abscess. Most common sites of occurrence include the back of the neck and the upper back.

Carbuncle – a subcutaneous abscess that contains purulent matter in multiple draining and interconnecting cutaneous sinuses. Purulent drainage eventually discharges to the skin surface through surface openings. Common sites for occurrences include the back of the neck and the buttocks.

Suppurative hidradenitis – an abscess involving a sweat gland most commonly occurring in the axillae, inguinal, and perianal regions.

Cyst – a thin-walled subcutaneous sac containing fluid or semisolid material. Cysts are generally asymptomatic until they rupture. The cyst may then become infected and form an abscess.

Paronychia – an infection of the marginal structures around the nail plate. This infection may result in the collection of purulent material and formation of an abscess.

Cutaneous and/or subcutaneous abscess – any other abscess involving the cutaneous and/or subcutaneous structures.

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 Podiatric Medical Association, Florida Society of Dermatology, and the Florida Chapter of American College of Surgeons.

Carrier Advisory Committee Meeting held on February 24, 2001.

Start Date of Comment Period

02/16/2001

End of Date of Comment Period

04/01/2001

Start Date of Notice Period

06/01/2001

Revision History

Revision Number	Original PCR B2001- 110
Start Date of Comment Period:	02/16/2001
Start Date of Notice Period:	06/01/2001
	June 2001 Special *Update!*
Original Effective Date	07/30/2001

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 2 for details concerning ABNs.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number

43235

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type

Carrier

LMRP Title

Diagnostic and Therapeutic Esophagogastroduodenoscopy

AMA CPT Copyright Statement

HCFA National Coverage Policy

Coverage Issues Manual, Section 35-59

Primary Geographic Jurisdiction

Florida

Secondary Geographic Jurisdiction

N/A

HCFA Region

Region IV

HCFA Consortium

Southern

Original Policy Effective Date

07/30/2001

Original Policy Ending Date

N/A

Revision Effective Date

N/A

Revision Ending Date

N/A

LMRP Description

Upper intestinal endoscopy is performed with a lighted, flexible, fiberoptic instrument passed through the cricopharynx. The patient receives conscious sedation. A topical anesthetic is sometimes applied to the posterior pharynx. Direct visualization of the entire esophagus, stomach, and duodenum (to the junction of the second and third portions) can be accomplished easily with modern instruments that are less than 12mm in diameter. Esophagogastroduodenoscopy (EGD) is a technique

utilized to examine, obtain samples, and in some instances, to treat pathological conditions.

Diagnostic observations are made concerning focal benign or malignant lesions, diffuse mucosal changes, luminal obstruction, motility, and extrinsic compression by contiguous structures. A diagnostic EGD allows the examiner to visualize abnormalities detectable by the technique and to photograph, biopsy, and/or remove lesions as appropriate.

The purpose of the therapeutic EGD is to manage hemorrhage; remove foreign bodies and neoplastic growths; to relieve obstruction due to stricture, malignancy, or other causes through dilatation or the placement of stents; and to assist in the placement of percutaneous gastrostomy tubes.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider EGD(s) to be medically reasonable and necessary under the following diagnostic conditions:

- Patient has upper abdominal distress (e.g., gastroesophageal reflux disease) which persists despite an appropriate trial of symptomatic therapy;
- Patient has upper abdominal distress associated with a short history of signs and symptoms suggesting significant associated disease or illness (e.g., weight loss, anorexia, vomiting, nonsteroidal anti-inflammatory drug [NSAID] intake, other gastric irritant intake);
- Patients over the age of 40 who have experienced a significant history of heartburn that returns after a course of symptomatic therapy;
- Patients who have dysphagia or odynophagia;
- Patient has persistent, unexplained vomiting;
- Patient has upper gastrointestinal x-ray findings of:
  - any lesion that requires biopsy for diagnosis; or
  - gastric ulcer suspicious of cancer; or
  - evidence of stricture or obstruction;
- To assess acute injury after caustic agent ingestion;
- When anti-reflux surgery is contemplated; or
- Patient has gastrointestinal bleeding:
  - in most actively bleeding patients; or
  - for presumed chronic blood loss and iron deficiency anemia when investigation of large bowel is negative.

Florida Medicare will consider EGD(s) to be medically reasonable and necessary for the following therapeutic purposes:

- Treatment of bleeding lesions;
- Removal of foreign bodies;
- Sclerotherapy and/or band ligation for bleeding from esophageal or gastric varices;
- Dilatation of strictures in the upper intestinal tract;
- Removal of selected polypoid lesions;
- Placement of feeding tubes; or
- Palliative therapy of stenosing neoplasms (e.g., laser, stent placement).

Gastrointestinal bleeding may be treated with a variety of methods. Direct contact heater probes and hemostatic injections into or around the bleeding vessels are both effective therapy for acute bleeding.

Foreign body removal from the stomach or esophagus is usually successful with these flexible instruments. The foreign bodies can be retrieved by either of two methods. The first method is to capture the foreign body with a snare device/grasping forceps and pull the item out with the endoscope. The second method is accomplished by piecemeal destruction and pushing the bolus through the esophagus into the stomach.

Esophageal varices may be injected with a variety of sclerosing solutions. Eradication of varices requires, on the average, five sclerotherapy sessions, with multiple injections given during each session.

Dilatation of strictures may be accomplished with a balloon placed through the endoscope and inflated using hydrostatic pressure. Bougies are rubber dilators available in various sizes up to approximately 2.0cm. Plastic bougies and other dilating probes are usually passed over a guide wire. This procedure involves placing the guide wire into the stomach through the endoscope. The endoscope is then withdrawn leaving the guide wire in place. The dilating probes and plastic bougies are then passed over the guide wire. After the largest dilator is used, the dilator and guide wire are removed. Esophageal dilation is performed after a definitive diagnosis has been established in patients exhibiting dysphagia. The goal in most cases is a lumenal diameter of 16-17mm which allows passage of solid food. A series of dilators may be passed over the guide wire to reach the goal of therapy.

Florida Medicare will consider follow-up EGD(s) medically reasonable and necessary for the following indications:

- Biopsy surveillance of patients with Barrett's esophagus every 12 to 24 months. However, if dysplasia is present, earlier surveillance intervals of from three to six months may be required;
- Follow-up of gastric ulcers to healing or satisfaction that they are benign;
- Follow-up and treatment of esophageal strictures requiring guidewire dilation;
- Follow-up of duodenal ulcer or other lesions of the upper gastrointestinal tract that have resulted in serious consequences (e.g., hemorrhage);
- Follow-up of patients having a previous gastric polypectomy for adenoma; or
- Follow-up and treatment of patients with esophageal varices or bleeding lesions requiring recurrent therapy (e.g., esophageal varices, gastric varices, angiodysplastic or watermelon stomach lesions, radiation gastritis).

Periodic EGD is NOT usually indicated in the following situations:

- Surveillance of healed, benign disease such as gastric or duodenal ulcer or benign esophageal strictures; or
- Cancer surveillance in patients with pernicious anemia, treated achalasia, or prior gastric resection.

EGD is generally contraindicated for patients with recent myocardial infarction.

CPT/HCPCS Section & Benefit Category

Digestive System/Surgery

CPT/HCPCS Codes

43235	43245	43250
43239	43246	43251
43241	43247	43255
43243	43248	43258
43244	43249	

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

040.2	531.00-531.91	786.6
112.84	532.00-532.91	787.01-787.91
150.0-152.9	533.00-533.91	789.00-789.09
155.0	534.00-534.91	789.30-789.39
156.0-156.9	535.00-535.61	789.60-789.69
157.0-157.9	536.1-536.8	790.5
159.8	537.0-537.89	790.99
176.3	551.3	792.1
197.4	552.3-552.8	793.4
197.6	553.3	793.6
198.89	555.0-555.9	799.4
202.80	560.9	862.22
211.0-211.9	562.01-562.03	874.4-874.5
214.3	569.62	935.1-935.2
214.9	569.82	936
215.9	571.1-571.6	938
228.04	572.3	947.0
230.1-230.8	574.00-574.41	947.2-947.3
235.2-235.4	575.0	959.01-959.09
239.0	575.5	983.2-983.9
251.5	576.0	990
261	576.4	996.82
263.0-263.9	577.0-577.2	997.4
280.0-280.9	578.0-578.9	E864.1-E864.4
285.1	579.0-579.9	E961
300.11	694.0	V10.00
306.4	710.1	V10.03- V10.04
307.1	747.61	V10.09
307.50-307.54	750.3-750.7	V12.72
438.82	783.0	V18.5
447.2	783.21-783.3	V58.61
448.0	784.49	V58.69
456.0-456.21	784.9	V69.1
507.0	786.2	
530.0-530.89	786.50-786.59	

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

Surgical endoscopy always includes diagnostic endoscopy according to the *Current Procedural Terminology* (*CPT*) book. Medicare has special payment rules related to endoscopic procedures. The higher valued endoscopy includes the value of the base endoscopy of the same family.

If the endoscopist has not traversed the pyloric channel into the duodenum, then an EGD has not been performed. Report the actual service performed under the esophagoscopy/esophagogastroscopy procedural family (procedure codes 43200-43234).

Some procedure codes listed in this policy represent the biopsy of one or more lesions or the removal of one or more polyps or foreign bodies. Bill the applicable procedure code once, regardless of the number of biopsies, polyps or foreign bodies obtained during the session.

Upper GI bleeding can be treated by several endoscopic techniques. All methods used during the session to control bleeding are reported using a single procedure code (43255).

Documentation Requirements

The patient's medical record (e.g., history and physical, office/progress notes, procedure report) maintained by the ordering/referring physician must clearly indicate the reason for the EGD. Also, the results of the EGD must be included in the patient's medical record.

Utilization Guidelines

N/A

Other Comments

Terms defined:

Odynophagia- pain when swallowing.

Dysphagia- inability or difficulty swallowing.

Achalasia- failure of the sphincter to relax. Failure of the cardiac sphincter to relax results in difficulty passing food to the stomach.

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 February 20, 1999.

Start Date of Comment Period
02/12/1999

End Date of Comment Period
03/29/1999

Start Date of Notice Period
06/01/2001

Revision History

Revision Number: Original	PCR B2001- 119
Start Date of Comment Period	02/12/1999
Start Date of Notice Period	06/01/2001
	June 2001 Special *Update!*
Original Effective Date	07/30/2001

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 2 for details concerning ABNs.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
70450

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Computerized Tomography Scans

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-12 A-E

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
06/1993

Original Policy Ending Date
N/A

Revision Effective Date
07/30/2001

Revision Ending Date
07/29/2001

LMRP Description
Tomography is the recording of internal body images at a pre-determined plane by x-ray. Computerized axial tomography, or CAT scans, involve the measurement of the emergent x-ray beam by a scintillation counter. The electronic pulses are recorded on a magnetic disk and then processed by a minicomputer for reconstruction display of the body in cross-section on a cathode ray tube.

Indications and Limitations of Coverage and/or Medical Necessity

Computerized Tomography Scans:- Head (Procedure codes 70450–70470)

Florida Medicare will consider a computerized tomography scan of the head to be medically reasonable and necessary when performed to establish a diagnosis or to monitor treatment for the following conditions:

Intracranial neoplasms, cerebral infarctions, ventricular displacement or enlargement, cortical atrophy, cerebral aneurysms, intracranial hemorrhage and hematoma, infection, edema, degenerative processes, cyst formation, multiple sclerosis, seizure disorders, head trauma, congenital abnormalities, presence of a foreign body, and radiation treatment planning.

Coverage for headache should only be for the following situations:

- Patient suffering from headaches after a head injury. Head CAT scan is performed to rule out the possibility of a bleed.
- Patient suffering from headaches unusual in duration and not responding to medical therapy. Head CAT scan is performed to rule out the possibility of a tumor.
- Patient suffering from headaches characterized by sudden onset and severity. Head CAT scan is performed to rule out possibility of aneurysm and/or arteriovenous malformation.

Computerized Tomography Scans (70480-70492, 72125-72133, 73200-73202, 73700-73702)

Florida Medicare will only consider computerized tomography scans to be reasonable and necessary when performed for documented cases of illness or injury.

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology

CPT/HCPCS Codes

70450	70490	72131
70460	70491	72132
70470	70492	72133
70480	72125	73200
70481	72126	73201
70482	72127	73202
70486	72128	73700
70487	72129	73701
70488	72130	73702

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity (70450, 70460, 70470)

006.5	225.8	742.8
013.00-013.36	227.3-227.4	742.9
013.60-013.96	237.0-237.1	747.81
036.0-036.2	239.6-239.7	756.0
042	250.20-250.23	759.2-759.9
046.0-046.9	250.30-250.33	765.00-765.19
047.0-047.9	253.0-253.9	767.0
049.0-049.9	255.0-255.9	767.1
052.0	290.0-290.9	767.3
053.0	293.0-293.83	768.5
054.3	294.0-294.9	768.6
054.72	298.9	768.9
055.0	310.0-310.9	770.8
056.01	320.0-326	772.1-772.2
062.0-062.9	330.0-334.9	779.0-779.2
063.0-063.9	341.0-341.9	780.01-780.09
064	342.00-342.92	780.1
072.1-072.2	343.0-343.9	780.2
090.40-090.49	344.00-344.9	780.31-780.39
094.0-094.9	345.00-345.91	780.4
112.83	348.0-348.9	780.6
114.2	349.1-349.9	780.9
115.01	350.1-350.9	781.0-781.8
115.11	351.0-351.9	781.99
115.91	352.0-352.9	784.0
130.0	368.11	784.2
162.0-162.9	368.12	784.3
170.0	368.2	784.5
191.0-191.9	368.40	784.60-784.69
192.0-192.1	368.8	793.0
194.3-194.4	368.9	794.00-794.09
195.0	374.31	800.00-804.99
196.0	377.00-377.01	850.0-854.19
198.3-198.5	377.51-377.52	873.0-873.1
199.0-199.1	377.61	873.9
200.11	377.71	950.0-950.9
200.21	378.51-378.56	951.0-951.9
201.11	386.2	959.01
201.21	388.2	996.2
201.41	388.5	997.00-997.09
201.51	430-438.9	V10.85
201.61	572.2	V10.86
201.71	674.00-674.04	V10.88
201.91	738.10-738.19	V45.2
213.0	740.0-740.2	V67.1
225.0-225.2	742.0-742.4	V67.2

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

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

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

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

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

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

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 Diagnostic Radiology Society and the Florida Neurology Society.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
06/01/2001

Revision History

Revision Number	13	PCR B2001-103
Start Date of Comment Period		N/A
Start Date of Notice Period		06/01/2001
		June 2001 Special *Update!*
Revised Effective Date		07/30/2001

Explanation of Revision: Separate policies have been developed for CT of the Thorax and CT of the Abdomen, therefore, the related procedure codes were deleted from 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 2 for details concerning ABNs.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
71250

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Computerized Axial Tomography of the Thorax

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-12

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
07/30/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
A computed tomographic (CT) image is a display of the anatomy of a thin slice of the body developed from multiple x-ray absorption measurements made around the body's periphery. Unlike conventional tomography, where the image of a thin section is created by blurring out the information from unwanted regions, the CT image is constructed mathematically using data arising only from the section of interest. Generating such an image is confined to cross sections of the anatomy that are oriented essentially perpendicular to the axial dimensions of the body. Reconstruction of the final image can be accomplished in any plane. The CT of the thorax extends from the lung apices to the posterior costophrenic sulci and may extend inferiorly to image the adrenal glands.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider a CT of the thorax medically reasonable and necessary under the following circumstances:

- Evaluation of abnormalities of the lungs, mediastinum, pleura and chest wall initially found on a standard chest radiograph or barium swallow.
- Evaluation, staging, and follow-up after therapy (e.g., surgery, radiation, and/or chemotherapy) of lung and other primary thoracic malignancies.
- Evaluation of a patient who sustained trauma to the pleura, chest wall, mediastinum, and lung.
- Localization of a thoracic mass prior to biopsy.
- Evaluation of a patient with myasthenia gravis to rule out thymic tumors.
- Performance of CT-guided biopsies and drainage procedures when fluoroscopy is inadequate.
- Evaluation of a patient presenting with signs and/or symptoms suggestive of an aortic dissection. The most common symptom of an aortic dissection (occurring in approximately 90% of the cases) is sudden, excruciating pain most commonly located in the anterior chest. Patients may describe the pain as "cutting," "ripping," or "tearing". A sudden neurologic episode usually accompanies the onset of most instances of "painless" aortic dissection.

NOTE: Posterior and lateral views of the chest represent the basic screening tool in identifying abnormalities involving the thorax. It is expected that the chest x-ray is used to evaluate patients who present with signs and/or symptoms suggestive of chest pathology prior to proceeding to a CT scan. .

In addition to the medical necessity requirements, the CT scan must be performed on a model of CT equipment that meets the following criteria:

- The model must be known to the Food and Drug Administration; and
- Must be in the full market release phase of development.

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology

CPT/HCPCS Codes
71250	71260	71270

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
010.00-010.96	510.0-510.9	875.0-875.1
011.00-011.96	513.0-513.1	908.0
135	515	934.0-934.9
140.0-239.9	518.1	959.1
277.00-277.01	518.2	V10.11-V10.12
358.0	710.1	V10.20-V10.29
415.11	748.60-748.69	V10.3
417.1	785.6	V10.71-V10.79
441.00-441.9	786.00-786.9	V10.81
442.81-442.82,	793.1	V58.0
442.89	793.2	V58.1
492.0-492.8	793.9	V58.49
494	809.0-809.1	V67.1
500-505	860.0-862.9	V67.2

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

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

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

Noncovered Diagnoses
N/A

Coding Guidelines
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 May 13, 2000.

Start Date of Comment Period
05/05/2000

End Date of Comment Period
06/19/2000

Start Date of Notice Period
06/01/2001

Revision History
Revision Number Original PCR B2001-108
Start Date of Comment Period: 05/05/2000
Start Date of Notice Period: 06/01/2001
June 2001 Special *Update!*
Original Effective Date 07/30/2001

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 2 for details concerning ABNs.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
74150

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Computerized Axial Tomography of the Abdomen

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-12

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
07/30/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
A computed tomographic (CT) image is a display of the anatomy of a thin slice of the body developed from multiple x-ray absorption measurements made around the periphery of the body. Unlike conventional tomography,

where the image of a thin section is created by blurring out the information from unwanted regions, the CT image is constructed mathematically using data arising only from the section of interest. Generating such an image is confined to cross sections of the anatomy that are oriented essentially perpendicular to the axial dimensions of the body. Reconstruction of the final image can be accomplished in any plane. The CT of the abdomen extends from the dome of the diaphragm to the pelvic brim or pubis symphysis depending upon whether one groups the pelvis with the abdomen or treats it separately.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider a CT of the abdomen medically reasonable and necessary under the following circumstances:

- Evaluation of abdominal pain.
- Evaluation of known or suspected abdominal masses or fluid collections, primary or metastatic malignancies.
- Evaluation of abdominal inflammatory processes.
- Evaluation of abnormalities of abdominal vascular structures.
- Evaluation of abdominal trauma.
- Clarification of findings from other imaging studies or laboratory abnormalities.
- Guidance for interventional diagnostic or therapeutic procedures within the abdomen.
- Treatment planning for radiation therapy.

In addition to the medical necessity requirements, the CT scan must be performed on a model of CT equipment that meets the following criteria:

- The model must be known to the Food and Drug Administration; and
- Must be in the full market phase of development.

NOTE: Plain and upright or lateral decubitus roentgenograms of the abdomen represent the basic screening tool in identifying abnormalities involving the abdomen. It is expected that the abdominal x-ray is used to evaluate patients who present with signs and symptoms suggestive of abdominal pathology prior to proceeding to a CT scan.

CPT/HCPCS Section & Benefit Category

Radiology/Diagnostic Radiology

CPT/HCPCS Codes

74150	74160	74170

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

006.0-006.9	122.0	194.0
014.00-014.86	122.5	195.2
016.00-016.96	122.8	196.2
017.20-017.26	150.0-159.9	197.4-197.8
017.60-017.66	171.5	198.0
017.70-017.76	176.3	198.6
036.3	179	198.7
070.0-070.9	180.0-183.9	200.00
120.0-120.9	188.0-188.9	200.03
121.0-121.9	189.0-189.9	200.06
200.07	239.0	577.0-577.9
200.08	239.4	578.0-578.9
200.10	251.4	590.2
200.13	251.5	591
200.16	251.8	592.0-592.9
200.17	251.9	593.0-593.9
200.18	256.2	599.7
200.20	256.3	750.7
200.23	256.4	751.0-751.9
200.26	256.9	753.0-753.9
200.27	289.4	759.0
200.28	289.50-289.59	759.1
202.40	441.00-441.9	785.6
202.43	442.1	789.00-789.9
202.46	442.2	793.4
202.47	442.83	793.5
202.88	442.84	793.6
211.1	444.0	794.4
211.2	453.3	794.8
211.3	459.0	794.9
211.5	531.00-531.91	863.0-863.99
211.6	532.00-532.91	868.00-868.19
211.7	533.00-533.91	876.0-876.1
211.8	534.00-534.91	879.2
214.3	535.00-535.61	879.3
215.5	536.0-536.9	879.4
218.0-218.9	537.0-537.9	879.5
219.0-219.9	540.0-543.9	879.6
220	550.00-550.93	879.7
221.0	551.00-551.9	902.0-902.9
223.0	552.00-552.9	908.1
223.1	553.00-553.9	908.4
223.2	555.0-555.9	935.2
223.3	556.0-556.9	936
227.0	557.0-557.9	938
228.04	558.1-558.9	958.4
230.2	560.0-560.9	996.30-996.39
230.3	562.00-562.13	996.81
230.7	564.0-564.9	996.82
230.8	567.0-567.9	996.86
230.9	568.0-568.9	996.87
233.1	569.5	996.89
233.2	569.62	997.5
235.3	569.81-569.89	998.2
235.4	570	998.4
236.0	571.0-571.9	V42.0
236.1	572.0-572.8	V42.7
236.2	573.0-573.9	V42.83
236.7	574.00-574.91	V42.84
236.91	575.0-575.9	V44.3
237.2	576.0-576.9	V44.50-V44.59

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 August 19, 2000.

Start Date of Comment Period
08/11/2000

End Date of Comment Period
09/25/2000

Start Date of Notice Period
06/01/2001

Revision History
Revision Number Original PCR B2001-116
Start Date of Comment Period: 08/11/2000
Start Date of Notice Period: 06/01/2001
June 2001 Special *Update!*
Original Effective Date 07/30/2001

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 2 for details concerning ABNs.

FLORIDA MEDICARE PART B
LOCAL MEDICAL REVIEW POLICY

Policy Number
84155

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Serum Protein

AMA CPT Copyright Statement

HCFA National Coverage Policy
Coverage Issues Manual, Section 50-17
Medicare Carriers Manual, Sections 2231, 4270.2, 15020D and 15020E

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

HCFA Region
Region IV

HCFA Consortium
Southern

Original Policy Effective Date
07/30/2001

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Proteins are constituents of muscle, enzymes, hormones, transport vehicles, hemoglobin, and several other key functional and structural entities within the body. Proteins are the most significant component contributing to the osmotic pressure within the vascular space. This osmotic pressure keeps fluid within the vascular space, minimizing extravasation of fluid.

Albumin and globulins constitute most of the protein within the body and are measured in the total protein. Serum total protein is defined as the sum of circulating serum proteins. Normal adult total protein is 6.0-8.0 g/dl.

Protein testing aids in the diagnosis of some inflammatory and neoplastic states, nephrotic syndromes, liver diseases, and immune dysfunctions. Protein testing aids in the evaluation of nutritional states and osmotic pressures in edematous and malnourished patients.

Indications and Limitations of Coverage and/or Medical Necessity

Increased or decreased protein levels cause no symptoms per se. Symptoms may arise, however, from underlying conditions. Therefore, Florida Medicare will consider serum protein testing medically reasonable and necessary under either of the following two conditions:

1. Evaluation of beneficiaries with conditions related to hyperproteinemia:
   Hemoconcentration states due to fluid loss (e.g., vomiting, diarrhea, poor kidney function);
   Dehydration;
   Specific chronic liver disease (e.g., active hepatitis and cirrhosis);
   Multiple myeloma and other gammopathies;
   Waldenstrom's macroglobulinemia;
   Tropical diseases (e.g., kala-azar, leprosy);
   Sarcoidosis and other granulomatous diseases;
   Collagen disorders (e.g., systemic lupus erythematosus, rheumatoid arthritis);
   Chronic inflammatory states; or
   Chronic infections.
2. Evaluation of beneficiaries with conditions related to hypoproteinemia:
   Insufficient nutritional intake (e.g., starvation, malnutrition, or malabsorption);
   Liver disease (e.g., cirrhosis, chronic alcoholism);
   Glomerulonephritis;
   Nephrotic syndrome;
   Crohn's disease and chronic ulcerative colitis;
   Severe skin diseases, severe and/or extensive burns;
   Severe hemorrhage (when plasma volume is replaced more rapidly than protein);
   Heart failure;
   Hyperthyroidism/hypothyroidism; or
   Prolonged immobilization (e.g., trauma, orthopedic surgery).

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

In accordance with national Medicare coverage policy, serum total protein tests (84155 or 84160) are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis beneficiaries. Serum total protein tests (84155 or 84160) are also routinely covered at a frequency of once per month if furnished to a continuous ambulatory peritoneal dialysis patient in a certified setting. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

CPT/HCPCS Codes

84155 84160

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

030.0-030.9	285.8	694.4
085.0	285.9	695.89
127.2	287.3	710.0
135	287.4	710.3
200.00-200.88	287.5	714.0
202.00-202.98	428.0-428.9	733.90
203.00-203.01	555.0-555.9	787.01
204.00-204.01	556.0-556.3	787.03
204.10-204.11	556.5-556.6	787.91
205.00-205.91	570	788.42
206.00-206.01	571.0-571.6	791.0
242.00-242.91	572.8	941.30-941.59
244.0-244.9	573.3	942.30-942.59
253.6	573.9	943.30-943.59
260-263.9	577.0	945.30-945.59
273.0-273.9	577.1	946.3-946.5
276.5	579.3	947.0-947.9
284.0	579.8	948.10-948.99
284.8	580.0-588.9	994.2

Diagnoses that Support Medical Necessity

N/A

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denial

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

Noncovered ICD-9-CM Code(s)

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

Noncovered Diagnosis

N/A

Coding Guidelines

Routine serum total protein laboratory tests (84155 or 84160), those performed at a frequency of one per month for hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis beneficiaries, are included in the *renal facility's* composite rate and may not be billed separately to the Medicare program. Routine tests performed for continuous ambulatory peritoneal dialysis beneficiaries in a certified setting are also included in the *facility's* composite rate. 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.

Documentation Requirements

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

documentation must substantiate that these results have been used to determine the beneficiary's course of treatment. The handwritten/typed interpretation for serum protein electrophoresis services may include computer-generated findings. Computer-generated findings however, may not substitute for nor be the only information provided to represent the pathologist's interpretation. A narrative statement from the pathologist is required.

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

Utilization Guidelines

In accordance with national Medicare coverage policy, serum total protein tests (84155 or 84160) are routinely covered at a frequency of once per month for hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis beneficiaries. Serum total protein tests (84155 or 84160) are also routinely covered at a frequency of once per month if furnished to a continuous ambulatory peritoneal dialysis patient in a certified setting. Services performed at a greater frequency are covered if medically necessary and used in timely medical decision making.

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 multiple specialties.

Carrier Advisory Committee Meeting held on November 11, 2000.

Start Date of Comment Period

08/11/2000

End Date of Comment Period

09/25/2000

Start Date of Notice Period

06/01/2001

Revision History

Revision Number Original PCR B2001-118
Start Date of Comment Period: 08/11/2000
Start Date of Notice Period: 06/01/2001
June 2001 Special *Update!*
Original Effective Date 07/30/2001

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 2 for details concerning ABNs.

93303: Transthoracic and Doppler Echocardiography, and Doppler Color Flow Velocity Mapping - Correction to Policy

The local medical review policy (LMRP) for Transthoracic and Doppler Echocardiography, and Doppler Color Flow Velocity Mapping (policy number 93303) was published in the January/February 2000 *Medicare B Update! (*pages 48-49). In the "ICD-9-CM Codes That Support Medical Necessity" section of the policy, ICD-9-CM code 997.2 was incorrectly identified as a covered diagnosis for procedure codes 93307 and 93308.

MEDICARE B UPDATE!

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