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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 Web site, www.floridamedicare.com.

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

Second Quarter 2002

Volume 15, Number 2

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# Medicare B Update!

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#### Publications

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The *Medicare B Update!* is published quarterly 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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# A Physician's Focus

# "But It's Only a 99211"

The Evaluation and Management (E/M) *CPT* code 99211 is probably the most overused and abused service billed to Medicare. In Florida, the code is very aberrant with a carrier-to-nation ratio of 1.98, and a six-month carrier allowed dollar variance of \$5,401,493. That means Florida physicians are billing this code *twice as often*, per 1000 Medicare patients, as the national average. This accounts for over \$20 million of the Florida Medicare expenditures. If Florida physicians billed at the same rate as the national average, Medicare would save over \$10 million a year.

Analysis of the data indicates that some Florida physicians may be inappropriately billing 99211 with other billable services. Another concern is that some physicians may be billing 99211 for services performed by their staff when they are not present in the office.



Billing 99211 with chemotherapy services (*CPT* codes 96400-96549) seems to be particularly prevalent in our state. Section 15400D of the Medicare Carrier's Manual (MCM), concerning chemotherapy administration and "incident to" services, states that a physician "...may report and be paid for "incident to" services...in addition to the chemotherapy, if they are furnished under direct personal supervision in the office by one of the physician's employees and the medical records reflect the physician's active participation in and management of the course of treatment."

The intent of this MCM section is that if *"a significant, separately identifiable"* E/M service is performed as an "incident to" service at the time of chemotherapy administration; the appropriate code to bill may be 99211. Insertion of a catheter, set-up of an IV, administration of chemotherapeutic drugs, monitoring for adverse reactions, dealing with nausea, etc., are all part of the chemotherapy administration service. Reviewing lab results and inquiring into the patient's well being prior to administration of chemotherapy do not satisfy the "significant and separately identifiable" requirements. Should, however, a problem arise which requires E/M decision making as an "incident to" service without face-to-face interaction with the physician, the appropriate code to bill may be 99211.

The *CPT* description of 99211 includes the words, "...that may not require the presence of a physician." This has led some physicians to mistakenly conclude they can bill Medicare for a 99211 visit for services performed by their staff when they are out of the office. This is absolutely not true. In order to bill Medicare for a 99211 service as "incident to" *all* of the "incident to" requirements must be met. This includes presence of the physician in the office at the time of service.

Another area of concern is the level of documentation required for a 99211 service. At a minimum, the health record should document the reason and actions taken to address the reason for the visit. Of course, all of the other requirements for records such as the patient's name, date, facility identity, provider identity, signature and legibility need to be documented. This subject is covered in much greater detail on pages 17-18 of this issue. Please read it and be sure your billing office is familiar with its contents. Our goal is to reduce payment errors to a minimum and keep them there. Before we can pay correctly, we must be billed correctly. Thanks for your help.

Sincerely,

Sidney R. Sewell, MD Medical Director

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# **A**DMINISTRATIVE

# About the Medicare B Update!

The *Medicare B Update!* is a comprehensive magazine published quarterly for all Part B providers in the State of Florida. In accordance with notification requirements established by the Centers for Medicare & Medicare Services, approximate delivery dates are:

| Publication Name    | Publication Date  | Effective Date of Changes |  |  |  |
|---------------------|-------------------|---------------------------|--|--|--|
| First Quarter 2002  | Mid-November 2001 | January 1, 2002           |  |  |  |
| Second Quarter 2002 | Mid-February 2002 | April 1, 2002             |  |  |  |
| Third Quarter 2002  | Mid-May 2002      | July 1, 2002              |  |  |  |
| Fourth Quarter 2002 | Mid-August 2002   | October 2002              |  |  |  |

Important notifications that require communication in between these dates will be posted to the First Coast Service Options, Inc. Florida provider Web site, **www.floridamedicare.com**. In some cases, additional unscheduled special issues will be published.

### Who Receives the Update?

Distribution of the *Update!* is limited to individual providers and Professional Association (PA) groups who bill at least one Part B claim to Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing copies to *all* 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 (order form on page 113). Issues published since January 1997 may be downloaded from our Web site, free of charge.

Medicare Part B of Florida 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 addresses current with the Medicare Provider Registration Department.

### What is in the Update?

The *Update!* is divided into several sections, starting with a letter from the **Carrier Medical Director**. Following is **Administrative** information, then **Claims**, which 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, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare Physician Fee Schedule, and other pricing issues. Local and Focused Medical Review Policies follows, then Electronic Media Claims, and General Information, which includes Fraud and Abuse, Medicare Registration, and Medicare Secondary Payer topics, and more. Educational **Resources** provides seminar schedules and reproducible forms. Important Addresses. Phone Numbers, and Web sites are listed on the inside back cover.

# The *Medicare B Update!* Represents Formal Notice of Coverage Policies

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 maintains copies of the mailing lists for each issue. 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.

# **Advance Beneficiary Notice**

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 Beneficiary Notice (ABN) must meet the following requirements:

- The ABN must be given in writing, in advance of furnishing the service or item.
- The ABN 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 ABN form should be maintained with the patient's medical record.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

# CLAIMS

# **Correct Coding Initiative**

Version 8.1 of the Correct Coding Initiative (CCI) will be implemented April 1, 2002. Version 8.1 includes all previous versions and updates from January 1996 to the present.

The U.S. Department of Commerce, National Technical Information Service (NTIS) has developed a national correct coding policy manual to assist physicians in correctly coding services for reimbursement. Medicare carriers are prohibited from publishing specific correct coding edits. 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 online at www.ntis.gov/product/correct-coding.htm.

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

Source: CMS Transmittal B-01-75, CR 1916

# Health Professional Shortage Area Designation Changes

Effective for claims processed on or after *December 1, 2001*, the following Health Professional Shortage Area (HPSA) designation changes have been made:

- Sumter County is a new geographic HPSA
- Volusia County, Pierson/Seville/Deleon Spring, Census tract 901.00, is now a low-income population HPSA
- Atmore/Century AL/FL name has changed to Northern Escambia, and remains a geographic HPSA

# **Billing Guidelines for Anesthesia Services**

Florida Medicare has noted a significant increase in Medicare claims development due to providers billing multiple anesthesia codes for the same operative session, and surgeons billing for both anesthesia and the surgical procedure for the same operative session.

The following information is being published to provide awareness and clarification to providers and billers of anesthesia services to eliminate these claim filing errors.

## Anesthesia for Multiple Surgeries

Payment may be made for the anesthesia services provided during multiple or bilateral surgery procedures. When billing anesthesia services associated with multiple or bilateral surgeries, report *only* the anesthesia procedure with the highest base unit. Report the total time for all procedures on *one detail line item*.

#### Incorrect

| Date of Service | Procedure Code | Units |
|-----------------|----------------|-------|
| 12/10/2001      | 00140QZ        | 60    |
| 12/10/2001      | 00140QZ        | 30    |
| Correct         |                |       |
| Date of Service | Procedure Code | Units |
| 12/10/2001      | 00140QZ        | 90    |
|                 |                |       |

# Administration of Anesthesia by the Surgeon

Reimbursement for anesthesia performed by the operating surgeon is included in the allowance of the surgical procedure rendered during the same operative session. Separate payment is not allowed when surgeon performs the surgical procedure *and* performs local or surgical anesthesia. *No claim should be submitted for the anesthesia service*.

#### Incorrect

| Date of Service | Procedure Code            | Provider           | 010 |
|-----------------|---------------------------|--------------------|-----|
| 12/10/2001      | 15823RT                   | D12345             |     |
| 12/10/2001      | 15823LT                   | D12345             |     |
|                 | Procedure Code<br>00140QZ | Provider<br>D12345 |     |
| Date of Service | Procedure Code            | Provider           | 010 |
| 12/10/2001      | 15823RT                   | D12345             |     |
| 12/10/2001      | 15823LT                   | D12345             |     |

# Jurisdictional Pricing on the Multi-Carrier System (MCS)

The jurisdictional payment policy for Medicare payments will be implemented by Florida Medicare when conversion to the MCS takes place on March 8, 2002. This policy, however, is effective for all claims received on or after July 1, 2001. Information concerning carrier jurisdiction was provided in the December 2001 *Medicare B Update! Special Issue—Conversion to Medicare's Multi-Carrier System.* Since release of that publication, the Centers for Medicare & Medicaid Services (CMS) has instructed carriers to provide the following information.

For services provided in a beneficiary's home (place of service [POS] "Home" -12), the MCS refers to the

beneficiary's home address to determine carrier payment jurisdiction. If this address is outside of the carrier's payment jurisdiction, the carrier will deny the claim. If the home address on the carrier's beneficiary file is not correct, or does not accurately reflect where the service was rendered, the denial may be appealed. **Providers who request an appeal or adjustment of denied services in which the original claim was received by the carrier on or after July 1, 2001,** *must* **include the appropriate ZIP code for where the service was rendered.** If the ZIP code is not provided, the denial will be upheld.

Source: CMS Transmittal B-01-62, CR 1866

# Coverage/Reimbursement

# MEDICARE PHYSICIAN FEE SCHEDULE

# Correction to Second Update to 2001 Medicare Physician Fee Schedule Database

The Centers for Medicare & Medicaid Services (CMS) has retracted changes to *CPT* code 76000 that were implemented July 1, 2001 (second update to the 2001 Medicare Physician Fee Schedule).

This correction is *effective for services performed January 1, 2001 through December 31, 2001*. The changes included are as follows:

| mended are as fono (is). |          |           |        |        |           |        |        |           |        |        |
|--------------------------|----------|-----------|--------|--------|-----------|--------|--------|-----------|--------|--------|
|                          |          |           | PAR    |        |           | NONPA  | R      | Limiting  | Charge |        |
|                          | Code/Mod | Loc 01/02 | Loc 03 | Loc 04 | Loc 01/02 | Loc 03 | Loc 04 | Loc 01/02 | Loc 03 | Loc 04 |
|                          | 76000    | 59.45     | 64.95  | 68.90  | 56.48     | 61.70  | 65.46  | 64.95     | 70.96  | 75.27  |
|                          | 76000 TC | 50.44     | 55.42  | 58.92  | 47.92     | 52.65  | 55.97  | 55.11     | 60.55  | 64.37  |
|                          | 76000 26 | 9.01      | 9.52   | 9.98   | 8.56      | 9.04   | 9.48   | 9.84      | 10.40  | 10.90  |
|                          |          |           |        |        |           |        |        |           |        |        |

Source: CMS Transmittal AB-01-167 CR 1937

# **Corrections to the 2002 Medicare Physician Fee Schedule Database**

**S** pecific reimbursement rules for procedure codes on the Medicare Physician Fee Schedule Database (MPFSDB) were provided in the *Medicare B Update! Special Issue 2002 Healthcare Common Procedure Coding System and Medicare Physician Fee Schedule Database Update* (December 2001). Since that publication was released, the Centers for Medicare & Medicaid Services (CMS) has made changes to the policy indicators for a number of procedure codes. These changes, effective for services rendered on or after January 1, 2002, do not affect the allowances that were published in the *2002 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* that was sent to providers in mid-November, **except as noted** herein.

Changes included in this emergency update to the 2002 MPFSDB are as follows:

- The **procedure code status** for codes **A4263**, **A4550**, and **G0025** is changed to **B** (Payment for covered services are always bundled into payment for other services not specified. There will be no relative value units (RVUs) or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident).
- The procedure code status for codes A4329, A5064, A5074, A5075, G0126, G0126-TC, G0126-26, G0163, G0163-TC, G0163-26, G0164, G0164-TC, G0164-26, G0165, G0165-TC, G0165-26, G0203, G0205, G0205-TC, G0205-26, G0207, G0207-TC, and G0207-26 is changed to F (Deleted/discontinued codes. (Code not subject to a 90-day grace period.).
- The **procedure code status** for codes **J7190**, **J7199**, **Q0187**, **Q3014**, and **Q3017** is changed to **X** (Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule.).
- The **multiple procedure indicator** for codes **85095** and **85102** is changed to **0** (No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.).
- The **multiple procedure indicator** for codes **29806**, **29807**, and **29284** is changed to **3** [Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure)]. Multiple endoscopy rules are applied to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

In addition, the **endoscopic base code** is changed to code **29805** for codes **29806**, **29807**, **29819**, **29820**, **29821**, **29822**, **29823**, **29824**, **29825**, and **29826**.

• The relative values units are changed for codes G0108, G0109, G0236, G0236-TC, 76092, 76092-TC, 76085, 76085-TC, 95951, and 95951-TC. *New allowances*, effective for services rendered on or after January 1, 2002 that replace those previously published are as follows:

| CODE/    | F         | PARTICIP | ATING   | N         | ONPARTIC | IPATING | LIMI      | TING CHA | ARGE     |
|----------|-----------|----------|---------|-----------|----------|---------|-----------|----------|----------|
| MOD      | LOC 01/02 | LOC 03   | LOC 04  | LOC 01/02 | LOC 03   | LOC 04  | LOC 01/02 | LOC 03   | 3 LOC 04 |
| G0108    | 28.54     | 30.90    | 32.14   | 27.11     | 29.36    | 30.53   | 31.18     | 33.76    | 35.11    |
| G0109    | 16.90     | 18.37    | 19.19   | 16.06     | 17.45    | 18.23   | 18.46     | 20.07    | 20.97    |
| G0236    | 17.07     | 18.63    | 19.65   | 16.22     | 17.70    | 18.67   | 18.65     | 20.35    | 21.47    |
| G0236 TC | 13.81     | 15.05    | 15.77   | 13.12     | 14.30    | 14.98   | 15.09     | 16.44    | 17.23    |
| 76000    | 54.07     | 59.16    | 62.54   | 51.37     | 56.20    | 59.41   | 59.07     | 64.63    | 68.32    |
| 76000 TC | 45.21     | 49.77    | 52.71   | 42.95     | 47.28    | 50.07   | 49.39     | 54.37    | 57.59    |
| 76000 26 | 8.86      | 9.39     | 9.83    | 8.42      | 8.92     | 9.34    | 9.68      | 10.26    | 10.74    |
| 76085    | 17.07     | 18.63    | 19.65   | 16.22     | 17.70    | 18.67   | 18.65     | 20.35    | 21.47    |
| 76085 TC | 13.81     | 15.05    | 15.77   | 13.12     | 14.30    | 14.98   | 15.09     | 16.44    | 17.23    |
| 76092    | 79.17     | 85.52    | 89.94   | 75.21     | 81.24    | 85.44   | 86.49     | 93.43    | 98.26    |
| 76092 TC | 44.53     | 49.03    | 51.95   | 42.30     | 46.58    | 49.35   | 48.65     | 53.57    | 56.76    |
| 95951    | 1598.51   | 1719.45  | 1786.13 | 1518.58   | 1633.48  | 1696.82 | 1746.37   | 1878.50  | 1951.35  |
| 95951 TC | 1284.45   | 1389.30  | 1443.79 | 1220.23   | 1319.84  | 1371.60 | 1403.26   | 1517.81  | 1577.34  |

Source: CMS Transmittal AB-01-177, CR 1971

# **Billing for Noncovered Services**

Effective for services performed on or after January 1, 2002, HCPCS code A9270 (non-covered item or service), A9160 (non-covered service by podiatrist), and A9170 (non-covered service by chiropractor) can no longer be used to bill Florida Medicare for a noncovered service. To assist providers in billing for noncovered services, please note the guidelines below. For additional information regarding a specific noncovered service or item, please refer to the local medical review policy "NCSVCS" beginning on page 22 of this issue.

• A service for which a specifically descriptive *CPT*/HCPCS code does *not* exist (e.g., Intestinal bypass for obesity) should be billed using the appropriate unlisted procedure code (44799 Unlisted procedure, intestine) with modifier GA, GY, or GZ as appropriate.

## COVERAGE/REIMBURSEMENT

- A service for which a specifically descriptive *CPT*/HCPCS code does exist but is *always* noncovered (e.g., spinal X-ray by chiropractor 72010) should be billed with the applicable procedure code and modifier GA, GY, or GZ.
- A service for which a specific *CPT*/HCPCS code exists but the procedure is performed for an investigational/ experimental indication, must be billed with the appropriate *CPT*/HCPCS code, modifier GA or GZ, as appropriate.
- A service for which a specific *CPT*/HCPCS code exists but the procedure is performed for a statutorily excluded indication (e.g., well woman annual visit *CPT* code 99397) must be billed with the appropriate *CPT*/HCPCS code and modifier GY.

## **Modifiers for Noncovered Services**

filel

The descriptors for modifiers to use with noncovered services are:

GA waiver of liability statement on file [item or service expected to be denied as not reasonable and necessary],
 GZ item or service expected to be denied as not reasonable and necessary [no waiver of liability statement on

### GY item or service statutorily excluded or does not meet the definition of any Medicare benefit

Complete information regarding the use of modifiers GA, GY, and GZ was published in the First Quarter 2002 *Medicare B Update!* (pages 7-8).

# **AMBULATORY SURGICAL CENTER**

# Update of Codes and Payments for Ambulatory Surgical Centers (ASCs)

|   |             | /             | • a. g.•a. ••.    |                         |
|---|-------------|---------------|-------------------|-------------------------|
| The following deletions from and  | Added Codes | Payment Group | Added Codes       | Payment Group           |
| additions to the list of codes payable                                  | 25024       | 3             | 53431             | 2                       |
| to an ASC are the result of changes in the                              | 25025       | 3             | 53444             | 2                       |
| AMA's Current Procedural Terminology                                    | 25275       | 4             | 53445             | 1                       |
| (CPT) for 2002.   | 25671       | 1             | 53446             | 1                       |
|   | 29805       | 3             | 54162             | 2                       |
| Effective for services performed on                                     | 29806       | 3             | 54163             | 2                       |
| or after January 1, 2002:   | 29807       | 3             | 54164             | 2                       |
| Deleted Codes   | 29824       | 5             | 54512             | 2                       |
| For codes to report, see the December                                   | 29900       | 3             | 64581*            | 1                       |
| 2001 Medicare B Update! Special Issue –                                 | 29901       | 3             | The comple        | ete list of ASC covered |
| 2001 Weddeure B Opdate: Special Issue –<br>2002 HCPCS and MPFSDB Update | 29902       | 3             |                   | 2002 will be provided   |
| 1   | 36819       | 3             | 1                 | 1                       |
| (pages 7-8).  | 36820       | 3             | in a future publi | cation.                 |
| 26585, 26597, 29815, 54510  | 46020       | 3             | Source: CMS Tr    | ransmittal AB-01-141,   |
| , , -,  | 52001       | 2             | CR 1860: *2002    | 2 HCPCS                 |

# CARDIOLOGY

## **External Counterpulsation for Severe Angina—Covered**

External counterpulsation (ECP), commonly referred invasive outpatient treatment for coronary artery disease refractory to medical and/or surgical therapy.

Although ECP devices are cleared by the Food and Drug Administration (FDA) for use in treating a variety of cardiac conditions, including stable or unstable angina pectoris, acute myocardial infarction and cardiogenic shock, the use of this device to treat cardiac conditions *other than* stable angina pectoris is not covered, since only that use has developed sufficient evidence to demonstrate its medical effectiveness. Non-coverage of hydraulic versions of these types of devices remains in force.

Coverage is provided for the use of ECP for patients who have been diagnosed with disabling angina (Class III or Class IV, Canadian Cardiovascular Society Classification or equivalent classification) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention, such as PTCA or cardiac bypass because: (1) their condition is inoperable, or at high risk of operative complications or post-operative failure; (2) their coronary anatomy is not readily amenable to such procedures; or (3) they have comorbid states which create excessive risk.

A full course of therapy usually consists of 35 onehour treatments, which may be offered once or twice daily, usually five days per week. The patient is placed on a treatment table where their lower trunk and lower extremities are wrapped in a series of three compressive air cuffs which inflate and deflate in synchronization with the patient's cardiac cycle.

For more information concerning ECP, refer to the local medical review policy published in the January/ February 2000 issue of the *Medicare B Update!* (pages 30-31).

Source: CMS Transmittal 146, CR 1884 (CIM 35-74)

# DERMATOLOGY

# **Treatment of Actinic Keratosis**

Effective for services performed on and after November 26, 2001, coverage is extended for surgical or medical treatment methods, including but not limited to cryosurgery with liquid nitrogen, curettage, excision, and photodynamic therapy (PDT), without restrictions based on patient or lesion characteristics.

Actinic keratoses (AKs), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have potential to become a skin cancer. Various options exist for treating AKs. Clinicians should select an appropriate treatment based on the patient's medical history, lesion's characteristics, and patient's preference for a specific treatment. Commonly performed treatments for AKs include cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and PDT. An alternative approach to treating AKs is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma.

For more information, refer to local medical review policy 17000: Benign or Premalignant Skin Lesion Removal and/or Destruction in the January/February 1998 issue of the *Medicare B Update*! (pages 19-21).

Source: CMS Transmittal 145 CR 1892 (CIM 35-101)

# **D**IAGNOSTIC **T**ESTS

# Ambulatory Blood Pressure Monitoring

A mbulatory blood pressure monitoring (ABPM) involves use of a non-invasive device to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and later interpreted at the physician's office. ABPM must be performed for at least 24 hours to meet coverage criteria.

Effective April 1, 2002, ABPM is only covered for those patients with suspected "white coat hypertension." Suspected "white coat hypertension" is defined as:

- Office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit,
- 2) At least two documented blood pressure measurements taken outside the office which are less than 140/90 mm Hg, and
- 3) No evidence of end-organ damage.

ABPM is not covered for any other uses. In the rare circumstance ABPM needs to be performed more than once for a patient, the qualifying criteria described above must be met for each subsequent ABPM test.

### **CPT** Codes

|       | oues -   |
|-------|--|
| 93784 | ABPM, utilizing a system such as magnetic tape |
|       | and/or computer disk, for 24 hours or longer;  |
|       | including recording, scanning analysis,        |
|       | interpretation and report                      |
| 93786 | ABPM, utilizing a system such as magnetic tape |
|       | and/or computer disk, for 24 hours or longer;  |
|       | recording only                                 |
| 93790 | ABPM, utilizing a system such as magnetic tape |
|       | and/or computer disk. for 24 hours or longer:  |

and/or computer disk, for 24 hours or longer; physician review with interpretation and report

*CPT* code 93788 (*ABPM*, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report) is not approved for Medicare payment.

Source: CMS Transmittal AB-01-188 & CIM 50-42; CR 1985

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology. CPT codes*, descriptions and other data only are copyrighted 2001 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

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

Most DMEPOS claims are processed by the durable medical equipment regional carriers (DMERCs). The DMERC that serves Florida is Palmetto Government Benefits Administrators (**www.palmettogba.com**). The two articles on the following page are intended to provide information to those providers who bill to the DMERC, as well as to local carriers. For more information concerning contractor jurisdiction for a specific service, refer to the Third Quarter 2001 Medicare B Update! (pages 7-14).

# **Supplier Billing for Glucose Test Strips and Supplies**

**P**rogram Memorandum B-01-74, issued November 15, 2001, instructs DMERCs to require suppliers of test strips to bill using appropriate "start" and "end" dates on their claim forms. DMERCs will edit claims for appropriate codes to check the Form HCFA-1500 to make sure the "start" and "end" dates are complete and dates

are not exact duplicates. This includes all blood glucose monitor supplies, including glucose test strips. For more information, please contact Palmetto Government Benefits Administrators at **www.palmettogba.com**.

CMS Transmittal B-01-74, CR 1612

# Providing Upgrades of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Without Any Extra Charge

Inder existing national Medicare policy, suppliers may collect from a beneficiary a payment amount greater than Medicare's allowed payment amount if the beneficiary, by signing an Advance Beneficiary Notice (ABN), agrees to pay extra for a DMEPOS item because the beneficiary prefers an item with features or upgrades that are not medically necessary. This policy applies to both assigned and unassigned claims. When a beneficiary does not sign an ABN, a supplier that accepts assignment cannot hold the beneficiary liable for the cost of medically unnecessary equipment or upgrades unless there is other acceptable evidence the beneficiary knew or could reasonably have been expected to know that Medicare would not pay for the medically unnecessary equipment or upgrades. With respect to unassigned claims, a signed ABN is necessary to hold the beneficiary liable.

Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain instances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and beneficiary the same price they would charge for a non-upgraded item. The reason for this may be that a supplier prefers to carry only higher-level models of medical equipment in order to reduce costs of maintaining an inventory that includes a wide variety of different models and products. In addition, a supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines.

Suppliers are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary as they would charge for a nonupgraded item. This policy allows suppliers to furnish to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds the nonupgraded item that Medicare considers medically necessary. Therefore, even though the beneficiary received an upgraded DMEPOS item, Medicare's payment and the beneficiary's coinsurance would be based on the Medicare allowed payment amount for a non-upgraded item that does not include features that exceed the beneficiary's medical needs.

#### **Billing Instructions for January 1, 2002**

When a supplier decides to furnish an upgraded DMEPOS item at the price of a non-upgraded item, the supplier should bill for the non-upgraded item, not the upgraded item. No modifier should be used to indicate that an upgraded item was furnished in place of the nonupgraded item. However, the upgraded item should be described in Item 19 (or as an attachment to the claim) on Form HCFA-1500 and the narrative record on an electronic claim. The contractor will process the claim for the non-upgraded item as if the beneficiary actually received the non-upgraded item. A certificate of medical necessity, if applicable, must be completed for the HCPCS code that identifies the non-upgraded item. These billing instructions will be implemented effective January 1, 2002, and be replaced with new billing instructions effective April 1, 2002.

### Billing Instructions for April 1, 2002

When a supplier decides to furnish an upgraded DMEPOS item at the price of a non-upgraded item, the supplier should bill for the non-upgraded item rather than for the item actually furnished. **The claim should only include the charge for the non-upgraded item.** The HCPCS code for the non-upgraded item must be accompanied by modifier GL (Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN).

In Item 19 of the claim (or as an attachment), the supplier must specify the make and model of the item actually furnished, that is, the upgraded item and describe why this item is an upgrade.

Contractors will pay based on Medicare's payment amount for the non-upgraded item if it meets Medicare's coverage requirements. A certificate of medical necessity, if applicable, must be completed for the HCPCS code that identifies the non-upgraded item (not the upgraded item).

A future instruction will be issued regarding use of ABNs when a supplier decides to hold the beneficiary responsible for paying for the difference between the cost of a non-upgraded item and a medically unnecessary upgrade.

Source: CMS Transmittal B-01-68, CR 1894

# INJECTABLE DRUGS

# Payment Allowance for Injectable Drugs

**P**roviders who bill for injectable drugs should be aware of the following updated payment allowances, so they may adjust their fees accordingly. These allowances are effective for services provided on or after January 1, 2002. Remember that assignment must be accepted for these services, as mandated by the Benefits Improvement and Protection Act of 2000.

| Code  | PAR     | NON-PAR | Code  | PAR    | NON-PAR | Code  | PAR   | NON-PAR |
|-------|---------|---------|-------|--------|---------|-------|-------|---------|
| 90379 | NC      | NC      | A9700 | IC     | IC      | J0395 | IC    | IC      |
| 90675 | 139.76  | 132.77  | J0170 | 2.12   | 2.01    | J0500 | 1.65  | 1.57    |
| 90703 | 3.38    | 3.21    | J0210 | 11.87  | 11.28   | J0540 | 17.97 | 17.07   |
| 90740 | 202.16  | 202.16  | J0282 | 18.81  | 17.87   | J0550 | 35.95 | 34.15   |
| 90746 | 67.45   | 67.45   | J0286 | 127.93 | 121.53  | J0560 | 7.41  | 7.04    |
| 90747 | 105.81  | 105.81  | J0330 | 0.12   | 0.11    | J0580 | 29.65 | 28.17   |
| A9500 | 133.86  | 127.17  | J0350 | IC     | IC      | J0587 | 8.78  | 8.34    |
| A9511 | IC      | IC      | J0360 | 8.26   | 7.85    | J0620 | 5.40  | 5.13    |
| A9505 | 34.22   | 32.51   | J0380 | 1.26   | 1.20    | J0635 | 13.17 | 12.51   |
| A9600 | 1059.75 | 1059.75 | J0390 | 18.95  | 18.00   | J0690 | 2.64  | 2.51    |

## COVERAGE/REIMBURSEMENT

| $\begin{array}{c c c c c c c c c c c c c c c c c c c $   | Code  | PAR   | NON-PAR | Code  | PAR    | NON-PAR | Code      | PAR           | NON-PAR  |
|--|-------|-------|---------|-------|--------|---------|-----------|---------------|----------|
| $\begin{array}{c c c c c c c c c c c c c c c c c c c $   | J0692 | 7.60  | 7.22    |       |        |         |           |               |          |
| $\begin{array}{c c c c c c c c c c c c c c c c c c c $   | J0694 | 10.13 | 9.62    | J1835 | 878.13 | 834.22  | J7320     | 223.25        | 212.09   |
| JÓG97         5.18         4.92         J1955         32.06         30.46         J7504         269.05         269.05           J0702         3.88         3.69         J2020         36.19         34.38         J7511         IC         IC         IC           J0713         6.75         6.41         J2150         2.78         2.64         J7624         IC         IC         IC           J0744         13.68         13.00         J2250         2.63         2.50         J7626         IC         IC         IC         J0745         0.44         0.42         J2270         0.57         0.54         J7641         IC         IC         IC         J0780         3.20         3.04         J2300         1.90         1.80         J9017         26.12         24.81           J0850         638.47         606.55         J2310         4.20         3.99         J9020         62.61         59.48           J0970         2.73         2.52         J2222         2.549         2.4.22         J9080         11.34         10.77           J1060         3.70         3.52         J2510         8.07         7.67         J9310         454.55         431.82                   |       |       |         |       |        |         |           |               |          |
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|  |       |       |         |       |        |         |           |               |          |
| J0970         21.73         20.64         J2321         6.32         6.00         J9031         166.48         158.16           J1056         23.71         22.52         J2200         25.49         24.22         J9080         11.34         10.77           J1060         3.70         3.52         J2500         25.09         23.84         J9214         13.49         12.82           J1070         4.70         4.46         J2510         8.07         7.67         J9300         1929.68         1833.20           J1080         17.61         16.73         J2550         0.24         0.23         J9310         454.55         431.82           J1090         2.35         2.23         J2560         6.04         5.74         Q0136         12.31         11.69           J1110         15.14         14.38         J2765         0.68         0.65         Q9921         12.31         11.69           J1180         2.54         1.45         J2920         1.94         1.84         Q9922         12.31         11.69           J1180         9.0         8.55         J2940         41.89         39.80         Q9924         12.31         11.69           J120                |       |       |         |       |        |         |           |               |          |
| J1056       23.71       22.52       J2322       25.49       24.22       J9080       11.34       10.77         J1060       3.70       3.52       J2500       25.09       23.84       J9214       13.49       12.82         J1070       4.70       4.46       J2510       8.07       7.67       J9300       1929.68       1833.20         J1080       17.61       16.73       J2560       6.04       5.74       Q0136       12.31       11.69         J1100       0.17       0.16       J2700       0.63       0.60       Q9920       12.31       11.69         J1110       15.14       14.38       J2765       0.68       0.65       Q9921       12.31       11.69         J1170       1.53       1.45       J2920       1.94       1.84       Q9922       12.31       11.69         J1180       9.00       8.55       J2940       41.89       39.80       Q9924       12.31       11.69         J1205       10.48       J2997       35.62       3.84       Q9926       12.31       11.69         J1200       0.51       0.48       J2997       35.62       3.84       Q9927       12.31       11.69     <  |       |       |         |       |        |         |           |               |          |
|  |       |       |         |       |        |         |           |               |          |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$  |       |       |         |       |        |         |           |               |          |
| J1080       17.61       16.73       J2550       0.24       0.23       J9310       454.55       431.82         J1090       2.35       2.23       J2560       6.04       5.74       Q0136       12.31       11.69         J1100       0.17       0.16       J2700       0.63       0.60       Q9920       12.31       11.69         J1110       15.14       14.38       J2765       0.68       0.65       Q9921       12.31       11.69         J1160       2.54       1.45       J2920       1.94       1.84       Q9922       12.31       11.69         J1180       9.00       8.55       J2940       41.89       39.80       Q9924       12.31       11.69         J1120       0.51       0.48       J2997       35.62       33.84       Q9926       12.31       11.69         J1205       10.48       9.96       J3010       2.52       2.39       Q9927       12.31       11.69         J1240       0.38       0.36       J3100       2612.50       2481.88       Q9929       12.31       11.69         J1245       28.02       26.62       J3120       0.57       0.54       Q9930       12.31   |       |       |         |       |        |         |           |               |          |
| J10902.352.23J25606.045.74Q013612.3111.69J11000.170.16J27000.630.60Q992012.3111.69J111015.1414.38J27650.680.65Q992112.3111.69J11602.541.45J29201.941.84Q992212.3111.69J11701.531.45J29303.233.07Q992312.3111.69J11809.008.55J294041.8939.80Q992412.3111.69J12000.510.48J297735.6233.84Q992612.3111.69J120510.489.96J30102.522.39Q992712.3111.69J12400.380.36J30102612.502481.88Q992612.3111.69J12400.380.36J31002612.502481.88Q992312.3111.69J124528.0226.62J31200.570.54Q993012.3111.69J12502.502.38J31301.141.08Q993112.3111.69J132518.0517.15J33601.821.73Q993312.3111.69J1330ICICICJ33951458.251385.34Q993412.3111.69J13409.669.18J34201.081.03Q993512.3111.69J13809.669.  |       |       |         |       |        |         |           |               |          |
| J11000.170.16J27000.630.60Q992012.3111.69J111015.1414.38J27650.680.65Q992112.3111.69J11602.541.45J29201.941.84Q992212.3111.69J11701.531.45J29303.233.07Q992312.3111.69J11809.008.55J294041.8939.80Q992412.3111.69J1190194.53184.80J2941NCNCQ992512.3111.69J120510.489.96J30102.522.39Q992712.3111.69J120510.489.96J30102.522.39Q992712.3111.69J124528.0226.62J31002612.502481.88Q992912.3111.69J12502.502.38J31301.141.08Q993012.3111.69J12502.502.38J31301.141.08Q993112.3111.69J12503.0517.15J33601.821.73Q993312.3111.69J1330ICICJ33951458.251385.34Q993412.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13809.669.18J34800.170.16Q993612.3111.69J141056.7553.91J7060<  |       |       |         |       |        |         |           |               |          |
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| $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$   |       |       |         |       |        |         |           |               |          |
| J11809.008.55J294041.8939.80Q992412.3111.69J1190194.53184.80J2941NCNCQ92512.3111.69J12000.510.48J299735.6233.84Q992612.3111.69J120510.489.96J30102.522.39Q992712.3111.69J12300.750.71J30703.953.75Q992812.3111.69J12400.380.36J31002612.502481.88Q992912.3111.69J124528.0226.62J31200.570.54Q993012.3111.69J12502.502.38J31301.141.08Q993112.3111.69J12502.554.99J31500.940.89Q93212.3111.69J132518.0517.15J33601.821.73Q993312.3111.69J1330ICICJ33951458.251385.34Q993412.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13609.669.18J34800.170.16Q993612.3111.69J141056.7553.91J7006.996.64Q993712.3111.69J145086.5382.20J712013.5912.91Q93812.3111.69J157035.2433.48J719  |       |       |         |       |        |         |           |               |          |
| J1190194.53184.80J2941NCNCNCQ992512.3111.69J12000.510.48J299735.6233.84Q992612.3111.69J120510.489.96J30102.522.39Q992712.3111.69J12300.750.71J30703.953.75Q992812.3111.69J12400.380.36J31002612.502481.88Q992912.3111.69J12502.502.38J31301.141.08Q993012.3111.69J12705.254.99J31500.940.89Q993212.3111.69J132518.0517.15J33601.821.73Q993312.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13643.503.33J34201.081.03Q993512.3111.69J141056.7553.91J70606.996.64Q993712.3111.69J145086.5382.20J712013.5912.91Q993812.3111.69J15700.850.81J71921.121.12Q993912.3111.69J16553.993.79J71951.121.06IC = Individual considerationJ1730119.36113.39J7302NCNCNC = Noncovered   |       |       |         |       |        |         |           |               |          |
| J12000.510.48J299735.6233.84Q992612.3111.69J120510.489.96J30102.522.39Q992712.3111.69J12300.750.71J30703.953.75Q992812.3111.69J12400.380.36J31002612.502481.88Q992912.3111.69J124528.0226.62J31200.570.54Q993012.3111.69J12502.502.38J31301.141.08Q993112.3111.69J12705.254.99J31500.940.89Q993212.3111.69J132518.0517.15J33601.821.73Q993312.3111.69J1330ICICJ33951458.251385.34Q993412.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13643.503.33J34201.081.03Q993512.3111.69J145086.5382.20J712013.5912.91Q993812.3111.69J145086.5382.20J71921.121.12Q993912.3111.69J157035.2433.48J71921.121.12Q993912.3111.69J16553.993.79J71940.330.33ICICIndividual considerationJ16553.993.   |       |       |         |       |        |         |           |               |          |
| J1205       10.48       9.96       J3010       2.52       2.39       Q9927       12.31       11.69         J1230       0.75       0.71       J3070       3.95       3.75       Q9928       12.31       11.69         J1240       0.38       0.36       J3100       2612.50       2481.88       Q9929       12.31       11.69         J1245       28.02       26.62       J3120       0.57       0.54       Q9930       12.31       11.69         J1250       2.50       2.38       J3130       1.14       1.08       Q9931       12.31       11.69         J1270       5.25       4.99       J3150       0.94       0.89       Q9932       12.31       11.69         J1325       18.05       17.15       J3360       1.82       1.73       Q9933       12.31       11.69         J1330       IC       IC       J3395       1458.25       1385.34       Q9934       12.31       11.69         J1364       3.50       3.33       J3420       1.08       1.03       Q9935       12.31       11.69         J1450       86.53       82.20       J7120       13.59       12.91       Q9938       12.31 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>    |       |       |         |       |        |         |           |               |          |
| J12300.750.71J30703.953.75Q992812.3111.69J12400.380.36J31002612.502481.88Q992912.3111.69J124528.0226.62J31200.570.54Q993012.3111.69J12502.502.38J31301.141.08Q993112.3111.69J12705.254.99J31500.940.89Q993212.3111.69J132518.0517.15J33601.821.73Q993312.3111.69J1330ICICJ33951458.251385.34Q993412.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13809.669.18J34800.170.16Q993612.3111.69J141056.7553.91J70606.996.64Q993712.3111.69J145086.5382.20J712013.5912.91Q993812.3111.69J15900.850.81J71931.121.06Q94012.3111.69J1620201.97191.87J71940.330.3311.2311.69J16553.993.79J71951.121.06IC = Individual considerationJ1730119.36113.39J7302NCNCNC= Noncovered   |       |       |         |       |        |         |           |               |          |
| J12400.380.36J31002612.502481.88Q992912.3111.69J124528.0226.62J31200.570.54Q993012.3111.69J12502.502.38J31301.141.08Q993112.3111.69J12705.254.99J31500.940.89Q993212.3111.69J132518.0517.15J33601.821.73Q993312.3111.69J1330ICICJ33951458.251385.34Q993412.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13809.669.18J34800.170.16Q993612.3111.69J141056.7553.91J70606.996.64Q993712.3111.69J145086.5382.20J712013.5912.91Q993812.3111.69J15900.850.81J71921.121.12Q93912.3111.69J1620201.97191.87J71940.330.33JJJJ1730119.36113.39J7302NCNCNC= Noncovered  |       |       |         |       |        |         |           |               |          |
| J1245       28.02       26.62       J3120       0.57       0.54       Q9930       12.31       11.69         J1250       2.50       2.38       J3130       1.14       1.08       Q9931       12.31       11.69         J1270       5.25       4.99       J3150       0.94       0.89       Q9932       12.31       11.69         J1325       18.05       17.15       J3360       1.82       1.73       Q9933       12.31       11.69         J1330       IC       IC       J3395       1458.25       1385.34       Q9934       12.31       11.69         J1380       9.66       9.18       J3480       0.17       0.16       Q9936       12.31       11.69         J1410       56.75       53.91       J7060       6.99       6.64       Q9937       12.31       11.69         J1450       86.53       82.20       J7120       13.59       12.91       Q9938       12.31       11.69         J1570       35.24       33.48       J7192       1.12       1.12       Q9939       12.31       11.69         J1500       0.85       0.81       J7193       1.12       1.06       Q9940       12.31       1  |       |       |         |       |        |         |           |               |          |
| J1250       2.50       2.38       J3130       1.14       1.08       Q9931       12.31       11.69         J1270       5.25       4.99       J3150       0.94       0.89       Q9932       12.31       11.69         J1325       18.05       17.15       J3360       1.82       1.73       Q9933       12.31       11.69         J1330       IC       IC       J3395       1458.25       1385.34       Q9934       12.31       11.69         J1364       3.50       3.33       J3420       1.08       1.03       Q9935       12.31       11.69         J1364       3.50       3.33       J3420       1.08       1.03       Q9935       12.31       11.69         J1380       9.66       9.18       J3480       0.17       0.16       Q9936       12.31       11.69         J1410       56.75       53.91       J7060       6.99       6.64       Q9937       12.31       11.69         J1450       86.53       82.20       J7120       13.59       12.91       Q9938       12.31       11.69         J1570       35.24       33.48       J7192       1.12       1.12       Q9939       12.31       11.  |       |       |         |       |        |         |           |               |          |
| J1270       5.25       4.99       J3150       0.94       0.89       Q9932       12.31       11.69         J1325       18.05       17.15       J3360       1.82       1.73       Q9933       12.31       11.69         J1330       IC       IC       IC       J3395       1458.25       1385.34       Q9934       12.31       11.69         J1364       3.50       3.33       J3420       1.08       1.03       Q9935       12.31       11.69         J1364       3.50       3.33       J3420       1.08       1.03       Q9935       12.31       11.69         J1380       9.66       9.18       J3480       0.17       0.16       Q9936       12.31       11.69         J1410       56.75       53.91       J7060       6.99       6.64       Q9937       12.31       11.69         J1450       86.53       82.20       J7120       13.59       12.91       Q9938       12.31       11.69         J1570       35.24       33.48       J7192       1.12       1.12       Q9939       12.31       11.69         J1620       201.97       191.87       J7194       0.33       0.33       11.69       11  |       |       |         |       |        |         |           |               |          |
| J1325       18.05       17.15       J3360       1.82       1.73       Q9933       12.31       11.69         J1330       IC       IC       IC       J3395       1458.25       1385.34       Q9934       12.31       11.69         J1364       3.50       3.33       J3420       1.08       1.03       Q9935       12.31       11.69         J1380       9.66       9.18       J3480       0.17       0.16       Q9936       12.31       11.69         J1410       56.75       53.91       J7060       6.99       6.64       Q9937       12.31       11.69         J1450       86.53       82.20       J7120       13.59       12.91       Q9938       12.31       11.69         J1570       35.24       33.48       J7192       1.12       1.12       Q9939       12.31       11.69         J1590       0.85       0.81       J7193       1.12       1.06       Q9930       12.31       11.69         J1620       201.97       191.87       J7194       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33       0.33 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> |       |       |         |       |        |         |           |               |          |
| J1330ICICJ33951458.251385.34Q993412.3111.69J13643.503.33J34201.081.03Q993512.3111.69J13809.669.18J34800.170.16Q993612.3111.69J141056.7553.91J70606.996.64Q993712.3111.69J145086.5382.20J712013.5912.91Q993812.3111.69J157035.2433.48J71921.121.12Q993912.3111.69J15900.850.81J71931.121.06Q994012.3111.69J1620201.97191.87J71940.330.33J16553.993.79J71951.121.06IC = Individual considerationJ1730119.36113.39J7302NCNCNC= NoncoveredNC=  |       |       |         |       |        |         |           |               |          |
| J1364         3.50         3.33         J3420         1.08         1.03         Q9935         12.31         11.69           J1380         9.66         9.18         J3480         0.17         0.16         Q9936         12.31         11.69           J1410         56.75         53.91         J7060         6.99         6.64         Q9937         12.31         11.69           J1450         86.53         82.20         J7120         13.59         12.91         Q9938         12.31         11.69           J1570         35.24         33.48         J7192         1.12         1.12         Q9939         12.31         11.69           J1590         0.85         0.81         J7193         1.12         1.06         Q9940         12.31         11.69           J1620         201.97         191.87         J7194         0.33         0.33  |       |       |         |       |        |         |           |               |          |
| J1380         9.66         9.18         J3480         0.17         0.16         Q9936         12.31         11.69           J1410         56.75         53.91         J7060         6.99         6.64         Q9937         12.31         11.69           J1450         86.53         82.20         J7120         13.59         12.91         Q9938         12.31         11.69           J1570         35.24         33.48         J7192         1.12         1.12         Q9939         12.31         11.69           J1590         0.85         0.81         J7193         1.12         1.06         Q9940         12.31         11.69           J1620         201.97         191.87         J7194         0.33         0.33         J1655         3.99         3.79         J7195         1.12         1.06         IC = Individual consideration           J1730         119.36         113.39         J7302         NC         NC         NC= Noncovered   |       |       |         |       |        |         |           |               |          |
| J1410         56.75         53.91         J7060         6.99         6.64         Q9937         12.31         11.69           J1450         86.53         82.20         J7120         13.59         12.91         Q9938         12.31         11.69           J1570         35.24         33.48         J7192         1.12         1.12         Q9939         12.31         11.69           J1590         0.85         0.81         J7193         1.12         1.06         Q9940         12.31         11.69           J1620         201.97         191.87         J7194         0.33         0.33  |       |       |         |       |        |         |           |               |          |
| J145086.5382.20J712013.5912.91Q993812.3111.69J157035.2433.48J71921.121.12Q993912.3111.69J15900.850.81J71931.121.06Q994012.3111.69J1620201.97191.87J71940.330.330.330.33J16553.993.79J71951.121.06IC = Individual considerationJ1730119.36113.39J7302NCNCNC= Noncovered   |       |       |         |       |        |         |           |               |          |
| J157035.2433.48J71921.121.12Q993912.3111.69J15900.850.81J71931.121.06Q994012.3111.69J1620201.97191.87J71940.330.330.33J16553.993.79J71951.121.06IC = Individual considerationJ1730119.36113.39J7302NCNCNC= Noncovered  |       |       |         |       |        |         |           |               |          |
| J1590         0.85         0.81         J7193         1.12         1.06         Q9940         12.31         11.69           J1620         201.97         191.87         J7194         0.33         0.33         0.33           J1655         3.99         3.79         J7195         1.12         1.06         IC = Individual consideration           J1730         119.36         113.39         J7302         NC         NC         NC= Noncovered  | J1570 | 35.24 | 33.48   | J7192 |        |         | Q9939     | 12.31         | 11.69    |
| J1620         201.97         191.87         J7194         0.33         0.33           J1655         3.99         3.79         J7195         1.12         1.06         IC = Individual consideration           J1730         119.36         113.39         J7302         NC         NC         NC= Noncovered   |       |       |         |       |        |         |           |               |          |
| J1655         3.99         3.79         J7195         1.12         1.06         IC = Individual consideration           J1730         119.36         113.39         J7302         NC         NC         NC= Noncovered   |       |       |         |       |        |         |           |               |          |
| J1730 119.36 113.39 J7302 NC NC NC= Noncovered   |       |       |         |       |        |         | IC = Indi | vidual consid | leration |
|  |       |       |         |       |        |         |           |               |          |
|  | J1755 |       |         |       |        | 95.88   |           |               |          |

# LABORATORY/PATHOLOGY

# Repeat Clinical Diagnostic Laboratory Tests

Effective January 1, 2000, modifier 91 was established for use when it becomes necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the repeated test performed can be identified by its usual procedure code and the addition of modifier 91. The repeated test should be billed on the same claim as the original, to prevent it from being denied as a duplicate service.

Modifier 91 is *not* to be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. It is not to be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/ suppression testing). Modifier 91 should only be used for laboratory test(s) performed more than once on the same day on the same patient.

# New CLIA Waived Test

Listed below is a test that has a new *Current Procedural Terminology* (*CPT*) code in 2002. This test was previously approved by the Food and Drug Administration as a waived test under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The *CPT* code for this test must have the modifier QW to be recognized as a waived test.

*CPT* code 87804 was developed for Infectious agent antigen detection byimmunoassay with direct optical observation; Influenza.

Therefore, effective for services rendered on or after January 1, 2002, *CPT* code 87804QW replaces *CPT* code 87899QW for the Quidell QuickVue® Influenza test.

Source: CMS Transmittal AB-01-187; CR 1976

# PULMONARY MEDICINE

# **Continuous Positive Airway Pressure (CPAP)**

CPAP is a non-invasive technique for providing single levels of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

For services furnished between and including January 12, 1987 and March 31, 2002, the diagnosis of OSA requires documentation of at least 30 episodes of apnea, each lasting a minimum of ten seconds, during 6-7 hours of recorded sleep. The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP.

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician, that specifies:

- a diagnosis of moderate or severe obstructive sleep apnea, and
- surgery is a likely alternative.

The claim must also certify that documentation supporting a diagnosis of OSA (described above) is available.

Effective for services furnished on or after April 1, 2002, the use of CPAP devices are covered under Medicare when ordered and prescribed by the licensed treating physician to be used in adult patients with OSA if

either of the following criteria using the Apnea-Hyopopnea Index (AHI) are met:

- AHI greater than or equal to 15 events per hour, or
- AHI greater than or equal to five and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, documented hypertension, ischemic heart disease or history of stroke.

The AHI (Apnea-Hypopnea Index) is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e, the AHI may not be extrapolated or projected). Apnea is defined as a cessation of airflow for at least ten seconds. Hypopnea is defined as an abnormal respiratory event lasting at least ten seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent oxygen desaturation.

The polysomnography must be performed in a facility-based sleep study laboratory, not in the home or in a mobile facility.

Initial claims for CPAP devices must be supported by information contained in the medical record indicating the patient meets Medicare's stated coverage criteria.

Source: CMS Transmittal 150, CR 1949 (CIM Section 60-17)

# Screening Services

## Screening Flexible Sigmoidoscopies—Expansion of Coverage

For claims with dates of service on or after January 1, 2002, Medicare may pay for screening flexible sigmoidoscopies (HCPCS code G0104) for beneficiaries who have attained age 50 when these services were performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act and in the Code of Federal Regulations at 42 sections 410.74, 410.75, and 410.76) at the frequencies noted below. For claims with dates of service prior to January 1, 2002, these services may be paid under the conditions noted only when they are performed by a doctor of medicine or osteopathy.

• 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) **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to Medicare Carriers Manual [MCM] section 4180.3) **and** he/she

has had a screening colonoscopy (code G0121) within the preceding ten years. If such a beneficiary has had a screening colonoscopy within the preceding ten 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.

For more information concerning coverage of colorectal cancer screening services, please refer to the Third Quarter 2001 *Medicare B Update!* (pages 23-24).

Source: CMS Transmittal 1735, CR1956 (MCM section 4180.2)

# RADIOLOGY

# The Use of Gamma Cameras and Full Ring and Partial Ring Positron Emission Tomography (PET) Scanners for PET Scans

This article summarizes the revision to section 50-36 of the Medicare Coverage Issues Manual (CIM) about types of 2-[F-18] Fluoro-D-Glucose (FDG) PET scanners. This decision does not change the covered clinical indications beyond the changes that took effect on July 1, 2001. Please refer to section 50-36 of the CIM for further details about coverage. New HCPCS codes are provided to clarify the type of PET scanner used by clinical indication.

# General Conditions of Coverage by Allowable Type of FDG PET Scanner

For purposes of this section, "Any FDA approved" and "FDA approved" means that the system indicated has been approved or cleared for marketing by the FDA to image radionuclides in the body. "Certain coincidence systems" refers to the systems that have all the following features:

- crystal at least 5/8-inch thick
- techniques to minimize or correct for scatter and/or randoms, and
- digital detectors and iterative reconstruction.

"Certain coincidence systems" must have all three design features. Scans performed with gamma camera PET systems with crystals thinner than 5/8 inch will not be covered by Medicare. In addition, scans performed with systems with crystals greater than or equal to 5/8 inch in thickness, but that do not meet the other listed design characteristics are not covered by Medicare.

Please refer to the "Allowable Type of FDG PET System" table in the local medical review policy (LMRP) for PET Scans found on page 31of this issue.

# HCPCS Codes for PET Scans—General Information

On July 1, 2001, new HCPCS codes G0210—G0230 were added to allow billing for all currently covered indications for FDG PET. **Effective January 1, 2002**:

- these codes have new descriptors to properly reflect the type of PET scanner used.
- there are four new "G" codes for covered conditions that may be billed if a gamma camera is used for the PET scan. The changes to the code descriptors are indicated in boldface.
- providers should bill using the revised HCPCS codes G0120—G0234.

### HCPCS Codes for PET Scans Performed with Full or Partial Ring PET Scanners for Services Furnished on or after January 1, 2002

- G0210 PET Imaging *whole body; full- and partial-ring PET* scanners only, diagnosis; lung cancer, non-small cell
- G0211 PET Imaging *whole body; full- and partial-ring PET scanners only, initial* staging; lung cancer; non-small cell (**replaces G0126**)
- G0212
   PET Imaging whole body; full- and partial-ring PET scanners only, restaging; lung cancer; non-small cell

   G0213
   PET Imaging whole body; full- and partial-ring PET
- G0213 PET Imaging *whole body*; *full- and partial-ring PET scanners only*, diagnosis; colorectal cancer
- G0214 PET Imaging *whole body; full- and partial-ring PET scanners only, initial* staging; colorectal cancer

| G0215        | PET Imaging whole body; <i>full- and partial-ring PET</i>        |
|--------------|--|
|              | scanners only, restaging; colorectal cancer (replaces            |
|              | G0163)   |
| G0216        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, diagnosis; melanoma                               |
| G0217        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, initial staging; melanoma                         |
| G0218        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, restaging; melanoma (replaces G0165)              |
| G0219        | PET Imaging whole body; (full- and partial-ring PET              |
|              | scanners only) for non-covered indications                       |
| G0220        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, diagnosis; lymphoma                               |
| G0221        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, initial staging; lymphoma (replaces               |
|              | G0164)   |
| G0222        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, restaging; lymphoma (replaces G0164)              |
| G0223        | PET Imaging whole body or regional; full- and partial-           |
|              | ring PET scanners only, diagnosis; head and neck                 |
|              | cancer; excluding thyroid and CNS cancers                        |
| G0224        | PET Imaging whole body or regional; full- and partial-           |
|              | ring PET scanners only, initial staging; head and neck           |
|              | cancer; excluding thyroid and CNS cancers                        |
| G0225        | PET Imaging whole body or regional; full- and partial-           |
|              | ring PET scanners only, restaging; head and neck                 |
|              | cancer, excluding thyroid and CNS cancers                        |
| G0226        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, diagnosis; esophageal cancer                      |
| G0227        | PET Imaging whole body; full- and partial-ring PET               |
|              | scanners only, initial staging; esophageal cancer                |
| G0228        | PET Imaging whole body; full- and partial-ring PET               |
| G0000        | scanners only, restaging; esophageal cancer                      |
| G0229        | PET Imaging; Metabolic brain imaging for pre-surgical            |
|              | evaluation of refractory seizures; <i>full- and partial-ring</i> |
| <b>C0220</b> | PET scanners only  |
| G0230        | PET Imaging; Metabolic assessment for myocardial                 |
|              | viability following inconclusive SPECT study; <i>full- and</i>   |
|              | partial-ring PET scanners only                                   |

**Note**: For purposes of this benefit, the terms "initial staging" and "staging" are used interchangeably.

### HCPCS Codes for PET Scans Performed with Gamma Cameras to be Used Only for Services Furnished on or after January 1, 2002

- G0231 PET, whole body, for recurrence of colorectal or colorectal metastatic cancer; *gamma cameras only* G0232 PET, whole body, for staging and characterization of
- G0232 PET, whole body, for staging and characterization of lymphoma; *gamma cameras only* G0233 PET, whole body, for recurrence of melanoma or
  - 0233 PET, whole body, for recurrence of melanoma or melanoma metastatic cancer, *gamma cameras only*
- G0234 PET, regional or whole body, for solitary pulmonary nodule following CT, or for initial staging of non-small cell lung cancer; *gamma cameras only*

## Local Medical Review Policy

Florida Medicare has revised its LMRP for PET Scans based on the information in this article and the 2002 HCPCS update. The revised LMRP may be found on pages 29-37 of this issue.

Source: CMS Transmittal AB-01-168, CR 1886

# 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 or focused medical review 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 local medical review policy (LMRP) format is consistent with the manner in which the carrier reports LMRPs to the Centers for Medicare & Medicaid Services.

## **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 Web site at: www.floridamedicare.com

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# **Progressive Corrective Action for 2001**

In an effort to decrease the claims payment error rate, the Centers for Medicare & Medicaid Services (CMS) mandated implementation of Progressive Corrective Action (PCA) for fiscal year 2001. This program changed the process by which providers are chosen for review, placed on prepayment review, or other corrective action measures. In addition, this process increases provider education based on results of the review process.

First Coast Service Options, Inc. (FCSO) has completed the first year of the new PCA process. Many changes have taken place during this transitional period, as FCSO strives to make the process beneficial to CMS, FCSO, and providers under review. FCSO would like to take this opportunity to thank all providers who participated in the PCA process for their patience and assistance during the past year.

A total of 271 probes were conducted in fiscal year 2001. The chart on the following page shows a breakdown of reviews by services.

| Services                      | Number of probes<br>conducted* |
|-------------------------------|--------------------------------|
| E/M Codes                     | 179                            |
| Psychiatric Codes             | 9                              |
| Echocardiogram Codes          | 10                             |
| Podiatry Codes                | 6                              |
| Joint Injection               | 11                             |
| Laboratory Services           | 3                              |
| EKG                           | 3                              |
| Physical Therapy Codes        | 31                             |
| Miscellaneous Services        | 19                             |
| Total number of probe reviews | 271                            |

\*Probes may have included more than one *CPT* (*Current Procedural Terminology*) code.

Results were categorized by error rate. Error rate and issues identified during review determine the corrective action process. The corrective action process may result in provider-specific education, prepayment review, or a statistically valid random sample review.

| Error Rate              |    |     |  |  |  |  |
|-------------------------|----|-----|--|--|--|--|
| 0%-20% 21%-45% 46%-100% |    |     |  |  |  |  |
| 31%                     | 5% | 64% |  |  |  |  |

# Issues and Educational Opportunities Identified

### Evaluation and Management (E/M)

- General principles of medical record documentation
- The medical record should be complete and legible
  The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
  - Plan for care
  - Date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- The *CPT* and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

Please refer to the E/M guidelines published in the *Medicare B Update!* (Dec 1994 and Sep 1997) for specific documentation guidelines for the level of care billed. Publications issued beginning January 1997 are available on our provider Web site, **www.floridamedicare.com**.

#### **Psychiatry Codes**

Medical record documentation requirements for individual psychotherapy:

Medical record documentation must indicate medical necessity and include the following:

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

Please refer to the *Medicare B Update!* (May/Jun 1996) for clinical indications and documentation requirements for psychotherapy. For clinical indications and documentation requirements for psychiatric services, see local medical review policy (LMRP) 90800, beginning on page 65 of this issue. In addition, LMRPs may be found on our provider Web site in the "Medical Policy" section.

#### Echocardiograms

Stress echocardiograms (*CPT* code 93350) and echocardiograms (93307, 93308) should not be billed during the same session, as this is considered duplicate billing.

Documented clinical findings should be specific and include duration, location, quality, frequency, severity, associated signs and symptoms, timing, and context. Additionally, signs and symptoms documented on the echocardiogram report that indicate the need for examination should be consistent with history and examination findings for the beneficiary.

Please see LMRP 93000 for clinical indications and documentation requirements for electrocardiogram services.

### Podiatry

E/M codes should not be billed in addition to, or in place of: nail debridement, routine foot care, or other podiatry services, unless there is a *separate and identifiable* E/M service performed.

Please refer to the *Medicare B Update!* (Sep/Oct 1995 and Mar/Apr 1997) for clinical indications and documentation requirements for routine foot care and nail debridement.

Please see LMRP 11055 for clinical indications and documentation requirements for podiatry services.

### Joint Injections/Arthrocentesis

Office records and/or test results must document medical necessity. The records must clearly indicate the number of injections given per session and sites(s) injected. Records must also clearly state the medical necessity for repeat injections.

Please refer to the *Medicare B Update!* (May/Jun 2000) for injection of tendon sheath, ligament, trigger points or ganglion cyst. Refer to the Sept/Oct 2000 issue for clinical indications and documentation requirements for arthrocentesis.

*CPT* code 27096 (*injection procedure for sacroiliac* [SI] *joint, arthrography and/or anesthetic/steroid*): As documented in the *CPT Assistant* November 1999, this code describes injection of contrast for radiologic evaluation when associated with SI joint arthrography and or therapeutic injection of an anesthetic/steroid to block the joint for immediate and potentially lasting pain relief. If radiologic assistance is not utilized, *CPT* code 27096 is not the correct code to bill. The correct code to use when radiologic assistance is not performed is 20610. *CPT* 2002 further clarifies the correct use of this code.

For clinical indications and documentation requirements for arthrocentesis services, refer to LMRP 20600.

#### Laboratory Services

The following guidelines are used when reviewing laboratory services:

42 CFR section 493.1105 Standard; Test Requisition states, the laboratory must perform tests only at the written or electronic request of an authorized person. Records of test requisitions or authorizations must be retained for a minimum of two years. The patient's chart or medical record, if used as a requisition, must be retained for a minimum of two years and must be available to the laboratory at the time of the testing and available to HHS upon request. The laboratory must assure that the requisition or the test authorization includes:

- 1. The patient's name or other unique identifier;
- 2. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for utilizing the test results or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminent life threatening laboratory results or panic values;
- 3. The test(s) to be performed;
- 4. The date of the specimen collection;
- 5. For Pap smears, the patient's last menstrual period, age or date of birth, and indication of whether the patient had a previous abnormal report, treatment or biopsy; and
- 6. Any additional information relevant and necessary to a specific test to assure accurate and timely testing and reporting of results.

If laboratory services are chosen for review, it is the responsibility of the laboratory to obtain documentation supporting medical necessity from the treating/and or ordering provider.

#### Electrocardiograms

Clinical indications that support medical necessity must be clearly documented in the patient's progress note. Additionally, a dated copy of the electrocardiogram with interpretation should be available upon request for services under review.

For specific medical necessity and documentation guidelines, please refer to LMRP 93000.

#### **Physical Medicine & Rehabilitation**

Medical record documentation must indicate the patient is under care of a physician for the presenting diagnosis.

Documentation should indicate the potential prognosis for restoration of functions in a reasonable and generally predictable period of time.

All providers billing for physical therapy services are required to maintain an established plan of treatment as a permanent part of the patient's clinical record.

- The plan must be established before treatment is begun.
- The physician must see the patient at least every 30 days during the course of therapy.
- The physician must review, initial and date the plan of treatment at least every 30 days.
- The plan must be kept on file in the physician's office and available for carrier review if requested.
- A physical therapy plan of treatment must include the type, amount, frequency, and duration of services that are to be furnished, and indicate the diagnosis and anticipated goals.
- Any changes in the treatment plan must be made in writing and signed by the physician.

Medical record documentation maintained by the ordering/referring physician must clearly indicate medical necessity of each physical therapy modality covered by the Medicare program.

Please see LMRP 97010 beginning on page 74 of this issue for physical medicine and rehabilitation.

#### Providers should compare this information to current practice patterns, to ensure compliance with the local medical review policies referenced.

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# **Medical Record Documentation**

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history. An appropriately documented record affords payers the ability to determine if billed services have been documented as having been performed, coded appropriately, are medically necessary and represent a covered service. As coverage is often affected by whether or not a service has been either ordered or performed by a physician/provider, the presence of a signature or other identification in the documentation is often an issue. General principles of medical record documentation were originally published in the September 1997 *Medicare B Update! Special Issue*. These principles are applicable to all types of medical and surgical services, in all settings. Certain principles may be modified to account for services provided in facilities that have documentation requirements. These principles (listed on the following page) may be applied to Part B services, and Part A services when applicable.

- 1. All portions of the medical record must be legible and should be complete. Providers may submit a translation of illegible documentation for review in addition to original documentation. However, it must be clear the translation is identical and does not embellish upon the original record.
- Documentation of the patient's identity must be legible and appear on each page of the record. Examples of documentation meeting this criterion
  - could include (but are not limited to):
  - Printed standard patient identificationHand written first and last name and date of birth
  - Patient's social security number
  - Any reasonable form of identification that would be recognized by any reader
- 3. Documentation of each patient encounter must include (to the extent possible):
  - The reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Plan of care
- 4. Documentation of each patient encounter must include the date and legible identity of the observer (physician/ provider).

Examples of documentation meeting the criteria could (but are not limited to):

- In a single physician/provider office:
- a. The physician's letterhead along with an initial at the time of treatment
- b. A complete signature at the time of treatment
- c. The physician's signature on the first page with an initial at the time of treatment in the rest of the chart
- d. If notes were dictated, an electronic signature would be acceptable
- In a multi-physician/provider office:
- a. A signature page included with the medical record, with each physician/provider's signature and an initial of the treating physician/provider at the time of treatment

# b. A complete signature at the time of treatment c. If notes were dictated, an electronic signature would be acceptable

- 5. The medical record must support the physician/ provider order for diagnostic and other ancillary services. Furthermore, if the rationale for ordering diagnostic and other ancillary services is not clearly documented, it should be easily inferred.
- 6. Past and present diagnoses must (to the extent possible) be accessible to the treating and/or consulting physician.
- 7. Appropriate health risk factors should be identified.
- 8. The patient's progress, response to and changes in treatment, and revision of diagnosis must (to the extent possible) be documented.
- 9. *CPT* and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by documentation in the medical record.
- 10. When services are performed by an employee of the provider as "Incident to" the physician/provider's service, documentation **must** clearly meet **all** "Incident to" requirements. Furthermore, upon request, documentation should be available to verify the physician/provider was present in the office suite on the date of service.

Examples of documentation meeting this criteria could include, but are not limited to, the following:

- A clear signature or initial (as described above) of the person rendering care and the clear signature or initial (as described above) of the physician/ provider
- A statement in the treatment notes by the person rendering care regarding the location of the physician/provider during the course of treatment
- An addendum to the treatment notes, by the physician/provider, stating their location during the treatment
- Other office records that would verify the physician/provider was present in the office suite on the date of service (e.g., office schedule, patient schedule with provider/physician name, etc.)

# 99211—Billing Issues

Florida Medicare has received inquiries from the provider community regarding medical record documentation that would support billing the Evaluation and Management (E/M) procedure code 99211 alone and/ or with other billable services. Therefore, the following general documentation *guidelines* are being provided for clarification:

- The E/M **must** be of an established patient.
- According to the AMA's *Current Procedural Terminology (CPT)*, the E/M service may not require the presence of a physician. However, in order to **qualify for Medicare payment**, if someone other than the billing provider performs the service, all requirements of "Incident to" services must be met. These include:
  - The services/supplies are an integral, although incidental, part of the physician's/ provider's professional services.
  - The services/supplies are of a type that are commonly furnished in a physician's/ provider's office or clinic.

- The services/supplies are furnished under the physician's/provider's direct personal supervision. This means the physician/ provider must be present in the immediate office suite and available to provide assistance and direction throughout the time the employee is providing the service.
- The services/supplies are furnished by an individual who qualifies as an employee of the physician/provider.
- The presenting problem(s) is usually minimal, and, typically, five minutes is spent providing the service. **Please note, there must be a presenting problem documented.** The documentation must demonstrate the reason for an E/M service on that particular date of service.
- The medical record should indicate the nature of E/M service that occurred for the date of service being billed. If the service is being provided "Incident to," the medical record should demonstrate that the service

is an integral, although incidental, part of the physician's professional service. The following clinical scenarios are meant to provide some general examples of documentation that would support billing procedure code 99211, and, is **not an all-inclusive list**:

- A blood pressure (B/P) written down on the medical record does not demonstrate a presenting problem and need for an E/M service. The medical record should indicate why the patient came in for a B/P check (e.g., follow-up after medication adjustment, the previous note in the medical record documented elevated B/P and the provider wrote instructions for the patient to come in weekly for three weeks for B/P reevaluation, etc.).
- A diabetic patient comes in for a monthly weight check related to an ongoing weight reduction plan for control of blood glucose levels. The medical record should document that the monthly weight check is an integral part of the patient's plan of care and that **some form of face-to-face E/M occurred** either by the provider or "Incident to" (e.g., the weight is documented **and** the patient was questioned regarding appetite, any associated problems, etc.).
- A patient comes in for a renewal of a prescribed medication. The medical record should demonstrate that the medication is part of the patient's plan of care and that **some form of face-to-face E/M occurred** either by the provider or "Incident to" (e.g., prescription documented **and** instructions given to the patient regarding medication, side effects, etc.).
- A patient comes in for E/M of his/her anticoagulation medication. The medical record should demonstrate that some form of face-to-face E/M occurred either by the provider or "Incident to" (e.g., the lab result is documented and a note made as to whether modification was made to the medication dosage).
- When 99211 is billed on the same date of service as another billable service it must meet the requirements for billing the modifier 25 (*Significant, Separately Identifiable Evaluation and Management*). This modifier indicates, "the patient's condition required a significant, separately identifiable E/M above and beyond the other service provided or beyond the usual pre- or postoperative care associated with the procedure." The following clinical scenarios are meant to provide some general examples of instances regarding billing 99211 in addition to other billable services, and, is **not an all inclusive list**:
  - Billing 99211 in addition to chemotherapy administration codes (96400-96549). The administration of chemotherapy does not automatically justify billing a 99211 visit. The documentation must support that an E/ M service was provided. The chemo administration code includes such things as the insertion of a catheter, set-up of the IV,

administration of the medication, monitoring of adverse reactions during treatment. However, should a problem arise that requires a significant, separately identifiable E/M service, then the appropriate level E/M code should be reported in addition to the chemo. The following clinical example would support billing 99211 with modifier 25: The patient was questioned regarding any problems/side effects since the last visit and the notes indicate the patient is experiencing significant nausea, and weight loss has occurred. This is communicated to the physician and some form of patient E/M occurred (e.g., prescription for medication, patient education, diet change, etc.).

- Billing 99211 in addition to a therapeutic, prophylactic or diagnostic injection (90782). If the patient came in for a routine injection (e.g., Vitamin B12) and no other services were provided, procedure code 90782 would be the appropriate code to bill. However, if the patient came in for a routine injection, and the patient's condition required a significant, separately identifiable E/M above and beyond the injection, it would be appropriate to bill the appropriate E/M code with modifier 25. The following clinical example would support billing 99211 with modifier 25: The patient came in for routine B12 injection and complained of increased tingling in lower legs over the past few weeks. The office employee documented this complaint and informed the physician. The notes indicate that the patient was instructed to make a follow-up appointment with the physician for further evaluation.
- Billing 99211 on the same date of service as 0 a CPT starred (\*) procedure code. In order to bill 99211 in addition to a starred procedure code, the documentation must demonstrate a significant, separately identifiable E/M service occurred. The following clinical example would support billing 99211 with modifier 25: An established patient came in for follow-up E/ M of heel pain. In the course of treatment, an avulsion of the nail plate (procedure code 11730) was performed. This service would represent a significant, separately identifiable E/M service. However, if the patient came in and the only E/M that occurred was to evaluate the problem requiring the nail avulsion, it would not be appropriate to bill 99211 in addition to 11730, as the service provided did not represent a significant, separately identifiable E/M service.

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# LMRP Changes Related to the 2002 HCPCS Update

The following table outlines changes to local medical review policies (LMRP) necessitated by the 2002 Healthcare Common Procedure Coding System (HCPCS) update. The complete LMRPs are easily accessible on our provider Web site, **www.floridamedicare.com**.

| Policy Number/Title   | Last Publication                  | Changes   |
|---|-----------------------------------|---|
| 00103 Anesthesia Services (Ocular Procedures)   | 4 <sup>th</sup> QTR 2001, page 54 | Descriptor change for code 67515<br>Added code 67225  |
| 11055 Routine Foot Care   | May/Jun 1998, page 46             | Deleted reference to codes A9160<br>and A9270<br>Added information regarding<br>modifier GY (Item or service<br>statutorily excluded or does not meet<br>the definition of any Medicare benefit)  |
| 11720 Nail Debridement  | Mar/Apr 1997, page 53             | Deleted reference to code A9160   |
| 12000 Cosmetic/Reconstructive Surgery   | 2 <sup>nd</sup> QTR 2001, page 38 | Descriptor change for codes <b>43860</b> -<br>43865<br>Changed policy number to 11920   |
| 17000 Benign or Premalignant Skin Lesion<br>Removal/Destruction                         | Jan/Feb 1998, page 19             | Descriptor changes for codes 17000<br>and 17110<br>Deleted reference to code A9270  |
| 17260 Destruction of Malignant Lesions  | Jul/Aug 1997, page 25             | Descriptor changes for codes 17260,<br>17270, and 17280<br>Changed policy name to "Destruc-<br>tion of Malignant Skin Lesions"  |
| 20550 Injection of Tendon Sheath, Ligament,<br>Trigger Points, Ganglion Cysts, or Bursa | May/Jun 2000, page 38             | Descriptor change for code 20550<br>Added codes 20551, 20552, and<br>20553<br>Changed policy name to "Injection<br>of Tendon Sheath, Ligament,<br>Trigger Points, or Ganglion Cysts"  |
| 27599 Autologous Cultured Chondrocyte<br>Implantation                                   | Mar/Apr 2000, page 32             | Deleted code 27599<br>Added codes 0012T and 0013T<br>Changed policy identification<br>number to 0012T   |
| 36430 Transfusion Medicine  | Jan/Feb 1999, page 18             | Deleted code P9042<br>Added codes P9045, P9046, P9047,<br>P9048, and P9050  |
| 40000 Digestive System  | 1 <sup>st</sup> QTR 2002, page 43 | Changed A9270 to code 44799 with<br>modifier GY (for intestinal by-pass<br>surgery)<br>Changed A9270 to code 84999 with<br>modifier GY (for diagnostic breath<br>analysis [lactose breath hydrogen<br>analysis])<br>Changed A9270 to code 44799 (for<br>colonic irrigation)<br>Changed A9270 to code 43999 (for<br>gastric balloon for treatment of<br>obesity) |
| 43235 Diagnostic and Therapeutic<br>Esophagogastroduodenoscopy                          | June 2001, page 13                | Descriptor change for code 43245  |
| 44388 Colonoscopy   | 2 <sup>nd</sup> QTR 2001, page 51 | Descriptor changes for codes 44391<br>and 45382   |
| 64553 Electrical Nerve Stimulation  | Jul/Aug 1999, page 27             | Descriptor changes for codes 64555<br>and 64575<br>Added codes 64561 and 64581  |

| 64555 Sacral Neuromodulation                              | Mar/Apr 2000, page 35             | Added codes 64561, 64581, A4290, E0752, and E0754   |
|---|-----------------------------------|---|
|   |                                   | Removed codes 64555, 64575, and<br>E0753 from the " <i>CPT</i> /HCPCS<br>Codes" section of the policy and   |
|   |                                   | added them to the "Coding Guide<br>lines" section referencing the correct   |
|   |                                   | way to bill these procedure codes<br>prior to 01/01/02<br>Changed policy identification   |
|   |                                   | number to 64561   |
| 66982 Cataract Extraction                                 | 2 <sup>nd</sup> QTR 2001, page 59 | Descriptor change for code 66982  |
| 67221 Ocular Photodynamic Therapy (OPT) with Verteporfin  | 3 <sup>rd</sup> QTR 2001, page 60 | Changed G0184 to code 67225<br>Changed Q3013 to code J3395  |
| 70370 Dysphagia/Swallowing Diagnosis                      | 2 <sup>nd</sup> QTR 2001, page 64 | Descriptor changes for codes 74230<br>and 76536   |
| 76075 Bone Mineral Density Studies                        | 1 <sup>st</sup> QTR 2002, page 51 | Descriptor change for code 76078  |
| 76090 Diagnostic Mammography                              | 3 <sup>rd</sup> QTR 2001, page 62 | Descriptor changes for codes G0204<br>and G0206<br>Deleted codes G0205 and G0207<br>Added code G0236<br>Added modifier GG   |
| 76092 Screening Mammograms                                | 3 <sup>rd</sup> QTR 2001, page 64 | Deleted code G0203<br>Added code 76085<br>Added modifier GG   |
| 77427 Weekly Radiation Therapy Management                 | Jan/Feb 2000, page 41             | Descriptor changes for codes 90780<br>and 99090   |
| 77750 Clinical Brachytherapy                              | Jan/Feb 2000, page 44             | Changed A9270 to code 77799 with<br>modifier GY(for radiofrequency<br>hyperthermia)<br>Moved code 77799 from the " <i>CPT</i> /<br>HCPCS Codes" section to the "Not<br>Otherwise Classified Codes (NOC)"<br>section of the policy |
| 78267 Breath Test for Helicobacter Pylori<br>(H. Pylori)  | Jan/Feb 2000, page 46             | Descriptor change for code 83013  |
| 82105 Tumor Markers                                       | 2 <sup>nd</sup> QTR 2001, page 76 | Deleted statement regarding the billing of code A9270   |
| 82270 Fecal Occult Blood Testing                          | 1 <sup>st</sup> QTR 2002, page 59 | Descriptor change for code 82270<br>Added code 82274  |
| 90732 Pneumococcal Vaccinations                           | Sep/Oct 2000, page 57             | Descriptor change for code 90732  |
| 90780 Therapeutic or Diagnostic<br>Infusion/Injections    | Jan/Feb 1999, page 48             | Descriptor change for code 90780<br>The reference to code A9270 was<br>changed to reflect the billing of the<br>applicable administration code and<br>modifier GY   |
| 90901 Biofeedback   | 4th QTR 2001, page 66             | Changed A9270 to code 97799 (for<br>pelvic floor stimulators used for a<br>bladder pacer or a retraining<br>mechanism)  |
| 92980 Interventional Cardiology                           | 1 <sup>st</sup> QTR 2002, page 64 | Added code 92973<br>Changed policy number to 92973  |
| 93268 Patient Demand Single or<br>Multiple Event Recorder | Mar/Apr 2000, page 43             | Deleted code G0016  |
| 93619 Intracardiac Electrophysiological Evaluation        | 2 <sup>nd</sup> QTR 2001, page 92 | Descriptor change for code 93619, 93620, 93621, and 93622   |

| 93724 Electronic Analysis of Pacemaker System  | 2 <sup>nd</sup> QTR 2001, page 93   | Deleted codes 93737 and 93738   |
|--|---|---|
| and Pacer Cardioverter-Defibrillator   |   | Changed A9270 to code 93799 with<br>modifier GY (for transtelephonic<br>monitoring of a pacer Cardioverter-<br>defibrillator)   |
| 93886 Transcranial Doppler Studies   | Nov/Dec 1999, page 36   | Changed A9270 to code 95999 (for<br>transcranial doppler studies to<br>monitor and manage the effects of<br>vasodilators and other drugs in the<br>treatment of strokes and other brain<br>damage)  |
| 95115 Allergen Immunotherapy   | 2 <sup>nd</sup> QTR 2001, page 96<br>3 <sup>rd</sup> QTR 2001, page 75<br>1 <sup>st</sup> QTR 2002, page 75 | Descriptor change for code 95165<br>Added language to reflect the billing<br>clarification for procedure code 95165   |
| 95900 Nerve Conduction Studies   | May/Jun 1998, page 49   | Descriptor change for code 95904  |
| 97010 Physical Medicine and Rehabilitation   | Jan/Feb 1999, p. 55   | Descriptor changes for codes 97112<br>and 97504<br>Changed A9270 to code 97799 with<br>modifier GY (for diapulse and rolfing)<br>Changed A9270 to code 22899 (for<br>Vertebral Axial Decompression)<br>Removed reference to noncoverage<br>of high voltage pulsed current therapy |
| 97110 Complex Decongestive Physiotherapy   | Sep/Oct 1997, page 38   | Descriptor change for code 97535  |
| 97535 Training in Activities of Daily Living   | Jan/Feb 1996, p. 13   | Descriptor change for code 97535<br>Policy deleted and incorporated into<br>policy 97010 Physical Medicine<br>and Rehabilitation  |
| 98940 Chiropractic Services  | Jan/Feb 1999, page 62   | The reference to modifier GX in the<br>"Coding Guidelines" section of the<br>policy was deleted and replaced with<br>modifier GY  |
| J0001 Self-Administered Drugs  | Jul/Aug 2000, page 30   | Changed Q2016 to code J2941   |
| J1950 Leuprolide Acetate   | July/Aug 2000, page 33<br>2 <sup>nd</sup> QTR 2001, page 29   | Added modifier GZ (Item or service<br>expected to be denied as not<br>reasonable and necessary and an<br>Advance Beneficiary Notification<br>[ABN] has not been signed by the<br>beneficiary)   |
| J7190 Hemophilia Clotting Factors  | 1 <sup>st</sup> QTR 2002, page 29   | Changed Q0160 to code J7193<br>Changed Q0161 to code J7195  |
| J9212 Interferon   | June 2001, page 9   | Changed A9270 to code J3490 with<br>modifier GY (for Rebetron)  |
| J9217 Luteinizing Hormone-Releasing Hormone<br>Analogs for Diagnosed Malignant Neoplasm<br>of the Prostate | Jul/Aug 1997, page 24   | Information regarding modifier GZ<br>was added to the "Coding Guide-<br>lines" section of the policy  |
| M0302 Cardiac Output by Electrical Bioimpedance  | Nov/Dec 1999, page 29   | Deleted code M0302<br>Added code 93701<br>Changed policy identification<br>number to 93701  |
| Q0185 Apligraf® (Graftskin)  | 3 <sup>rd</sup> QTR 2001, page 44   | Changed Q0185 to code J7340<br>Changed policy number to J7340   |
| VISCO Viscosupplementation Therapy for Knee  | Jan/Feb 1999, page 15   | Deleted code J7315<br>Added code J7316  |
|  |   | •   |

# **NCSVCS: The List of Medicare Noncovered Services**

Revision Overview: This publication covers two revisions:

Revision #28 – The Annual 2002 HCPCS Update no longer recognizes code A9270 for local carrier use. Therefore, providers must use the appropriate assigned or unlisted CPT/HCPCS code for noncovered services. In addition, effective for services provided on or after January 1, 2002, the new modifier GY is required to indicate items or services that are statutorily noncovered or do not meet the definition of any Medicare benefit.

Revision #27 - CMS letter dated 10/26/2001 indicated that cultures performed for patients exposed or infected with anthrax should be billed with procedure code 87081; therefore, this code was deleted from the local noncoverage list.

#### **Policy Number**

NCSVCS

Contractor Name

First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title

The List of Medicare Noncovered Services

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# CMS National Coverage Policy $N\!/\!A$

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

# CMS Consortium

Southern

Original Policy Effective Date 10/20/1997

**Original Policy Ending Date** N/A

# **Revision Effective Date** 01/01/2002

# Revision Ending Date 12/31/2001

## **LMRP** Description

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

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

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

### Indications and Limitations of Coverage and/ or Medical Necessity

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

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

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

# CPT/HCPCS Section & Benefit Category N/A

#### CPT/HCPCS Codes Local Noncoverage Decisions Devices

| E1399GY+ | Disposable pain control infusion pump |
|----------|---------------------------------------|
|          | (PCIP)                                |

### Laboratory Procedures

| 0026T   | Lipoprotein, direct measurement,          |
|---------|---|
|         | intermediate density lipoproteins (IDC)   |
|         | (remnant lipoproteins)                    |
| 82016*  | Acylcarnitines; qualitative, each         |
|         | specimen                                  |
| 82017*  | Acylcarnitines; quantitative, each        |
|         | specimen                                  |
| 82172   | Apolipoprotein, each                      |
| 82379*  | Carnitine (total and free), quantitative, |
|         | each specimen                             |
| 82523*  | Collagen cross links, any method          |
|         | (Urinary Biochemical Assays for Bone      |
|         | Resorption)                               |
| 83090GY | Homocysteine testing for                  |
|         | cardiovascular risk assessment            |
| 83883   | Nephelometry, each analyte not            |
|         | elsewhere specified                       |
|         |   |

| 84134          | Prealbumin  | 87557          | Mycobacteria tuberculosis,                    |
|----------------|---|----------------|---|
| 84999*+        | Neuronal thread protein (NTP)                     |                | quantification                                |
| 86141          | <i>C</i> -reactive protein; high sensitivity      | 87562          | Mycobacteria avium-intracellulare,            |
| 00141          |   | 07302          |   |
| 062014         | (HsCRP)   | 07500          | quantification                                |
| 86301*         | Immunoassay for tumor antigen,                    | 87580          | Mycoplasma pneumoniae, direct probe           |
|                | quantitative; CA 19-9                             |                | technique                                     |
| 86316*         | Immunoassay for tumor antigen; other              | 87581          | Mycoplasma pneumoniae, amplified              |
|                | antigen, quantitative (e.g., CA 50, 72-4,         |                | probe technique                               |
|                | 549), each  | 87582          | Mycoplasma pneumoniae,                        |
| 06212*         |   | 07302          |   |
| 86343*         | Leukocyte histamine release test (LHR)            |                | quantification                                |
| 86618          | Antibody; Borrelia burgdorferi (Lyme              | 87592          | Neisseria gonorrhoeae, quantification         |
|                | disease)  | 87620          | papillomavirus, human, direct probe           |
| 86628          | Antibody; Candida                                 |                | technique                                     |
| 86631          | Antibody; Chlamydia                               | 87622          | papillomavirus, human, quantification         |
| 86849*+        | Zstat flu influenza test kits                     | 88000-88099    | Necropsy (autopsy)                            |
| 86910          |   | 88299*+        | BRCA1 and BRCA2                               |
| 00910          | Blood typing, for paternity testing, per          |                |   |
|                | individual; ABO, Rh, and MN                       | 88349          | Electron microscopy: scanning                 |
| 86911          | each additional antigen system                    | 89250-89261    | <i>Culture and fertilization of oocyte(s)</i> |
| 87084          | Culture, presumptive, pathogenic                  |                | and other artificial insemination             |
|                | organisms, screening only; with colony            |                | procedures                                    |
|                | estimation from density chart                     | 89264          | Sperm identification from testis tissue,      |
| 07270          |   | 0/204          |   |
| 87270          | Infectious agent antigen detection by             | 00200#         | fresh or cryopreserved                        |
|                | direct fluorescent antibody technique;            | 89399*+        | Epiluminescense microscopy                    |
|                | Chlamydia trachomatis                             | 89399*+        | In-vitro chemosensitivity and/or              |
| 87320          | Infectious agent antigen detection by             |                | resistance assays                             |
|                | enzyme immunoassay technique,                     | <b>D</b> 101   | •   |
|                | qualitative or semiquantitative multiple          | Drugs and Bio  |   |
|                |   | 90476          | Adenovirus vaccine, type 4, live, for         |
| 07.470         | step method; Chlamydia trachomatis                |                | oral use                                      |
| 87470          | Infectious agent detection by nucleic             | 90477          | Adenovirus vaccine, type 7, live, for         |
|                | acid (DNA or RNA); Bartonella                     | <i>J</i> 0177  | oral use                                      |
|                | hanselae and Bartonella quintana,                 | 00501          |   |
|                | direct probe technique                            | 90581          | Anthrax vaccine, for subcutaneous use         |
| 87471          | Bartonella hanselae and Bartonella                | 90585          | Bacillus Calmette-Guerin vaccine              |
| 0/4/1          |   |                | (BCG) for tuberculosis, live, for             |
| 07470          | quintana, amplified probe technique               |                | percutaneous use                              |
| 87472          | Bartonella hanselae and Bartonella                | 90586          | Bacillus Calmette-Guerin vaccine              |
|                | quintana, quantification                          | ,              | (BCG) for bladder cancer, live, for           |
| 87475          | Borrelia burgdorferi, direct probe                |                |   |
|                | technique   | 00(22          | intravesical use                              |
| 87477          | Borrelia burgdorferi, quantification              | 90632          | Hepatitis A vaccine, adult dosage, for        |
| 87482          | Candida species, quantification                   |                | intramuscular use                             |
|                |   | 90633          | Hepatitis A vaccine, pediatric/               |
| 87485          | Infectious agent detection by nucleic             |                | adolescent dosage-2 dose schedule, for        |
|                | acid (DNA or RNA); Chlamydia                      |                | intramuscular use                             |
|                | pneumoniae, direct probe technique                | 90634          |   |
| 87487          | Chlamydia pneumoniae, quantification              | 90034          | Hepatitis A vaccine, pediatric/               |
| 87492          | Chlamydia trachomatis, quantification             |                | adolescent dosage-3 dose schedule, for        |
| 87511          | Gardnerella vaginalis, amplified probe            |                | intramuscular use                             |
| 07511          |   | 90645          | Hemophilus Influenza b vaccine (Hib),         |
| 0.5510         | technique   |                | HbOC conjugate (4 dose schedule), for         |
| 87512          | Gardnerella vaginalis, quantification             |                | intramuscular use                             |
| 87515          | hepatitis B virus, direct probe technique         | 90646          | Hemophilus Influenza b vaccine (Hib),         |
| 87520          | hepatitis C, direct probe technique               | 90040          |   |
| 87522*         | hepatitis C, quantification                       |                | PRP-D conjugate, for booster use only,        |
| 87525          | hepatitis G, direct probe technique               |                | intramuscular use                             |
| 87526          |   | 90647          | Hemophilus Influenza b vaccine (Hib),         |
|                | hepatitis G, amplified probe technique            |                | PRP-OMP conjugate (3 dose schedule),          |
| 87527          | hepatitis G, quantification                       |                | for intramuscular use                         |
| 87531          | Herpes virus-6, direct probe technique            | 90648          | Hemophilus Influenza b vaccine (Hib),         |
| 87532          | Herpes virus-6, amplified probe                   | 20040          |   |
|                | technique   |                | PRP-T conjugate (4 dose schedule), for        |
| 87533          | Herpes virus-6, quantification                    | 0.04550        | intramuscular use                             |
| 87534          | HIV-1, direct probe technique                     | 90660          | Influenza virus vaccine, live, for            |
|                |   |                | intranasal use                                |
| 87537          | HIV-2, direct probe technique                     | 90665          | Lyme disease vaccine, adult dosage, for       |
| 87538          | HIV-2, amplified probe technique                  |                | intramuscular use                             |
| 87539          | HIV-2, quantification                             | 90680          |   |
| 87540          | Legionella pneumophila, direct probe              | 20000          | Rotavirus vaccine, tetravalent, live, for     |
|                |   |                | oral use                                      |
|                | tecnnique   | 00000          |   |
| 87541          | technique<br>Legionella pneumophila, amplified    | 90690          | Typhoid vaccine, live, oral                   |
| 87541          | Legionella pneumophila, amplified                 | 90690<br>90691 | Typhoid vaccine, Vi capsular                  |
|                | Legionella pneumophila, amplified probe technique |                | Typhoid vaccine, Vi capsular                  |
| 87541<br>87542 | Legionella pneumophila, amplified                 |                |   |

| 00602           |   | 59012        | Condesentaria (interactorias) and       |
|-----------------|---|--------------|---|
| 90692           | Typhoid vaccine, heat-and phenol-         | 59012        | Cordocentesis (intrauterine), any       |
|                 | inactivated (H-P), for subcutaneous or    | 64999*+      | method<br>Blood Brain Barrier Dismution |
| 00(0)           | intradermal use                           |              | Blood Brain Barrier Disruption          |
| 90693           | Typhoid vaccine, Acetone-Killed, Dried    | 64999*+      | Bretylium Bier Block                    |
|                 | (AKD), for subcutaneous or jet injection  | 64999*+      | Fetal Tissue Transplantation            |
|                 | use (U.S. military)                       | 66899*+      | Balloon Lacrimoplasty                   |
| J0275           | Alprostadil urethral suppository (Muse)   | 76499*+      | MRI for use in measuring the blood      |
| J1056           | Injection, medroxyprogesterone acetate/   |              | flow, spectroscopy imaging of cortical  |
|                 | estradiol cypionate, 5mg/25mg             |              | bone and calcification, and procedures  |
| J3490*+         | Becaplermin (Regranex)                    |              | involving resolution of bone or         |
| J3490*+         | Shark Cartiledge Injections               |              | calcification                           |
| J3520           | Edetate disodium, per 150 mg              | 76999*+      | Ultrasound guided sclerotherapy         |
|                 | (chemical endarterectomy)                 | 78699*+      | SPECT with Altropane for early          |
| J3530           | Nasal vaccine inhalation                  |              | diagnosis of Parkinson's Disease        |
| <b>р</b> 1      |   | 92548*       | Computerized dynamic posturography      |
| Procedures      |   | 92599GY+     | Politzer procedure                      |
| 0014T*          | Meniscal Allograft Transplantation        | 92970*       | Cardioassist-method of circulatory      |
| 0019T*-0020T*   |   |              | assist; internal                        |
|                 | (OssaTron)                                | 92971*       | Cardioassist-method of circulatory      |
| 01990           | Physiological support for harvesting of   |              | assist; external                        |
|                 | organs from brain-dead patients           | 92997-92998  | Percutaneous transluminal pulmonary     |
| 01995           | Regional intravenous administration of    |              | artery balloon angioplasty              |
|                 | local anesthetic agent or other           | 93720-93722* | Plethysmography, total body             |
|                 | medication (upper or lower extremity)     | 93740        | Temperature gradient studies            |
| 11975           | Insertion, implantable contraceptive      | 93799*+      | Metaidobenzylquanidine (MIBG)           |
|                 | capsules                                  |              | imaging                                 |
| 11977           | Removal with reinsertion, implantable     | 94014        | Patient initiated spirometric recording |
|                 | contraceptive capsules                    |              | per 30 day period of time; includes     |
| 11980           | Subcutaneous hormone pellet               |              | reinforced education, transmission of   |
| 11/00           | implantation (implantation of estradiol   |              | spirometric tracing, data capture,      |
|                 | and/or testosterone pellets underneath    |              | analysis of transmitted data, periodic  |
|                 | the skin)                                 |              | recalibration and physician review and  |
| 15820-15821     | Blepharoplasty, lower lid                 |              | interpretation                          |
| 15824-15829     | Rhytidectomy                              | 94015        | Patient initiated spirometric recording |
| 15876-15879     |   | 21015        | per 30 day period of time; recording    |
|                 | Suction assisted lipectomy                |              | (includes hook-up, reinforced           |
| 17380           | Electrolysis epilation, each ½ hour       |              | education, data transmission, data      |
| 22899*+         | Arthroscopic laser arthrodesis/           |              | capture, trend analysis, and periodic   |
|                 | rhizotomy of the facet joint with         |              | recalibration)                          |
|                 | cancellous bone allograph and             | 94016        | Patient initiated spirometric recording |
| <b>22</b> 000th | autologous platelet gell patch            | 94010        | per 30 day period of time; physician    |
| 22899*+         | Epiduroscopy/Myeloscopy                   |              | review and interpretation only          |
| 22899*+         | Intradiscal electrothermal therapy        | 95199*+      | Adoptive Immunotherapy                  |
|                 | (annuloplasty)                            | 95806        | Sleep Study unattended by a             |
| 27599*+         | Tidal knee irrigation                     | 95000        | technologist                            |
| 33999*+         | Abdominal aorta transplant from a         | 95831        | Muscle testing, manual (separate        |
|                 | cadaver                                   | 95051        | procedure) with report; extremity       |
| 37799*+         | Stenting of the vertebral and cerebral    |              | (excluding hand) or trunk, with report  |
|                 | arteries                                  | 95832        | hand, with or without comparison with   |
| <i>43999*</i> + | Gastric Electrical Stimulation            | 93032        | normal side                             |
| 44799*+         | Large and Small Bowel Transplants         | 05022        |   |
| 53899*+         | Neocontrol (Magnetic Incontinence         | 95833        | total evaluation of body, excluding     |
|                 | Chair)                                    | 05024        | hands                                   |
| 58670           | Laparoscopy, surgical; with fulguration   | 95834        | total evaluation of body, including     |
|                 | of oviducts (with or without transection) | 05951        | hands                                   |
| 58671           | with occlusion of oviducts by device      | 95851        | Range of motion measurements and        |
|                 | (eg, band, clip, or Falope ring)          |              | report (separate procedure); each       |
| 58321           | Artificial insemination; intra-cervical   |              | extremity (excluding hand) or each      |
| 58322           | Artificial insemination; intra-uterine    | 05052        | truck section (spine)                   |
| 58323           | Sperm washing for artificial              | 95852        | hand, with or without comparison with   |
| 2.0020          | insemination                              | 050004       | normal side                             |
| 58970           | Follicle puncture for oocyte retrieval,   | 95999*+      | Biothesiometry                          |
| 50770           | any method                                | 95999+       | Current Perception Threshold Testing    |
| 58974           | Embryo transfer, intrauterine             | 05000 01     | (CPT)                                   |
| 58976           | Gamete, zygote, or embryo                 | 95999GY+     | Quantitative sensory testing (QST)      |
| 50970           | intrafallopian transfer, any method       | 95999*+      | Surface electromyography                |
| 58000CV         |   | 96150-96155  | Health and behavior assessment/         |
| 58999GY+        | Pap plus speculoscopy (PPS)               |              | intervention                            |

Transfer factor for treatment of multiple

Punch graft for hair transplant (MCM

Prolotherapy, joint sclerotherapy and

ligamentous injections with sclerosing

Vertebral Axial Decompression (VAX-

reduction, sternal split or transthoracic approach, with or without any pleural procedure (prior to 1/1/97 HCPCS code

Partial ventriculectomy (ventricular reduction, ventricular remodeling, heart volume reduction surgery) (CIM 35-95)

Transluminal balloon angioplasty (PTA) in treatment of obstructive

lesions of aortic arch (CIM 50-32.3)

Transvenous (catheter) pulmonary embolectomy (CIM 35-55)

Colonic irrigation (CIM 35-1) Intestinal bypass for obesity (CIM 35-

Bladder Stimulator (CIM 65-11)

Clitoroplasty for intersex state (CIM

Vaginoplasty for intersex state (CIM

Ambulatory home monitoring of uterine

Stereotactic cingulotomy as a means of

Oxygen treatment of inner ear/carbon

Magnetic resonance angiography, upper extremity, with or without contrast material(s) (CIM 50-14) Dual Photon Absorptiometry, one or

Magnetic resonance angiography, spine canal and contents, with or without contrast material(s) (CIM 50-14) Magnetic resonance angiography, pelvis, with or without contrast material(s) (CIM 50-14)

Intersex surgery (CIM 35-61)

contractions (MCM 2005.1)

psychosurgery (CIM 35-84)

therapy (CIM 35-29)

more sites (CIM 50-44)

Carotid body resection to relieve pulmonary symptoms, including asthma

Refractive keratoplasty to correct refractive error (CIM 35-54) Cochleostomy with neurovascular transplant for Meniere's Disease (CIM

Percutaneous transluminal angioplasty (PTA) of the vertebral and cerebral

Gastric balloon for treatment of obesity

Removal of lung, other than total pneumonectomy; excision-plication of emphysematous lung(s) (bullous or non-bullous), for lung volume

Oral, Cabergoline, 0.5 mg (MCM

sclerosis (CIM 45-17)

agents (CIM 35-13)

G0061) (CIM 35-93)

arteries (CIM 50-32)

(CIM 35-86)

33)

35-61)

35-61)

(CIM 35-7)

35-50)

D) (CIM 35-97)

2049.5)

2329)

P9033\*

Q2001

**Procedures** 15775-15776

20999\*+

22899\*+

32491\*

33999\*+

35452\*

37799\*+

37799\*+

43999\*+

44799\*+

53899\*+

56805

57335

59899\*+

55970-55980\*

44799GY+

| 97545        | Work hardening/conditioning; initial 2 hours                                     |
|--------------|--|
| 97546        | each additional hour (List separately in addition to code for primary procedure) |
| 97799*+      | Matrix Pro elect/DT  |
| 99199*+      | Gamma knife for lesions outside the head   |
| 99199*+      | Intravenous lidocaine for chronic pain   |
| 99199*+      | Light reflecting rheography  |
| 99360        | Stand-by anesthesia  |
| D9248        | Non-intravenous conscious sedation   |
| G0167        | Hyperbaric oxygen treatment not  |
|              | requiring physician attendance, per  |
|              | treatment session  |
| G0193*       | Endoscopic study of swallowing   |
|              | function (also fiberoptic endoscopic   |
|              | evaluation of swallowing (FEES)  |
| G0194*       | Sensory testing during endoscopic  |
|              | study of swallowing (add on code)  |
|              | referred to as fiberoptic endoscopic   |
|              | evaluation of swallowing with sensory  |
|              | testing (FEEST)  |
| Notional Nam | anverage Decisions   |
| Devices      | coverage Decisions   |

| DUTICUS |                                       |
|---------|---------------------------------------|
| 33999*+ | Artificial hearts and related devices |
|         | (CIM 65-15)                           |
| E1399*+ | Electrical continence aid (CIM 65-2)  |
| E1399*+ | Intrapulmonary percussive ventilator  |
|         | for home use (CIM 60-21)              |
| E1399*+ | Pelvic floor stimulator (CIM 65-9)    |
|         |                                       |

#### Laboratory Procedures

| 80050   | General Health Panel                     |
|---------|--|
| 82435*  | Sweat test as predictor of efficacy of   |
|         | sympathectomy in PVD (CIM 50-3)          |
| 86999*+ | Cytotoxic leukocyte tests for food       |
|         | allergies (CIM 50-2)                     |
| 86910   | Blood typing, for paternity testing, per |
|         | individual; ABO, Rh and MN               |
| 86911   | each additional antigen system           |
| 88399*+ | Human tumor stem cell drug sensitivity   |
|         | assays (CIM 50-41)                       |

#### **Drugs and Biologicals**

| Drugs and Diolo | Igicais   | 60699*+                |
|-----------------|---|------------------------|
| 90669           | Pneumococcal conjugate vaccine, polyvalent, for children under five                                       | 00099*+                |
| A4260*          | years, for intramuscular use<br>Levonorgestral (contraceptive) implants                                   | 64999*+                |
|                 | system, including implants and supplies (Statute 1862 [a][1][a])  | 65760-65767,<br>65771* |
| A4261           | Cervical cap for contraceptive use<br>(Statute 1862[a][1][a])   | 69949*+                |
| G0192           | Intranasal or oral administration; one<br>vaccine (single or combination vaccine/<br>toxoid) (MCM 2049.4) | 69949*+                |
| J3420GY         | Vitamin B-12 injections to strengthen<br>tendons, ligaments of the foot (CIM 45-4)                        | 72159                  |
| J3490GY+        | Rebetron (MCM 2049)   |                        |
| J3570*          | Laetrile (Amygdalin, Vit B17) (CIM<br>45-10)  | 72198                  |
| J8499GY+        | Prescription drug, oral,<br>nonchemotherapeutic, not otherwise<br>specified (MCM 2049)                    | 73225                  |
| J8499*+         | Sublingually administered antigens (CIM 45-28)  | 78351*                 |
| P9019*          | Platelet-derived wound healing formula (Procuren) (CIM 45-26)   | / 0001                 |

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|---------------------|--|

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| 78608*                                  | Brain imaging, positron emission<br>tomography (PET); metabolic<br>evaluation (CIM 50-36)                           | 98943                            | <i>Chiropractic manipulative treatment</i><br>( <i>CMT</i> ); <i>extraspinal, one or more</i><br><i>regions</i> (MCM 2251)                               |
|---|---|----------------------------------|--|
| 78609*<br>78810*                        | perfusion evaluation (CIM 50-36)<br>Tumor Imaging, Positron Emission<br>Tomography (PET), metabolic<br>evaluation   | 99172                            | Visual function screening, automated or<br>semi-automated bilateral quantitative<br>determination of visual acuity, ocular<br>alignment, color vision by |
| 90760<br>90875-90876                    | Routine physical exam (MCM 2320)<br>Individual psychophysiological therapy<br>incorporating biofeedback (CIM 35-27) |                                  | pseudoisochromatic plates, and field of<br>vision (may include all or some<br>screening of the determination(s) for                                      |
| 90899*+                                 | <i>Electrical aversion therapy for</i><br><i>treatment of alcoholism</i> (CIM 35-23.1)                              | 99173                            | contrast sensitivity, vision under glare)<br>Screening test of visual acuity,  |
| 90899*+<br>90908                        | Transcendental meditation (CIM 35-92)   |                                  | quantitative, bilateral  |
| (prior to 1/1/97)                       | <i>Biofeedback (psychiatric only)</i><br>(CIM 35-27)  | 99199*+<br>99199*+               | Cellular Therapy (CIM 35-5)  |
| 90935-90937*                            | Hemodialysis procedure for treatment  | 99199*+<br>99199*+               | Electrosleep therapy (CIM 35-18)<br>Indirect calorimetry used to assess  |
| 90999*+                                 | of schizophrenia (CIM 35-51)<br>Ultrafiltration independent of  |                                  | nutritional status as a respiratory  |
| <i>30333</i> <sup>+</sup>               | conventional dialysis (CIM 55-3)  | 99199*+                          | therapy<br>Intravenous histamine therapy (CIM  |
| 92310                                   | Prescription of optical and physical  | 99199 · +                        | 35-19)   |
|   | characteristics of and fitting of contact<br>lens, with medical supervision of                                      | 99199*+                          | Thermogenic therapy (CIM 35-6)   |
|   | adaptation; corneal lens, both eyes,  | 99199*+                          | Transilluminator light scanning or   |
| 00014                                   | except for aphakia  | G0122                            | <i>diaphanography</i> (CIM 50-46)<br>Colorectal cancer screening; barium   |
| 92314                                   | Prescription of optical and physical characteristics of contact lens, with  | 00122                            | enema  |
|   | medical supervision of adaptation and   | G0219                            | PET Imaging whole body; melanoma for   |
|   | direction of fitting by independent   | G9016                            | non-covered indications (CIM 50-36)<br>Smoking cessation counseling,   |
|   | technician; corneal lens, both eyes,<br>except for aphakia  | 0,010                            | individual, in the absence of or in  |
| 92599*+                                 | Tinnitus masking (CIM 35-63)  |                                  | addition to any other evaluation and   |
| 93668                                   | Peripheral arterial disease (PAD)   |                                  | management service, per session (6-10 minutes) demo project code only  |
| 93760                                   | rehabilitation, per session<br>Thermogram; cephalic   | M0100*                           | Gastric freezing (CIM 35-65)   |
| 93762                                   | peripheral  | M0301*                           | Fabric wrapping of abdominal   |
| 93784-93790*                            | Ambulatory blood pressure monitoring<br>(CIM 50-42)   | V2799*+                          | aneurysms (CIM 35-34)<br>Investigational IOLs in FDA Core  |
| 93799*+                                 | Cardiointegram (CIG) as an alternative to stress test or thallium stress test                                       |                                  | Study or Modified Core Study (MCM 2020.25)   |
|   | (CIM 50-47)   | V5010                            | Hearing exam for the purpose of a  |
| 93799*+                                 | Carotid sinus nerve stimulator for  |                                  | hearing aid (MCM 2320)   |
|   | treatment of paroxysmal supraventricular tachycardia (CIM 65-4)   |                                  | covered due to being investigational/  |
| 93799*+                                 | Chelation therapy (EDTA) for treatment  | experimental.<br>+Claims for the | ese services will always be reviewed, as   |
| 93799*+                                 | of arteriosclerosis (CIM 35-64)<br>Circulator Boot System (CIM 35-74)   |                                  | rently be billed with an unlisted procedure  |
| 95199GY+                                | Repository antigen (MCM 2005.2)   | code.                            |  |
| 95999*+                                 | EEG monitoring during open heart  |                                  | quoted material is excerpted from the  |
|   | surgery and in immediate post-op<br>period (CIM 35-57.1)  |                                  | cal Association <i>Current Procedural</i><br>PT codes, descriptions and other data only  |
| 96902*                                  | Hair analysis to detect mineral traces  | are copyrighted                  | 2001 American Medical Association (or  |
|   | as an aid in diagnosing human disease   | other such date                  | of publication of <i>CPT</i> ). All rights reserved.<br>S/DFARS apply.   |
| 97014*                                  | (CIM 50-24)<br>Electrotherapy for the treatment of  |                                  |  |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | facial nerve paralysis (Bell's Palsy)<br>(CIM 35-72)  | inclusive.                       | noncovered services are not all-   |
| 97014*                                  | Treatment of motor function disorders   | Not Otherwi                      | se Classified Codes (NOC)  |
|   | with electrical nerve stimulation (CIM 35-20)   | N/A                              |  |
| 97024*                                  | Diathermy or ultrasound treatments  | ICD-9-CM Co                      | odes that Support Medical  |
|   | performed for respiratory conditions or   | Necessity                        |  |
| 97780-97781*                            | diseases (CIM 35-41)<br>Acupuncture (CIM 35-8)  | N/A                              |  |
| 97799*+                                 | Treatment of decubitus ulcers by<br>ultraviolet light, low intensity direct   | Diagnoses t<br>N/A               | hat Support Medical Necessity  |
|   | current, topical application of oxygen  | ICD-9-CM Co                      | odes that DO NOT Support   |
|   | and topical dressings with balsam of<br>Peru in castor oil (CIM 35-31)  | Medical Nec                      |  |

# Diagnoses that DO NOT Support Medical Necessity

N/A

## **Reason for Denials**

See criteria for noncoverage.

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

# Noncovered ICD-9-CM Codes

N/A

# Noncovered Diagnoses N/A

 $\begin{array}{c} \textbf{Coding Guidelines} \\ N\!/\!A \end{array}$ 

### **Documentation Requirements**

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

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

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

Utilization Guidelines N/A

## **Other Comments**

N/A

# Sources of Information and Basis for Decision

N/A

### **Advisory Committee Notes**

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

Carrier Advisory Committee Meeting held on February 24, 2001.

# Start Date of Comment Period N/A

# End of Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

### **Revision History**

Revision Number:28PCR B2002-051Start Date of Comment PeriodN/AStart Date of Notice Period02/01/20022nd QTR 2002 Update!Revised Effective Date:01/01/2002Explanation of Revision:Annual 2002 HCPCS Update.Revision Number:27PCR B2001-176

Start Date of Comment Period Start Date of Notice Period

Revised Effective Date: Explanation of Revision: PCR B2001-176 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 11/09/2001

Explanation of Revision: A memorandum dated 10/26/ 2001 indicated that cultures performed for patients exposed or infected with anthrax should be billed with procedure code 87081, therefore, this code was deleted from the local noncoverage list.

# Documentation Requirements for Certification/Recertification of Psychiatric Partial Hospitalization Services

Documentation requirements for certifications/ recertifications for Psychiatric Partial Hospitalization (PHP) services were published in the 2<sup>nd</sup> Quarter 2001 *Medicare B Update!* (page 86). Since that time, the Centers for Medicare & Medicaid Services has further defined these requirements. Therefore, the local medical review policy for PHP has been revised.

# Oasis<sup>™</sup> Wound Dressing Coverage

Florida Medicare has received inquiries regarding appropriate billing of the Oasis<sup>™</sup> wound dressing. The Oasis<sup>™</sup> wound dressing is used in management of partial and full thickness skin loss injury such as pressure and chronic vascular ulcers, diabetic ulcers, abrasions, second-degree burns, and autograft donor sites. Oasis<sup>™</sup> is Please ensure that certifications/recertification statements for PHP services include the following language: "I certify the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services, and services will be furnished under the care of a physician, and under a written plan of treatment."

considered a biological dressing, as it acts as a primary wound cover.

It has been determined that application of Oasis<sup>™</sup> is included in reimbursement for an evaluation and management visit; therefore, it is not appropriate to bill for application of Oasis<sup>™</sup> separately.

# Medicare Coverage and Coding for Services Related to Anthrax

A number of questions have recently arisen regarding Medicare's coverage and coding rules for services related to anthrax testing and treatment. The purpose of this article is to provide the existing policy regarding Medicare coverage for screening services and coding policies relative to these services. In essence, Medicare covers anthrax testing when reasonable and necessary and ordered by a physician.

Medicare beneficiaries who believe they may have been exposed to anthrax may present to a physician's office, emergency room, clinic or other Medicare provider, even in the absence of signs or symptoms of infection, to request testing to determine if they have the disease or have been exposed to it. After examining such a patient, a physician or other qualified practitioner may determine a nasal swab or other diagnostic test should be performed to ascertain whether the patient has been exposed to, or is infected with, anthrax. In this specific clinical situation, Medicare will cover the test and related services. All usual rules regarding documentation for the reason for the test and need for a written order apply. As always, Medicare covers only testing necessary to diagnose and treat the patient.

The culture should be coded using *CPT* code 87081 (*culture, presumptive, pathogenic organisms, screening only*). Payment for obtaining the specimen is included in the evaluation and management payment.

When the test is performed because the patient has had contact with, or exposure to, a communicable disease or biological agent, the appropriate ICD-9-CM code, V01.8 (Contact with or exposure to communicable diseases, other communicable diseases) should be used, whether or not the patient has signs or symptoms of a disease. When submitting claims for a patient with a nasal swab positive for *B. anthracis* (anthrax) who will be treated with antibiotics, code 795.3 (nonspecific positive culture findings) should be used. If prophylactic antibiotics are prescribed, code V07.39 (other prophylactic chemotherapy) should be used. Only if the patient is confirmed to have disease caused by anthrax bacillus should codes from the anthrax series (022.1 -022.9) be used.

Medicare coverage of anthrax testing (as with other public health sponsored testing) does not extend to mass testing performed by public health officials in response to a confirmed anthrax exposure. However, Medicare will cover any subsequent medically appropriate and necessary diagnosis and treatment consistent with existing policy.

Source: CMS letter dated October 26, 2001

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## A4300: Implantable Vascular Access Devices

Revision Overview: Annual HCPCS 2002 Update

### **Policy Number**

A4300

#### **Contractor Name** First Coast Service Options, Inc.

Contractor Number

00590

#### Contractor Type Carrier

LMRP Title

Implantable Vascular Access Devices

## AMA CPT Copyright Statement

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CMS National Coverage Policy Medicare Carriers Manual, Sections 2130 and 2265.5

**Primary Geographic Jurisdiction** Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern Original Policy Effective Date 06/18/1996

# Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

Revision Ending Date 12/31/2001

### **LMRP** Description

Various types of implantable vascular access portal/ catheter/reservoirs are available. Management of patients with the need for the administration of repeated cycles of chemotherapy or other forms of systemic drug therapy are covered services.

### Indications and Limitations of Coverage and/ or Medical Necessity

Implantable devices are ideally suited to patients who require intermittent (either bolus or continuous infusion therapy of drugs that do not cause tissue damage when extravasated); blood samplings; and nonintensive support therapy and are covered services when reasonable and medically necessary.

### **CPT/HCPCS Section & Benefit Category** Prosthetic Devices

**CPT/HCPCS Codes** A4300 A4301

# Not Otherwise Classified Codes (NOC) $\rm N\!/\!A$

# 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 Denials**

Implantation is contraindicated in the presence of known or suspected infections, bacteremia, septicemia, and periotonitis or in patients who have exhibited prior intolerance to the materials of construction.

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 Codes N/A

Noncovered Diagnoses

## **Coding Guidelines**

A vascular access device is covered when furnished in conjunction with the insertion of an implantable venous access device, with or without subcutaneous reservoir (36533) in an approved ASC.

Effective 01/01/2002, procedure code A4300 is considered a bundled service.

### **Documentation Requirements**

- Implantable devices when billed by an Ambulatory Surgical Center (ASC) must include an invoice. The acquisition cost will be based on the actual cost incurred by the ASC to acquire the device. Code A4301 is reimbursed on an individual consideration (IC) basis.
- The medical record maintained must document that the service is both reasonable and medically necessary. However, the medical record does not need to be submitted with the claim.

## Utilization Guidelines

N/A

### **Other Comments**

External infusion pumps are covered for:

- Iron poisoning;
- Thromboembolic disease; and
- Chemotherapy for liver cancer.

Services related to durable medical equipment are processed by the DMERC.

Implantable infusion pumps are covered for:

- Chemotherapy to treat liver cancer;
- To administer antispasmodic drugs;
- To administer opioid drugs (e.g., morphine); and
- For other uses, drugs must be validated for reasonableness and be medically necessary for the patient's treatment.

# Sources of Information and Basis for Decision

Strate Medical Corporation/Pfizer Manufacturer, 1993

## **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 02/01/2002

### **Revision History**

| Revision Number:            | 2      | PCR B2002-002                    |
|-----------------------------|--------|----------------------------------|
| Start Date of Comment       | Period | N/A                              |
| Start Date of Notice Period |        | 02/01/2002                       |
|                             |        | 2 <sup>nd</sup> QTR 2002 Update! |

01/01/2002

Revised Effective Date:

## **Advance Notice Statement**

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

# G0030: Positron Emission Tomography (PET) Scan

*Revision Overview: Annual 2002 HCPCS Update, and changes related to Transmittals AB-01-168 and 147 (Change Request 1886) dated November 27, 2001, which provide clarification regarding the types of allowable PET scanners.* 

Policy Number G0030

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

## LMRP Title

Positron Emission Tomography (PET) Scan

## AMA CPT Copyright Statement

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## **CMS National Coverage Policy**

Coverage Issues Manual, Section 50-36

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium

Original Policy Effective Date 10/02/1995

**Original Policy Ending Date** N/A

**Revision Effective Date** 01/01/2002

Revision Ending Date

12/31/2001

## LMRP Description

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

## Indications and Limitations of Coverage and/ or Medical Necessity

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

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

| Clinical Condition                               | Effective Date  | Coverage   |
|--|-----------------|--|
| Solitary Pulmonary Nodules (SPNs)                | January 1, 1998 | Characterization   |
| Lung Cancer (Non Small Cell)                     | January 1, 1998 | Initial Staging  |
| Lung Cancer (Non Small Cell)                     | July 1, 2001    | Diagnosis, staging, and restaging  |
| Esophageal Cancer                                | July 1, 2001    | Diagnosis, staging, and restaging  |
| Colorectal Cancer                                | July 1, 1999    | Determining location of tumors if<br>rising CEA level suggests recurrence        |
| Colorectal Cancer                                | July 1, 2001    | Diagnosis, staging, and restaging  |
| Lymphoma   | July 1, 1999    | Staging and restaging only when used as an alternative to Gallium scan           |
| Lymphoma   | July 1, 2001    | Diagnosis, staging, and restaging  |
| Melanoma   | July 1, 1999    | Evaluating recurrence prior to surgery as an alternative to Gallium scan         |
| Melanoma   | July 1, 2001    | Diagnosis, staging, and restaging; non-<br>covered for evaluating regional nodes |
| Refractory Seizures                              | July 1, 2001    | Covered for pre-surgical evaluation only   |
| Perfusion of the heart using Rubidium 82* tracer | March 14, 1995  | Covered for noninvasive imaging of the perfusion of the heart                    |
| Head and Neck Cancer                             | July 1, 2001    | Diagnosis, staging, and restaging; non-<br>covered for CNS and thyroid cancers   |
| Myocardial Viability                             | July 1, 2001    | Covered only following an inconclu-<br>sive SPECT                                |

\*Not FDG PET.

## General Conditions of Coverage for FDG PET

A. Allowable FDG PET Systems

- 1. Definitions: For purposes of this section,
  - a. "Any FDA approved" means all systems approved or cleared for marketing by the FDA to image radionuclides in the body.
  - b. "FDA approved" means that the system indicated has been approved or cleared for marketing by the FDA to image radionuclides in the body.
  - c. "Certain coincidence systems" refers to the systems that have all the following features:

- Crystal at least 5/8-inch thick
- Techniques to minimize or correct for scatter and/or randoms, and
- Digital detectors and iterative reconstruction.

Scans performed with gamma camera PET systems with crystals thinner than 5/8-inch will not be covered by Medicare. In addition, scans performed with systems with crystals greater than or equal to 5/8-inch in thickness, but that do not meet the other listed design characteristics are not covered by Medicare.

### 2. Allowable PET systems by covered clinical indication:

|   | Allowable Type of FDG Pl                | ET System                                 |   |
|---|---|---|---|
| Covered Clinical<br>Condition   | Prior to July 1, 2001                   | July 1, 2001 through<br>December 31, 2001 | On or after January 1, 2002   |
| Characterization of single<br>pulmonary nodules   | Effective 1/1/1998,<br>any FDA approved | Any FDA approved                          | FDA approved:<br>Full ring<br>Partial ring<br>Certain coincidence systems |
| Initial staging of lung cancer<br>(non small cell)  | Effective 1/1/1998,<br>any FDA approved | Any FDA approved                          | FDA approved:<br>Full ring<br>Partial ring<br>Certain coincidence systems |
| Determining location of<br>colorectal tumors if rising<br>CEA level suggests<br>recurrence        | Effective 7/1/1999,<br>any FDA approved | Any FDA approved                          | FDA approved:<br>Full ring<br>Partial ring<br>Certain coincidence systems |
| Staging or restaging of<br>lymphoma only when used<br>as an alternative to a<br>gallium scan      | Effective 7/1/1999,<br>any FDA approved | Any FDA approved                          | FDA approved:<br>Full ring<br>Partial ring<br>Certain coincidence systems |
| Evaluating recurrence of<br>melanoma prior to surgery<br>as an alternative to a<br>gallium scan   | Effective 7/1/1999,<br>any FDA approved | Any FDA approved                          | FDA approved:<br>Full ring<br>Partial ring<br>Certain coincidence systems |
| Diagnosis, staging, and restaging of colorectal cancer  | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Diagnosis, staging, and restaging of esophageal cancer  | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Diagnosis, staging, and<br>restaging of head and neck<br>cancers (excluding CNS<br>and thyroid)   | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Diagnosis, staging, and<br>restaging of lung cancer<br>(non small cell)                           | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Diagnosis, staging, and restaging of lymphoma   | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Diagnosis, staging, and<br>restaging of melanoma<br>(noncovered for evaluating<br>regional nodes) | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Determination of myocardial<br>viability only following an<br>inconclusive SPECT                  | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |
| Presurgical evaluation of refractory seizures   | Not covered by Medicare                 | Full ring                                 | FDA approved:<br>Full ring<br>Partial ring                                |

- B. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions prior to June 30, 2001:
  - 1. Submission of claims for payment must include any information Medicare requires to assure that

the PET scans performed: (a) were medically necessary; (b) did not unnecessarily duplicate other covered diagnostic tests; and (c) did not involve investigational drugs or procedures using investigational drugs as determined by the FDA.

- 2. The PET scan entity submitting claims for payment must keep such patient records, as Medicare requires on file for each patient for whom a PET scan claim is made.
- C. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions as of July 1, 2001:
  - 1. The provider should maintain on file the doctor's referral and documentation that the procedure involved only FDA approved drugs and devices, as is normal business practice.
  - 2. The ordering physician is responsible for certifying the medical necessity of the study and that it meets the conditions specified in the instructions. The physician should have documentation in the beneficiary's medical record to support the referral to the PET scan provider.

#### Covered Indications for PET Scans and Limitations/ Requirements for Usage

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

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

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

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

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

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

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

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

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

For any PET scan for which Medicare payment is claimed for dates of service prior to July 1, 2001, the claimant must submit additional specified information on the claim form (including proper codes and/or modifiers), to indicate the results of the PET scan. The claimant must also include information on whether the PET scan was done after an inconclusive noninvasive cardiac test. The information submitted with respect to the previous noninvasive cardiac test must specify the type of test done prior to the PET scan and whether it was inconclusive or unsatisfactory. These codes are in the form of special G codes used for billing PET scans using Rb 82. Beginning July 1, 2001 claims should be submitted with the appropriate codes.

### **Coverage of FDG PET for Lung Cancer**

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

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

### Requirements:

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

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

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

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

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

### Limitations:

This service is covered only when the primary cancerous lung tumor has been pathologically confirmed; claims for PET must include a statement or other evidence of the detection of such primary lung tumor. The evidence should include, but is not restricted to, a surgical pathology report, which documents the presence of an NSCLC. Whole body PET scan results and results of concurrent computed tomography (CT) and follow-up lymph node biopsy must be properly coordinated with other diagnostic modalities. Claims must include both:

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

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

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

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

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

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

### **Coverage of FDG PET for Esophageal Cancer**

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

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

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

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical

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

### **Coverage of FDG PET for Colorectal Cancer**

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

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

Frequency Limitations:

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

Limitations:

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

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

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

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

Staging and/or Restaging - PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging

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

### **Coverage of FDG PET for Lymphoma**

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

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

### Requirements:

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

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

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

Frequency Limitations for Restaging:

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

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

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

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

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

### **Coverage of FDG PET for Melanoma**

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

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

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

Limitations:

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

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

### Limitations:

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

**Requirements:** 

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

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

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

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

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

### Limitations:

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

### Requirements:

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

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

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

### Coverage of FDG PET for Myocardial Viability

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

Limitations:

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

#### **Coverage of FDG PET for Refractory Seizures**

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

Limitations:

Covered only for pre-surgical evaluation.

### **CPT/HCPCS Section & and Benefit Category** Radiology/Nuclear Medicine

### **CPT/HCPCS** Codes

| G0030 | G0041 | G0213 | G0225 |
|-------|-------|-------|-------|
| G0031 | G0042 | G0214 | G0226 |
| G0032 | G0043 | G0215 | G0227 |
| G0033 | G0044 | G0216 | G0228 |
| G0034 | G0045 | G0217 | G0229 |
| G0035 | G0046 | G0218 | G0230 |
| G0036 | G0047 | G0220 | G0231 |
| G0037 | G0125 | G0221 | G0232 |
| G0038 | G0210 | G0222 | G0233 |
| G0039 | G0211 | G0223 | G0234 |
| G0040 | G0212 | G0224 |       |

# Not Otherwise Classified Codes (NOC) N/A

# ICD-9-CM Codes that Support Medical Necessity

The following ICD-9-CM codes are applicable to HCPCS codes **G0030-G0047 only**: 411.81 414.00-414.03 414.11 414.8

Diagnoses that Support Medical Necessity  $N\!/\!A$ 

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

Diagnoses that DO NOT Support Medical Necessity N/A

### **Reasons for Denials**

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

HCPCS code G0219 Pet Imaging whole body; (full- and partial-ring pet scanners), for non-covered indications is noncovered by Medicare, effective for dates of service on/after 07/01/2001.

### Noncovered ICD-9-CM Codes

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

# Noncovered Diagnoses

# Coding Guidelines N/A

### **Documentation Requirements**

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

### Utilization Guidelines

N/A

# Other Comments

N/A

# Sources of Information and Basis for Decision

#### N/A

### Advisory Committee Notes

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

# Start Date of Comment Period N/A

End Date of Comment Period N/A

# Start Date of Notice Period 02/01/2002
#### **Revision History**

Revision Number: 10 Start Date of Comment Period Start Date of Notice Period PCR B2002-042 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

#### 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 5 for details concerning ABNs.

Revised Effective Date:

### **G0117: Screening Glaucoma Services**

Revision Overview: Original policy.

### Policy Number

G0117

**Contractor Name** First Coast Service Options, Inc.

#### **Contractor Number**

00590

Contractor Type Carrier

LMRP Title Screening Glaucoma Services

#### AMA CPT Copyright Statement

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**CMS National Coverage Policy** Medicare Carriers Manual, Section 4184

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 01/01/2002

Original Policy Ending Date N/A

Revision Effective Date N/A

Revision Ending Date  $N\!/\!A$ 

#### **LMRP** Description

Glaucoma is not a single disease, but a collection of conditions that have in common the tendency to produce a characteristic type of optic nerve damage called cupping. While some glaucomas are acute and associated with symptoms at onset, most glaucoma patients have a chronic disease that slowly develops and does not produce symptoms until the optic nerve damage and visual loss are far advanced. Glaucoma is treated in order to preserve vision. Glaucoma exams on a screening basis are covered annually for eligible Medicare beneficiaries. The glaucoma exam includes: (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit lamp, biomicroscopic examination.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Medicare will consider annual glaucoma screening medically reasonable and necessary for services performed on or after January 1, 2002 for eligible Medicare beneficiaries in the following high risk categories: (1) Individuals with diabetes mellitus, (2) Individuals with a family history of glaucoma, or (3) African-Americans age 50 and over.

Glaucoma screening examinations must be furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

#### CPT/HCPCS Section & Benefit Category

Procedures/Professional Services

#### CPT/HCPCS Codes

G0117 G0118

> Not Otherwise Classified Codes (NOC) N/A

ICD-9-CM Codes that Support Medical Necessity V80.1

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 Denials**

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 Codes

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 must support that the patient has diabetes mellitus, a family history of glaucoma, or is an African-American age 50 and over. In addition, the documentation must support that a dilated eye exam with intraocular pressure measurement; and a direct ophthalmoscopy examination, or a slit lamp, biomicroscopic examination was performed. This information is normally found in the office/progress notes, and test results.

#### Utilization Guidelines

Screening glaucoma services are allowed annually for eligible Medicare beneficiaries.

#### **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.

### J0470: Chelation Therapy

Revision Overview: Annual HCPCS 2002 Update

### **Policy Number**

J0470

#### **Contractor Name** First Coast Service Options, Inc.

**Contractor Number** 

00590

#### **Contractor Type** Carrier

#### LMRP Title

Chelation Therapy

#### AMA CPT Copyright Statement

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#### CMS National Coverage Policy

Coverage Issues Manual, Sections 35-64, 45-20

#### **Primary Geographic Jurisdiction** Florida

**Secondary Geographic Jurisdiction** N/A

**CMS** Region Region IV

**CMS Consortium** Southern

**Original Policy Effective Date** 01/01/1993

**Original Policy Ending Date** N/A

**Revision Effective Date** 01/01/2002

#### Advisory Committee Notes

N/A

Start Date of Comment Period N/A

#### End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

**Revision Number** Original PCR B2002-069 Start Date of Comment Period: N/A Start Date of Notice Period: 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Original Effective Date

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### **Revision Ending Date**

12/31/2001

#### LMRP Description

Chelation therapy is the application of chelation techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body for the treatment of metal intoxication.

Combination therapy with two or more chelating agents, each capable of permeating different target tissue compartments, may prove beneficial.

#### Indications and Limitations of Coverage and/ or Medical Necessity

#### Dimercaprol (BAL) (procedure code J0470):

Chelation therapy is a covered service when performed by a physician provided diagnosis criteria are met for Dimercaprol (J0470).

Dimercaprol (BAL) is a useful antidote in arsenic, mercury, lead, and cadmium poisoning and is most efficient if administered immediately following exposure to the metals. Dimercaprol is administered intramuscularly.

#### Edetate Calcium Disodium (Calcium EDTA) (procedure code J0600):

Chelation therapy is a covered service when performed by a physician provided diagnosis criteria are met for Edetate Calcium Disodium (J0600).

Edetate Calcium Disodium (Calcium EDTA) is a useful antidote in lead poisoning and lead encephalopathy. Calcium EDTA is administered intravenously, subcutaneously or intramuscularly with the intramuscular route preferred.

#### Deferoxamine Mesylate (Desferal) (procedure code J0895):

Chelation therapy is a covered service when performed by a physician provided diagnosis criteria are met for Deferoxamine Mesylate (J0895).

Deferoxamine mesylate (Desferal) is the chelator of choice for iron poisoning. Deferoxamine is most effective when administered intramuscularly or intravenously.

#### CPT/HCPCS Section & Benefit Category

Drugs and Biologicals

CPT/HCPCS Codes

J0470 J0600 J0895

Not Otherwise Classified Codes (NOC) N/A

# ICD-9-CM Codes that Support Medical Necessity

| For procedu | ire code <b>J0470</b> : |       |
|-------------|-------------------------|-------|
| 961.1       | 984.1                   | 985.1 |
| 961.2       | 984.8                   | 985.5 |
| 984.0       | 985.0                   |       |

For procedure code **J0600:** 961.2 984.1 984.0 984.8

For procedure code **J0895:** 285.0 964.0 985.8

Diagnoses that Support Medical Necessity  $N\!/\!A$ 

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

#### **Reasons for Denials**

Endrate Ethylenediamine-Tetra-Acetic Acid (EDTA) (J3520) is a noncovered service for Medicare.

IV Chelation therapy (chemical endarterectomy) (M0300) is a noncovered service for Medicare.

When noncovered chelation therapy (J3520 and M0300) is administered, both the drug and the administration (90780-90799) are noncovered.

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 Codes**

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**

Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour (90780) and each additional hour, up to eight (8) hours (90781) are included in the basic allowance for visits or other procedures performed on the same day by the same physician as the intravenous (IV) infusion therapy. Separate payment for IV infusion therapy is allowed if no other service is rendered by the same physician at the same time as the IV infusion therapy.

Therapeutic or diagnostic injection; subcutaneous or intramuscular (90782) and intravenous (90784) are

included in the basic allowance for visits or other procedures performed on the same day by the same physician as the injection. Separate payment for a subcutaneous, intramuscular or intravenous injection is allowed if no other service is rendered by the same physician at the same time as the injection.

#### **Documentation Requirements**

Medical record documentation must clearly indicate the medical necessity of the services being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the history and physical, office/ progress notes, hospital notes, and/or procedural note.

#### **Utilization Guidelines**

N/A

#### **Other Comments**

#### Terms Defined:

*Chelate*: in toxicology, to use a compound to enclose or grasp a toxic substance and make it nonactive and thus nontoxic.

*Chelating agent*: a drug that is used to chelate, q.v., substances, especially toxic chemicals in the body. *Chelation therapy*: combining of metallic ions with certain heterocyclic ring structures, so that the ion is held by chemical bonds from each of the participating rings. *Metal*: any of the elements that tend to lose electrons and form positive ions in chemical reactions, form bases in combination with hydroxyl groups, and are usually lustrous, malleable, ductile, and good conductors of heat and electricity.

*Ions*: a particle carrying an electric charge, consisting of an atom or group of atoms into which the molecules of an electrolyte are divided or one of the electrified particles into which the molecules of a gas are divided by ultraviolet rays, gamma rays, or X-rays or by other ionizing agents.

*Pharmacokinetics*: study of the metabolism and action of drugs with particular emphasis on the time required for absorption, duration of action, distribution in the body, and method of excretion.

*Antidotes*: a substance that neutralizes poisons or their effects.

*In vivo*: In the living body or organism. A test performed on a living organism.

#### Sources of Information and Basis for Decision

Facts and Comparisons

#### **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 Internal Medicine.

# Start Date of Comment Period N/A

End Date of Comment Period N/A

# Start Date of Notice Period 02/01/2002

02/01/2002

#### **Revision History**

**Revision Number:** 3 Start Date of Comment Period Start Date of Notice Period

PCR B2002-004 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

### J2915: Ferrlecit®

Revision Overview: Original policy.

### **Policy Number**

J2915

**Contractor Name** First Coast Service Options, Inc.

**Contractor Number** 00590

**Contractor Type** Carrier

LMRP Title Ferrlecit®

#### AMA CPT Copyright Statement

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#### CMS National Coverage Policy

Coverage Issues Manual, Section 45-29 Program Memorandum B-01-48 (Change Request 1682, dated June 01, 2001)

#### **Primary Geographic Jurisdiction** Florida

**Secondary Geographic Jurisdiction** N/A

#### **CMS** Region

Region IV

#### **CMS Consortium**

Southern

**Original Policy Effective Date** 03/28/2002

**Original Policy Ending Date** N/A

**Revision Effective Date** N/A

# **Revision Ending Date**

#### **LMRP** Description

Iron deficiency is a common condition in end stage renal disease (ESRD) patients undergoing hemodialysis. Iron is a critical structural component of hemoglobin, a key protein found in normal red blood cells (RBCs) which transport oxygen. Without this important building block, anemic patients experiencing difficulty in restoring adequate, healthy RBCs that improve hematocrit levels. Clinical management of iron deficiency involves treating patients with iron replacement products while they undergo dialysis. Body iron stores can be supplemented with either oral or intravenous (IV) iron products.

#### 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 5 for details concerning ABNs.

The evidence suggests that there is little to distinguish various forms of IV iron therapy in terms of effectiveness. Rather, the medical literature indicates that the mode of intravenous administration is perhaps the most effective treatment for iron deficiency in hemodialysis patients. Unlike oral products which must be absorbed through the gastrointestinal (GI) tract, IV iron products are infused directly into the bloodstream in a form that is readily available to the bone marrow for RBC synthesis, resulting in an earlier correction of iron deficiency and anemia.

Review of medical literature indicates that the distinction among IV iron products lies within their safety profiles. The IV iron dextran products are associated with a small incidence of severe, life-threatening anaphylaxis. These type I hypersensitivity reactions, which are not doserelated, are immunoglobulin (Ig) E-mediated and are apparently exclusively associated with the dextran forms of injectable iron. In fact, clinical evidence indicates that the dextran component itself is what triggers the severe, life-threatening anaphylactic reactions. Ferrlecit® has demonstrated no life-threatening anaphylaxis and a less severe adverse-reaction rate when compared to iron dextran products.

#### Indications and Limitations of Coverage and/or Medical Necessity

Effective for services performed on or after December 1, 2000, Medicare covers sodium ferric gluconate complex in sucrose injection (Ferrlecit®) when used as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy.

According to Drug Facts and Comparisons® (2000), Ferrlecit® is administered by infusion during the dialysis session itself. The recommended dosage for repletion therapy is 10 ml (125 mg of elemental iron) diluted in 100 ml of 0.9% Sodium Chloride for Injection, administered immediately after dilution in a one-hour IV infusion. Most patients will require a minimum cumulative dose of 1.0 gram of elemental iron, administered over eight sessions at sequential dialysis treatments, to achieve favorable hemoglobin or hematocrit response. Patients may continue to require therapy with Ferrlecit® or other iron preparations at the lowest dose necessary to maintain target levels of hemoglobin, hematocrit, and laboratory parameters of iron storage within acceptable limits.

Dosages in excess of iron needs may lead to accumulation of iron in iron storage sites and hemosidrosis. Periodic monitoring of laboratory parameters of iron storage levels may assist in recognition of iron accumulation. Ferrlecit® should not be administered to patients with iron overload. The Ferrlecit® iron complex is not dialyzable.

N/A

#### CPT/HCPCS Section & Benefit Category

Drugs and Biologicals

#### CPT/HCPCS Codes

J2915 Injection, sodium ferric gluconate complex in sucrose injection, 62.5 mg

#### Not Otherwise Classified Codes (NOC)

J3490 Unclassified drugs (for services provided in December 2000)

# ICD-9-CM Codes that Support Medical Necessity

280.0 280.1 280.8 280.9 \*585

\* The billing of Ferrlecit® for renal disease requires a dual diagnosis. ICD-9-CM codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9-CM codes 280.0, 280.1, 280.8, or 280.9) *must* be submitted to ensure reimbursement.

# 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 Denials**

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 Codes

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

#### **Noncovered Diagnoses**

N/A

#### **Coding Guidelines**

For services performed on and after January 1, 2001, bill for the drug utilizing HCPCS J2915.

#### **Documentation Requirements**

Medical record documentation maintained by the performing provider must substantiate the medical necessity for the use of Ferrlecit® by clearly indicating the condition for which this drug is being used. The documentation must support the criteria as set forth in the "Indications and Limitation of Coverage and/or Medical Necessity" section of this policy. The managing physician's target values for hemoglobin, hematocrit, transferrin saturation and/or serum ferritin levels must be recorded. Laboratory results must be maintained. In addition, documentation that the service was performed must be included in the patient's medical record. This documentation is normally found in the history and physical or in the office/facility progress notes.

### Utilization Guidelines N/A

#### Other Comments

Iron deficiency in ESRD patients has been classically defined as:

*Absolute-* transferrin saturation (TSAT) less than 16 percent and/or serum ferritin less than 50ng/mL; or *Relative-* transferrin saturation (TSAT) 16 to 20 percent and/or serum ferritin 50-100 ng/mL.

#### 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 Nephrologists.

Carrier Advisory Committee Meeting held on February 24, 2001.

### Start Date of Comment Period 02/16/2001

# End Date of Comment Period 04/14/2001

### Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:Original PCR B2002-072Start Date of Comment Period:02/16/2001Start Date of Notice Period:02/01/20022nd QTR 2002 Update!

03/28/2002

Original Effective Date

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

# J9219: Leuprolide Acetate Implant (VIADUR™)—New Billing Instructions for Insertion/Removal

A n article regarding the appropriate billing of J9219, Leuprolide Acetate Implant (VIADUR<sup>™</sup>), was published in the Fourth Quarter 2001 *Medicare B Update!* (page 41). VIADUR<sup>™</sup> is a leuprolide acetate-filled implant for the palliative treatment of advanced prostate cancer. It is inserted subcutaneously in the inner aspect of the upper arm. The recommended dose of VIADUR<sup>™</sup> is one implant for a 12-month period. VIADUR<sup>™</sup> must be removed after 12 months of therapy. Once removed, another implant may be inserted to continue therapy.

Since that publication, new *CPT* codes have been developed for the insertion, removal, and removal with reinsertion for non-biodegradable drug delivery implants.

#### Effective for services provided on or after January 1, 2002:

- insertion of the implant should be billed as procedure code 11981 (Insertion, non-biodegradable drug delivery implant)
- removal of the implant should be billed as procedure code 11982 (Removal, non-biodegradable drug delivery implant)
- removal of the implant with reinsertion should be billed as procedure code 11983 (Removal with reinsertion, nonbiodegradable drug delivery implant).

The *drug* should continue to be billed as J9219, and will be reimbursed at 95 percent of the average wholesale price (AWP). Documentation is no longer required on a prepayment basis for the insertion/removal of J9219.

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### J9999: Antineoplastic Drugs—Additions to Policy

The complete local medical review policy (LMRP) for antineoplastic drugs was published in the First Quarter 2002 *Medicare B Update!* (pages 31-36). Three additional drugs, Epirubicin HCl (Ellence<sup>TM</sup>), Gemtuzumab ozogamicin (Mylotarg<sup>TM</sup>) and Alemtuzumab (Campath®) have since been added to this policy.

In addition, for Carboplatin, the following ICD-9-CM codes have been added: 200.00-200.88, 201.00-201.98 and 202.00-202.98.

#### J9180- Epirubicin HCl (Ellence<sup>TM</sup>)

Epirubicin HCl is an anthracycline antineoplastic agent and is approved by the Food and Drug Administration (FDA) for the adjuvant treatment of patients with axillary-node tumor involvement following resection in primary breast cancer.

Florida Medicare will consider Epirubicin HCl medically reasonable and necessary when provided for its FDA approved uses, as well as for the treatment of the following off-labeled indications:

- As a single agent and in combination therapy with other agents for the treatment of locally unresectable and metastatic gastric carcinoma.
- In combination with other agents for the treatment of esophageal and esophagogastric junction carcinomas and adenocarcinomas.
- As a single agent and in combination therapy for the treatment of non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC).
- As a single agent and in combination therapy for the treatment of stage III and stage IV ovarian carcinoma.
- In combination therapy for the treatment of Hodgkin's lymphoma.
- As a single agent and in combination therapy for the treatment of non-Hodgkin's lymphoma.
- As a single agent and in combination therapy for the treatment of soft tissue sarcoma in place of Doxorubicin.
- As a single agent and in combination therapy with other agents, for the treatment of metastatic breast carcinoma.

**J9300-Gemtuzumab ozogamicin (Mylotarg™)** Gemtuzumab ozogamicin is a monoclonal antibody and is used as an antineoplastic. Gemtuzumab ozogamicin is FDA approved for the treatment of patients with CD33 positive acute myeloid leukemia in first relapse who are 60 years of age or older and who are not considered candidates for cytotoxic chemotherapy.

#### J9999- Alemtuzumab (Campath®)

Alemtuzumab is a monoclonal antibody, which causes the lysis of lymphocytes by binding to CD52, a highly expressed antigen that is present on the surface of all B- and T-cell lymphocytes. Alemtuzumab is FDA approved for the treatment of B-cell chronic lymphocytic leukemia (B-CLL) in patients who have been treated with alkylating agents and who have failed fludarabine therapy.

#### **HCPCS** Codes

J9180 Epirubicin HCl (Ellence<sup>™</sup>), 50 mg J9300 Gemtuzumab ozogamicin (Mylotarg<sup>™</sup>), 5 mg

J9999 Alemtuzumab (Campath®)

# ICD-9-CM Codes That Support Medical Necessity

| For procedure code J9180 |             |               |  |
|--------------------------|-------------|---------------|--|
| 150.0-150.9              | 174.0-174.9 | 200.00-200.88 |  |
| 151.0-151.9              | 175.0-175.9 | 201.00-201.98 |  |
| 162.2-162.9              | 183.0-183.9 | 202.00-202.98 |  |
| 171.0-171.9              |             |               |  |

**For procedure code J9300** 205.00-205.01

### For procedure code J9999

204.10-204.11

#### **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.

#### Effective Date

These additions will be effective for services processed on or after March 28, 2002.

#### **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 5 for details concerning ABNs.

### 00001: Independent Diagnostic Testing Facility (IDTF)

The local medical review policy (LMRP) for IDTFs was published in its entirety in the Fourth Quarter 2001 issue of the *Medicare B Update!* Since that publication, the following revisions have been made:

- A recommendation was made to add credentialing criteria for PET Scans. In addition, other codes were added and local physician supervision levels were assigned to services not provided to contractors by the Centers for Medicare & Medicaid Services. These changes are effective March 28, 2002.
- The level of supervision changes, indicated by transmittal 1725 (CR 1756), were effective July 1, 2001.
- All additions and deletions related to the 2002 HCPCS update were effective January 1, 2002.
- The name and credentialing changes were effective August 1, 2001.

The complete revised LMRP is being furnished directly to all Florida IDTFs. In addition, it is available on our provider Web site, **www.floridamedicare.com**. Physicians who are employed by, or provide services in or to an IDTF are encouraged to obtain the complete LMRP from one of these sources.

### Percutaneous Transluminal Angioplasty (PTA) with Carotid Stenting

Medicare covers PTA of the carotid artery concurrent with carotid stent placement, when furnished in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials, effective for services provided on or after July 1, 2001. Prior to January 1, 2002, providers were instructed to bill procedure code 35475 for PTA and procedure code 37205 for the actual stent placement. These services must be billed on Form HCFA-1500 (or electronic equivalent) with procedure code modifier QA and the IDE number assigned by the FDA entered in item 23.

**Effective for services provided on or after January 1, 2002**, placement of the stent should be billed under procedure code 0005T and/or 0006T, in addition to procedure code 0007T. PTA should continue to be billed with procedure code 35474. These services must be billed with modifier QA and the IDE number entered in item 23. Medical record documentation supporting medical necessity of the service must be submitted with the claim.

### 20000: Musculoskeletal System

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 20000

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Musculoskeletal System

#### AMA CPT Copyright Statement

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CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction  $N\!/\!A$ 

CMS Region Region IV

CMS Consortium Southern Original Policy Effective Date 1992

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

Revision Ending Date 12/31/2001

#### **LMRP** Description

Various Musculoskeletal System services and procedures.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare considers procedures to be reasonable and necessary in documented cases of injury or disease of the musculoskeletal system.

#### **CPT/HCPCS Section & Benefit Category**

Surgery/Musculoskeletal System

# **CPT/HCPCS Codes** 20000-29999

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 Denials**

Prolotherapy, joint sclerotherapy, and ligamentous injections with sclerosing agents 20999\* have not been verified by scientifically controlled studies. These therapies are not medically effective and are noncovered under the Medicare program.

Tidal knee irrigation (27599) is considered an investigational procedure and therefore is noncovered.

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

\*Services that are noncovered due to being investigational/experimental.

# Noncovered ICD-9-CM Codes N/A

Noncovered Diagnoses

N/A

#### **Coding Guidelines**

If cast application or strapping (29000-29590) is provided as an *initial* procedure in which no surgery is performed (e.g., casting of a sprained ankle or knee), the appropriate level of an evaluation and management in addition to the supply codes would be appropriate. When cast application or strapping is a *replacement* procedure used during or after the period of follow-up care, additional visits are reported only if significant identifiable services are provided at the time of the cast application or strapping.

# Documentation Requirements N/A

Utilization Guidelines N/A

Other Comments N/A

Sources of Information and Basis for Decision

Advisory Committee Notes N/A

Start Date of Comment Period N/A

End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:1Start Date of Comment PeriodStart Date of Notice Period

PCR B2002-043 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 20974: Osteogenic Stimulation

Revision Overview: An all-inclusive diagnosis list was established for each procedure code listed in the policy.

**Policy Number** 

20974

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Osteogenic Stimulation

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Coverage Issues Manual, Section 35-48

Primary Geographic Jurisdiction Florida Secondary Geographic Jurisdiction N/A

CMS Region Region IV

**CMS** Consortium

Southern

Original Policy Effective Date 1994

Original Policy Ending Date N/A

Revision Effective Date 03/28/2002

Revision Ending Date 03/27/2002

#### **LMRP** Description

Electrical stimulation to augment bone repair can be attained either invasively or noninvasively. Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. The power pack for the latter device is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a selfcontained system with no external components. The power supply for the former device is externally placed and the leads are connected to the inserted cathodes. With the noninvasive device, opposing pads, wired to an external power supply, are placed over the cast. An electromagnetic field is created between the pads at the fracture site.

An ultrasonic osteogenic stimulator is a non-invasive device that emits low intensity, pulsed ultrasound. The ultrasound signal is applied to the skin surface at the fracture location via ultrasound using conductive gel in order to stimulate fracture healing.

#### Indications and Limitations of Coverage and/ or Medical Necessity

#### Noninvasive Stimulator (procedure code 20974):

The noninvasive stimulator device is covered only for the following indications:

- Nonunion of long bone fractures;
- Failed fusion, where a minimum of nine months has elapsed since the last surgery;
- Congenital pseudarthroses; and
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.).

# Invasive (Implantable) Stimulator (procedure code 20975):

The invasive stimulator device is covered only for the following indications:

- Nonunion of long bone fractures; and
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.).

Effective for services performed on or after September 15, 1980, nonunion of long bone fractures, for both noninvasive and invasive devices, is considered to exist only after six or more months have elapsed without healing of the fracture.

Effective for services performed on or after April 1, 2000, nonunion of long bone fractures, for both noninvasive and invasive devices, is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the electrical osteogenic stimulator. Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

### Ultrasonic Osteogenic Stimulators (procedure code 20979):

Effective for services performed on or after January 1, 2001, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of non-union fractures. In demonstrating nonunion of fractures, we would expect:

• A minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator,

separated by a minimum of 90 days. Each radiograph must include views of the fracture site accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

• Indications that the patient failed at least one surgical intervention for the treatment of the fracture.

Non-union fractures of the skull, vertebrae, and those that are tumor-related are excluded from coverage. The ultrasonic stimulator may not be used concurrently with other non-invasive osteogenic devices. The national noncoverage policy related to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place.

#### CPT/HCPCS Section & Benefit Category

Musculoskeletal System/Surgery

#### CPT/HCPCS Codes

20974 20975 20979

# Not Otherwise Classified Codes (NOC) N/A

#### ICD-9-CM Codes that Support Medical Necessity

For procedure code **20974**, the following ICD-9-CM codes apply:

733.81 733.82 996.4 V45.4

For procedure code **20975**, the following ICD-9-CM codes apply: 733.81 733.82

For procedure code **20979**, the following ICD-9-CM code applies: 733.82

# Diagnoses that Support Medical Necessity N/A

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

# Diagnoses that DO NOT Support Medical Necessity

N/A

#### **Reasons for Denials**

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

Ultrasonic osteogenic stimulators used for non-union fractures of the skull, vertebrae, and those that are tumorrelated are excluded from coverage. In addition, national non-coverage related to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place.

#### Noncovered ICD-9-CM Codes

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**

Bill the *CPT* code which describes the services rendered and the ICD-9-CM code which describes the medical condition being treated.

When billing for the Osteogenesis Stimulator, electrical, (surgically implanted), the procedure should be coded as E0749.

The ultrasonic method of osteogenic stimulation is generally performed in the residence of the beneficiary. Therefore, it would be generally expected to see only one electrical or ultrasonic stimulator service billed per beneficiary per episode of injury.

#### **Documentation Requirements**

Documentation must support that this service meets the requirements as listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy. This information is normally found in the office/ progress notes and/or operative report.

#### **Utilization Guidelines**

N/A

Other Comments

N/A

Sources of Information and Basis for Decision N/A

#### **Advisory Committee Notes**

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the

### 44388: Colonoscopy

final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the Orthopedic and Surgical 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 02/01/2002

#### **Revision History**

Revision Number:6P0Start Date of Comment Period02Start Date of Notice Period02

PCR B2002-075 02/16/2001 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 03/28/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

The local medical review policy for colonoscopy was published in the Second Quarter 2001 *Medicare B Update!* (pages 51-53). Since that time, the following diagnoses have been added to the list of ICD-9-CM codes that support medical necessity. This is to allow services initiated as a *screening* colonoscopy but during the course of the exam resulted in a *diagnostic* service.

| V16.0         | Family history of malignant neoplasm, gastrointestinal tract             |
|---------------|--|
| V18.5         | Family history of certain other specific conditions, digestive disorders |
| V76.50-V76.52 | Special screening for malignant neoplasms, intestine                     |

This change is effective for services processed on or after February 11, 2002.

### **53850: Prostate Treatments**

*Revision Overview: A recent evaluation of water-induced thermotherapy was completed resulting in a coverage decision. The information regarding this thermotherapy was added to the policy.* 

Policy Number 53850

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Prostate Treatments

#### AMA CPT Copyright Statement

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# CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida Secondary Geographic Jurisdiction

CMS Region Region IV

#### **CMS Consortium**

Southern

Original Policy Effective Date 06/16/1997

# Original Policy Ending Date N/A

**Revision Effective Date** 03/28/2002

Revision Ending Date 03/27/2002

#### LMRP Description

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

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

Benign prostatic hyperplasia (BPH), the most common benign neoplasm in the aging human male, has a high prevalence that increases progressively with age. The prevalence of histologically identifiable BPH for 60 year old males is greater than 50 percent. By age 85, the prevalence is approximately 90 percent. BPH is fundamentally a disease that causes morbidity through the urinary symptoms with which it is associated. While a minority of men undergo prostatectomy for absolute indications such as recurrent or refractory urinary retention, urinary tract infections, obstructive uropathy or severe hematuria, the majority of men undergo an operation to relieve bothersome urinary symptoms such as frequency, urgency and sensation of incomplete emptying and to improve their quality of life.

For many years prostatectomy, particularly transurethral prostatectomy, has been the standard treatment for symptomatic BPH. More recently, however, a plethora of competing therapies is being used to treat patients with symptomatic BPH. These treatments include transurethral incision of the prostate, laser prostatotomy, balloon dilation, hyperthermia, insertion of prostatic stents, aadrenergic blocking drugs and hormonal therapy. In addition, a "watchful waiting" approach can be followed.

This policy addresses three treatment options for BPH: Transurethral Microwave Thermotherapy (TUMT), Transurethral Radiofrequency Thermotherapy, and Water-induced Thermotherapy (WIT). Thermotherapy for BPH is based on the principle that heating the adenoma (greater than 45°) causes necrosis of obstructing tissue and leads to relief of prostatic obstruction. Transurethral Microwave Thermotherapy provides simultaneous microwave heating of the prostate with temperatures of 45-55 C with some devices also providing concurrent conductive cooling of the urethra. This treatment results in high-power microwave application deep in the lateral lobes, leading to irreversible cell damage of prostatic tissue without damaging the urethra. TUMT effectively maintains temperatures in the urethra sphincter and rectum at physiologically safe temperatures while targeting heat deep within the prostate transition zone.

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

Water-induced Thermotherapy (WIT) for BPH is performed in a single outpatient session without anesthesia and delivers heat conductively, thus sparing the need for rectal or urethral temperature monitoring. This type of thermotherapy uses a closed-loop catheter set which heats and maintains circulating hot water at 60 degrees Celsius. The thermally transmissive treatment balloon is inflated within the prostatic urethra. The remaining portion of the catheter shaft is insulated and remains at temperatures below 40 degrees Celsius. This single 45-minute procedure produces deep necrosis within the prostate tissue. The necrosed tissue either sloughs off or is reabsorbed, providing an adequate pathway for the passage of urine.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare will consider the thermotherapy procedures addressed in this policy medically reasonable and necessary when performed with a FDA approved device approved for this specific indication and the patient meets the following criteria:

- Clinical diagnosis of benign prostatic hyperplasia (BPH); and
- American Urological Association Symptom Score of 11 or greater.

#### **Relative Contraindications**

The following conditions are considered relative contraindications to thermotherapy procedures:

- Active/untreated cystolithiasis, gross hematuria, urethral stricture, bladder neck contracture, active prostatitis, or diabetes mellitus affecting bladder function.
- Active urinary tract infection.
- Neurogenic bladder without obstruction.
- Prostate cancer.
- Prostate gland with an obstructive median lobe.

#### **CPT/HCPCS Section & Benefit Category** Surgery/Urinary System

#### **CPT/HCPCS** Codes

53850

53852 53853

Not Otherwise Classified Codes (NOC) N/A

ICD-9-CM Codes that Support Medical Necessity

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 Denials**

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 Codes

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

### Noncovered Diagnoses

#### **Coding Guidelines**

N/A

#### **Documentation Requirements**

Medical record documentation maintained in the patient's file must document that the patient has a clinical diagnosis of BPH and a AUA symptom score of 11 or greater. In addition, a description of the thermotherapy procedure must be documented. This information is usually found in the office/progress notes, history and physical, and/or procedure note.

#### **Utilization Guidelines**

N/A

#### **Other Comments**

N/A

# Sources of Information 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

### 61793: Stereotactic Radiosurgery

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 61793

#### **Contractor Name**

First Coast Service Options, Inc.

Contractor Number 00590

#### Contractor Type Carrier

LMRP Title Stereotactic Radiosurgery

#### AMA CPT Copyright Statement

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# CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction  $N\!/\!A$ 

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 11/01/1994

Original Policy Ending Date N/A

final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the Florida Urological Society.

Carrier Advisory Committee Meeting held on May 19, 2001.

### Start Date of Comment Period 05/11/2001

End Date of Comment Period 06/25/2001

# Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:6Start Date of Comment PeriodStart Date of Notice Period

PCR B2002-066 05/11/2001 02/01/2002 2<sup>nd</sup> QTR Update! 03/28/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### **Revision Effective Date** 01/01/2002

### **Revision Ending Date**

12/31/2001

#### LMRP Description

Stereotactic radiosurgery is a technique for the noninvasive destruction of intracranial tissues or lesions that may be inaccessible or unsuitable for open surgery. Radiosurgery delivers a highly focused ionizing beam which leaves the tissue surrounding the target nearly unaffected.

There are several types of stereotactic radiosurgery, differing technically in how the radiation is delivered; these are as follows:

- Gamma beam (e.g., Gamma Knife)
- Heavy charged particles (e.g., proton bean and helium ion)
- Linear accelerator (Linac)

The three methods of radiation delivery devices differ technically in the source of radiation, size and shape of the radiation field, and the range of radiation doses.

The radiosurgical procedure is preceded by a process of localizing the target, which can be performed with one or more of the following techniques: skull x-ray, cerebral angiography, computerized tomography, or magnetic resonance imaging.

A maximal dose to be delivered at the target point and doses to the margins of the lesion are determined by the neurosurgeon and radiation oncologist.

The appropriate isodose configuration, total dose, and treatment time are calculated, evaluated, and optimized by the clinical physics staff with the aide of computerization. Patients undergo an application of a stereotactic head frame under local anesthesia. During actual irradiation, the patient's head with the stereotactic frame attached, is placed within a collimator helmet at the chosen target coordinates.

#### Indications and Limitations of Coverage and/ or Medical Necessity

The following are eligible for coverage:

- AVMs (Arteriovenous malformation) 5 cm or less in greatest dimension
- Schwannomas
- Craniopharyngiomas
- Ocular melanomas
- Pineal tumors
- Pituitary adenomas
- Primary brain tumors
- Small solitary metastatic tumors
- Surgical inaccessible meningiomas
- Skull based chordomas and chondrosarcomas
- Recurrent naropharyngeal carcinomas
- Skull based recurrences from head and neck cancer

#### Clinical Indications:

Stereotactic Radiosurgery is performed for the most part under local anesthesia. Patients return to their rooms immediately, bypassing the post-anesthesia recovery room and require no post-operative intensive care.

Stereotactic Radiosurgery provides an alternative to conventional neurosurgery craniotomy in selected patients. All of the equipment has FDA 510K approval.

#### CPT/HCPCS Section & Benefit Category

Surgery/Nervous System

#### **CPT/HCPCS Codes**

61793

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 Denials**

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 Codes N/A

#### **Noncovered Diagnoses**

N/A

#### **Coding Guidelines**

Stereotatic radiosurgery may be billed with a combination of any of the following codes and/or range of codes.

Allowable procedures are all necessary CAT scans, MRIs, and angiographies plus:

Neurosurgeon 20660 20661 61793 76355 76375 Radiation Oncologist 77263 77295 77300 77315 77370 77432 77470

The initial evaluation or consultation is reported separately using an evaluation and management code.

#### **Documentation Requirements**

Medical record documentation (e.g., office/progress notes, procedure notes) 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.

# Utilization Guidelines N/A

**Other Comments** 

N/A

# Sources of Information and Basis for Decision

N/A

#### Advisory Committee Notes

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

### Start Date of Comment Period N/A

End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number: 5 Start Date of Comment Period Start Date of Notice Period PCR B2002-012 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 71250: Computerized Axial Tomography of the Thorax

The local medical review policy for computerized axial tomography of the thorax was published in the June 2001 *Medicare B Update! Special Issue*. ICD-9-CM diagnosis 518.89 (Other diseases of lung, not elsewhere classified) has since been added to the "ICD-9

### 76700: Abdominal Ultrasound

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 76700

#### **Contractor Name** First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type Carrier

LMRP Title Abdominal Ultrasound

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Medicare Carriers Manual, Section 2070 Coverage Issues Manual, Section 50-7

#### Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

### **CMS Consortium**

Southern

Original Policy Effective Date 06/17/1996 Original Policy Ending Date

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

# Revision Ending Date 12/31/2001

#### **LMRP** Description

Abdominal ultrasound is a technique which produces a photograph of the echo produced when sound waves are reflected from the tissues of different density. Abdominal ultrasound can evaluate all of the upper abdominal organs or may also be ordered for a specific organ (e.g., liver) or a specific region of the abdomen.

Procedure code 76700 (ultrasound, abdominal, B-scan and/or real time with image documentation; complete), describes a complete ultrasound examination of the upper abdomen from the diaphragm to the level of the of the umbilicus. It will include grey-scale real-time or static CM Codes that Support Medical Necessity" section of this policy. In addition, the diagnosis for bronchiectasis was changed from 494 to 494.0-494.1.

These changes are effective for claims processed on or after December 17, 2001.

images of the liver, spleen, gallbladder common duct, pancreas, and hollow upper abdominal viscera. The examination will include views of each kidney showing the renal length and renal sinus and evaluate any incidental renal masses. Vessels including the inferior vena cava and upper abdominal aorta and masses in the mesentery or within the peritoneal cavity can also be assessed with this code.

Procedure code 76705 (ultrasound, abdominal, B-scan and/or real time with image documentation; limited (e.g., single organ, quadrant, follow-up), describes an examination which is limited to either a single organ or a limited area of the abdomen such as an examination of the liver only or an examination of the right upper quadrant. This code can also be used for a limited follow-up examination (e.g., of a liver mass or a gallbladder).

#### Indications and Limitations of Coverage and/ or Medical Necessity

An abdominal ultrasound will be eligible for coverage by Florida Medicare when medically reasonable and necessary such as the following conditions:

#### Liver/Gallbladder: to evaluate

- size variations
- thickened wall, indicative of cholecystitis
- benign and malignant lesions, such as polyps
- gallstones
- dilation of ducts
- duct obstruction by calculi or tumor
- hepatic or biliary abscess
- parenchymal disease, such as cirrhosis
- masses, including cysts, solid lesions, and metastatic tumors
- hepatitis patients to rule out hepatoma development
- liver transplant patients to look at the vascularity of the liver and to rule out thrombosis
- follow-up of a hematoma, contusion, or laceration secondary to trauma of the liver
- ascites; follow-up of ascites

Signs and symptoms characteristic of liver and gallbladder disorders may include abdominal or right upper quadrant pain, jaundice, nausea and vomiting, fever, weight loss, anorexia, ascites, and liver enlargement, with or without tenderness.

#### Kidneys: to evaluate

- cysts
- solid masses
- hydronephrosis
- obstruction of ureters
- calculi
- the size, site, and internal structure of the kidneys
- acute renal failure
- perirenal fluid collections which can include abscess, hematomas, urinomas, and lymphocele

- the spread of cancerous conditions from the kidney into the renal vein
- the progression of a renal artery aneurysm
- renal vein thrombosis
- renal arterial flow

Signs and symptoms characteristic of kidney disease may include abdominal, flank or back pain, hypertension, persistent hematuria, persistent protein in the urine, pus in the urine, edema, difficult urination, a sudden or significant increase in creatinine, or an inappropriate decrease in urine volume.

**Pancreas:** to detect abnormalities such as pancreatitis, pseudocyst, cysts and tumors including adenocarcinoma. Signs and symptoms characteristic of disorders of the pancreas can include severe abdominal pain moving to the back, fever, loss of appetite, weight loss, nausea and vomiting, and jaundice.

Aorta and other large abdominal vessels: to evaluate the patient with abdominal pain with a history of an abdominal aortic aneurysm; to look for an increase in size of the aneurysm, especially in those patients who are hypertensive and have borderline aneurysms to enable a surgeon or physician to decide to proceed with surgery; and to determine the presence of thrombi and abdominal blood flow patterns.

#### Spleen and Lymph nodes:

- To determine organ size as with splenomegaly;
- To evaluate for the presence of lymphatic disease, lymph node enlargement, calcifications, infarction, masses or cysts;
- To follow-up on a hematoma, contusion, or laceration secondary to trauma of the spleen.

Additional Structures: to demonstrate suspected appendicitis, mesenteric or ornamental cysts or tumors, and retroperitoneal tumors.

Abdominal ultrasound is indicated for patients who are allergic to contrast agents.

Abdominal ultrasound is contraindicated with patients with an open wound or incision overlying the examination area.

#### **CPT/HCPCS Section & Benefit Category**

Radiology/Diagnostic Ultrasound

#### CPT/HCPCS Codes

76700 76705

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 Denials**

Abdominal ultrasound; complete (76700) and abdominal ultrasound; limited (76705) will not be covered by Florida Medicare if performed for screening purposes.

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 Codes N/A

#### Noncovered Diagnoses N/A

#### **Coding Guidelines**

Reimbursement for procedure code 76705 is included in the basic allowance of procedure code 76700 when billed for the same patient on the same day by the same provider.

For detailed evaluation of the kidneys, aorta, inferior vena cava, and lymph nodes, procedure code 76770 (ultrasound, retroperitoneal (e.g., renal, aorta, nodes), Bscan and/or real time with image documentation; complete) should be used.

For evaluation of the transplanted kidney, procedure code 76778 (ultrasound of transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study) should be used.

#### **Documentation Requirements**

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for the abdominal ultrasound procedure covered by the Medicare program. The procedure results/report must be included in the patient's medical record.

If the provider of the abdominal ultrasound is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of the procedure results/report along with copies of the ordering/ referring physician's order for the procedure.

#### **Utilization Guidelines**

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

### $\begin{array}{c} \text{Other Comments} \\ N\!/\!A \end{array}$

# 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 Urology, Diagnostic Radiology, Nephrology, and Gastroenterology Societies.

# Start Date of Comment Period N/A

# End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revised Effective Date:

Revision Number:2Start Date of Comment PeriodStart Date of Notice Period

PCR B2002-015 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

### 76770: Retroperitoneal Ultrasound

Revision Overview: Annual 2002 HCPCS Update

Policy Number 76770

#### **Contractor Name**

First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Retroperitoneal Ultrasound

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Medicare Carriers Manual, Section 2070 Coverage Issues Manual, Section 50-7

#### Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 06/17/1996

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

# Revision Ending Date 12/31/2001

#### **LMRP** Description

Retroperitoneal ultrasound is a technique which produces a photograph of echo produced when sound waves are reflected from tissues of different density. Retroperitoneal ultrasound can evaluate the aorta, inferior vena cava, retroperitoneal structures and possibly abdominal lymph nodes, and views of the kidneys. Retroperitoneal

#### 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 5 for details concerning ABNs.

ultrasound may also be ordered for a specific organ or region.

Procedure code 76770 (ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete) refers to an examination of the retroperitoneal structures some of which overlap with the abdominal code (76700). A complete retroperitoneal examination would include images of the aorta, inferior vena cava, retroperitoneal structures and retroperitoneal lymph nodes. A retroperitoneal examination could also include a complete examination of the urinary tract which would include the kidneys, ureters, and urinary bladder. When examining retroperitoneal vascular structures, it is appropriate to perform an examination of branches of the structures as well as examining the iliac vessels.

Procedure code 76775 (ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; limited) refers to an examination of one retroperitoneal organ or area or a follow-up examination of a limited area, e.g., the abdominal aorta for aneurysm.

# Indications and Limitations of Coverage and/ or Medical Necessity

A retroperitoneal ultrasound will be eligible by Florida Medicare for coverage when medically reasonable and necessary such as the following conditions:

Kidneys: to evaluate

- cysts
- solid masses
- hydronephrosis
- obstruction of ureters
- calculi
- the size, site, and internal structure of the kidneys
- acute renal failure
- perirenal fluid collections which can include abscess, hematomas, urinomas, and lymphocele
- the spread of cancerous conditions from the kidney into the renal vein
- the progression of a renal artery aneurysm
- renal vein thrombosis
- renal arterial flow

Signs and symptoms characteristic of kidney disease may include abdominal, flank or back pain, hypertension, persistent hematuria, persistent protein in the urine, pus in the urine, edema, difficult urination, a sudden or significant increase in creatinine, or an inappropriate decrease in urine volume. **Pancreas:** to detect abnormalities such as pancreatitis, pseudocyst, cysts and tumors including adenocarcinoma. Signs and symptoms characteristic of disorders of the pancreas can include severe abdominal pain moving to the back, fever, loss of appetite, weight loss, nausea and vomiting, and jaundice.

Aorta and other large abdominal vessels: to evaluate the patient with abdominal pain with a history of an abdominal aortic aneurysms; to look for an increase in size of the aneurysm, especially in those patients who are hypertensive and have borderline aneurysms to enable a surgeon or physician to decide to proceed with surgery; and to determine the presence of thrombi and abdominal blood flow patterns.

#### Lymphatic System:

• To evaluate for the presence of lymphatic disease, lymph node enlargement, calcifications, infarction, masses, or cysts.

Additional Structures: To demonstrate suspected adrenal tumor, mesenteric or omental cysts or tumors, and retroperitoneal tumors.

Retroperitoneal ultrasound is indicated for patients who are allergic to contrast agents.

Retroperitoneal ultrasound is contraindicated with patients with an open wound or incision overlying the examination area.

#### CPT/HCPCS Section & Benefit Category

Radiology/Diagnostic Ultrasound

#### **CPT/HCPCS Codes**

76770 76775

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 Denials**

Retroperitoneal ultrasound; complete (76770) and retroperitoneal ultrasound; limited (76775) will not be covered by Florida Medicare if performed for screening purposes.

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 Codes N/A

Noncovered Diagnoses

#### **Coding Guidelines**

Reimbursement or procedure code 76775 is included in the basic allowance of procedure code 76770 when billed for the same patient on the same day by the same provider.

For evaluation of the transplanted kidney, procedure code 76778 (ultrasound, transplanted kidney, B-scan and/or real time with image documentation, with or without duplex Doppler study) should be used.

#### **Documentation Requirements**

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for the retroperitoneal ultrasound procedure covered by the Medicare program. A report of the ultrasound findings must be included in the patient's medical records.

If the provider of the retroperitoneal ultrasound is other than the ordering/referring physician, the provider of the service must maintain documentation of the ultrasound examination and its interpretation along with copies of the ordering/referring physician's order for the procedure.

#### **Utilization Guidelines**

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

#### **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 Urology, Diagnostic Radiology, Nephrology, and Gastroenterology Societies.

Start Date of Comment Period N/A

End Date of Comment Period N/A

# Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:2PCRStart Date of Comment PeriodN/AStart Date of Notice Period02/02md O2md O

PCR B2002-016 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 77300: Basic Radiation Dosimetry Calculation

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 77300

**Contractor Name** First Coast Service Options, Inc.

# Contractor Number

Contractor Type Carrier

LMRP Title Basic Radiation Dosimetry Calculation

#### AMA CPT Copyright Statement

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# CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 12/18/1995

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

Revision Ending Date 12/31/2001

#### **LMRP** Description

Basic dosimetry is a calculation of the amount of radiation being received at a tumor site and is only performed when requested by the radiation oncologist. This is done either by the radiation oncologist, the medical radiological physicist, or the medical treatment planning dosimetrist under the technical supervision of the radiation oncologist.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare will consider basic radiation dosimetry to be medically necessary for each treatment field (area) if the patient has off-axis calculations, if there are calculations for different depth doses, different target areas, secondary film dosimetry, abutting fields, or any other situation requiring individual point calculations of radiation dosage. Changes in a patient's weight during the course of radiation treatment may necessitate dosimetry recalculation. This procedure is not to be routinely performed each time the patient is treated. It would be expected that utilization of this procedure would correspond with the level of complexity of the clinical treatment planning services provided for the patient.

#### CPT/HCPCS Section & Benefit Category

Radiology/Radiation Oncology

### CPT/HCPCS Codes 77300

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 Denials**

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 Codes N/A

Noncovered Diagnoses

N/A

#### **Coding Guidelines**

Basic dosimetry calculations may be reported as many times as the calculations are performed; however, the calculation of different projections for the same site are considered to be included as one (1) calculation. Example: if the site of treatment will be the prostate but calculations will be done from different directions such as AP, PA and lateral, this is considered one (1) calculation for billing purposes. If different organ sites will be treated such as a primary and metastatic site, additional calculations may then be allowed.

This service can be performed in the following places of service:

- Freestanding Radiation Treatment Center;
- Inpatient Hospital; and
- Outpatient Hospital

#### **Documentation Requirements**

Medical record documentation maintained in the patient's medical record must include the following:

- identification of all body area(s) being treated and requiring dosimetry calculations,
- an explanation for the need for additional calculations,

- the calculation of the radiation dose distribution (i.e., the radiation dosage and length of time to deliver the dose) either by hand calculation or computer, and
- the signature of both the medical radiological physicist and the radiation oncologist on the approved calculations.

### Utilization Guidelines

#### **Other Comments**

N/A

# Sources of Information and Basis for Decision

User's Guide for the Radiation Oncology Related *CPT* Codes; 4th Edition; American College of Radiology

#### **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 Radiology and Radiation Oncology Societies.

# Start Date of Comment Period N/A

# End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:1Start Date of Comment PeriodStart Date of Notice Period

PCR-B2002-005 N/A 02/01/2002 2<sup>nd</sup> QTR Update! 01/01/2002

Revised Effective Date:

#### **Advance Notice Statement**

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 80500: Clinical Pathology Consultations and Clinical Laboratory Interpretation Services

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 80500

**Contractor Name** 

First Coast Service Options, Inc.

Contractor Number 00590

### Contractor Type

Carrier

#### LMRP Title

Clinical Pathology Consultations and Clinical Laboratory Interpretation Services

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Medicare Carriers Manual, Sections 15020D, 15020E, 4142

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 06/16/1997

Original Policy Ending Date N/A

### Revision Effective Date 01/01/2002

Revision Ending Date 12/31/2001

#### **LMRP** Description

A clinical pathology consultation and clinical lab interpretation are services generally rendered by the pathologist to assist the attending physician in planning care for his/her patient.

A clinical pathology consultation results from a request from the attending physician for assistance in interpreting the results of a test (or tests) and advice on the plan of care for the patient in light of the patient's clinical condition. This consultation includes a written report containing the interpretive judgment and clinical recommendations of the pathologist.

A clinical lab interpretation service provides a written interpretation of the result of a specific lab test by the pathologist for a specific patient, at the request of the attending physician. This interpretation includes a written narrative report by the pathologist and may include computer generated findings. Computer generated findings may not, however, substitute for, or be the only information provided, in the interpretation by the pathologist.

#### Indications and Limitations of Coverage and/ or Medical Necessity

### Clinical Pathology Consultations (procedure codes 80500 and 80502)

Clinical consultations are reimbursed by Florida Medicare if all of the following requirements are met:

**1. Medical necessity requirements.** A Clinical Pathology Consultation is considered medically reasonable and necessary when the ordering physician is unsure of the clinical relevance of the result(s) of a complex or infrequently ordered test(s) and requires the medical judgement of a Pathologist to

appropriately apply the data to the management of his/ her patient. The results of the test(s) would generally be reviewed by the ordering physician prior to a consultation being requested to determine the need for further consultation by a pathologist.

2. Are requested specifically by the patient's attending physician. The clinical record/medical documentation must clearly indicate that the attending physician requested a clinical pathology consultation and specifically what test or tests the consultation is to address.

The need for this consultation must also be clear in the patient's record. The ordering of the test itself does not constitute an order for the consultation.

Note: Prior to 01/01/98, standing orders were allowed as a substitute for the individual request by the patient's attending physician to meet this requirement of a clinical consult.

Effective 01/01/98, standing orders may not be used as a substitute for the individual request by the attending physician.

- **3.** Relate to a test result or results that lies outside the clinically significant normal or expected range in view of the condition of the patient. It is not considered medically reasonable and necessary for a consult to be performed on test results that are not outside the clinically significant normal or expected range in view of the condition of the patient. Again, unless the medical reason for the clinical consultation is clearly documented in the clinical record/medical documentation, consultations performed on patients with normal test results will not be considered medically reasonable and necessary.
- 4. Result in a written narrative report included in the patient's record. This may be in the form of a consultative report, a clear notation in the progress notes or a narrative on the lab slip indicating the pathologist performing the service. Routine conversations a laboratory director has with attending physicians about test orders or results are not consultations unless all five requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. These contacts do not constitute clinical consultations. However, if in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is paid under the fee schedule.
- **5.** Require the exercise of medical judgment by the consultant physician/pathologist. Clinical pathology consultations are commonly billed for the following test result(s). In order to determine whether these consultations meet the above coverage requirements including medical necessity requirements, supporting medical documentation may be required. However, we would expect the need for consultative advice on these tests to be infrequent.
- Cardiac Enzymes (82552, 83625)
- Unusual Urine Sediment with exam and report
- Coagulation Profiles (Clotting inhibitors or anticoagulants [85300])

- Minimum Inhibitory Concentrations
- Glucose Tolerance Tests (82951-82952)
- Endocrine Chemistry Battery
- Lipoprotein Electrophoresis (83715, 83716)
- Drug Screens (80100-80101)
- Electrophoretic technique, not elsewhere classified (Alkaline Phosphatase Isoenzymes) [82664]
- Body Fluid Cell counts and differential (89051)
- Ova and Parasites direct smears, concentration and identification (87177)
- Dark field exam, any source, without collection (87166)
- Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multi-antimicrobial, per plate (87186)
- Hemoglobin, fractionation and quantitation; electrophoresis (eg, A2, S, C and/or F) (83020)
- Molecular diagnostics; interpretation and report (83912)
- Protein; electrophoretic fractionation and quantitation (84165)
- Western Blot, with interpretation and report, blood or other body fluid (84181)
- Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each (84182)
- Fibrinolysins; or coagulopathy screen, interpretation and report (85390)
- Platelet; aggregation (in vitro) any agent (85576)
- Fluorescent noninfectious agent antibody; screen, each antibody (86255)
- Fluorescent antibody; titer, each antibody (86256)
- Immunoelectrophoresis; serum (86320)
- Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentration (86325)
- Immunoelectrophoresis; crossed (2 dimensional assay) (86327)
- Immunofixation electrophoresis (86334)
- Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection (87164)
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (eg, malaria, coccidia, microsporidia, cytomegalovirus, herpes viruses) (87207)
- Protein analysis of tissue by Western Blot, with interpretation and report (88371)
- Protein analysis of tissue by Western Blot, with interpretation and report; immunological probe for band identification, each (88372)
- Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine) (89060)

The coverage of Clinical Pathology Consultations for laboratory test(s) not listed above will be determined in a similar fashion. However, we would expect the medical reasonableness and necessity of such consultations to be uncommon.

# Clinical Laboratory Interpretation Service (procedure codes 83020, 83912, 84165, 84181, 84182, 85390, 85576, 86255, 86256, 86320, 86325, 86327, 86334, 87164, 87207, 88371, 88372, 89060)

There are a limited number of clinical laboratory codes that have been identified as needing the pathologist to furnish an interpretation. Therefore, only for the laboratory tests listed above, will the clinical laboratory interpretation service be considered medically necessary. Additionally the following criteria must be met for the clinical laboratory interpretive service to be covered by Florida Medicare:

- Are requested by the patient's attending physician;
- Result in a written narrative report included in the patient's medical record; and
- Require the exercise of medical judgment by the consultant physician.

In addition, the general criteria for physicians' services in the hospital must be met. These are:

- The services are personally furnished for an individual beneficiary by a physician;
- The services contribute to the diagnosis or treatment of an individual beneficiary; and
- The services ordinarily require performance by a physician.

Clinical Interpretative Services do not involve the patient's history or condition of the patient. When clinical interpretative services are performed on these tests, the applicable procedure code with a modifier 26 (professional component) should be billed. It is not appropriate to bill for a clinical pathology consultation (**procedure codes 80500 or 80502**) in addition to the interpretation unless the five requirements for a consultation are met. Finally, although computer generated findings may be included with the interpretation, they cannot serve as the medical judgment of the pathologist. Therefore, the documentation of the interpretation should include a narrative statement from the pathologist.

#### **CPT/HCPCS Section & Benefit Category**

Pathology and Laboratory/Consultations (Clinical Pathology) Pathology and Laboratory/Chemistry Pathology and Laboratory/Hematology and Coagulation Pathology and Laboratory/Immunology Pathology and Laboratory/Microbiology Pathology and Laboratory/Surgical Pathology Pathology and Laboratory/Other Procedures

#### **CPT/HCPCS Codes**

| 80500 | 84181 | 86256 | 87164 |
|-------|-------|-------|-------|
| 80502 | 84182 | 86320 | 87207 |
| 83020 | 85390 | 86325 | 88371 |
| 83912 | 85576 | 86327 | 88372 |
| 84165 | 86255 | 86334 | 89060 |

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 Denials**

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 Codes

N/A

### Noncovered Diagnoses

#### **Coding Guidelines**

We expect the need for more than one Clinical Pathology Consultation per day to be an infrequent occurrence. However, if additional consultations are billed, they must meet all the criteria of medical necessity and reasonableness.

When clinical interpretation services are performed on the tests identified in the HCPCS code section, the applicable procedure code with a modifier 26 should be billed.

#### **Documentation Requirements**

For Clinical Pathology Consultation services, the clinical record/ medical documentation must clearly indicate that the attending physician requested a clinical pathology consultation and specifically what test or tests the consultation is to address. The medical necessity for this consultation must also be clear from documentation in the patient's record. In addition, a copy of the lab test(s) result(s), and the written narrative of the pathologist's findings is required.

For Clinical Laboratory Interpretation Services, the medical documentation must support that one of the eighteen listed procedure codes were ordered. In addition, the patient record must contain the lab results and a written narrative report from the pathologist.

#### Utilization Guidelines N/A

#### Other Comments N/A

# Sources of Information and Basis for Decision

Federal Register, Vol 56, No. 227, November 25, 1991 Federal Register, Vol 62, No. 211, October 31, 1997

#### **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 September 28, 1996.

# Start Date of Comment Period N/A

# End Date of Comment Period N/A

# Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number: 5 Start Date of Comment Period Start Date of Notice Period PCR B2002-034 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 81000: Urinalysis

*Revision Overview:* CMS Change Request 1724 clarifies coding guidelines for diagnostic tests. Therefore, language changes were made to the policy.

Policy Number 81000

**Contractor Name** First Coast Service Options, Inc.

Contractor Number

00590

Contractor Type Carrier LMRP Title Urinalysis

#### AMA CPT Copyright Statement

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CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 11/18/1996

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

### **Revision Ending Date**

12/31/2001

#### **LMRP** Description

Urinalysis is one of the most useful indicators of health and disease, and is especially helpful in the detection of renal or metabolic disorders. It aids in diagnosing and following the course of treatment in diseases of the kidney and urinary system and in detecting disorders in other parts of the body such as metabolic or endocrinologic abnormalities in which the kidneys function normally.

The components of a urinalysis include an evaluation of physical characteristics (color, odor, and opacity); determination of specific gravity and pH; detection and measurement of protein, glucose, and ketone bodies; and examination of sediment for blood cells, casts, and crystals. Some laboratories include screening for leukocyte esterase and nitrate and do not perform a microscopic examination unless one of the chemical screening (macroscopic) tests is abnormal or unless a specific request for microscopic examination is made.

Diagnostic laboratory methods include visual

examination; reagent strip screening; refractometry for specific gravity; and microscopic inspection of centrifuged sediment.

Urinalysis can be performed either by automated instruments or the use of tablets, tapes or dipsticks. Dipsticks are chemically impregnated reagent (reactive) strips that allow for quick determination of pH, protein, glucose, ketones, bilirubin, hemoglobin, nitrate, leukocyte esterase, and urobilinogen. The tip of the dipstick is impregnated with chemicals that react with specific substances in the urine to produce colored end products. Color standards are provided against which the actual color can be compared. The reaction rates of the impregnated chemicals are standard for each dipstick, and color changes must be matched at the correct time after each stick is dipped into the urine specimen.

Normally, the color is straw to dark yellow, specific gravity 1.005-1.035, pH 4.5-8.0, normal urobilinogen, and negative for protein, glucose, ketones, bilirubin, hemoglobin, erythrocytes (RBCs), Nitrite (bacteria), and leukocytes (WBCs).

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare will consider a urinalysis study medically reasonable and necessary for the following conditions:

- Clinical symptomatology which may indicate a urinary system condition such as urgency; frequency; dysuria; flank pain; suprapubic discomfort; hematuria; fever of unknown origin; chills; swelling in the periorbital, abdominal and pedal areas of the body; heavy foaming urine, etc.;
- Physical examination reveals distended bladder with associated symptoms listed above;
- Patients on medications that are nephrotoxic (e.g., aminoglycosides); or
- Evaluation of patient's response to treatment, such as antibiotic therapy for a UTI.

Conditions in which a urinalysis may be medically necessary are not limited to the following: urinary tract infection, glomerulonephritis, kidney stone, interstitial nephritis, nephrotic syndrome, acute renal failure, polynephritis, diabetic neuropathy, polycystic kidney disease, hyperplasia of prostate, rheumatoid arthritis, and renoparenchymal hypertension.

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

### CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Urinalysis

#### CPT/HCPCS Codes

81000 81001 81002 81003

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 Denials**

Urinalysis testing will not be covered by Florida Medicare if performed on a routine or screening basis in the absence of abnormal signs or symptoms, or a medical condition warranting urinalysis testing. Testing performed on a screening basis should be billed with diagnosis V72.6 (special investigations and exam, laboratory)

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 Codes

N/A

#### Noncovered Diagnosis

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 including:

• office/progress notes

laboratory results

If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain 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 numerous societies.

Carrier Advisory Committee Meeting held on July 20,1996.

# Start Date of Comment Period N/A

End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

| Revision Number: 1           | PCR B2001-181 |
|------------------------------|---------------|
| Start Date of Comment Period | d N/A         |
| Start Date of Notice Period  | 02/01/2002    |

N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 82378: Carcinoembryonic Antigen (CEA)

Revision Overview: Added ICD-9-CM code range 150.0-150.9

Policy Number 82378

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Carcinoembryonic Antigen (CEA)

#### AMA CPT Copyright Statement

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CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction  $N\!/\!A$ 

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 06/16/1997

Original Policy Ending Date N/A

Revision Effective Date 01/28/2002

Revision Ending Date 01/27/2002

#### LMRP Description

Carcinoembryonic antigen (CEA) is a glycoprotein that circulates at a high level during fetal life and is detectable in only tiny amounts in the bloodstream of adults. CEA is elevated in certain types of malignancies, and thus is useful as a tumor marker.

In the early 1960's, CEA was thought to be a specific indicator for the presence of colorectal cancer. However, this protein has been found in patients who have other types of carcinomas, sarcomas, and even many benign diseases (e.g., ulcerative colitis, diverticulitis, cirrhosis, rectal polyps, peptic ulcer disease, pancreatitis). Another condition which causes elevated CEA levels is heavy cigarette smoking.

Because the CEA level can be elevated in both benign and malignant diseases, it is not considered to be a specific test for colorectal caner. As a result, CEA is not a reliable screening test for the detection of colorectal cancer. CEA is useful in determining the prognosis and monitoring the patient's response to antineoplastic therapy. The degree of increase in the CEA level on the initial test can be an indicator of tumor burden and prognosis. A drastic reduction to normal CEA levels is expected with a complete eradication of the tumor. Therefore, this test is used to determine the adequacy of treatment.

CEA is useful for the follow-up of certain types of known cancer. If the CEA level begins to rise after treatment, this can be an indication of tumor recurrence. This makes CEA testing valuable in the follow-up of patients who have had potentially curative therapy.

CEA is helpful but not conclusive, and thus of little value, in a diagnostic work-up for cancer because (1) many patients with advanced breast or gastrointestinal tumors may not have elevated CEA levels and (2) many conditions other than cancer may cause elevated CEA levels.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare will consider a CEA test medically reasonable and necessary when performed for the following indications:

- To determine the adequacy of antineoplastic therapy.
- As a serum tumor marker to monitor the status of various kinds of malignant tumors (see the "ICD-9-CM Codes That Support Medical Necessity" Section ).

CEA is not indicated as a screening test for cancer.

#### **CPT/HCPCS** Section & Benefit Category Pathology and Laboratory/Chemistry

### **CPT/HCPCS** Codes

82378

#### Not Otherwise Classified Codes (NOC) N/A

#### ICD-9-CM Codes that Support Medical Necessitv

| 150.0-150.9 | 162.0-162.9 | V10.03 |
|-------------|-------------|--------|
| 151.0-151.9 | 174.0-174.9 | V10.04 |
| 152.0-152.9 | 175.0-175.9 | V10.05 |
| 153.0-153.9 | 197.4       | V10.06 |
| 154.0-154.8 | 197.5       | V10.11 |
| 159.0       | 235.2       | V10.3  |

**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 Denials

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 Codes

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. In addition, the documentation must support that the procedure was performed. This information is usually found in the history and physical, office/progress notes, or lab reports.

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 numerous societies.

#### Start Date of Comment Period N/A

#### End Date of Comment Period N/A

#### Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number 6 Start Date of Comment Period Start Date of Notice Period

PCR B2002-074 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/28/2002

**Revised Effective Date** 

#### **Advance Notice Statement**

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 82746: Folic Acid

Revision Overview: CMS Change Request 1724 clarifies coding guidelines for diagnostic tests. Therefore, language changes were made to the policy.

**Policy Number** 82746

#### **Contractor Name** First Coast Service Options, Inc.

**Contractor Number** 

00590

#### **Contractor Type** Carrier

### LMRP Title

Folic Acid

#### AMA CPT Copyright Statement

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#### CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

**CMS** Region Region IV

#### CMS Consortium Southern

**Original Policy Effective Date** 12/01/1993

#### **Original Policy Ending Date** N/A

**Revision Effective Date** 01/01/2002

#### **Revision Ending Date** 12/31/2001

#### **LMRP** Description

Folic acid is a water-soluble vitamin that is needed for the normal function of red and white blood cells and is required for the production of nucleic acids.

This test is indicated in the differential diagnosis of certain hematologic disorders and in the investigation of folic acid deficiency. Folic acid is a more potent growth promoter than vitamin  $B_{12}$ , although both depend on the normal functioning of intestinal mucosa for their absorption. When folic acid absorption is blocked, the liver and body stores of folic acid are depleted, and blood cell production and maturation are affected. If folic acid is deficient, large red cells are produced with shortened life span and impaired oxygen-carrying capacity. Deficiency of folic acid also causes white cell abnormalities related to altered DNA or RNA synthesis.

Folic acid is found by bacteria in the intestines, stored in the liver, and present in eggs, milk, leafy vegetables,

yeast, and liver. The normal folate level is 3-20 ng/ml. It takes several weeks for folate deficiency to develop. The test is usually done in conjunction with vitamin  $B_{12}$  levels.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare will consider a folic acid study medically reasonable and necessary for the following conditions:

- Hematologic abnormalities such as megaloblastic • anemia, hemolytic anemia, macrocytic anemia, leukopenia or thrombocytopenia;
- Liver disease associated with cirrhosis, alcoholism and hepatoma;
- Diseases causing malabsorption such as sprue, celiac disease, and small bowel disease (e.g., Crohn's disease);
- Patients with chronic renal failure on dialysis;
- Patients with hyperthyroidism; •
- Patients on medications that are folic antagonists including:
  - anticonvulsants,
  - aminopterin and methotrexate used in leukemia treatment, and
  - antimalarials; or
- · Initial diagnostic workup for patients with symptomotology of malaise, weakness and/or mental confusion which may be caused by folic acid/ $B_{12}$ deficiency.

Once an initial diagnosis of folate deficiency is determined, testing should only be performed to monitor folate replacement therapy.

### **CPT/HCPCS** Section & Benefit Category

Pathology and Laboratory/Chemistry

### CPT/HCPCS Codes

82746

Not Otherwise Classified Codes (NOC) N/A

#### **ICD-9-CM Codes that Support Medical** Necessitv

| 242.00-242.91 | 293.1       | 579.0-579.9 |
|---------------|-------------|-------------|
| 266.2         | 555.0-557.9 | 585         |
| 280.0-289.9   | 570         | 780.79      |
| 293.0         | 571.0-571.9 | 995.2       |

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** Necessitv N/A

#### **Reasons for Denials**

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 Codes

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**

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

Vitamin  $B_{12}$  levels are often billed in conjunction with folic acid levels.

#### **Documentation Requirements**

Documentation supporting the medical necessity of this procedure, such as ICD-9-CM codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

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

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

### Utilization Guidelines

N/A

#### Other Comments Terms Defined:

*Folic Acid*: found in liver, yeast, green leaves. Used in treating macrocytic anemia due to folic acid deficiency, hemolysis, celiac syndrome, and sprue. *Macrocytic Anemia*: abnormal numbers of macrocytes (erythrocyte larger than normal) in the blood.

### 84066: Phosphatase, Acid; Prostatic

*Revision Overview:* Change Request 1724 clarifies coding guidelines for diagnostic tests. Therefore, language changes were made to the policy.

Policy Number 84066

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Phosphatase, Acid; Prostatic

#### AMA CPT Copyright Statement

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### CMS National Coverage Policy N/A

*Pernicious Anemia*: severe form of blood disease marked by progressive decrease in red blood corpuscles, muscular weakness, and gastrointestinal and neural disturbances. *Vitamin B*<sub>12</sub>: a red crystalline substance extracted from the liver, essential for the formation of red cells. Its deficiency results in pernicious anemia.

# 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 April 20, 1996.

# Start Date of Comment Period N/A

End Date of Comment Period N/A

# Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:5PCR B2001-181Start Date of Comment PeriodN/AStart Date of Notice Period02/01/20022nd QTR 2002 Update!

01/01/2002

Revised Effective Date:

#### **Advance Notice Statement**

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 12/01/1993

Original Policy Ending Date  $N\!/\!A$ 

Revision Effective Date 01/01/2002

# Revision Ending Date 12/31/2001

#### **LMRP** Description

Acid Phosphatase levels are used to aid in the diagnosis of metastatic cancer of the prostate gland and to follow the effectiveness of treatment. This laboratory procedure is rarely used except to confirm other procedures that are more specific and sensitive, (Prostate Specific Antigen) in diagnosis of Prostatic disease. It is known that elevated levels of acid phosphatase are seen in patients with prostate cancer that has metastasized beyond the capsule to other parts of the body, especially the bone. It is believed that once the carcinoma has spread, the prostate starts to release acid phosphatase, resulting in an increase in the blood level. The prostatic fraction procedure specifically measures the concentration of prostatic acid phosphatase secreted by cells of the prostate gland in contrast to the total enzyme activity, which is an indirect measurement.

#### Indications and Limitations of Coverage and/ or Medical Necessity

The acid phosphatase is indicated to aid in the diagnosis and staging of metastatic cancer of the prostate and to monitor the effectiveness of treatment.

#### CPT/HCPCS Section & Benefit Category

Pathology and Laboratory/Chemistry

#### **CPT/HCPCS** Codes

84066

Not Otherwise Classified Codes (NOC)  $\rm N/A$ 

# ICD-9-CM Codes that Support Medical Necessity

| 185   | 222.2 | 790.93 |
|-------|-------|--------|
| 198.5 | 233.4 | V10.46 |
| 199.0 | 236.5 |        |
| 199.1 | 239.5 |        |

Diagnoses that Support Medical Necessity  $N\!/\!A$ 

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

#### **Reasons for Denials**

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 Codes

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**

V70.0-70.9 (General medical examination) should be used to indicate screening if the test is not performed per the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. A prostate specific antigen, total (84153) and/or an Immunoassay for tumor antigen (86316) often will be drawn in conjunction with an acid phosphatase (84066).

#### **Documentation Requirements**

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

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

# Utilization Guidelines N/A

#### Other Comments Terms Defined:

*Prostate*: a firm partly muscular, partly glandular body that is situated about the base of the male urethra and secretes an alkaline viscid fluid. *Metastases*: transfer of a disease-producing agent from an original site of disease to another part of the body.

# Sources of Information and Basis for Decision

Fischback, F. (1996). A manual of laboratory and diagnostic tests (5<sup>th</sup> ed.). Philadelphia: J.B. Lippincott Company.

#### **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 April 19, 1997.

### Start Date of Comment Period N/A

End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number:3PCR B2001-181Start Date of Comment PeriodN/AStart Date of Notice Period02/01/20022<sup>nd</sup> QTR 2002 Update!

Revised Effective Date:

#### **Advance Notice Statement**

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

01/01/2002

### 86430: Rheumatoid Factor

*Revision Overview: CMS Change Request 1724 clarifies coding guidelines for diagnostic tests. Therefore, language changes were made to the policy.* 

Policy Number 86430

#### Contractor Name

First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

#### LMRP Title

Rheumatoid Factor

#### AMA CPT Copyright Statement

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### CMS National Coverage Policy N/A

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 12/15/1997

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

# Revision Ending Date 12/31/2001

#### **LMRP** Description

The blood of many individuals with rheumatoid arthritis (RA) contains a macroglobulin-type antibody called rheumatoid factor (RF). Evidence indicates that rheumatoid factors are antigammaglobulin antibodies; however, a specific antigen that produces RF has not been discovered. It is believed that a genetically susceptible individual develops abnormal or altered immunoglobulin G (IgG) antibodies when exposed to an antigen. This altered IgG antibody isn't recognized as "self," and the individual forms an antibody against it, known as RF, which is directed against the Fc fragment of IgG. Most rheumatoid factors are the IgM type. Less commonly, rheumatoid factors are the IgG or IgA variety. By aggregating into complexes, RF generates inflammation.

Rheumatoid factor is detected in approximately 40 to 50% of patients with rheumatoid arthritis during the early

stages of the disease. In later stages, a positive rheumatoid factor test is seen in 80 to 90% of cases. Once present, the factor usually persists. However, the presence of rheumatoid factors is not unique to rheumatoid arthritis, and a positive titer for these antibodies should not be used as the sole criterion for the diagnosis of RA. Rather, a positive titer should be used to help confirm RA when the clinical syndrome is present. In most, but not all, nonrheumatic conditions, titers of rheumatoid factor are lower than in rheumatoid arthritis. Thus, the specificity of the rheumatoid factor reaction for rheumatoid arthritis increases with serum titer.

The latex and bentonite tube dilution tests, utilizing human IgG adsorbed to particulate carriers such as latex or bentonite, are less specific but more sensitive than the sensitized sheep cell test using rabbit IgG. In most laboratories, a latex fixation tube dilution titer of 1:160 is considered the lowest positive value favoring a diagnosis of RA. A very high RF titer suggests a worse prognosis and is often associated with progressive disease, nodules, vasculitis, and pulmonary involvement. The titer can be influenced by treatment or spontaneous improvement, and it often falls as inflammatory joint activity decreases.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Rheumatoid factor testing is medically indicated for those patients whose clinical diagnosis is highly suspicious for rheumatoid arthritis and the blood test is needed to help confirm the diagnosis. By helping to differentiate between a diagnosis of rheumatoid arthritis and other diagnoses with similar symptomatology, the outcome of rheumatoid factor testing would affect the patient's treatment. Rheumatoid factor testing would be medically indicated after it has been demonstrated that the clinical examination is unable to distinguish between rheumatoid arthritis and the following conditions:

- Chronic interstitial fibrosis
- Chronic hepatitis disease
- Fibromyalgia
- Infectious mononucleosis
- Polymyositis
- Psoriatic arthritis
- Reiter's Syndrome
- Sarcoidosis
- Scleroderma
- Syphilis
- Systemic lupus erythematosus
- Tuberculosis

#### **CPT/HCPCS Section & Benefit Category**

Pathology and Laboratory/Immunology

#### CPT/HCPCS Codes

86430 86431

Not Otherwise Classified Codes (NOC) N/A

# ICD-9-CM Codes that Support Medical Necessity

| Necessity   |               |               |
|-------------|---------------|---------------|
| 015.0-015.9 | 571.9         | 714.30-714.33 |
| 075         | 695.4         | 714.4         |
| 095.8       | 701.0         | 714.81        |
| 099.3       | 710.0-710.4   | 714.89        |
| 135         | 710.9         | 714.9         |
| 273.2       | 711.10-711.39 | 719.49        |
| 274.0       | 712.10-712.99 | 725           |
| 446.5       | 713.0-713.6   | 729.1         |
| 516.3       | 714.0-714.2   |               |
|             |               |               |

# 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 Denials**

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 Codes

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

### Noncovered Diagnoses

#### **Coding Guidelines**

It would not be expected to see the quantitative test (*CPT* code 86431) billed for patients suspected of having rheumatoid arthritis, in the absence of a positive qualitative test (*CPT* code 86430).

#### **Documentation Requirements**

Medical records maintained by the physician must substantiate the medical necessity for this test by

### 87086: Urine Bacterial Culture

documenting the condition for which the test was ordered, which could be stated in the office/progress notes. The test results must be included in the medical record.

#### **Utilization Guidelines**

N/A

### Other Comments

#### 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 8, 1997.

# Start Date of Comment Period N/A

# End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number: 2 Start Date of Comment Period Start Date of Notice Period PCR B2001-181 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

The local medical review policy for urine bacterial culture was published in the November/December 1999 *Medicare B Update!* (page 35). Since that time, ICD-9-CM diagnosis code 601.1 (chronic prostatitis) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy. This change is effective for services processed on or after January 28, 2002.

### 90800: Psychiatric Services

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 90800

**Contractor Name** First Coast Service Options, Inc.

Contractor Number 00590

Contractor Type Carrier

LMRP Title Psychiatric Services

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Coverage Issues Manual, Section 35-14 Medicare Carriers Manual, Sections 2476.2-2476.5 and 4900.6

#### **Primary Geographic Jurisdiction** Florida

# Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 04/11/1994

Original Policy Ending Date N/A

**Revision Effective Date** 01/01/2002

Revision Ending Date 12/31/2001

#### **LMRP** Description

Psychology is the study of human behavior. The study of human behavior can be accomplished at four levels:

- Observation
- Understanding
- Prediction
- Control

To control behavior it is necessary to understand it. To understand it is to appreciate the nature of the variables that cause behavior. There are two broad sets of variables; individual and environmental.

The goal of therapy is to change the patient's faulty evaluation of future outcomes, either by changing the way environmental information is processed or by training the patient in skills that will allow him or her to expect desired behavioral outcomes, or by doing both.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Family counseling services (90846, 90847, 90849, 90887) are covered *only* where the primary purpose of counseling is for the treatment of the patient's condition.

Two situations where family counseling services would be appropriate are:

- there is a need to observe the patient's interaction with family members, or
- there is a need to assess capability of and assist the family members in aiding in the management of the patient.

Documentation for family counseling services should be maintained on file in the event of a postpayment audit.

Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders (M0064) are not subject to the benefit limitation. However, where a particular treatment rendered to a patient is primarily psychotherapy, it will be subject to the limitation and 908xx series of codes should be used.

Psychological testing (96100) with interpretation and report per hour is a covered service. The hours reported should include administration, scoring, and reporting.

Reimbursement for hypnotherapy (90880) will be limited to the session having the greatest length of time when performed on the same day by the same physician. **CPT/HCPCS Section & Benefit Category** Medicine/Psychiatry

#### **CPT/HCPCS** Codes

90845 90846 90847 90849 90862 90880 90882 90885 90887 90889 96100

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 Denials**

Psychological testing (96100) is not covered for Licensed Clinical Social Workers.

Environmental intervention for medical management purpose on a psychiatric patient's behalf with agencies, employers, or institutions (90882) is a noncovered service.

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

Procedure codes 90885, 90887, and 90889 are bundled services, and, therefore, not separately reimbursable.

### Noncovered ICD-9-CM Codes N/A

#### Noncovered Diagnoses N/A

#### **Coding Guidelines**

Reimbursement for other psychotherapeutic services (90842-90844, 90849) on the same day of service as insulin shock therapy (90899) or convulsive therapy (90870-90871) is made only if it is documented that psychotherapy was rendered prior to insulin shock or convulsive therapy.

Conjoint marital therapy and supervision of treatment team are noncovered services. For services not covered under the psychology or social worker benefit, modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) should be added to the applicable procedure code.

The outpatient psychiatric limitation applies to the physician's therapeutic services, but not to his diagnostic services (except those administered to follow the progress of a course of psychiatric treatment for a diagnosed condition).

Three types of diagnostic services that are exempt from the limitation:

- Psychiatric testing Use of actual testing instruments.
- Psychiatric consultations Evaluation made by a physician for the purpose of preparing a report for the attending physician.
- Initial psychiatric visits Evaluation made by the physician who treats the patient.

Clinical psychologists should use the AH modifier with covered services. Licensed Clinical Social Worker should apply the AJ modifier when filing for covered services.

The approved charges are the lower of the billed amount or the fee schedule amount and are based on an assigned basis.

#### **Documentation Requirements**

Psychological Testing (96100) should only be performed in the following situations:

- Diagnostic puzzle that cannot be answered by other means or a re-examination of patient status in regards to significant aspects of daily living (such as driving). The result of testing will change the treatment plan.
- Documentation should clearly state the questions to be answered, and why they cannot be answered on the basis of clinical interview alone. If the patient has a diagnosis of senile dementia and is incapable of a physical/verbal response or cannot actively participate in the testing, then testing would not be appropriate.

The provider has a responsibility to maintain a record for prepayment audit.

The required documentation for medical necessity should include:

Interpretation and report per hour of psychological testing, including, but not limited to: MMPI, Wechsler Index, Beck Depression Inventory, Bender-Gestalt Test, and Projective Drawings in patients with severe conditions as major depression or schizophrenia.

### Utilization Guidelines

N/A

#### Other Comments Terms defined:

*Alzheimer's Disease*: a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration.

*Hypnotherapy*: psychotherapy that facilitates suggestion, re-education or analysis by means of hypnosis. *Narcosynthesis (Narcoanalysis)*: psychotherapy performed under sedation for the recovery of repressed memories together with the emotion accompanying the experience. The goal is toward reintegration of the patient's personality.

*Psychotherapy*: treatment of mental or emotional disorder or maladjustment by psychological means especially involving verbal communication (as in psychoanalysis, nondirective psychotherapy, re-education, or hypnosis).

#### Sources of Information and Basis for Decision

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

# Advisory Committee Notes N/A

Start Date of Comment Period N/A

End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

| Revision Number:        | 4        | PCR B2  |
|-------------------------|----------|---------|
| Start Date of Commen    | t Period | N/A     |
| Start Date of Notice Pe | eriod    | 02/01/2 |

PCR B2002-049 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 92502: Special Otorhinolaryngologic Services

*Revision Overview: Annual 2002 HCPCS Update* **Policy Number** 92502

**Contractor Name** First Coast Service Options, Inc.

**Contractor Number** 00590

Contractor Type Carrier

LMRP Title Special Otorhinolaryngologic Services

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Coverage Issues Manual, Sections 35-29, 35-67 Medicare Carriers Manual, Section 2070.3 Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

#### CMS Consortium Southern

Original Policy Effective Date 1992

# Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

### **Revision Ending Date** 12/31/2001

12/31/2001

#### **LMRP** Description

Special otorhinolaryngologic services are those diagnostic and treatment services not usually included in a comprehensive otorhinolaryngologic evaluation or office visit.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Vestibular function tests with recording (92541-92547) and audiologic function tests (92552-92557, 92561-92584, 92587-92589), when performed by qualified independently-practicing audiologists (Specialty 64), must be ordered by the attending/referring physician.

Vestibular function tests without electrical recordings (92531-93534) are always bundled into payment for other services not specified.

#### **CPT/HCPCS Section & Benefit Category**

Medicine/Special Otorhinolaryngologic Services

### CPT/HCPCS Codes

92502-92599

Not Otherwise Classified Codes (NOC)  $\rm N/A$ 

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 Denials**

Myofunctional therapy (92599 with the GY modifier) to correct deviate swallowing patterns with resultant ortho and periodontal, lisping problems, facial imbalance, pain and digestive problems is a noncovered service.

Iontophoretic therapy (97799 with the GY modifier) for the treatment of torticollis is a noncovered service.

Therapeutic services performed by privately practicing audiologists on the staff of a clinic which is not physician directed are not covered services under the Medicare Part B program.

Hearing aid examinations (92590-92595) are not covered services under the Medicare Part B program.

Hearing Screening (V5008), Assessment for a hearing aid (V5010), fitting and checking (V5011), Repair (V5020, V5014, V5336), Conformity evaluation (V5020), hearing aid devices (V5030-V5080, V5100, V5120-V5150, V5170-V5190, V5210-V5230), and dispensing fees (V5090, V5110, V5160, V5200, V5240) are not covered services under the Medicare Part B program.

Oxygen treatment of inner ear/carbon therapy (69949\*) is noncovered. Oxygen (95 percent) and carbon dioxide (5 percent) inhalation therapy for inner ear disease, such as, endolymphatic hydrops and fluctuant hearing loss are not reasonable and necessary.

Ear protector attenuation measurement (92596) is a noncovered service.

Screening test, pure tone, air only (92551), audiometric testing of groups (92559), and bekesy audiometry screening (92560) are not covered under the Medicare Part B program.

\* Services that are noncovered due to being investigational/experimental.

### Noncovered ICD-9-CM Codes

Noncovered Diagnoses N/A

### $\begin{array}{c} \textbf{Coding Guidelines} \\ N\!/\!A \end{array}$

#### **Documentation Requirements**

Office records must contain sufficient information to show medical necessity for the test as well as documentation of the test results and/or evaluation or modification procedure.

# Utilization Guidelines N/A

#### **Other Comments**

As noted in the *CPT*, the audiometric tests listed in this section imply the use of calibrated electronic equipment. Descriptors refer to testing both ears, unless specifically noted otherwise.

# 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 02/01/2002

#### **Revision History**

| Revision Number:         | 9      | PCR B2002-044                    |
|--------------------------|--------|----------------------------------|
| Start Date of Comment    | Period | N/A                              |
| Start Date of Notice Per | iod    | 02/01/2002                       |
|                          |        | 2 <sup>nd</sup> QTR 2002 Update! |
|                          |        |                                  |

01/01/2002

Revised Effective Date:

### Advance Notice Statement

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

### 93600: Intracardiac Electrophysiological Procedures

Revision Overview: Annual 2002 HCPCS Update

Policy Number 93600

**Contractor Name** First Coast Service Options, Inc.

### Contractor Number 00590

Contractor Type

Carrier

#### LMRP Title

Intracardiac Electrophysiological Procedures

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Coverage Issues Manual, Sections 35-75, 35-78, and 50-3 Medicare Carriers Manual, Section 2070

#### Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction  $N\!/\!A$ 

CMS Region Region IV

#### CMS Consortium Southern

Original Policy Effective Date 09/16/1996

Original Policy Ending Date N/A

# Revision Effective Date 01/01/2002

Revision Ending Date 12/31/2001

#### **LMRP** Description

Intracardiac electrophysiologic studies involve the placement of multiple catheter electrodes into the heart chambers for the diagnosis and management of selected cardiac conditions.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Intracardiac electrophysiological studies are covered for certain conditions.

#### CPT/HCPCS Section & Benefit Category

Medicine/Cardiovascular

#### CPT/HCPCS Codes

| 93600 | 93602 | 93603 |
|-------|-------|-------|
| 93609 | 93610 | 93612 |
| 93618 |       |       |

Not Otherwise Classified Codes (NOC)  $\rm N/A$ 

#### **ICD-9-CM Codes that Support Medical**

| Necessity     |               |        |
|---------------|---------------|--------|
| 426.0         | 426.9         | 427.69 |
| 426.10-426.13 | 427.0         | 427.81 |
| 426.2         | 427.1         | 427.89 |
| 426.3         | 427.2         | 427.9  |
| 426.4         | 427.31-427.32 | 746.9  |
| 426.50-426.54 | 427.41-427.42 | 780.2  |
| 426.6         | 427.5         |        |
| 426.7         | 427.61        |        |
|               |               |        |

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 Denials**

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 Codes

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**

The provider has responsibility for ensuring medical necessity for this procedure and must maintain documentation (including the procedural report, history and physical) which might be required for postpayment review.

### Utilization Guidelines N/A

WH Other Comp

#### Other Comments Intracardiac electrophysiologic studies involve the

placement of multiple catheter electrodes into the heart chambers for the diagnosis and management of selected cardiac conditions. These procedures have been used for the following purposes:

- to characterize the electrophysiologic properties of the heart;
- to identify the mechanisms, site, and severity of bradycardias or tachycardias;
- to uncover latent arrhythmias whose intermittent nature causes diagnostic problems; and
- to evaluate the benefits or adverse effects of different therapeutic approaches.

There are three general categories of intracardiac electrophysiologic studies; each entails the use of both endocardial electrical stimulation and electrocardiographic recordings. The first consists of programmed stimulation techniques used to assess the function of the sinoatrial (SA) node and the atrioventricular (AV) conduction system. In the second category, there are programmed stimulation techniques to induce and terminate supraventricular and ventricular arrhythmias. The third category is comprised of mapping techniques to determine tachycardia pathways.

#### Sources of Information and Basis for Decision

TEC Manual

#### **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 02/01/2002

#### **Revision History**

Revision Number: 2 Start Date of Comment Period Start Date of Notice Period PCR B2002-007 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 93619: Intracardiac Electrophysiological Evaluation—Correction to Article

The local medical review policy for Intracardiac Electrophysiological Evaluation was published in the Second Quarter 2001 *Medicare B Update!* (pages 92-93). In the list of ICD-9-CM codes that support medical necessity on page 92, it was not made clear that ICD-9-CM codes 996.04 and V45.02 are payable *only* for *CPT* code 93642. These diagnosis codes are *not* payable for procedure codes 93640 or 93641. Florida Medicare apologizes for any inconvenience this may have caused.

### 93975: Duplex Scanning

Revision Overview: Additional diagnoses were added to reflect the signs/symptoms associated with the covered indications.

Policy Number 93975

#### Contractor Name

First Coast Service Options, Inc.

Contractor Number 00590

#### Contractor Type Carrier

LMRP Title

Duplex Scanning

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Coverage Issues Manual, Section 50-7

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction  $N\!/\!A$ 

CMS Region Region IV

CMS Consortium Southern

Original Policy Effective Date 09/01/1992

Original Policy Ending Date N/A

Revision Effective Date 01/28/2002

Revision Ending Date 01/27/2002

#### LMRP Description

Duplex scanning describes an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

#### Indications and Limitations of Coverage and/ or Medical Necessity

#### Arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs (procedure codes 93975 and 93976)

Florida Medicare may provide coverage for duplex scanning of arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs when performed for the following indications:

- To evaluate patients presenting with signs or symptoms such as epigastric or periumbilical postprandial pains that last for 1-3 hours and/or with associated weight loss resulting from decreased oral intake which may indicate chronic intestinal ischemia.
- To evaluate patients presenting with an acute onset of crampy or steady epigastric and periumbilical abdominal pain combined with minimal or no findings on abdominal examination and a high leukocyte count to rule out acute intestinal ischemia.
- To evaluate a patient who has sustained trauma to the abdominal, pelvic and/or retroperitoneal area resulting in a possible injury to the arterial inflow and/or venous outflow of the abdominal, pelvic and/or retroperitoneal organs.
- To evaluate a suspicion of an aneurysm of the renal artery or other visceral artery based on a patients signs and symptoms of abdominal pain or noted as an incidental finding on another radiological examination.
- To evaluate a hypertensive patient who has failed first line antihypertensive drug therapy in order to rule out renovascular disease such as renal artery stenosis, renal arteriovenous fistula, or renal aneurysm as a cause for the uncontrolled hypertension.
- To evaluate a patient with signs and symptoms of portal hypertension. These may include abdominal

discomfort and distention, abdominal collaterals (caput medusae), abdominal bruit, ascites, encephalopathy, esophageal varices, splenomegaly, etc.

• To evaluate patients suspected of an embolism, thrombosis, hemorrhage or infarction of the portal vein, renal vein and/or renal artery. These patients may present with many different symptoms such as abdominal discomfort, hematuria, cardiac failure, diastolic hypertension, jaundice, fatigue, weakness, malaise, etc.

#### Aorta, inferior vena cava, iliac vasculature, or bypass grafts (procedure codes 93978 and 93979)

Florida Medicare may provide coverage for duplex scanning of aorta, inferior venacava, iliac vasculature, or bypass grafts when performed for the following indications:

- To confirm a suspicion of an abdominal or iliac aneurysm raised by a physical examination or noted as an incidental finding on another radiological examination. The physical examination usually reveals a palpable, pulsatile and nontender abdominal mass.
- To monitor the progression of an abdominal aortic aneurysm. It is usually expected that monitoring occurs approximately every six (6) months.
- To evaluate patients presenting with signs and symptoms of a thoracic aneurysm. The symptoms usually associated with a thoracic aneurysm are substernal chest pain, back or neck pain described as deep and aching or throbbing as well as symptoms due to pressure on the trachea (dyspnea, stridor, a brassy cough), the esophagus (dysphagia), the laryngeal nerve (hoarseness), or superior vena cava (edema in necks and arms, distended neck veins).
- To evaluate patients presenting with signs and symptoms of an abdominal aneurysm. The symptoms usually associated with an abdominal aneurysm are constant pain located in the midabdomen, lumbar region or pelvis which can be severe and may be described as having a boring quality. A leaking aneurysm is characterized by lower back pain, whereas, acute pain and hypotension usually occur with rupture.
- To evaluate a patient presenting with signs and symptoms suggestive of an aortic dissection. A patient with an aortic dissection has symptoms such as a sudden onset of severe, continuous tearing or crushing pain in the chest that radiates to the back and is generally unaccompanied by EKG evidence of a myocardial infarction. On physical examination, the patient is agitated, has a murmur of aortic regurgitation, asymmetric diminution of arterial pulses and systolic bruits over the areas where the aortic lumen is narrowed.
- Initial evaluation of a patient presenting with signs and symptoms such as intermittent claudication in the calf muscles, thighs and/or buttocks, rest pain, weakness in legs or feeling of tiredness in the buttocks, etc. which may suggest occlusive disease of the aorta and iliac arteries. The physical examination usually reveals decreased or absent femoral pulses, a bruit over the narrowed artery, and possibly muscle atrophy. If severe occlusive disease exists, the patient will have atrophic changes of the skin, thick nails, coolness of the skin with pallor and cyanosis.
- To evaluate patients suspected of an abdominal or thoracic arterial embolism or thrombosis. These patients usually present with severe pain in one or both

lower extremities, numbness, and symmetric weakness of the legs, with absent or severely reduced pulses below the embolism site.

- To evaluate patients presenting with complaints of pain in the calf or thigh, slight swelling in the involved leg, tenderness of the iliac vein, etc. which may suggest phlebitis or thrombophlebitis of the iliac vein or inferior vena cava.
- To evaluate a patient who has sustained trauma to the chest wall and/or abdomen resulting in a possible injury to the aorta, inferior vena cava and/or iliac vasculature.
- To assess the continued patency of both native venous and prosthetic arterial grafts following surgical intervention. Usually this is performed at 6 weeks, 3 months, then every six (6) months.
- To monitor the sites of various percutaneous interventions, including, but not limited to angioplasty, thrombolysis/thrombectomy, atherectomy, or stent placement. Usually this is performed at 6 weeks, 3 months, then every six (6) months.

**Note**: Duplex testing should be reserved for specific indications for which the precise anatomic information obtained by this technique is likely to be useful. Therefore, it would be rare to see duplex scanning being performed for conditions in which another diagnostic test is recommended (e.g., an aortic dissection is better diagnosed with a chest X-ray, transesophageal echocardiogram or aortography)

### CPT/HCPCS Section & Benefit Category

Non-invasive Vascular Diagnostic Studies/Medicine

#### CPT/HCPCS Codes

93975 93976 93978 93979

# Not Otherwise Classified Codes (NOC) N/A

# ICD-9-CM Codes that Support Medical Necessity

Arterial inflow and venous outflow of abdominal, pelvic, and/or retroperitoneal organs (procedure codes 93975 and 93976)

| 939/5 and 939/0) |               |               |
|------------------|---------------|---------------|
| 288.8            | 572.3         | 789.2         |
| 401.9            | 593.81        | 789.30-789.39 |
| 440.1            | 593.89        | 789.5         |
| 442.1            | 599.7         | 793.6         |
| 442.84           | 780.79        | 902.20-902.27 |
| 452              | 782.4         | 902.31-902.39 |
| 453.3            | 783.21        | 902.41        |
| 456.0-456.21     | 785.9         | 902.42        |
| 557.0            | 789.00-789.09 | 902.87        |
| 557.1            | 789.1         | 902.9         |
|                  |               |               |

### Aorta, inferior vena cava, iliac vasculature, or bypass grafts (procedure codes 93978 and 93979)

| grans (procedure could session und session) |        |               |  |  |
|---|--------|---------------|--|--|
| 424.1                                       | 458.9  | 786.1         |  |  |
| 440.21-440.24                               | 723.1  | 786.2         |  |  |
| 441.00-441.03                               | 724.1  | 786.50        |  |  |
| 441.2                                       | 724.2  | 789.00-789.09 |  |  |
| 441.4                                       | 729.5  | 789.30-789.39 |  |  |
| 441.7                                       | 782.0  | 793.6         |  |  |
| 441.9                                       | 782.3  | 902.0         |  |  |
| 442.2                                       | 782.5  | 902.10        |  |  |
| 443.9                                       | 782.61 | 902.53        |  |  |
| 444.0                                       | 782.8  | 902.54        |  |  |
| 444.1                                       | 784.49 | V67.00        |  |  |
| 444.81                                      | 784.5  | V67.09        |  |  |
| 451.81                                      | 785.9  | V67.59        |  |  |
| 453.2                                       | 786.05 |               |  |  |

# 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 Denials**

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 Codes

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

### Noncovered Diagnoses

#### **Coding Guidelines**

Reimbursement for non-invasive vascular diagnostic studies include the following:

- patient care required to perform the studies;
- supervision of the studies;
- interpretation of study results with hard copy output for patient records; and

• bidirectional vascular flow or imaging when provided. The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported.

#### **Documentation Requirements**

Medical record documentation maintained by the ordering physician must clearly indicate the medical necessity of the services being billed. The results of the study must also be included in the patient's medical record. This information is normally found in the office/ progress notes, hospital notes, and/or test results.

If the provider of the duplex scan study(ies) is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies.

### Utilization Guidelines

N/A

#### Other Comments Terms defined:

*Aneurysm* - localized abnormal dilatation of a blood vessel, usually an artery.

*Arteriosclerosis* - generic term for processes causing hardening and thickening of arteries. Arteriosclerosis is the thickening and narrowing of small arteries and arterioles that develops in hypertension, diabetes, and amyloidosis. *Atherosclerosis* - is a disease of the elastic arteries, including the aorta and iliac arteries, and large and mediumsized muscular arteries, including the coronary, carotid, intracerebral and femoropopliteal arteries.

*Aortic dissection* - caused by a forceful penetration of blood between the layers of the vessel, characteristically separating the outer third from the inner two-thirds of the media. *Embolism* - obstruction of a blood vessel by foreign

substances or a blood clot.

*Fusiform aneurysm* - affects the entire circumference of a segment of the vessel, resulting in a diffusely dilated lesion. *Intermittent claudication* - an aching sensation that occurs reproducibly on walking and then resolves promptly (within 10 minutes) of rest.

*Peripheral vascular disease (PVD)-* an imprecise term indicating diseases of the arteries and veins of the extremities, especially those conditions that interfere with adequate flow of blood to or from the extremities, such as atherosclerosis with narrowing of the arterial lumen. *Phlebitis* - inflammation of a vein.

*Portal hypertension* - increases pressure in the portal vein as a result of obstruction of the flow of blood through the liver. *Saccular aneurysm* - involves only a portion of the circumference, resulting in an outpouching of the vessel wall. *Thrombophlebitis*- inflammation of a vein in conjunction with the formation of a thrombus.

*Thrombosis*- the formation, development, or existence of a blood clot that obstructs a blood vessel or a cavity of the heart.

# 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.

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

# Start Date of Comment Period N/A

# End Date of Comment Period N/A

Start Date of Notice Period 02/01/2002

#### **Revision History**

Revision Number: 10 Start Date of Comment Period Start Date of Notice Period

PCR B2002-064 N/A 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 01/28/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.
### 93990: Duplex Scan of Hemodialysis Access

Revision Overview: CMS Transmittal AB-01-189 was released September 15, 2001. Policy was revised for clarification. **Policy Number** 93990 with end stage renal disease (ESRD). These procedures are medically necessary only in the presence of signs and

Contractor Name First Coast Service Options, Inc. Contractor Number

00590

#### **Contractor Type**

Carrier

**LMRP Title** Duplex Scan of Hemodialysis Access

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Provider Reimbursement Manual, Section 2710 Program Memorandum AB-01-189 (Change Request 1855, dated December 20, 2001)

Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction  $N\!/\!A$ 

CMS Region Region IV

#### CMS Consortium Southern

Original Policy Effective Date 10/20/1997

Original Policy Ending Date N/A

Revision Effective Date 01/01/2002

Revision Ending Date 12/31/2001

#### **LMRP** Description

Duplex scanning is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging. This technique allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Evaluation of endogenous arteriovenous fistulae and synthetic polytetrafluoroethylene (PTFE) grafts, which are the two principal means of creating permanent vascular access for hemodialysis, can be achieved by duplex scanning.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Limited coverage has been established for diagnostic duplex scanning of hemodialysis access sites in patients September 15, 2001. Policy was revised for clarification. with end stage renal disease (ESRD). These procedures are medically necessary only in the presence of signs and symptoms of possible failure of the access site, and when the results of the procedures will permit medical intervention to address the problem. However, other diagnostic vascular services, such as venography, would be considered duplicative services and would not be covered by Medicare.

Appropriate indications for duplex scan of hemodialyis access site would include clear documentation in the dialysis record of signs of chronic (i.e., 3 successive dialysis sessions) abnormal function, including:

#### 1. Clinical Indicators

- difficult canulation by multiple personnel;
- thrombus aspiration by multiple personnel;
- prolonged bleeding after needle withdrawal;
- pain in graft arm;
- persistent swelling in graft arm;
- elevated dynamic venous pressure greater than 200 mm Hg when measured during dialysis with the blood pump set on a 200 cc/min;
- access recirculation time of 12 % or greater;
- an otherwise unexplained urea reduction ratio of less than 60%; or
- shunt collapse, suggesting poor arterial flow.

#### 2. Physical Findings by Examination of Graft

- bruit is discontinuous, systolic only, harsh, high pitched;
- thrill is at stenotic sites, possibly multiple, discontinuous, systolic only; and/or
- an access with a palpable "water hammer" pulse on examination, (which implies venous outflow obstruction).

#### CPT/HCPCS Section & Benefit Category

Medicine /Non-invasive Vascular Diagnostic Studies

CPT/HCPCS Codes 93990

Not Otherwise Classified Codes (NOC) N/A

# ICD-9-CM Codes that Support Medical Necessity

996.73

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 Denials**

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

### LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

#### Noncovered ICD-9-CM Codes

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

# Noncovered Diagnoses

#### **Coding Guidelines**

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be a part of the physical examination of the vascular system and is not separately reported.

Doppler flow studies being used to monitor the hemodialysis access site are not covered as separately billable services. The professional component of these monitoring studies is included in the monthly capitation payment or other evaluation and management visits delivered to the patient. The technical component of monitoring procedures is included in the ESRD facility's composite payment rate.

Billing for monitoring of hemodialysis access using *CPT* codes for non-invasive vascular studies other than 93990 (e.g., 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971) is considered a misrepresentation of the service actually provided.

#### **Documentation Requirements**

Medical record documentation maintained by the physician must clearly indicate the medical necessity of the services being billed. The documentation must also indicates that the service was performed. This information is normally included in the office/progress notes, facility/ hospital records, and/or procedure report.

#### **Utilization Guidelines**

Unless the documentation is provided supporting the necessity of more than one study, Medicare will limit payment to either a Doppler flow study or an arteriogram (fistulogram or venogram) but not both.

#### **Other Comments**

Medicare pays for outpatient maintenance dialysis services furnished by ESRD facilities based on a composite payment rate. This rate is a comprehensive payment and includes all services, equipment, supplies, and certain laboratory tests and drugs that are necessary to furnish a dialysis treatment.

ESRD facilities are responsible as part of the dialysis treatment to monitor access. A number of ESRD facilities are monitoring hemodialysis access through flow studies. All such procedures are covered under the composite rate.

# 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 societies.

# Start Date of Comment Period N/A

# End Date of Comment Period N/A

# Start Date of Notice Period 02/01/2002

#### **Revision History**

| Revision Number:          | 2      | PCR B2002-067                    |
|---------------------------|--------|----------------------------------|
| Start Date of Comment I   | Period | N/A                              |
| Start Date of Notice Peri | iod    | 02/01/2002                       |
|                           |        | 2 <sup>nd</sup> OTR 2002 Update! |

01/01/2002

Revised Effective Date:

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

### 97010: Physical Medicine and Rehabilitation

Revision Overview: The original policy, 97010 was deleted due to extensive revisions. In addition, policies 97530 and 97535 were deleted and incorporated into this policy. This policy was revised to further define the physical therapy modalities and to ensure consistency with the Part A policy. Revisions included instructions for billing electrostimulation for treatment of wounds; clarification of the treatment plan language, and verbiage regarding optometrists was added in relation to referring patients and performing evaluations.

Policy Number 97010

#### **Contractor Name** First Coast Service Options, Inc.

Contractor Number

#### Contractor Type Carrier

Carrier

### LMRP Title

Physical Medicine and Rehabilitation

#### AMA CPT Copyright Statement

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#### **CMS National Coverage Policy**

Coverage Issues Manual, Sections 35-2, 35-3, 35-20, 35-41, 35-56, 35-72, 35-77, 35-98, 60-24 & 65-9 Medicare Carriers Manual, Sections 2050-2050.1, 2200, 2206.1, 2210, 2215, 2217, 2218 & 4161 Program Memorandum B-99-44, CR #746, December 1999 Program Memorandum AB-99-101, CR #1086 Program Memorandum AB-00-53, CR #577, June 2000 Program Memorandum AB-00-120, CR #1419, December 2000

#### Primary Geographic Jurisdiction Florida

Secondary Geographic Jurisdiction N/A

CMS Region Region IV

CMS Consortium Southern

Policy Effective Date 06/1993

Original Policy Ending Date N/A

Revision Effective Date 03/28/2002

**Revision Ending Effective Date** 03/27/2002

# Policy Ending Date N/A

#### **LMRP** Description

Physical Medicine and Rehabilitative (PM & R) services are those services designed to improve or restore physical functioning following disease, injury, or loss of a body part. These services utilize the therapeutic properties of exercise, heat, cold, electricity, ultraviolet, ultrasound, hydrotherapy, massage, and manual therapy to improve circulation, strengthen muscles, maintain or restore motion, and train or retrain an individual to perform the activities of daily living.

#### Indications and Limitations of Coverage and/ or Medical Necessity

Florida Medicare covers physical medicine and rehabilitation services when performed by a physician or by an incident-to employee of the physician in the physician's office or the beneficiary's home. The services must be provided by, or under the direct supervision of a physician. The patient must be under the care of a physician for a condition that is medically necessary, reasonable, and appropriate for physical therapy treatment. The services must be of a level of complexity that requires that they be performed by or under the direct supervision of the physician.

Florida Medicare covers physical medicine and rehabilitation services when performed by a physical therapist in private practice. The service may be provided in the beneficiary's home or the office of a physical therapist in private practice. The patient must be under the care of a physician for a condition that is medically necessary, reasonable, and appropriate for physical therapy treatment. The beneficiary's medical record, maintained by the physical therapist in private practice must indicate that the physician has seen the patient at least every thirty (30) days. The services provided must be of a level of complexity that requires that they be performed by a physical therapist in private practice.

Services which do not require a physician, physician supervision or a physical therapist in private practice to perform are not considered reasonable and necessary and therefore, not covered. Services normally considered to be a routine part of nursing care are not covered as

physical therapy (e.g., turning patients to prevent pressure injuries or walking a patient in the hallway postoperatively). The physical therapy services provided to the beneficiary must be restorative or for the purpose of designing and teaching a maintenance program required in connection with a specific disease state. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. If the patient's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, the physical therapy would not be considered reasonable and necessary.

Effective January 1, 2000, optometrists may refer patients for therapy services as well as establish and review the plan of treatment. The plan of treatment established and/ or reviewed by an optometrist must relate to disease conditions that are treated by an optometrist.

The referring physician or optometrist must document an adequate assessment of the patient that will provide justification for the physical therapy (the physician or optometrist has evaluated the patient and has determined that a medical need and rehabilitation potential exists). The assessment must occur prior to the initiation of the referral process or the therapy.

Covered physical therapy services must relate directly and specifically to an active written treatment regimen established by the physician, optometrist, or physical therapist in private practice. This plan must be reasonable and necessary for the treatment of the individual's illness or injury. Additionally, in order for the plan of treatment to be covered, it must address a condition for which physical therapy is an accepted method of treatment as defined by standards of medical practice. It must also outline a condition that is expected to improve significantly within a reasonable and generally predictable period of time or establishes a safe and effective maintenance program. The plan of treatment must address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency and duration.

#### Specific Procedure and Modality Guidelines Hot or Cold Modality (97010):

Hot or cold packs are used primarily in conjunction with therapeutic procedures to provide analgesia, relieve muscle spasm, and reduce inflammation and edema. Typically, cold packs are used for acute, painful conditions, and hot packs for subacute or chronic painful conditions.

As of 1/1/97, payment for the application of Hot or Cold Packs is bundled into the payment for other services not specified. The payment for the hot or cold packs is not separately reimbursable.

#### Traction/Mechanical Modality (97012):

Traction is generally used for joints, especially of the lumbar or cervical spine, with the expectation of relieving pain in or originating from those areas, or increasing the range of motion of the joint. Specific indications for the use of Mechanical Traction include, but are not limited to, neck and back disorders such as disc herniation, lumbago, cervicalgia, sciatica, cervical and lumbar radiculopathy. This modality is generally used in conjunction with therapeutic procedures and not as an isolated treatment.

### LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

#### **Electrical Stimulation Modality (97014):**

Effective April 1, 2001, pelvic floor electrical stimulation with a non-implantable stimulator 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 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.

This modality *does not* require direct (one-on-one) patient contact by the provider.

Please refer to procedure code 97032 for additional clinical guidelines for procedure code 97014.

#### Vasopneumatic Devices Modality (97016):

The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema.

Specific indications for the use of Vasopneumatic Devices include:

- reduction of edema after acute injury;
- lymphedema of an extremity; and/or
- education on the use of a lymphedema pump for home use.

**Note:** Further treatment of lymphedema by a provider after the educational visits are generally not medically necessary. Education on the use of a lymphedema pump for home use can typically be completed in no more than three (3) visits.

The use of vasopneumatic devices would not be covered as a temporary treatment while awaiting receipt of ordered Jobst stockings.

#### Paraffin Bath Modality (97018):

Paraffin Bath, also known as hot wax treatment, is primarily used for pain relief in chronic joint problems of the wrists, hands, and feet.

Specific indications for the use of Paraffin Baths include:

- the patient has a contracture as a result of rheumatoid arthritis;
- the patient has a contracture as a result of scleroderma;
- the patient has acute synovitis;
- the patient has post-traumatic conditions;
- the patient has hypertrophic scarring;
- the patient has degenerative joint disease;
- the patient has osteoarthritis;
- the patient has post-surgical conditions or tendon repairs; or
- the patient who is status post sprains or strains.

#### Microwave Modality (97020):

Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this modality, this service will be denied as not reasonable and necessary.

#### Whirlpool (97022)/Hubbard Tank (97036):

Whirlpool Bath and Hubbard Tanks are the most common forms of hydrotherapy. Whirlpool Therapies (*CPT* code 97022)/Hubbard Tank (*CPT* code 97036) are considered medically necessary when used to enhance the patient's ability to perform therapeutic exercise.

Specific indications for the use of General Whirlpool Therapies include:

- The patient suffers from generalized weakness in addition to a specific functional limitation, and requires the buoyancy provided in the whirlpool in order to perform the therapeutic exercise, and/or
- the patient requires joint stretching (joint range of motion) prior to exercise on dry land.

Whirlpool Therapies/Hubbard Tank may be considered medically necessary when either circulatory deficiency or areas of desensitization complicate the patient's condition, and the therapeutic goal is to increase circulation or decrease skin sensitivity.

The use of *sterile* whirlpool is considered medically necessary when used as part of a plan directed at facilitating the healing of an open wound (e.g., burns).

Specific indications for the use of *sterile* whirlpools include:

- the patient has a documented open wound which is draining, has a foul odor, or evidence of necrotic tissue; and/or
- the patient has a documented need for wound debridement/bandage removal.

**Note**: This code should not be used if aquatic (97113) exercises are performed.

#### Fluidized Therapy for Dry Heat (97022):

Fluidized Therapy is a high intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having properties of a liquid. Use of fluidized therapy for dry heat is considered medically necessary when provided as part of a plan of care for patients having acute or subacute traumatic or nontraumatic musculoskeletal disorders of the extremities.

#### **Diathermy Modality (97024):**

Short wave diathermy is an effective modality for heating skeletal muscle. Because heating is accomplished without physical contact between the modality and the skin, it can be used even if skin is abraded, as long as there is no significant edema. The use of Diathermy is considered medically necessary for the delivery of heat to deep tissues such as skeletal muscle and joints, for the reduction of pain, joint stiffness, and muscle spasms.

Specific indications for the use of Diathermy include:

- the patient has osteoarthritis, rheumatoid arthritis, or traumatic arthritis;
- the patient has sustained a strain or sprain;
- the patient has acute or chronic bursitis;
- the patient has sustained a traumatic injury to muscle, ligament, or tendon resulting in functional loss;
- the patient has a joint dislocation or subluxation;
- the patient requires treatment for a post surgical functional loss;
- the patient has an adhesive capsulitis; and/or
- the patient has a joint contracture.

Diathermy is *not* considered medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. Please refer to the ICD-9-CM Codes that Do Not Support Medical Necessity section of the policy.

#### Diathermy/Diapulse (97024):

High energy pulsed wave diathermy machines have been determined to produce the same therapeutic benefit as standard diathermy; therefore, any reimbursement for diathermy will be made at the same level as standard diathermy.

#### Infrared Modality (97026):

The application of infrared therapy is considered medically necessary for patients requiring the application of superficial heat in conjunction with other procedures or modalities, to reduce or decrease pain/produce analgesia, reduce stiffness/tension, myalgia, spasm, or swelling.

Specific indications for the use of infrared application include:

- the patient has a painful superficial condition for which heat is beneficial (e.g., neuropathy), *or*
- the patient has muscle spasms for which heat application has been ordered, *and*
- the patient's condition is acute or subacute.

Infrared application applied in the absence of associated procedures or modalities, or used alone to reduce discomfort, are considered *not* medically necessary and therefore, are not covered.

#### Ultraviolet Modality (97028):

Photons in the ultraviolet (UV) spectrum are more energetic than those in the visible or infrared regions. Their interaction with tissue and bacteria can produce nonthermal photochemical reactions, the effects of which provide the rationale for ultraviolet treatment. Ultraviolet light is highly bacteriocidal to motile bacteria, and it increases vascularization at the margins of the wounds.

The application of Ultraviolet Therapy is considered medically necessary for the patient requiring the application of a drying heat. The specific indications for this therapy are:

- A patient has an open wound. Minimal erythema dosage must be documented.
- Severe psoriasis limiting range of motion.

#### **Electrical Stimulation (Manual) (97032):**

This modality includes the following types of electrical stimulation:

- Transcutaneous electrical nerve stimulation which produces analgesia, strengthening, and functional electrical stimulation. The use of electrical stimulation is considered medically necessary to reduce pain and/or edema and achieve muscular contraction during exercise.
- Neuro-muscular stimulation which is used for retraining weak muscles following surgery or injury and is taken to the point of visible muscle contraction.
- Interferential current/medium current units, which use a frequency that allows the current to go deeper. IFC is used to control swelling and pain.

Specific indications for the use of Electrical Stimulation include:

- the patient has documented dependent peripheral edema with an accompanying reduction in the ability to contract muscles;
- the patient has a documented reduction in the ability to contract muscles or in the strength of the muscle contraction;
- the patient has a condition that requires an educational program for self-stimulation of denervated muscle (educational program should be limited to 5-7 sessions);
- the patient has a condition that requires muscle reeducation involving a training program (e.g., functional electrical stimulation);
- the patient has a painful condition that requires analgesia or a muscle spasm that requires reduction prior to an exercise program; or

 the patient is undergoing treatment for disuse atrophy using a specific type of neurostimulator (NMES) which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes.
 \*\*Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post casting or splinting of a limb, and contracture due to soft tissue scarring).

Standard treatment is 3 to 4 sessions a week for one month when used as adjunctive therapy or for muscle retraining.

This modality requires direct (one-on-one) patient contact by the provider.

Electrical Stimulation (*CPT* code 97032) used in the treatment of facial nerve paralysis, commonly known as Bell's Palsy, is considered investigational and *noncovered*. Please refer to the ICD-9-CM Codes that Do Not Support Medical Necessity section.

Electrical Nerve Stimulation (*CPT* code 97032) used to treat motor function disorders, such as multiple sclerosis, is considered investigational and, therefore, *noncovered*.

Electrical Stimulation (*CPT* code 97032) is not medically necessary for the treatment of strokes when there is no potential for restoration of function.

As of April 1, 2001, pelvic floor electrical stimulators, whether inserted into the vaginal canal or rectum, that are used as a treatment for urinary incontinence (e.g., as a bladder pacer or a retraining mechanism) are covered. Please see procedure code 97014 for coverage guidelines for this indication.

Electrical Stimulation used in the treatment of wound healing will be reviewed for coverage on a case-by-case basis. Please refer to procedure code 97799 for clinical guidelines for using electrical stimulation for wound healing.

#### Iontophoresis (97033):

Iontophoresis is a process in which electrically charged molecules or atoms (e.g., ions) are driven into tissue with an electric field. Voltage provides the driving force. Parameters such as drug polarity and electrophoretic mobility must be known in order to be able to assess whether iontophoresis can deliver therapeutic concentrations of a medication at sites in or below the skin.

The application of Iontophoresis is considered medically necessary for the topical delivery of medications into a specific area of the body. The medication and dosage information may be recorded in the plan of treatment or maintained on a separate prescription signed by the health care provider responsible for certifying the plan of treatment.

Specific indications for the use of Iontophoresis application include:

- the patient has tendonitis or calcific tendonitis;
- the patient has bursitis; or
- the patient has adhesive capsulitis.

#### Contrast Baths (97034):

Contrast Baths are a special form of therapeutic heat and cold that can be applied to distal extremities. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold. Although a variety of applications are possible, contrast baths often are used in treatment programs for rheumatoid arthritis and reflex sympathetic dystrophy.

The use of Contrast Baths is considered medically necessary to desensitize patients to pain by reflex hyperemia produced by the alternating exposure to heat and cold.

Specific indications for the use of Contrast Baths include:

- the patient has rheumatoid arthritis or other inflammatory arthritis;
- the patient has reflex sympathetic dystrophy; or
- the patient has a sprain or strain resulting from an acute injury.

Standard treatment is 3-4 treatments per week for one month.

#### Ultrasound (97035):

Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 Mhz. In the human body, ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone can receive an even greater dosage of ultrasound, as much as 30% more. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where they receive a more intense irradiation, it is an ideal modality for increasing mobility in those tissues with restricted range of motion.

The application of ultrasound is considered medically necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and for the increase of muscle, tendon and ligament flexibility.

Specific indications for the use of Ultrasound Application include:

- the patient has tightened structures limiting joint motion that require an increase in extensibility; or
- the patient has symptomatic soft tissue calcification.

When phonopheresis is performed, use procedure code 97035.

Ultrasound Application is *not* considered to be medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. Please see ICD-9-CM Codes That Do Not Support Medical Necessity section of the policy.

Standard treatment is 3-4 treatments per week for one month.

#### Hubbard Tank (97036):

Please refer to procedure code 97022 for clinical guidelines for procedure code 97036.

#### Unlisted Modality (97039):

All claims submitted with an unlisted service or procedure must be accompanied by:

- A description of the service or procedure, and
- The appropriate documentation listed under the "Documentation Requirements" section of this policy.

#### **Therapeutic Procedures:**

Therapeutic procedures require direct one-on-one patient contact by a physician or therapist. If a provider is performing therapeutic procedures in a group of two or more individuals, *CPT* code 97150 is reported once for each patient.

#### Therapeutic Exercise (97110):

Therapeutic exercise is performed on dry land with a patient either actively, active-assisted, or passively participating (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening).

Therapeutic exercise is considered medically necessary if at least one of the following conditions is present and documented:

- The patient has weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problem, balance and/or coordination deficits, abnormal posture, muscle imbalance; *or*
- The patient needs to improve mobility, stretching, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or re-education.

Documentation for therapeutic exercise must show objective loss of joint motion, strength, and mobility (e.g., degrees of motion, strength grades, levels of assistance).

**Note**: For guidelines regarding Complex Decongestive Physiotherapy services, please refer to the Complex Decongestive Physiotherapy Policy (97110).

#### Neuromuscular Re-education (97112):

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkreis, Bobath, BAP's boards, and desensitization techniques).

Neuromuscular Re-education may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or
- the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or has had a spinal cord disease or trauma.

Aquatic Therapy with Therapeutic Exercise (97113): This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). Hydrotherapy is useful in post-operative extremity (joint) rehabilitation (e.g., total hip or knee arthroplasty, total shoulder, elbow, and wrist arthroplasty).

Aquatic therapy with therapeutic exercise may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has rheumatoid arthritis;
- the patient has had a cast removed and requires mobilization of limbs;
- the patient has paraparesis or hemiparesis;
- the patient has had a recent amputation;
- the patient is recovering from a paralytic condition;
- the patient requires limb mobilization after a head trauma; or
- the patient is unable to tolerate exercise for rehabilitation under gravity based weight bearing.

Aquatic Therapy (*CPT* code 97113) should not be billed in situations where exercise is not being performed in the water environment (e.g., debridement of ulcers).

Aquatic therapy with therapeutic exercise (97113) should not be billed when there is not one-on-one contact

between therapist and patient. For example, an aqua aerobic class of more than one patient with the instructor directing the class from a distance would not be considered reasonable and necessary and therefore, not a covered service.

#### Gait Training (97116):

This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

Specific indications for gait training include:

- the patient has suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation;
- the patient has recently suffered a musculoskeletal trauma, either due to an accident or surgery, requiring ambulation education;
- the patient has a chronic, progressively debilitating condition for which safe ambulation has recently become a concern;
- the patient has had an injury or condition that requires instruction in the use of a walker, crutches, or cane;
- the patient has been fitted with a brace prosthesis and requires instruction in ambulation; and/or
- the patient has a condition that requires retraining in stairs/steps or chair transfer in addition to general ambulation.

Gait training is *not* considered medically reasonable and necessary when the patient's walking ability is not expected to improve.

This procedure is *not* considered medically necessary when the goal is to increase the patient's strength and endurance.

#### Therapeutic Massage Therapy (97124):

Massage is the application of systematic manipulation to the soft tissues of the body for therapeutic purposes. Although various assistive devices and electrical equipment are available for the purpose of delivering massage, use of the hands is considered the most effective method of application, because palpation can be used as an assessment as well as a treatment tool.

Massage therapy, including effleurage, petrissage, and/or tapotement (stroking, compression, and/or percussion) may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has paralyzed musculature contributing to impaired circulation;
- the patient has excessive fluids in interstitial spaces or joints;
- the patient has sensitivity of tissues to pressure;
- the patient has tight muscles resulting in shortening and/ or spasticity of affective muscles;
- the patient has abnormal adherence of tissue to surrounding tissue;
- the patient requires relaxation in preparation for neuromuscular re-education or therapeutic exercise; *or*
- the patient has contractures and decreased range of motion.

#### **Unlisted Therapeutic Procedure (97139):**

All claims submitted with an unlisted service or procedure must be accompanied by:

- A description of the service or procedure, and
- The appropriate documentation listed under the "Documentation Requirements" section of this policy.

#### Manual Therapy (97140):

Manual therapy includes the following modalities:

- Manual traction may be considered reasonable and necessary for cervical radiculopathy.
- Joint mobilization (peripheral or spinal) may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.
- Myofascial release/soft tissue mobilization, one or more regions, may be medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, or stretching of shortened muscular or connective tissue. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.
- Manipulation may be medically necessary for treatment of painful spasm or restricted motion of soft tissues. It may also be used as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

**Note**: For guidelines regarding Complex Decongestive Physiotherapy services, please refer to the Complex Decongestive Physiotherapy Policy (97110).

If 97140 is billed on the same day as Osteopathic Manipulation Therapy (*CPT* code 98925-98929), the service will be denied as not medically necessary.

# Therapeutic Procedure(s), group (2 or more individuals) (97150):

If a therapist or physician performs any of the Physical Medicine procedures with two or more individuals concurrently or during the same time period, then only 97150 is reported for each patient.

Documentation must be maintained in the patient's medical record identifying the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, and the treatment goal in the individualized plan. The number of persons in the group must also be furnished.

#### **Orthotics Fitting and Training (97504):**

Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk may be considered reasonable and necessary if there is an indication for education for the application of orthotics and the functional use of orthotics is present and documented in the patient's medical records maintained by the provider.

Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk reflects the fitting as well as the training, as the training in the use of the orthotic is done at the time of the fitting. Typically, orthotic training can be completed in three (3) visits, but based on patient condition/ status, may require additional visits. In addition, subsequent visits may be necessary for re-evaluation in modification of the orthotic and/or program.

Orthotic training (*CPT* code 97504) for a lower extremity performed during the same visit as gait training (*CPT* code 97116) or self-care/home management training (*CPT* code 97535) should not be reported unless documentation in the medical record shows that distinct treatments were rendered.

In addition, the casting and strapping codes should not be reported in addition to code 97504. If casting and strapping of a fracture, injury, or dislocation is performed, procedure codes 29000-29590 should be reported. Please refer to the LMRP policy (29580) for further guidelines regarding strapping.

#### **Prosthetic Training (97520):**

Prosthetic training may be considered reasonable and necessary if there is an indication for education for the application of a prosthetic and the functional use of a prosthetic is present and documented in the patient's medical records maintained by the provider.

The medical record should document the distinct goals and service rendered when prosthetic training for a lower extremity is done during the same visit as gait training (*CPT* code 97116) or self-care/home management training (*CPT* code 97535).

Periodic revisits beyond the third month would require documentation to support medical necessity.

#### **Therapeutic Activities (97530):**

Therapeutic activities are considered medically necessary for patients needing a broad range of rehabilitative techniques that involve movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the professional skills of a therapist and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and be directed at a specific outcome.

In order for Therapeutic Activities to be covered, the following requirements must be met:

- the patient has a condition for which therapeutic activities can reasonably be expected to restore or improve functioning;
- the patient's condition is such that he/she is unable to perform therapeutic activities except under the direct supervision of a physician, optometrist or physical therapist; and
- there is a clear correlation between the type of exercise performed and the patient's underlying medical condition for which the therapeutic activities were prescribed.

#### Other Therapeutic Procedures (97532 and 97533):

Development of cognitive skills to improve attention, memory, problem solving may be considered reasonable and necessary for patients having neurologic conditions such as head injury or trauma, stroke, muscular dystrophy, and/or multiple sclerosis. It is not appropriate for patients with chronic, progressive, or stable brain conditions who do not have potential for restoration.

Reassessment of the patient's progress should occur every 2-3 months with documentation indicating drastic improvement, as opposed to slow/subtle improvement. This service is not considered to be outpatient physical therapy and is, therefore, noncovered when billed by an Independent Practicing Physical Therapist (Specialty 65).

#### Self-Care/Home Management Training (97535):

This procedure is medically necessary only when it requires the professional skills of a therapist, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific outcome.

The patient must have a condition for which training in activities of daily living is medically reasonable and necessary, and such training must be reasonably expected to restore or improve the functioning of the patient.

The patient must have the capacity to learn from instructions.

Services provided concurrently by physicians, optometrists, physical therapists, and occupational therapists may be covered if separate and distinct goals are documented in the treatment plans.

# Community/Work Reintegration Training (CPT Code 97537):

Community reintegration is performed in conjunction with other therapeutic procedures such as gait training and selfcare/home management training. The payment for community reintegration training is bundled into the payment for those other services. Therefore, these services are not separately reimbursable by Florida Medicare.

Services that are related *solely* to specific employment opportunities, work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by Section 1862(a)(1) of the Social Security Act.

# Wheelchair Management/Propulsion Training (CPT Code 97542):

This service trains the patient in functional activities that promote optimal safety, mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractures, and other medical complications.

This procedure is medically necessary only when it requires the professional skills of a therapist, is designed to address specific needs of the patient, and must be part of an active treatment plan directed at a specific goal.

The patient must have the capacity to learn from instructions.

Typically 3-4 total sessions should be sufficient to teach the patient these skills.

When billing 97542 for wheelchair propulsion training, documentation must relate the training to expected functional goals that are attainable by the patient.

# Work Hardening/Conditioning (CPT Codes 97545-97546):

Florida Medicare does not cover this service. These services are related solely to specific work skills, and they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are not covered.

# Checkout for Orthotic/Prosthetic Use, Established Patient (*CPT* Code 97703):

These assessments are medically necessary when a device is newly issued or when there is a modification or re-issue of the orthotic/prosthetic device.

These assessments may also be medically necessary when patients experience a loss of function directly related to the device (e.g., pain, skin breakdown, or falls).

These assessments are *not* medically necessary when a device is replaced after normal wear.

# Unlisted Physical Medicine/Rehabilitiation Service or Procedure (97799):

When using an unlisted service or procedure code, providers must submit documentation to support the medical necessity and rationale for using this treatment modality. Please refer to the "Documentation Requirements" section of this policy.

Electrical Stimulation used in the treatment of wound healing will be reviewed for coverage on a case-by-case basis. This policy applies to all electrical stimulation devices including but not limited to those that produce the stimulation by direct current, alternating current, pulsed current, pulsed electromagnetic induction, and pulsed electromagnetic field. It applies to treatment of wounds including pressure ulcers, venous ulcer wounds, and arterial wounds. Providers should bill these procedures with procedure code 97799 (Unlisted physical medicine/rehabilitation service or procedure). Providers must include documentation to support the medical necessity and rationale for using this treatment modality for wound treatment.

\*Note: In order to achieve accelerated wound healing, it may be medically necessary to perform these treatments two to three times per day to each wound site.

#### CPT/HCPCS Section & Benefit Category

Medicine/Physical Medicine and Rehabilitation

#### **CPT/HCPCS Codes**

|       | 00 00003 |       |       |
|-------|----------|-------|-------|
| 97010 | 97028    | 97113 | 97533 |
| 97012 | 97032    | 97116 | 97535 |
| 97014 | 97033    | 97124 | 97537 |
| 97016 | 97034    | 97139 | 97542 |
| 97018 | 97035    | 97140 | 97545 |
| 97020 | 97036    | 97150 | 97546 |
| 97022 | 97039    | 97504 | 97703 |
| 97024 | 97110    | 97520 | 97799 |
| 97026 | 97112    | 97530 |       |

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 Denials**

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

Vertebral Axial Decompression (VAD) therapy is considered "investigational" and is a noncovered service under Florida Medicare. VAD therapy should be billed with code 22899\* (\*Services noncovered due to being investigational/experimental).

Services related to activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute physical therapy services for Medicare purposes. Work hardening/conditioning (*CPT* codes 97545-97546) is a noncovered service by the Carrier. These services are related solely to specific work skills and do not provide any diagnostic or therapeutic benefit for the patient that requires physical rehabilitation.

The professional component of a diagnostic test (e.g., nerve conduction study, EMG, biofeedback, neuro-muscular junction test) is not considered to be outpatient physical therapy and is therefore, noncovered when billed by an Independent Practicing Physical Therapist (Specialty 65).

Electrotherapy performed for the treatment of facial nerve paralysis is the application of electrical stimulation (97014) to affected facial muscles to provide muscle innervation with the intention of preventing muscle degeneration. A device that generates an electrical current with controlled frequency, intensity, waveform and type (galanic or faradic) is used in combination with a pad electrode and a hand applicator electrode to provide electrical stimulation.

Electrotherapy for the treatment of facial nerve paralysis, commonly known as Bell's Palsy (ICD-9-CM code 351.0), is not covered under Medicare because its clinical effectiveness has not been established.

Diathermy (97024) or ultrasound (97035) heat treatments performed for respiratory conditions or diseases (ICD-9-CM codes 460-519.9) are investigational under the Medicare program.

The following services should not be billed as therapeutic activities (97530):

- General exercise programs to improve a patient's general cardiovascular fitness;
- Pulmonary rehabilitation;
- Cardiac rehabilitation; or
- A maintenance program of therapeutic activities.

Aquatic therapy with therapeutic exercise (97113) should not be billed when there is not one-on-one contact between therapist and patient. For example, an aqua aerobic class of more than one patient with the instructor directing the class from a distance would not be considered reasonable and necessary and therefore, not a covered service.

Diapulse and Rolfing (97799) treatment is a noncovered service. This service should be billed with a -GY modifier (Item or service statutorilily excluded or does not meet the definition of any Medicare benefit.).

#### Noncovered ICD-9-CM Codes

**For Procedure Code 97032 (Electrical-Stimulation)** 351.0

For Procedure Codes 97024 (Diathermy) and 97035 (Ultrasound)

460-519.9

#### Noncovered Diagnoses N/A

Coding Guidelines

Providers may report Evaluation and Management services on the same day as physical medicine treatments provided the services are separately identifiable.

#### **Documentation Requirements**

The medical record must identify the physician's order for physical therapy.

The medical record must indicate that the patient is under the care of a physician or optometrist for the presenting diagnosis.

#### LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

Documentation should indicate the potential prognosis for restoration of functions in a reasonable and generally predictable period of time.

All providers billing for physical therapy services are required to maintain an established plan of treatment as a permanent part of the patient's clinical record. The plan must be established before the treatment is begun. The physician or optometrist must see the patient at least every 30 days during the course of therapy. The physician or optometrist must review, initial and date the plan of treatment at least every 30 days. The plan must be kept on file in the physician or optometrist's office and available for Carrier review if requested.

A physical therapy plan of treatment must include the type, amount, frequency, and duration of the services that are to be furnished and indicate the diagnosis and anticipated goals. Any changes in the treatment plan must be made in writing and signed by the physician or optometrist.

Medical record documentation maintained by the ordering/referring physician or optometrist must clearly indicate the medical necessity of each physical therapy modality covered by the Medicare program.

The physician, optometrist and/or therapist must document the patient's functional limitations in terms that are objective and measurable. Documentation must show objective loss of joint motion, strength, or mobility (e.g. degrees of motion, strength grades, levels of assistance.)

All claims submitted with an unlisted service or procedure must be accompanied by documentation that describes the service, supports medical necessity, and the rationale for using the treatment modality.

The office/progress note must contain necessary and sufficient information, which indicates the services were actually provided and were reasonable and necessary to treat the patient's condition.

The name and dosage of the medication utilized during Phonopheresis (97035) or Iontophoresis (97033) should be maintained in the medical record. This information may be indicated in the plan of treatment or on a prescription signed by the health care provider responsible for certifying the plan of treatment.

#### **Utilization Guidelines**

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

#### **Other Comments**

It is usually not medically necessary to have more than one form of heat treatment (*CPT* codes 97010, 97018, 97026) for a condition per day. It may not be medically necessary to have more than one form of hydrotherapy (*CPT* codes 97022, 97036) for a condition per day.

Services must be furnished under a plan of treatment that has been written and developed by the physician caring for the patient. The plan must be established prior to the initiation of treatment, must be signed by the physician, and must be incorporated into the physician's permanent record for the patient. The services provided must relate directly to the written treatment regimen.

The plan of care contains the following information:

- The patient's significant past history;
- Patient's diagnoses that require physical therapy;
- Related physician orders;
- Therapy goals and potential for achievement;
- Any contraindications;
- Patient's awareness and understanding of diagnoses, prognosis, treatment goals; and
- When appropriate, the summary of treatment provided and results achieved during previous periods of physical therapy services.

# 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 of Date of Comment Period 12/18/2000

# Start Date of Notice Period 02/01/2002

02/01/2002

#### **Revision History**

Revision Number:8PCStart Date of Comment Period11Start Date of Notice Period02Output02

PCR B2002-071 11/03/2000 02/01/2002 2<sup>nd</sup> QTR 2002 Update! 03/28/2002

**Revised Effective Date:** 

#### Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

# ELECTRONIC MEDIA CLAIMS

## The Health Insurance Portability and Accountability Act

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA-AS) requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for specified health care transactions as established by the Secretary of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at **www.wpc-edi.com**.

The following information is intended to serve only as a companion document to the HIPAA-AS ANSI X12N 837, version 004010X098 Implementation Guide. The use of this document is solely for the purpose of clarification and is not a substitute for review of the relevant implementation guide.

The information describes specific requirements to be used for processing data in the Multi-Carrier System of First Coast Service Options, Inc. (FCSO), carrier number 00590. The information in this document is subject to change. Changes will be communicated in the standard Medicare B EDI news bulletin and on the FCSO provider Web site at **www.floridamedicare.com**. This companion document supplements, but does not contradict, any requirements in the X12N 837 Professional Implementation Guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA-AS standards, as they become available.

#### Medicare Specific Guidelines Related To the HIPAA-AS 4010 837 Transaction

- Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
- The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and may result in duplicate claim rejection. The claims processing system does not process electronic replacements.
- The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of \$99,999.99 will be rejected.
- Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.
- Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal will be rejected.
- Data submitted in CLM20 (Delay Reason Code) will not be used for processing.
- FCSO will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the inter- change (transmission) to be rejected at the carrier translator. Use of the tilde (~), asterisk (\*) or greater than sign (>) other than as delimiters will cause the file to reject.
- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
- Currency code (CUR02) must equal 'USA'
- Diagnosis codes have a maximum size of five. Medicare does not accept decimal points in diagnosis codes.
- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
- Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).
- Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
- For Medicare, the subscriber is always the same as the patient (SBR02=18,SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
- The incoming 837 transactions utilize delimiters from the following list: >, \*, :, ^, |, and ~. Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected.
- Only loops, segments, and data elements valid for the HIPAA Professional Implementation Guide will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
- Any data submitted in the PWK (Paperwork) segment will not be considered for processing.
- Purchased diagnostic tests (PDT) amounts should be submitted at the detail line level (Loop 2400), not at the header claim level (Loop 2300). PDT amounts submitted at the header claim level (Loop 2300) may be ignored.
- Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) may be ignored.

### ELECTRONIC MEDIA CLAIMS

- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
- Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
- Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
- FCSO will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
- FCSO will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
- FCSO will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
- FCSO will reject an interchange (transmission) that is not submitted with a valid carrier code.
- FCSO will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
- You may send up to eight diagnosis codes per claim. If diagnosis codes are submitted, you must point to the primary diagnosis for each service line.
- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing will cause the claim or the transaction to be rejected.
- You may send up to four modifiers; however, the last two modifiers may not be considered. The FCSO processing system will only use the first two modifiers for adjudication and payment determination of claims.
- FCSO may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
- Compression of files using PKZIP is supported for transmissions between the submitter and First Coast Service Options.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.
- FCSO will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997 (Functional Acknowledgment report).

# Don't Delay—Schedule Your Testing Appointment

Software vendors should request a testing appointment as soon as possible to facilitate completing testing and correcting any detected system problems prior to October 2002. Appointment slots will be assigned on a first come basis. *To schedule an appointment, call (904)* **791-6055**. FCSO will not be able to guarantee testing by the end of September 2002 for any entities that delay scheduling testing until late in the transition period. If a test transmission is received from a vendor, clearinghouse or billing service that does not have an appointment, FCSO may not be able to review the transmission.

If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for a specific transaction and is using the same program to generate the translation for all of their clients, then all clients of the vendor/clearinghouse/billing service will not need to test prior to acceptance of production submission of the HIPAA claim transaction. If a vendor, clearinghouse or billing service supports multiple software products, each product will require testing.

It is the responsibility of the vendor, clearinghouse or billing service to provide Medicare a listing of their clients to be migrated.

### Specifications Necessary for Creating and Transmitting Test Files

#### Test File

Please limit version 4010 test files to 10-25 claims each, representative of all types of bills you currently send to Medicare Part B. We ask that you only send us positive test files, which contain claims you believe should process and pay. **Note**: this file will only be processed as a test; no claims will be paid.

#### Delimiters

The Functional Acknowledgment report (997) will be returned to you using the delimiters specified within the 837. If you would like the 997 to be returned with other delimiters, you will need to notify us of those override delimiters before testing. **Note**: if you use the tilde (~) as a segment delimiter your 997 will be returned to you as one string, 'unwrapped.'

#### Enveloping

Enveloping information must be as follows:

| ELEMENT     | CONTENT      |
|-------------|--------------|
| ISA 05 & 07 | ZZ           |
| ISA 08      | 592015694    |
| ISA 15      | T *          |
| GS 03       | MEDBCLM00590 |
| GS 08       | 004010X098   |
| REF 02      | 004010X098   |

\* Please note: Once approval is given to begin submitting production version 4010, this indicator will change to "P."

#### Commands

The commands used to submit the ANSI X12 files and obtain acknowledgments are slightly different than those that are used to submit and obtain acknowledgments for National Standard Format. The appropriate command instructions can be found in our publication *Guide to Gateway* that is available on our Web site at **www.floridamedicare.com**.

#### Reports

If your test file contains incorrect enveloping information (ISA, GS, ST, SE, GE, and IEA segments) a TA1 will be returned to you. If you need assistance reading your TA1 please contact Medicare EDI at (904) 791-6055.

If your enveloping information is correct, your file will create a 997 report. This report, sent to your mailbox for retrieval, will tell you if your file has been accepted under **X12 Standard**. Standard requirements can be found in the 4010 Implementation Guide (IG) under the "STANDARD" heading for each segment (the X12 Implementation Guide can be downloaded from **www.wpc-edi.com**).

If your file passes the Standard, it is then reviewed for **X12 Implementation Guide (IG)** requirements. X12 Implementation Guide requirements can be found in the 4010 Implementation Guide under the

"IMPLEMENTATION" heading for each segment and in the body of the segment information. If your file fails any IG requirements, we will call you with the details of your errors, including line number and segments. *Note. If you have received a 997 indicating your file rejected, you will not receive any further word from us regarding that file. You must make the corrections indicated on the 997 and resubmit the file.* 

If your file passes both Standard and IG edits, Medicare will contact you with your test results within 10 business days.

If you have additional questions please contact Floyd Rosenberger at (904) 791-6055 or email at floyd.rosenberger@fcso.com.

#### Testing the ANSI 835 4010

Version 4010 of the 835 includes some significant changes from earlier versions of Medicare supported Electronic Remittance Advice (ERA) formats. Changes include requirements to: (1) electronically void and correct claim history when adjusting a claim, rather than simply posting differences in payment; (2) identify the primary payer if denying a claim because Medicare is not primary; and (3) identify any secondary payer with whom benefits are coordinated. Please read this notice carefully as it contains information necessary for testing the ANSI 4010 835 transaction.

To test the 835 remittance advice, you will need to contact the Medicare EDI Department of FCSO at (904) 791-6895 to schedule a test. At that time, you will be

configured to receive a test ANSI 835 v 4010 in addition to any version of electronic remittance you are currently receiving following your submission of production claims.

- The ANSI 835 version 4010 data will consist of both the basic and extended character set, with the exception of the \* (asterisk) and the > (greater than) symbols. All alpha characters will be generated in upper case.
- The phone number to dial for retrieval of the 835 4010 will be:

| BISYNCHRONOUS  |
|----------------|
| (904) 356-0534 |
| (904) 355-2670 |
| (904) 350-1150 |
| ASYNCHRONOUS   |
| (904) 356-0237 |

MODEM TYPE Sync 201/208 Sync 201 CCITT V.32

You may obtain an electronic remittance advice by sending a set of "logon" and "obtain" script commands. An established mailbox number and password is necessary to communicate with the EDI gateway. An example of the script commands include:

> \$BCBSF\$ LOGON mailbox# password \$BCBSF\$ \$BCBSF\$ OBTAIN EDI \$BCBSF\$ \$BCBSF\$ LOGOFF \$BCBSF\$

Please note that the transaction code necessary to pick up ANSI remittance advices is "EDI", not "NSR" (which is used to retrieve NSF remittance advices). More information on creating and submitting your script commands is available in the *Guide to Gateway* document at www.floridamedicare.com.

- Medicare will not accept a 997 response transaction from trading partners in response to their retrieval of the electronic remittance advice.
- The characters used currently as file delimiters are as follows:
  - Segment 0A (line feed) Element 2A (\*) Sub element 3E (>)
- If your software requires characters other than the standard delimiters, please notify us.
- If problems or inconsistencies are identified within the 835 v 4010, please contact Elizabeth Templeton at (904) 791-6895 or via email at: elizabeth.templeton@fcso.com.

| DOCUMENT  | FILENAME                   | LOCATION/URL   |
|---|----------------------------|--|
| 835 Implementation Guide<br>X12N 835 (004010X091)                 |                            | www.wpc-edi.com/hipaa/ASC<br>hipaa_40.asp  |
| 835 4010 crosswalk  | B835v 4010-1.xls           | www.hcfa.gov/medicare/edi/<br>hipaadoc.htm   |
| Medicare X12N 835 v 4010 HIPAA<br>Companion Document for Carriers | PM AB-01-132, attachment C | www.hcfa.gov/medicare/edi/<br>hipaadoc.htm   |
| Remark Codes  |                            | www.wpc-edi.com/hipaa/<br>hipaa_40.asp   |
| Guide to Gateway  | gtg.pdf                    | www.floridamedicare.com<br>(Go to the EDI section under<br>"specs" and select gtg.pdf) |

#### Useful Documents

#### **Enveloping Information**

| ELEMENT | DESCRIPTION                 | VALUE            |
|---------|-----------------------------|------------------|
| ISA05   | Interchange ID Qualifier    | 27               |
| ISA 06  | Interchange Sender ID       | 00590            |
| ISA 07  | Interchange ID Qualifier    | ZZ               |
| ISA 08  | Interchange Receiver ID     | Your sender code |
| GS 02   | Application Sender's Code   | 00590            |
| GS 03   | Application Receiver's Code | Your sender code |

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

If you have any questions, please call EDI Support at (904) 354-5977.

# GENERAL INFORMATION

# FRAUD AND ABUSE

# **Ordering Diagnostic Services**

edicare coverage requirements for diagnostic services (e.g., laboratory tests and radiology procedures) indicate these services must be medically necessary for treatment and/or diagnosis of the patient. In addition, any diagnostic service may be covered only when furnished on the order of a physician. An exception to this requirement is when the treating physician performs a diagnostic service. It is expected the physician's order for diagnostic services is documented and maintained in the patient's medical record by both the ordering physician and provider who performs the service. To help ensure that payment is made only for medically necessary services, any diagnostic service furnished on the referral or order of a physician must include in the physician order the reason why the diagnostic service is medically necessary-this may be in the form of an ICD-9-CM diagnosis code.

A physician's order for diagnostic services may list one or more tests/procedures. For the most part, the services are furnished as ordered by the physician. However, there are instances when tests/procedures are furnished other than or in addition to those ordered by the physician. These services should not be covered by Medicare because they are not ordered by a physician. Physicians who order diagnostic services can assist the Medicare program in ensuring that only those services actually ordered are paid by Medicare, by considering the following process:

- Maintain copies of the physician orders and annotate specific diagnostic services ordered in the patient's medical records.
- When results of the diagnostic services are received by the physician, compare the report of services furnished against the physician orders.
- If it is noted that services were furnished other than or in addition to the diagnostic services on the physician order, the physician should contact the provider of services to determine why the services furnished were not the same as those ordered.
- If the physician cannot resolve the issue, contact the Medicare contractor for assistance.

By implementing this process, physicians who order diagnostic services can help ensure only those services that are medically necessary *and ordered*, are paid by the Medicare program. The result would be a savings in tax dollars that may be used to pay for non-covered and/or inappropriate services.

Source: 42 CFR 410.32

# FINANCIAL SERVICES

#### Notice of Interest Rate for Medicare Overpayments and Underpayments

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 is based on the higher of the private consumer rate (PCR) or the current value of funds rate (5 percent for calendar year 2001).

Effective October 31, 2001, the interest rate applied to Medicare overpayments will remain at 13.25 percent. Previous interest rates may be found in past issues of the *Medicare B Update!* on our provider Web site, www.floridamedicare.com.

# HOME HEALTH CONSOLIDATED BILLING

### Annual Update of Non-Routine Medical Supply and Therapy Codes for Home Health Consolidated Billing

The Centers for Medicare & Medicaid Services (CMS) provides annual updates to the list of non-routine medical supply and therapy codes included in home health consolidated billing (CB) to reflect the annual Healthcare Common Procedure Coding System code revisions. These codes are bundled into the prospective payment system rate. Therefore, providers and suppliers may not bill for these codes separately while a Medicare beneficiary is in an open home health episode.

The following are the changes to the non-routine medical supply list for dates of service beginning January 1, 2002: **New code subject to CB:** 

A6010Collagen based wound filler, dry foam**Discontinued code, no longer subject to CB:**A4329External catheter start set

There are no changes to the list of 69 therapy codes subject to CB that was provided in the First Quarter 2002 *Medicare B Update!* (pages 80-81).

Source: CMS Transmittal AB-01-128, CR 1854

# SNF CONSOLIDATED BILLING

## Skilled Nursing Facility (SNF) Consolidated Billing (CB) Coding Information on CMS Web Site

s of January 1, 2002, coding information for SNF CB A may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at www.hcfa.gov/ medlearn/refsnf.htm under the topic "Consolidated Billing for Skilled Nursing Facility Residents Claims Billed to Medicare Carriers or DMERCs by Physicians, Non-Physician Practitioners, and Suppliers." This information may be used by carriers and providers to determine by procedure code whether services rendered to beneficiaries in Part A covered SNF stays or non-Part A covered SNF stays (Part A benefits exhausted) are included or excluded from CB. Carriers will reimburse services that are excluded from CB. Services that are included in CB must be billed to the SNF for payment. These files are for services rendered in calendar year 2002. Carriers and providers will be notified of any subsequent coding changes.

Four code files will be found on the Web site:

• Codes for physician professional services (other than the interpretation of diagnostic tests) that when rendered to beneficiaries in a Part A covered stay are not included in CB and must be submitted to the carrier or DMERC for payment.

- Codes for the physician interpretation of diagnostic tests that when rendered to beneficiaries in a Part A covered stay and submitted with a 26-professional component modifier are not included in CB. These services must be submitted to the carrier for payment.
- Codes for ambulance services that will always be included in CB when submitted with an NN modifier and must not be submitted to the carrier for payment. These services must be submitted to the SNF for payment. There are additional situations in which ambulance services are consolidated. Refer to Program Memorandum AB-01-159 to identify these situations.
- Codes for physical, occupational, and speech therapy services that, when rendered to a beneficiary in a non-Part A covered stay, (i.e., Part A benefits exhausted), are included in CB and may not be submitted to the carrier for payment. They must be submitted to the SNF for payment.

Source: CMS Transmittal B-02-002, CR 1997

go to the appropriate processing entity.) This process is

only available for claims for the flu and PPV vaccines

based on the Medicare Physician Fee Schedule for the

appropriate locality. The vaccines will be reimbursed at

and their administration. The administration of the

vaccinations will be reimbursed at the assigned rate

# **GENERAL** INFORMATION

#### Centralized Billing for Flu and Pneumococcal (PPV) Vaccination Claims Centralized billing is a process in which a provider, Indian Health Services. These claims must continue to

Centralized billing is a process in which a provider, who provides mass immunization services 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 does not include claims for the Railroad Retirement Board, United Mine Workers or the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals, which is based on the lower of cost or 95 percent of the Average Wholesale Price (AWP).

Individuals and entities interested in centralized billing must contact CMS central office (CO), in writing, at the following address by June 1 of the year they wish to begin centrally billing.

> Division of Practitioner Claims Processing Provider Billing and Education Group Center for Medicare and Medicaid Services 7500 Security Boulevard Mail Stop C4-12-18 Baltimore, Maryland 21244

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

#### **Criteria for Centralized Billing**

- To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given.
- Centralized billers 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 Medicare beneficiaries can not be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary \$10 for an influenza vaccination and give the beneficiary a coupon for \$10 to be used in the drugstore. This practice is unacceptable.
- The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned carrier for this year is TrailBlazer Health Enterprises.
- Payment rates for the administration of vaccinations will be based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment will be made at the assigned rate.
- The payment rates for 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. Payment will be made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an Electronic Media Claims standard format using either the National Standard Format (NSF) or American National Standards Institute ANSI X12N 837 (version 3051) format (or the HIPAA ANSI X12N 837(version 4010) when required). Paper claims will not be accepted.
- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer Health Enterprises must be contacted prior to the season

for exact requirements. The responsibility lies with the centralized biller 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.

- Centralized billers 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, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. 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.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer Health Enterprises can provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer Health Enterprises. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from TrailBlazer Health Enterprises.
- If an individual or entity's request for centralized billing is approved, the approval is limited to the twelve-month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. TrailBlazer Health Enterprises will not process claims for any centralized biller without permission from CMS CO.
- Each year the centralized biller must contact TrailBlazer Health Enterprises to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller will be responsible for providing the beneficiary with a record of the PPV vaccination.

The information in items 1 through 6 below must be included with the individual or entity'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 the 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 the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

Source: CMS Transmittal 1731, CR 1950 (MCM Section 4481)

## **Remittance Advice Remark Codes**

Remark codes are used in a remittance advice to relay informational messages that cannot be expressed with a claim adjustment reason code. Remark codes are maintained by the Centers for Medicare & Medicaid Services (CMS), but may be used by any health care payer when they apply. Medicare contractors may use their discretion to determine when certain remark codes apply to a payment decision, but a Medicare contractor must report any remark codes that do apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level and claim level categories. Some of the same messages were included in both categories. To simplify remark code use, these categories have been eliminated. Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version. To eliminate duplication, the following remark code messages have been made inactive and should no longer be used effective with implementation of version 4010 of the X12 835: M34 (duplicates MA120), M72 (duplicates MA52), MA05 (information included in MA30, or MA40 or MA43), N41 (duplicates reason code 39), and N44 (duplicates reason code 137).

Rather than renumber existing M (prior service level) and MA (prior claim level) codes, and possibly confuse providers, "old" code numbers have been retained. All new post-consolidation remark codes, however, will begin with an "N." The "N" is used to quickly differentiate remark codes from claim adjustment reason codes. Remark codes that apply at the service level must be reported in the X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in the X12 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable.

Due to the growing number of remark codes, the codes have been classified according to subject matter to make it easier to locate particular remark codes. Some codes are listed under multiple classes. Class, however, does not have any bearing on remark code identifiers.

#### **Remark Code Changes/Additions**

The following "M" codes contain changes or are new since release of the October 1998 version of this list: M51, M109, M110, M116, M118, M120-M144. Codes M122-137 are substitutes for the D series reason codes that will be inactive for use in X12 835 transactions effective with version 4010. Effective with version 4010, the information formerly in D1-15 will be conveyed with reason code 16 and the appropriate remark code. The information in D98 will be conveyed with reason code 96 and remark code M137.

The following "MA" codes have changed or been added since release of the October 1998 version of this list: MA06, MA44, MA52, MA118, MA119, MA125, MA130-MA134. Codes MA131 and 132 are substitutes for the D series reason codes D97 and D99, which will be inactive for use in X12 835 transactions effective with version 4010. Effective with version 4010, the information formerly in D97 and D99 will be conveyed with reason code 96 and the applicable remark code.

The following "N" codes have been changed or added since October 1998: N3, N10, N16 ff. Codes changes or added since April 12, 2001, are *italicized* for easier identification.

#### **Remark Code Classifications**

**Appeal Remarks**: M25, M26, M27, M60, MA01, MA02, MA03, MA28, MA44, MA46, MA62, MA91, MA113, MA130, N1, N11, N83, *N91* 

Assignment Remarks: M40, MA09, MA28, MA72, N71

**Coverage Remarks**: M13, M14, M28, M37, M41, M55, M61, M63, M65, M71, M73, M74, M80, M82, M83, M86, M89, M90, M100, M101, M107, M111, M115, M116, M121, M134, M138, M139, M140, MA14, MA20, MA84, MA103, MA109, MA123, N30, N43, N86, N87, N90

**Enrollment Remarks**: M138, MA25, MA47, MA54, MA55, MA56, MA57, MA73, MA96, MA97, MA98, N6, N12, N30, N52

**Equipment/Orthotic/Prosthetic Remarks**: M3, M4, M5, M6, M7, M9, M10, M11, M36, M93, M94, M98, M102, M103, M104, M105, M106, M112, M113, M114, M115, M116, M124, M125, MA50, MA128

Home Care Remarks: M18, M21, M92, M95, M135, M141, MA49, MA76, MA116, N69, N70, N88

Justification for Services Remarks: M25, M26, M42, M62, M69, MA20, MA54, N41, N72

Liability Remarks: M17, M25, M26, M27, M38, M39, M41, M48, MA11, MA13, MA47, MA56, MA59, MA72, MA74, MA77, MA78, MA101, N12, N23, N44, N58, N71

Medical Test Remarks: M1, M8, M12, M19, M30, M31, M66, M71, M73, M75, M88, M91, M96, M108, M111, M126, M129, M133, M142, MA51, MA110, MA111, MA116, MA120, MA121, MA129, N40, N86

Missing/Invalid Information Remarks: M12, M19, M20, M21, M22, M23, M24, M29, M30, M31, M33, M34, M35, M42, M44, M45, M46, M47, M49, M50, M51, M52, M53, M54, M56, M57, M58, M59, M60, M62, M64, M65, M67, M68, M69, M72, M73, M76, M77, M78, M79, M81, M84, M96, M98, M99, M101, M108, M110, M119, M120, M122, M123, M124, M125, M126, M127, M128, M129, M130, M131, M132, M133, M135, M136, M141, M142, M143, MA04, MA05, MA06, MA19, MA21, MA27, MA29, MA30, MA31, MA32, MA33, MA34, MA35, MA36, MA37, MA38, MA39, MA40, MA41, MA42, MA43, MA48, MA49, MA50, MA51, MA52, MA53, MA54, MA58, MA60, MA61, MA63, MA64, MA65, MA66, MA68, MA69, MA70, MA71, MA75, MA76, MA81, MA82, MA83, MA85, MA86, MA87, MA88, MA89, MA90, MA92, MA94, MA95, MA96, MA97, MA98, MA99, MA100, MA102, MA104, MA105, MA107, MA108, MA110, MA111, MA112, MA113, MA114, MA115, MA116, MA120, MA121, MA122, MA128, MA129, MA130, MA134, N3, N4, N5, N8, N21, N24, N26, N27, N28, N29, N31, N33, N34, N37, N38, N39, N40, N42, N46, N49, N50, N51, N53, N54, N56, N57, N60, N64, N65, N66, N75, N76, N77, N78, N80, N81, N93, N94

**Overpayment Remarks**: MA10, MA11, MA59, MA72, MA77, MA78

**Payment Basis**: M32, M69, M71, M74, M75, M109, M114, MA93, MA101, MA103, MA106, MA109, N2, N6, N9, N12, N13, N14, N16, N18, N45,N67, N68, N69, N84, N85.

**Place of Service Remarks**: M77, M97, M134, MA24, MA25, MA105, MA114, MA115, MA123, MA134, N38, N47, N79, N92

**Responsible Provider**: M40, M43, M48, M88, M96, M97, M109, M115, M116, M120, M134, M136, M142, M143, MA12, MA24, MA47, MA80, MA101, MA109, MA123, MA129, MA131, N32, N40, N47, N55, N73

Secondary Payment Remarks: M32, M43, M56, MA04, MA07, MA08, MA11, MA14, MA16, MA17, MA18, MA19, MA64, MA68, MA73, MA83, MA85, MA86, MA87, MA88, MA89, MA90, MA92, MA99, MA118, N4, N5, N6, N8, N9, N12, N23, N36, N48, N82, N89

**Separate Payment Remarks**: M2, M14, M15, M80, M86, M109, M121, M144, MA15, N15, N19, N20, N44, N61, N62, N63

**Miscellaneous Remarks**: M16, M70, M85, M87, M109, M114, M117, M118, M137, M144, MA22, MA23, MA26, MA45, MA67, MA74, MA79, MA93, MA103, MA106, MA117, MA118, MA19, MA124, MA125, MA132, MA133, N2, N7, N10, N13, N14, N16, N17, N18, N21, N22, N25, N35, N41, N44, N59, N74

#### **Remark Codes**

#### Code

| Code  |  |
|-------|--|
| Value | Description  |
| M1    | X-ray not taken within the past 12 months or near  |
|       | enough to the start of treatment.  |
| M2    | Not paid separately when the patient is an inpatient.  |
| M3    | Equipment is the same or similar to equipment  |
|       | already being used.  |
| M4    | This is the last monthly installment payment for this  |
|       | durable medical equipment.   |
| M5    | Monthly rental payments can continue until the   |
|       | earlier of the 15th month from the first rental  |
|       | month, or the month when the equipment is no   |
|       | longer needed.   |
| M6    | You must furnish and service this item for as long   |
|       | as the patient continues to need it. We can pay for  |
|       | maintenance and/or servicing for every 6 month   |
|       | period after the end of the 15th paid rental month or  |
| M7    | the end of the warranty period.  |
| IVI / | No rental payments after the item is purchased, or<br>after the total of issued rental payments equals the |
|       | purchase price.  |
| M8    | We do not accept blood gas tests results when the  |
| NIO 1 | test was conducted by a medical supplier or taken  |
|       | while the patient is on oxygen.  |
| M9    | This is the tenth rental month. You must offer the   |
|       | patient the choice of changing the rental to a   |
|       | purchase agreement.  |
| M10   | Equipment purchases are limited to the first or the  |
|       | tenth month of medical necessity.  |
| M11   | DME, orthotics and prosthetics must be billed to   |
|       | the DME carrier who services the patient's zip   |
|       | code.  |
| M12   | Diagnostic tests performed by a physician must   |
|       | indicate whether purchased services are included on  |
|       | the claim.   |
| M13   | No more than one initial visit may be covered per  |
|       | specialty per medical group. Visit may be rebilled   |
|       | with an established visit code.  |
| M14   | No separate payment for an injection administered  |
|       | during an office visit, and no payment for a full  |

- M15 office visit if the patient only received an injection. Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- M16 Please see the letter or bulletin of (date) for further information. [Note: Payer must supply the date of the letter/bulletin.]
- M17 Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
- M18 Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.
- M19 Oxygen certification/recertification (HCFA-484) is incomplete or is required.
- M20 HCPCS needed.
- M21 Claim for services/items provided in a home must indicate the place of residence.
- M22 Claim lacks the number of miles traveled.
- M23 Invoice needed for the cost of the material or contrast agent.
- M24 Claim must indicate the number of doses per vial.
- M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
- M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases:
  - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service: or
  - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in section 1842(1) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

- M28 This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
- M29 Claim lacks the operative report.
- M30 Claim lacks the pathology report.
- M31 Claim lacks the radiology report.
- M32 This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
- M33 Claim lacks the UPIN of the ordering/referring or performing physician or practitioner, or the UPIN is invalid.
- M34 Claim lacks the CLIA certification number. (Note: M34 duplicates remark code message MA120. Message M34 is inactive effective with implementation of version 4010 of the X12 835. M34 may not be used after that date.)

- M35 Claim lacks pre-operative photos or visual field results.
- M36 This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
- M37 Service not covered when the patient is under age 35.
- M38 The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
- M39 The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
   M40 Claim must be assigned and must be filed by the
- M41 practitioner's employer. We do not pay for this as the patient has no legal
- M42 obligation to pay for this. The medical necessity form must be personally signed by the attending physician.
- M43 Payment for this service previously issued to you or another provider by another carrier/intermediary.
   M44 Incomplete/invalid condition code.
- M45 Incomplete/invalid occurrence codes and dates.
- M46 Incomplete/invalid occurrence span code and dates. M47 Incomplete/invalid internal or document control
- number. M48 Payment for services furnished to hospital inpatients (other than professional services of physicians)can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
- M49Incomplete/invalid value code(s) and/or amount(s).M50Incomplete/invalid revenue code(s).
- M51 Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.
- M52 Incomplete/invalid "from" date(s) of service.
   M53 Did not complete or enter the appropriate number (one or more) of days or units(s) of service.
- M54 Did not complete or enter the correct total charges for services rendered.
- M55 We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
- M56 Incomplete/invalid payer identification.
- M57 Incomplete/invalid provider number.
- M58 Please resubmit the claim with the missing/correct information so that it may be processed.
   M59 Incomplete/invalid "to" date(s) of service.
- M60 Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMBapproved form or in an approved format.
- M61 We cannot pay for this as the approval period for the FDA clinical trial has expired.
   M62 Incomplete/invalid treatment authorization code.
- M63 We do not pay for more than one of these on the same day.
- M64 Incomplete/invalid other diagnosis code. M65 One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each
- interpreting physician.
   M66
   Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.

| M67        | Incomplete/invalid other procedure code(s) and/or  |
|------------|--|
| M68        | date(s).<br>Incomplete/invalid attending or referring physician  |
| 1100       | identification.  |
| M69        | Paid at the regular rate as you did not submit   |
|            | documentation to justify modifier 22.  |
| M70        | NDC code submitted for this service was translated   |
|            | to a HCPCS code for processing, but please<br>continue to submit the NDC on future claims for          |
|            | this item.   |
| M71        | Total payment reduced due to overlap of tests  |
| . (72)     | billed.  |
| M72        | Did not enter full 8-digit date (MM/DD/CCYY).  |
|            | (Note: M72 duplicates remark code message<br>MA52. Message M72 is inactive effective with              |
|            | implementation of version 4010 of the X12 835.   |
|            | M72 may not be used after that date.)  |
| M73        | The HPSA bonus can only be paid on the   |
|            | professional component of this service. Rebill as separate professional and technical components.      |
|            | Use the HPSA modifier on the professional  |
|            | component only.  |
| M74        | This service does not qualify for a HPSA bonus   |
| M75        | payment.   |
| M75        | Allowed amount adjusted. Multiple automated multichannel tests performed on the same day               |
|            | combined for payment.  |
| M76        | Incomplete/invalid patient's diagnosis(es) and   |
|            | condition(s).  |
| M77<br>M78 | Incomplete/invalid place of service(s).  |
| M78        | Did not complete or enter accurately an appropriate HCPCS modifier(s).                                 |
| M79        | Did not complete or enter the appropriate charge for   |
|            | each listed service.   |
| M80        | We cannot pay for this when performed during the   |
|            | same session as a previously processed service for the patient.  |
| M81        | Patient's diagnosis code(s) is truncated, incorrect or   |
|            | missing; you are required to code to the highest   |
| 1.602      | level of specificity.  |
| M82<br>M83 | Service is not covered when patient is under age 50.<br>Service is not covered unless the patient is   |
| 1005       | classified as at high risk.  |
| M84        | Old and new HCPCS cannot be billed for the same  |
| 1.605      | date of service.   |
| M85        | Subjected to review of physician evaluation and management services.                                   |
| M86        | Service denied because payment already made for  |
|            | similar procedure within set time frame.   |
| M87        | Claim/service(s) subjected to CFO-CAP  |
| M88        | prepayment review.   |
| W100       | We cannot pay for laboratory tests unless billed by<br>the laboratory that did the work.               |
| M89        | Not covered more than once under age 40.   |
| M90        | Not covered more than once in a 12 month period.   |
| M91        | Lab procedures with different CLIA certification   |
| M92        | numbers must be billed on separate claims.<br>Services subjected to review under the Home              |
| 11/2       | Health Medical Review Initiative.  |
| M93        | Information supplied supports a break in therapy. A  |
|            | new capped rental period began with delivery of  |
| M94        | this equipment.<br>Information supplied does not support a break in                                    |
| 101/4      | therapy. A new capped rental period will not begin.  |
| M95        | Services subjected to Home Health Initiative   |
| 100        | medical review/cost report audit.  |
| M96        | The technical component of a service furnished to<br>an inpatient may only be billed by that inpatient |
|            | facility. You must contact the inpatient facility for  |
|            | technical component reimbursement. If not already  |
|            | billed, you should bill us for the professional  |
| M07        | component only.  |
| M97        | Not paid to practitioner when provided to patient in<br>this place of service. Payment included in the |
|            | reimbursement issued the facility.   |

| M98 | Begin to report the Universal Product Number on      |
|-----|--|
|     | claims for items of this type. We will soon begin to |
|     | deny payment for items of this type if billed        |
|     | without the correct UPN.                             |
|     |  |

- M99 Incomplete/invalid/missing Universal Product Number.
- M100 We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
- M101 Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
- M102 Service not performed on equipment approved by the FDA for this purpose.
- M103 Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
- M104 Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
- M105 Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
- M106 Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.
- M107 Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
- M108 Must report the PIN of the physician who interpreted the diagnostic test.
- M109 We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
- M110 Missing/invalid provider number for the provider from whom you purchased interpretation services.
- M111 We do not pay for chiropractic manipulative treatment when the patient refuses to have an X-ray taken.
- M112 The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.
- M113 Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
- M114 This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.
- M115 This item is denied when provided to this patient by a nondemonstration supplier.
- M116 Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided this patient by a nondemonstration supplier. If you would like more information regarding this project, you may phone 1-888-289-0710.
- M117 Not covered unless supplier files an electronic media claim (EMC).
- M118 Letter to follow containing further information.

| M119         | National Drug Code (NDC) needed.  |    |
|--------------|---|----|
| M120         | Lacks UPIN of the substituting physician who  |    |
|              | furnished the service(s) under a reciprocal billing or  |    |
| M121         | locum tenens arrangement.<br>We pay for this service only when performed with a                                 |    |
|              | covered cryosurgical ablation.  |    |
| M122         | Level of subluxation is missing or inadequate.  |    |
| M123         | Failed to submit the name, strength, or dosage of the drug furnished.   |    |
| M124         | Information to indicate if the patient owns the   |    |
|              | equipment that requires the part or supply was  | Μ  |
| M125         | missing.<br>Information about the period of time for which this   |    |
| 11125        | will be needed was missing.   |    |
| M126         | The individual lab codes included in the test were  |    |
| M127         | not submitted.<br>The patient's medical record for this service was   |    |
| 1112/        | not submitted with the claim as required.   |    |
| M128         | The date of the patient's most recent physician visit   |    |
| M120         | must be submitted.<br>Indicator lacking that "X-ray is available for  |    |
| M129         | review."  | Μ  |
| M130         | Invoice or statement certifying the actual cost of the  |    |
|              | lens, less discounts, or the type of intraocular lens   |    |
| M131         | used was missing.<br>Completed physician financial relationship form not  | Μ  |
| 101131       | on file.  |    |
| M132         | Completed pacemaker registration form required.   |    |
| M133         | Claim did not identify who performed the purchased diagnostic test or the amount you were                       |    |
|              | charged for the test.   |    |
| M134         | Performed by a facility/supplier in which the   | Μ  |
| M135         | ordering/referring physician has a financial interest.<br>Claim lacked indication that the plan of treatment is | Μ  |
| W1155        | on file.  |    |
| M136         | Claim lacked indication that the service was  | Μ  |
| M127         | supervised or evaluated by a physician.   |    |
| M137<br>M138 | Part B coinsurance under a demonstration project.<br>Patient identified as a demonstration participant but      |    |
|              | the patient was not enrolled in the demonstration at  |    |
|              | the time services were rendered. Coverage is  | Μ  |
| M139         | limited to demonstration participants.<br>Denied services exceed the coverage limit for the                     |    |
|              | demonstration.  | Μ  |
| M140         | Service not covered until after the patient's 50th  |    |
|              | birthday, i.e., no coverage prior to the day after the 50th birthday.   | Μ  |
| M141         | Missing/incomplete/invalid physician certified plan   | 10 |
|              | of care.  |    |
| M142         | Missing/incomplete/invalid American Diabetes<br>Association Certificate of Recognition to establish             |    |
|              | qualification.  |    |
| M143         | We have no record that you are licensed to  |    |
| M144         | dispensed drugs in the State where located.   | Μ  |
| IVI 144      | Pre-/post-operative care payment is included in the allowance for the surgery/procedure.                        |    |
| MA01         | (Initial Part B determination, Medicare carrier or  | Μ  |
| 1017 101     | intermediary)—If you do not agree with what we  |    |
|              | approved for these services, you may appeal our   | М  |
|              | decision. To make sure that we are fair to you, we  | IV |
|              | require another individual that did not process your<br>initial claim to conduct the review. However, in        |    |
|              | order to be eligible for a review, you must write to  |    |
|              | us within 6 months of the date of this notice, unless   |    |
|              | you have a good reason for being late. If you meet<br>the criteria for a telephone review, you should           | Μ  |
|              | phone this office if you wish to request a telephone  |    |
|              | review.   |    |
| MA02         | (Initial Medicare Part A determination)—If you do   | Μ  |
|              | not agree with this determination, you have the<br>right to appeal. You must file a written request for a       |    |
|              | reconsideration within 60 days of receipt of this   |    |

reconsideration within 60 days of receipt of this

notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.)

MA03 (Medicare Hearing)—If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.
 MA04

the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05 Incorrect admission date, patient status or type of bill entry on claim. (Note: MA05 duplicates information in remark codes MA30, MA40 and MA43. Message MA05 is inactive effective with implementation of version 4010 of the X12 835. MA05 may not be used after that date.)

- AA06 Incorrect/incomplete/missing beginning and/or ending date(s) on claim.
- MA07 The claim information has also been forwarded to Medicaid for review.
- MA08 You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
- MA09 Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
- MA10 The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
- MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.
- MA12 You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
- MA13 You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- MA14 Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for nonplan services.
- MA15 Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
- MA16 The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

| MA17         | We are the primary payer and have paid at the  |
|--------------|--|
|              | primary rate. You must contact the patient's other   |
|              |  |
|              | insurer to refund any excess it may have paid due to   |
|              | its erroneous primary payment.   |
| MA18         | The claim information is also being forwarded to   |
| 101110       |  |
|              | the patient's supplemental insurer. Send any   |
|              | questions regarding supplemental benefits to them.   |
| MA19         | Information was not sent to the Medigap insurer  |
| 101111       |  |
|              | due to incorrect/invalid information you submitted   |
|              | concerning that insurer. Please verify your  |
|              | information and submit your secondary claim  |
|              | directly to that insurer.  |
| 14.00        |  |
| MA20         | SNF stay not covered when care is primarily related  |
|              | to the use of an urethral catheter for convenience or  |
|              | the control of incontinence.   |
| MA21         | SSA records indicate mismatch with name and sex.   |
|              |  |
| MA22         | Payment of less than \$1.00 suppressed.  |
| MA23         | Demand bill approved as result of medical review.  |
| MA24         | Christian Science Sanitorium/ SNF bill in the same   |
| 101112-1     |  |
|              | benefit period.  |
| MA25         | A patient may not elect to change a hospice  |
|              | provider more than once in a benefit period.   |
| MA26         | Our records indicate that you were previously  |
| 1111 120     |  |
|              | informed of this rule.   |
| MA27         | Incorrect entitlement number or name shown on the  |
|              | claim. Please use the entitlement number or name   |
|              | shown on this notice for future claims for this  |
|              | · · · · · · · · · · · · · · · · · · ·  |
|              | patient.   |
| MA28         | Receipt of this notice by a physician or supplier  |
|              | who did not accept assignment is for information   |
|              |  |
|              | only and does not make the physician or supplier a   |
|              | party to the determination. No additional rights to  |
|              | appeal this decision, above those rights already   |
|              |  |
|              | provided for by regulation/instruction, are conferred  |
|              | by receipt of this notice.   |
| MA29         | Incomplete/invalid provider name, city, state, and   |
|              | zip code.  |
| MA30         | 1  |
|              | Incomplete/invalid type of bill.   |
| MA31         | Incomplete/invalid beginning and ending dates of   |
|              | the period billed.   |
| MA32         | Incomplete/invalid number of covered days during   |
| 1011152      |  |
|              | the billing period.  |
| MA33         | Incomplete/invalid number of noncovered days   |
|              | during the billing period.   |
| MA34         | Incomplete/invalid number of coinsurance days  |
| 101113-4     |  |
| 14405        | during the billing period.   |
| MA35         | Incomplete/invalid number of lifetime reserve days.  |
| MA36         | Incomplete/invalid patient's name.   |
| MA37         | Incomplete/invalid patient's address. (Note: When  |
|              |  |
|              | used, a payer must verify that an address, with city,  |
|              | State, and zip code, and a phone number are  |
|              | present.)  |
| MA38         | Incomplete/invalid patient's birthdate.  |
|              |  |
| MA39         | Incomplete/invalid patient's sex.  |
| MA40         | Incomplete/invalid admission date.   |
| MA41         | Incomplete/invalid type of admission.  |
| MA42         | Incomplete/invalid source of admission.  |
| MA43         |  |
|              | Incomplete/invalid patient status.   |
| MA44         | No appeal rights. Adjudicative decision based on   |
|              | law.   |
| MA45         | As previously advised, a portion or all of your  |
| 1417 145     |  |
|              | payment is being held in a special account.  |
| MA46         | The new information was considered, however,   |
|              | additional payment cannot be issued. Please review   |
|              | the information listed for the explanation.  |
| N / A /7     | and mitormation instea for the explaination.   |
|              |  |
| MA47         | Our records show you have opted out of Medicare,   |
| MA4/         |  |
| MA47         | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for   |
| MA47         | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we   |
| MA47         | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for  |
|              | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for<br>payment.  |
| MA47<br>MA48 | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for  |
|              | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for<br>payment.<br>Incomplete/invalid name and/or address of   |
| MA48         | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for<br>payment.<br>Incomplete/invalid name and/or address of<br>responsible party or primary payer.  |
|              | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for<br>payment.<br>Incomplete/invalid name and/or address of<br>responsible party or primary payer.<br>Incomplete/invalid six-digit provider number of   |
| MA48         | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for<br>payment.<br>Incomplete/invalid name and/or address of<br>responsible party or primary payer.<br>Incomplete/invalid six-digit provider number of<br>home health agency or hospice for physician(s) |
| MA48         | Our records show you have opted out of Medicare,<br>agreeing with the patient not to bill Medicare for<br>services/tests/supplies furnished. As result, we<br>cannot pay this claim. The patient is responsible for<br>payment.<br>Incomplete/invalid name and/or address of<br>responsible party or primary payer.<br>Incomplete/invalid six-digit provider number of   |

- MA50 Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
- MA51 Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
- MA52 Did not enter full 8-digit date (MM/DD/CCYY for paper form or CCYY/MM/DD for electronic format).
- MA53 Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
- MA54 Physician certification or election consent for hospice care not received timely.
- MA55 Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
- MA56 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
- MA57 Patient submitted written request to revoke his/her election for religious non- medical health care services.
- MA58 Incomplete release of information indicator.
- MA59 The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
- MA60 Incomplete/invalid patient's relationship to insured. MA61 Did not complete or enter correctly the patient's social security number or health insurance claim number
- MA62 Telephone review decision.
- MA63 Incomplete/invalid principal diagnosis code.
- MA64 Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
- MA65 Incomplete/invalid admitting diagnosis.
- MA66 Incomplete/invalid principal procedure code and/or date.

MA67 Correction to a prior claim.

- MA68 We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
- MA69 Incomplete/invalid remarks.
- MA70 Incomplete provider representative signature.
- MA71 Incomplete/invalid provider representative signature date.
- MA72 The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
- MA73 Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
- MA74 This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
- MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
- MA76 Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.

| MA77         | The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our |
|--------------|---|
|              | and other payer payments and the amount shown as patient responsibility on this notice.   |
| MA78         | The patient overpaid you. You must issue the patient a refund within 30 days for the difference   |
|              | between our allowed amount total and the amount   |
| MA79         | paid by the patient.<br>Billed in excess of interim rate.   |
| MA80         | Informational notice. No payment issued for this  |
|              | claim with this notice. Payment issued to the<br>hospital by its intermediary for all services for this   |
| MA81         | encounter under a demonstration project.<br>Our records indicate neither a physician or supplier  |
|              | signature is on the claim or on file.   |
| MA82         | Did not complete or enter the correct physician/<br>supplier's billing number/NPI and/or billing name,  |
| NI A 92      | address, city, state, zip code, and phone number.   |
| MA83         | Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-   |
| MA84         | 1500 instructions for assistance.<br>Patient identified as participating in the National  |
| 1011 10-7    | Emphysema Treatment Trial but our records   |
|              | indicate that this patient is either not a participant,<br>or has not yet been approved for this phase of the                                       |
|              | study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.  |
| MA85         | Our records indicate that a primary payer exists  |
|              | (other than ourselves); however, you did not<br>complete or enter accurately the insurance plan/  |
|              | group/program name or identification number.  |
| MA86         | Enter the PlanID when effective.<br>Our records indicate that there is insurance primary  |
|              | to ours; however, you either did not complete or<br>enter accurately the group or policy number of the  |
| 14407        | insured.  |
| MA87         | Our records indicate that a primary payer exists (other than ourselves); however, you did not   |
|              | complete or enter accurately the correct insured's name.  |
| MA88         | Our records indicate that a primary payer exists  |
|              | (other than ourselves); however, you did not<br>complete or enter accurately the insured's address  |
| MA89         | and/or telephone number.<br>Our records indicate that a primary payer exists  |
| WIA07        | (other than ourselves); however, you did not  |
|              | complete or enter the appropriate patient's relationship to the insured.  |
| MA90         | Our records indicate that there is insurance primary  |
|              | to ours; however, you either did not complete or<br>enter accurately the employment status code of the  |
| MA91         | primary insured.<br>This determination is the result of the appeal you  |
|              | filed.  |
| MA92         | Our records indicate that there is insurance primary<br>to ours; however, you did not complete or enter   |
|              | accurately the required information. Refer to the HCFA-1500 instructions on how to complete MSP   |
|              | information.  |
| MA93<br>MA94 | Non-PIP claim.<br>Did not enter the statement "Attending physician  |
|              | not hospice employee" on the claim to certify that  |
|              | the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.   |
| MA95         | A "not otherwise classified" or "unlisted" procedure code(s) was billed, but a narrative description of the   |
|              | procedure was not entered on the claim. Refer to  |
| MA96         | item 19 on the HCFA-1500.<br>Claim rejected. Coded as a Medicare Managed Care   |
|              | Demonstration but patient is not enrolled in a  |
| MA97         | Medicare managed care plan.<br>Claim rejected. Does not contain the Medicare  |
|              | Managed Care Demonstration contract number,<br>however, the beneficiary is enrolled in a Medicare   |
|              | managed care plan.  |

| MA98 | Claim rejected. Does not contain the correct |
|------|--|
|      | Medicare Managed Care Demonstration contract |
|      | number for this beneficiary.                 |

- MA99 Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.
- MA100 Did not complete or enter accurately the date of current illness, injury or pregnancy.
- MA101 A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.
- MA102 Did not complete or enter accurately the referring/ ordering/supervising physician's/physician's assistant's, nurse practitioner's, or clinical nurse specialist's name and/or UPIN
- MA103 Hemophilia Add On
- MA104 Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. MA105 Missing/invalid provider number for this place of service. Place of service code shown as 21, 22, or 23 (hospital)
   MA106 PIP claim
- MA107 Paper claim contains more than three separate data items in field 19.
- MA108 Paper claim contains more than one data item in field 23.
- MA109 Claim processed in accordance with ambulatory surgical guidelines.
- MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.
- MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.
- MA112 Our records indicate that the performing physician/ supplier/practitioner is a member of a group practice; however, you did not complete or enter accurately their carrier assigned individual and group PINs.
- MA113 Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
- MA114 Did not complete or enter accurately the name and address, the carrier assigned PIN, or the Regional Office assigned OSCAR number of the entity where services were furnished.
- MA115 Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered.
- MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
- MA117 This claim has been assessed a \$1.00 user fee.
- MA118 Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
- MA119 Provider level adjustment for late claim filing applies to this claim.

| MA120          | Did not complete or enter accurately the CLIA   |
|----------------|---|
| MA121          | number.<br>Did not complete or enter accurately the date the X-   |
| MA122          | ray was performed.<br>Did not complete or enter accurately the initial date<br>"actual" treatment occurred. |
| MA123          | Your center was not selected to participate in this study, therefore, we cannot pay for these services.     |
| MA124          | Processed for IME only.   |
| MA125          | Per legislation governing this program, payment constitutes payment in full.                                |
| MA126<br>MA127 | Reserved for future use.<br>Reserved for future use.  |
| MA127<br>MA128 | Did not complete or enter accurately the six digit<br>FDA approved, identification number.                  |
| MA129          | This provider was not certified for this procedure<br>on this date of service. Effective 1/1/98, we will    |
|                | begin to deny payment for such procedures. Please   |
|                | contact to correct or obtain CLIA   |
|                | certification. (Claim processor will provide the<br>name and phone number of the State Agency to be         |
|                | contacted.)   |
| MA130          | Your claim contains incomplete and/or invalid   |
|                | information, and no appeal rights are afforded because the claim is unprocessable. Please submit a          |
|                | new claim with the complete/correct information.  |
| MA131          | Physician already paid for services in conjunction  |
|                | with this demonstration claim. You must have the physician withdraw that claim and refund the               |
|                | payment before we can process your claim.   |
| MA132          | Adjustment to the pre-demonstration rate.   |
| MA133          | Claim overlaps inpatient stay. Rebill only those  |
| MA134          | services rendered outside the inpatient stay.<br>Missing/incomplete/invalid provider number of the          |
|                | facility where the patient resides.   |
| N1             | You may appeal this decision in writing within the  |
|                | required time limits following receipt of this notice.  |
| N2             | This allowance has been made in accordance with<br>the most appropriate course of treatment provision       |
|                | of the plan.  |
| N3             | Required/consent form incomplete, incorrect, or not on file.  |
| N4             | Prior insurance carrier EOB received was  |
| N5             | insufficient.<br>EOB received from previous payer. Claim not on   |
|                | file.   |
| N6             | Under FEHB law (U.S.C. 8904(b)), we cannot pay  |
|                | more for covered care than the amount Medicare<br>would have allowed if the patient were enrolled in        |
|                | Medicare Part A.  |
| N7             | Processing of this claim/service has included   |
| N8             | consideration under Major Medical provisions.<br>Crossover claim denied by previous payer and               |
|                | complete claim data not forwarded. Resubmit this  |
|                | claim to this payer to provide adequate data for  |
| N9             | adjudication.<br>Adjustment represents the estimated amount the   |
|                | primary payer may have paid.  |
| N10            | Claim/service adjusted because of the finding of a  |
|                | Review Organization/professional consult/manual adjudication.   |
| N11            | Denial reversed because of medical review.  |
| N12            | Policy provides coverage supplemental to  |
|                | Medicare. As member does not appear to be<br>enrolled in Medicare Part B, the member is                     |
|                | responsible for payment of the portion of the charge  |
| N12            | that would have been covered by Medicare.   |
| N13            | Payment based on professional/technical component modifier(s).  |
| N14            | Payment based on a contractual amount or  |
|                | agreement, fee schedule, or maximum allowable   |
| N15            | amount.<br>Services for a newborn must be billed separately.  |
| 1113           | services for a new offit must be officer separately.  |

| N16        | Family/member Out-of-Pocket maximum has been   |
|------------|--|
| N117       | met. Payment based on a higher percentage.   |
| N17        | Per admission deductible.  |
| N18        | Payment based on the Medicare allowed amount.  |
| N19        | Procedure code incidental to primary procedure.  |
| N20        | Service not payable with other service rendered on   |
| 1101       | the same date.   |
| N21        | Range of dates separated onto single lines.  |
| N22        | This procedure was added because it more   |
|            | accurately describes the services rendered.  |
| N23        | Patient liability may be affected due to coordination  |
|            | of benefits with primary carrier and/or maximum  |
|            | benefit provisions.  |
| N24        | Electronic Funds Transfer (EFT) banking  |
|            | information incomplete/invalid.  |
| N25        | This company has been contracted by your benefit   |
|            | plan to provide administrative claims payment  |
|            | services only. This company does not assume  |
|            | financial risk or obligation with respect to claims  |
|            | processed on behalf of your benefit plan.  |
| N26        | Itemized bill required for claim adjudication.   |
| N27        | Treatment number not indicated on claim.   |
| N28        | Consent form requirements not fulfilled.   |
| N29        | Required documentation/orders/notes/summary/   |
|            | report/invoice needed to adjudicate.   |
| N30        | Recipient ineligible for this service.   |
| N31        | Prescribing/referring/attending practitioner license   |
|            | number is absent/incorrect/incomplete.   |
| N32        | Provider performing service must submit claim.   |
| N33        | No record of health check prior to initiation of   |
| 1,00       | treatment.   |
| N34        | Incorrect claim form for this service.   |
| N35        | Program integrity/utilization review decision.   |
| N36        | Claim must meet primary payer's processing   |
| 1150       | requirements before we can consider payment.   |
| N37        | Tooth number/letter required.  |
| N38        | Place of service missing.  |
| N39        | Procedure code is not compatible with tooth  |
| 1(3)       | number/letter.   |
| N40        | Procedure requires X-ray.  |
| N40<br>N41 | Authorization request denied. (Note: N41   |
| 1441       | duplicates reason code message 39. Message N41 is  |
|            | inactive effective with implementation of version  |
|            | 4010 of the X12 835. N41 may not be used after   |
|            | that date.)  |
| N42        | No record of mental health assessment.   |
| N42<br>N43 | Bed hold or leave days exceeded.   |
| N43<br>N44 |  |
| 1844       | Payor's share of regulatory surcharges,  |
|            | assessments, allowances or health care-related taxes   |
|            | paid directly to the regulatory authority. (Note: N44<br>duplicates remark and message 127 Message N44 |
|            | duplicates remark code message 137. Message N44  |
|            | is inactive effective with implementation of version   |
|            | 4010 of the X12 835. N44 may not be used after   |
| 2145       | that date.)  |
| N45        | Payment based on authorized amount.  |
| N46        | Missing/incomplete/invalid admission hour.   |
| N47        | Claim conflicts with another inpatient stay.   |
| N48        | Claim information does not agree with information  |
|            | received from other insurance carrier.   |
| N49        | Court ordered coverage information needs   |
|            | validation.  |
| N50        | Discharge information missing/incomplete/  |
|            | incorrect/invalid.   |
| N51        | Electronic interchange agreement not on file for   |
|            | provider/submitter.  |
| N52        | Patient not enrolled in the billing provider's   |
|            | managed care plan on the date of service.  |
| N53        | Incomplete/invalid street, city, state and/or zip code   |
|            | for the point of pickup.   |
|            |  |

- N54 Claim information is inconsistent with pre-certified/ authorized services.
- N55 Procedures for billing with group/referring/ performing providers were not followed.

| N56  | Procedure code billed is not correct for the service  |
|------|---|
|      | billed.   |
| N57  | Missing/incomplete/invalid prescribing/dispensed  |
|      | date.   |
| N58  | Patient liability amount missing, invalid, or not on  |
| 1150 | file.   |
| N59  | Please refer to your provider manual for additional   |
| NCO  | program and provider information.   |
| N60  | A valid NDC is required for payment of drug claims effective October 2002.                                |
| N61  | Rebill services on separate claims.   |
| N62  | Inpatient admission spans multiple rate periods.  |
| 1102 | Resubmit separate claims.   |
| N63  | Rebill services on separate claim lines.  |
| N64  | The "from" and "to" dates must be different.  |
| N65  | Procedure code or procedure rate count cannot be  |
|      | determined, or was not on file, for the date of   |
|      | service/provider. Please contact the Health Plan  |
|      | prior to refiling the claim.  |
| N66  | Claim lacks necessary documentation.  |
| N67  | Professional provider services not paid separately.   |
|      | Included in facility payment under a demonstration  |
|      | project. Apply to that facility for payment, or   |
|      | resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if |
|      | you furnished these services in another location on   |
|      | the date of the patient's admission or discharge  |
|      | from a demonstration hospital. If services were   |
|      | furnished in a facility not involved in the   |
|      | demonstration on the same date the patient was  |
|      | discharged from or admitted to a demonstration  |
|      | facility, you must report the provider ID number for  |
|      | the non-demonstration facility on the new claim.  |
| N68  | Prior payment being cancelled as we were  |
|      | subsequently notified this patient was covered by a   |
|      | demonstration project in this site of service.  |
|      | Professional services were included in the payment<br>made to the facility. You must contact the facility |
|      | made to the facility. You must contact the facility for your payment. Prior payment made to you by        |
|      | the patient or another insurer for this claim must be   |
|      | refunded to the payer within 30 days.   |
| N69  | PPS code changed by claims processing system.   |
|      | Insufficient visits or therapies.   |
| N70  | Home health consolidated billing and payment  |
|      | applies. Ancillary providers/suppliers must contact   |
|      | the HHA for reimbursement.  |
| N71  | Your unassigned claim for a drug or biological,   |
|      | clinical diagnostic laboratory services or  |
|      | ambulance service was processed as an assigned  |
|      | claim. You are required by law to accept  |
| N72  | assignment for these types of claims.<br>PPS code changed by medical reviewers. Not                       |
| 11/2 | supported by clinical records.  |
| N73  | A SNF is responsible for payment of outside   |
| 1175 | providers who furnish these services/supplies to  |
|      | residents.  |
| N74  | Resubmit with multiple claims, each claim covering  |
|      | services provided in only one calendar month  |
| N75  | Missing or invalid tooth surface information  |
| N76  | Missing or invalid number of riders (for ambulance  |
|      | services).  |
| N77  | Missing or invalid designated provider number.  |
| N78  | The necessary components of the child and teen  |
|      | checkup (EPSDT) were not completed.   |

| N79        | Service billed is not compatible with patient  |
|------------|--|
|            | location information.  |
| N80        | Missing or invalid prenatal screening information  |
| N81        | Procedure billed is not compatible with tooth  |
|            | surface code.  |
| N82        | Provider must accept insurance payment as  |
|            | payment in full when a third party payer contract  |
|            | specifies full reimbursement.  |
| N83        | No appeal rights. Adjudicative decision based on   |
|            | the provisions of a demonstration project.   |
| N84        | Further installment payments forthcoming.  |
| N85        | Final installment payment.   |
| N86        | A failed trial of pelvic muscle exercise training is   |
|            | required in order for biofeedback training for the   |
|            | treatment of urinary incontinence to be covered.   |
| N87        | Home use of biofeedback therapy is not covered.  |
| N88        | This payment is being made conditionally. An   |
|            | HHA episode of care notice has been filed for this   |
|            | patient. When a patient is treated under a HHA   |
|            | episode of care, consolidated billing requires that  |
|            | certain therapy services and supplies, such as this,   |
|            | be included in the HHA's payment. This payment   |
|            | will need to be recouped from you if we establish  |
|            | that the patient is concurrently receiving treatment   |
| NICO       | under a HHA episode of care.   |
| N89        | Payment information for this claim has been  |
|            | forwarded to more than one other payer, but format   |
|            | limitations permit only one of the secondary payers<br>to be identified in this remittance advice. |
| NOO        |  |
| N90        | Covered only when performed by the attending   |
| N91        | physician.   |
| N91<br>N92 | Services not included in the appeal review.<br>This facility is not certified for digital          |
| 1192       | mammography.   |
| N93        | A separate claim must be submitted for each place  |
| 193        | of service. Services furnished at multiple sites may   |
|            | not be billed in the same claim.   |
| N94        | Claim/Service denied because a more specific   |
| 1174       | taxonomy code is required for adjudication.  |
|            |  |
|            | a sta fan Aslalitianal Caslaa  |

#### **Requests for Additional Codes**

CMS has national responsibility for maintenance of the remittance advice remark codes. Requests for new or changed remark codes should be submitted to CMS via the Washington Publishing Company Webpage remark code request function. Requests for codes must include the name, phone number, company name, and email address of the requestor, the suggested wording for the new or revised message, and an explanation of how the message will be used and why it is needed. A fax number or mail address is acceptable in the absence of an email address. Requests may also be mailed to:

> Centers for Medicare & Medicaid Services OIS/SSG/DHCISS Mail Stop N2-14-26 7500 Security Blvd. Baltimore MD 21244-1850

CMS expects to issue a response to most remark message requests within 2 weeks of receipt.

Source: CMS Transmittal B-01-35, CR 1523 (downloaded from **www.wpc-edi.com/HIPAA**)

## Do Not Forward Initiative—"Return Service Requested" for Remittance Advice

The Do Not Forward initiative implemented on July 1, 2000, entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks to locations other than what is recorded on the Medicare provider files.

Program Memorandum (PM) B-02-001, Change Request 1933, amends Medicare Carriers Manual (MCM) section 4021 to instruct contractors to also use "return service requested" envelopes for remittance advice as part of the DNF initiative. Any new requirements in the PM that conflict with MCM 4021 supersede the MCM requirements.

Because some providers are paid via electronic funds transfer (EFT), there may be cases where a provider does not have a correct address on file, but the contractor continues to pay the provider through EFT. Therefore, **effective for claims processed on or after April 1, 2002**, contractors will use "return service requested" envelopes for hardcopy remittance advices, in addition to using them for hardcopy checks, with respect to providers who have elected to receive hardcopy remittance advices.

When the post office returns a remittance advice due to an incorrect address, the contractor will cease generating any more payments to that provider or supplier until he or she furnishes a new address on the appropriate Form CMS-855. Providers or suppliers must indicate the "pay to" address *and* the physical or street address even if only one address is changed. Upon verification of the new address, the contractor may begin issuing payments to the provider or supplier again.

Source: CMS Transmittal B-02-001, CR 1933

# THE PATIENT FRIENDLY ADVISORY

### Medicare Sets its "Sights" on Healthy Eyes

Medicare cares about keeping people with Medicare healthy, including their eyes. In this installment of the Patient Friendly Advisory, we'll look at a new screening glaucoma benefit and a program that helps diabetics receive free eye exams.

Effective January 1, 2002, a new provision under the Benefits Improvement and Protection Act of 2000 adds Medicare coverage for glaucoma screenings every 12 months for persons determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes.

The service has to be furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to perform such services in the state where the services are furnished.

Glaucoma is an eye disease in which the normal fluid pressure inside the eyes slowly rises, leading to vision loss or even blindness. According to the National Eye Institute, nearly 3 million people have glaucoma, a leading cause of blindness in the United States. Although anyone can get glaucoma, some people are at higher risk. African Americans, for example, are at a higher risk.

Glaucoma is:

- Five times more likely to occur in African Americans than in whites
- About four times more likely to cause blindness in African Americans than in whites
- Fifteen times more likely to cause blindness in African Americans between the ages of 45-64 than in whites of the same age group

The National Eye Institute also emphasizes that early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Diabetics who have Medicare may be eligible for free eye exams. The Centers for Medicare & Medicaid Services, in collaboration with the American Academy of Ophthalmology and the American Optometric Association, have initiated a National program for people with Medicare who have diabetes to encourage them to get their eyes examined. Under the initiative, people with Medicare age 65 and older who have diabetes and have not had a medical eye exam in the past three years will be matched with a volunteer ophthalmologist in their area. Participants receive a free comprehensive eye exam and up to one year of follow-up care for any condition diagnosed at the initial exam. To get the name of an ophthalmologist participating in the EyeCare America<sup>SM</sup>—National Eye Care Project<sup>®</sup> in a specific area, call the 24 hour toll-free number at 1-800-222-3937.

People with Medicare can also call the American Optometric Association's Diabetes Hot Line at 1-800-262-3947 (7a.m. – 7p.m. Monday through Friday CST) to be matched with an optometrist in your area who will perform an eye exam and arrange for subsequent care. Depending on financial need, the optometrist may waive the Medicare deductible and copayment for this service.

For more information about Medicare's coverage of glaucoma screenings or diabetes benefits, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD for the hearing and speech impaired is available at 1-877-486-2048. Additional information is available on the Medicare Web site at **www.medicare.gov** and in the *Medicare and You 2002 Handbook*.

First Coast Service Options, Inc. (FCSO) contracts with the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) to administer the Medicare program in Florida and Connecticut. FCSO's parent company, Blue Cross and Blue Shield of Florida, Inc. (BCBSF), is an independent licensee of the Blue Cross and Blue Shield Association.



# Take this Eye-Q test — See how much you know about glaucoma

Fifty million Americans are at risk for vision loss from glaucoma, a leading cause of blindness in the United States. Are you one of them? If you are, do you know how to reduce your risk of blindness? To determine how high your Eye-Q is, answer the following questions about glaucoma.

|    |  | True | False | Not Sure |
|----|--|------|-------|----------|
| 1  | Glaucoma is more common in Blacks than in Whites.  |      |       |          |
| 2  | Glaucoma tends to run in families.   |      |       |          |
| 3  | A person can have glaucoma and not know it.  |      |       |          |
| 4  | People over age 60 are more likely to get glaucoma.                                      |      |       |          |
| 5  | Eye pain is often a symptom of glaucoma.   |      |       |          |
| 6  | Glaucoma can be controlled.  |      |       |          |
| 7  | Glaucoma is caused by increased eye pressure.  |      |       |          |
| 8  | Vision lost from glaucoma can be restored.   |      |       |          |
| 9  | A complete glaucoma exam consists only of measuring eye pressure.                        |      |       |          |
| 10 | People at risk for glaucoma should<br>have an eye examination through<br>dilated pupils. |      |       |          |

To see if you have a perfect Eye-Q score, read all the answers on the back. If you got 9 or 10 right, congratulations. You know a lot about glaucoma. If you missed some, review the answers so you can share your knowledge with your family and friends.









# Answers

- **1 True.** In a study funded by the National Eye Institute, researchers at The Johns Hopkins University reported that glaucoma is three to four times more likely to occur in Blacks than in Whites. In addition, glaucoma is six times more likely to cause blindness in Blacks than in Whites.
- **2 True.** Although glaucoma tends to run in families, a hereditary basis has not been established. If someone in your immediate family has glaucoma, you should have your eyes examined through dilated pupils at least every two years.
- **3 True.** The early stages of open-angle glaucoma, the most common form, usually have no warning signs. However, as the disease progresses, a person with glaucoma may notice his or her side vision gradually failing.
- **4 True.** Everyone over age 60 has an increased risk for glaucoma. Other groups at increased risk include Blacks over age 40 and people with a family history of the disease.
- **5 False.** People with glaucoma usually do not experience pain from the disease.
- **6 True.** Although glaucoma cannot be cured, it usually can be controlled by eyedrops or pills, conventional surgery, or laser surgery. Sometimes eye care professionals will recommend a combination of surgery and medication.
- **7 True.** In glaucoma, for reasons still not completely understood, fluid drains too slowly out of the eye. As the fluid builds up, the pressure inside the eye rises. Unless this pressure is controlled, it may cause damage to the optic nerve and other parts of the eye and loss of vision.
- **8 False.** Vision loss from glaucoma is permanent. However, with early detection and treatment, the progression of visual loss can be slowed, or halted, and the risk of blindness reduced.
- **9 False.** A measurement of eye pressure by tonometry, though an important part of a comprehensive eye exam, is by itself not sufficient for the detection of glaucoma. Glaucoma is detected most often during an eye examination through dilated pupils. This means drops are put into the eyes during the exam to enlarge the pupils, which allows the eye care professional to see more of the inside of the eye to check for signs of glaucoma. When indicated, a visual field test should also be performed.
- **10 True.** An eye examination through dilated pupils is the best way to diagnose glaucoma. Individuals at increased risk for the disease should have their eyes examined through dilated pupils at least every two years by an eye care professional.

# Get your eyes examined. Don't lose sight of glaucoma.

For more information about glaucoma, write: National Eye Health Education Program 2020 Vision Place Bethesda, MD 20892–3655 www.nei.nih.gov



# EDUCATIONAL RESOURCES

### **New Educational Materials for Cervical Cancer Screening**

Women rely on their health care providers for screening recommendations. Many women, especially older women, are not aware of the importance of cervical cancer screening and may not ask for Pap tests. Your reminder about the need for a regular Pap test is important.

The National Cancer Institute (NCI) estimates that about 12,900 cases of newly diagnosed invasive cervical cancer will occur in the United States this year and that about 4,400 of the women affected by the disease will die. Women age 65 and older have the highest mortality but the lowest screening rates. To increase the rates of cervical cancer screening among older women, Medicare has changed its coverage of Pap tests to once every two years. Women may be more likely to get a Pap test if they know Medicare will help pay for it.

Congress has designated January as Cervical Health Month. This may be an opportunity for you to talk to your patients about cervical health. To assist you in communicating with your patients, the Centers for Medicare & Medicaid Services and the National Cancer Institute have developed a Health Professional's Pap Test Packet. The packet contains a brochure on Pap tests designed for older women, a resource guide for health professionals, and a Pap test reminder pad with tear-off sheets to give to your patients. This information can be accessed at http://cancer.gov/publications. After reaching the site, click on "Type of Cancer", then on "Cervix". You then may view and/or order publications. You may also call the National Cancer Institute at 1-800-4CANCER (1-800-422-6237) to order the materials. Up to 20 items may be ordered for free. Shipping and handling charges may be applied to larger orders.

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

Source: CMS Transmittal B-01-75, CR 1912

# The Ultimate Medicare Expo

First Coast Service Options, Inc. is proud to present this year's most spectacular Medicare event, the Ultimate Medicare Expo (UME). This two-day symposium is structured to offer a variety of educational sessions and you can enroll in courses of your choice. The UME is open to Florida providers, People with Medicare (PWM), caregivers, pre-retirees, and billing staff. The UME will also offer an "interactive" session. This session will include PWM, caregivers, pre-retirees, providers, and billing staff working together to understand the important issue of the Advance Beneficiary Notice (ABN).

This Expo is packed with everything needed to help optimize Medicare providers' performance and offers PWM information needed to make informed healthcare decisions. All participants will have an opportunity to participate in a panel discussion featuring a panel of experts (including FCSO representatives) available to answer questions about the Medicare program.

| When:         | May 16 & 17, 2002   |
|---------------|---|
| Where:        | Grenelefe Golf and Tennis Resort<br>3200 State Road 546<br>Haines City, Florida 33844 |
| Registration: | Complete the registration form and class schedules and fax to: (904) 791-6035         |

#### Come and join us for this exciting event!

You can't afford to miss this Expo. Some of the many benefits to the provider are:

- You'll gain strategies for implementing processes to improve reimbursement efficiency.
- You'll discover proven ways to resolve your Medicare denials.
- Medicare experts will answer your questions.

The Ultimate Medicare Expo is a one-of-a-kind event guaranteed to increase your Medicare Knowledge!

# Florida Medicare Education and Outreach Department

REGISTRANT'S NAME:

IMPORTANT CLASS

SCHEDULE INSTRUCTIONS

REGISTRATION DEADLINE MAY 2, 2002

# MAY 16 - DAY 1

9:00-9:15

### General Session (All UME attendees)

### 9:30 - 11:00

- nesthagia (P)
- Anesthesia (B)Dermatology (B)

- Primary Care (B)
- UB 92/Direct Data Entry Workshop (A)

### 11:30 - 12:30

### Panel Discussion (All UME Attendees)

1:30 – 3:00

- E/M Documentation (B)
- □ Fraud and Abuse (A/B)
- HCFA 1500 Workshop (B)
- HOPPS (A)
- □ Vision (B)

### 3:30 - 5:00

- Advanced Modifiers (A/B)
- Fraud and Abuse (A/B)
- □ Medical Review (A/B)
- Medicare Secondary Payer (A)
- □ Reimbursement Efficiency (B)

#### 1. Submit one registration form per person

- 2. Select only one class per time slot
- 3. Your registration form must accompany your class schedule(s)

# MAY 17 - DAY 2

### 8:00 - 9:30

- Advanced Modifiers (A/B)
- E/M Coding (B)
- □ IRF/PPS (A)
- Orthopedics (B)
- Provider Enrollment Workshop (A/B)

#### 9:45 – 11:15

Interactive Session (All UME Attendees) Topic: Advanced Beneficiary Notices

#### 11:30 - 1:00

□ HIPAA (A/B)

D Partial Hospital Program (A)

- □ Medicare Secondary Payer Workshop (B)
- Rehabilitation Services (A/B)
- □ Reimbursement Efficiency (A)
- (A) Part A Course (B) – Part B Course
- (A/B) Part A & B Course

PROVIDER #:

**ULTIMATE MEDICARE EXPO** 

**CLASS SCHEDULE** 

May 16 & 17, 2002

(Day 1 & 2)

## Florida Medicare Education and Outreach Department

## ULTIMATE MEDICARE EXPO REGISTRATION FORM May 16 & 17, 2002

| Four Easy Steps to Register<br>Note: All registrations<br>must be received by May 2, 2002 | <ol> <li>Fax both registration form and class schedule(s) to (904) 791-6035</li> <li>Make checks payable to: FCSO Account #756240</li> <li>Mail the forms (after you have faxed them) and payment to:<br/>UME Seminar Registration<br/>PO Box 45157<br/>Jacksonville, Florida 32231</li> <li>Bring your UME Confirmation notice (or number) to the event</li> </ol> |  |  |
|---|---|--|--|
| Registrant's Name   |   |  |  |
| Provider's Name   |   |  |  |
| Medicare Billing Provider #   | Sender Number:  |  |  |
| Address   |   |  |  |
| City, State, ZIP Code   |   |  |  |
| Phone() Fax()   | E-mail:   |  |  |

#### Payment is being issued for:

| Seminar/Material<br>*UME Course Materials will be provided at the event (upon arrival)  | Quanti | ty                        | Price<br>(each)  | Total |
|---|--------|---------------------------|------------------|-------|
| Ultimate Medicare Expo (UME)<br>Note: UME Course Materials are not included.  | N/A    |                           | \$299.00         |       |
| <b>UME Part A Handbook*</b> (see course descriptions for a list of the courses included)  |        |                           | \$75.00          |       |
| UME Part B Handbook* (see course descriptions for a list of the courses included)   |        |                           | \$75.00          |       |
| UME Individual Course Material*<br>(see course descriptions for a list of the courses available)<br>Please list course topics you are ordering:                                     |        |                           | \$30.00          |       |
| I<br>Method of payment: Cash, Visa, MasterCard, American Express, Discover, and other credit<br>cards are not acceptable forms of payment. Please send only checks or money orders. |        | Subto<br>Tax (a<br>Total: | otal:<br>dd 7%): |       |

All payments must be received prior to the registration deadline May 2, 2002. Check (# \_\_\_\_\_\_) Money Order

#### **Important Registration Information:**

| <b>Cancellations and Refunds</b>   | Substitutions   | Confirmation Number  | Hotel Information  |
|--|---|--|--|
| All cancellation requests<br>must be received 14 days<br>prior to the event. All refunds<br>are subject to a \$35.00<br>cancellation fee per person.<br>(Rain checks will not be | If you are unable to attend, your<br>company may send one<br>substitute to take your place for<br>the entire seminar. Remember:<br>Registration must be informed<br>of all changes. | A confirmation number will be<br>faxed to you within 14 days of<br>receiving your registration<br>form.<br>If you do not receive a   | Grenelefe Golf and<br>Tennis Resort<br>3200 State Road 546<br>Haines City, Florida 33844<br>(863) 421-5004 |
| Additionally, rain checks<br>issued for previous seminars<br>may not be applied towards<br>this event)   | Once you have signed in at the<br>registration desk, substitutions<br>will not be permitted during the<br>remainder of the event.   | confirmation number (not the<br>confirmation form generated<br>from your fax machine, but the<br>confirmation notice provided by<br>Medicare Education and<br>Training), please contact us at<br>(904) 791-8103. | Ask for FCSO's Special<br>Room Rate.   |

For additional information, please visit our Web site at www.floridamedicare.com or call our registration hotline at (904) 791-8103.

#### MEDICARE EDUCATION AND OUTREACH SURVEY FORM Ultimate Medicare Expo (UME)—May 16-17, 2002

This educational symposium includes five workshops and seventeen classes. The presentations are designed to include advanced topics and specific issues. To ensure that we include the appropriate material in these sessions, we are seeking your input.

Please complete one survey form for each course or workshop you plan to attend. This survey form is designed for input specifically related to courses and workshops scheduled for UME. (A separate survey form for other upcoming educational events is provided for your use elsewhere in this publication)

#### Note: Check one course per survey submission

| Part A                   | Part B                   | Parts A and B           |
|--------------------------|--------------------------|-------------------------|
| HOPPS                    | □ Anesthesia             | Advanced Modifiers      |
| IRF/PPS                  | Dermatology              | Fraud and Abuse         |
| MSP (workshop)           | E/M Coding               |                         |
| PHP                      | E/M Documentation        | Medical Review          |
| Reimbursement Efficiency | HCFA-1500/EMC (workshop) | Provider Enrollment     |
| UB-92/DDE (workshop)     | □MSP (workshop)          | (workshop)              |
|                          | Orthopedics              | Rehabilitation Services |
|                          | Primary Care             |                         |
|                          | Reimbursement Efficiency |                         |
|                          | □ Vision                 |                         |

Include examples and/or any supporting documentation.

Claims submission: (e.g., claim filing questions, denials)

Electronic Claims Submission:

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

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

Other: (e.g., your specialty)

What type of provider or facility do you represent? Part A \_\_\_\_\_ Part B \_\_\_\_\_

Field: (e.g., general practice, cardiology, podiatry):

Fax your completed survey (one per course or workshop) to (904) 791-6035 no later than **March 4, 2002**, to allow sufficient time for your questions/concerns to be considered.

# **BASIC SKILLS WORKSHOP FOR MEDICARE PART B PROVIDERS**

Presented by First Coast Service Options, Inc. Your Florida Medicare Contractor

# **Designed for New Office Personnel!**

The Medicare Education and Outreach department has designed a new Workshop that provides an in-depth tutorial of Form HCFA-1500, the ICD-9-CM (diagnosis) coding book, and the *CPT* (*Current Procedural Terminology*) book. This workshop includes hand-on exercises that underscore the training and provides you with the basic tools needed to bill for Medicare services. This educational event is a *must* for any new (or relatively new) Medicare biller.

| Date                          | Location                     |
|-------------------------------|------------------------------|
| February 26, 2002             | Hyatt Regency                |
| 8:30 a.m. – 4:30 p.m.         | Two Tampa City               |
| Registration deadline 2/19/02 | Tampa, FL                    |
| March 20, 2002                | Embassy Suites PGA           |
| 8:30 a.m. 4:30 p.m.           | 4380 PGA Boulevard           |
| Registration deadline 3/13/02 | Palm Beach Gardens, FL       |
| June 13, 2002                 | Sheraton Gainesville Hotel   |
| 8:30 a.m. – 4:30 p.m.         | 2900 SW 13 <sup>th</sup> St. |
| Registration deadline 6/6/02  | Gainesville, FL              |

Have your questions answered by the Medicare experts. Register today for one of the sessions listed below!

All sessions include a continental breakfast and afternoon snack. Lunch will **not** be provided

# Don't Delay – Register Today – Only \$249

Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration)

# **Free Seminar! MEDICARE BUILDING BLOCKS** FOR **BEGINNERS PART B**

Presented by First Coast Service Options, Inc. Your Florida Medicare Contractor

# **Designed for New and Experienced Office Personnel!**

The Medicare Education and Outreach department has designed two sessions that provide general information about Medicare guidelines. Each three-hour session consists of two topics.

Session I - Inquiries, Appeals and Overpayments; and Form HCFA-1500 Session II – Global Surgery and Coding (CPT & ICD-9-CM combined)

These sessions are designed for providers new to the Medicare program or for those who want a refresher course.

> Have your questions answered by the Medicare experts. Register today for one of the sessions listed below!

|       | SESSION I<br>February 20, 2002<br>9:00 a.m. – 12:00 p.m.<br>or<br>1:00 p.m. – 4:00 p.m.<br>Registration deadline 2/13/02<br>Embassy Suites Hotel<br>0200 Barman Add | SESSION II<br>April 3, 2002<br>9:00 a.m. – 12:00 p.m.<br>or<br>1:00 p.m. – 4:00 p.m.<br>Registration deadline 3/27/02<br>Holiday Inn Ft Lauderdale Beach<br>999 Ft Lauderdale Beach Blvd. |  |  |  |  |
|-------|---|---|--|--|--|--|
|       | 9300 Baymeadows Rd.<br>Jacksonville, FL   | FT LAUDERDALE, FL   |  |  |  |  |
| 's N  | ame:  |   |  |  |  |  |
| Nai   | ne:   |   |  |  |  |  |
| Billi | ng Provider/Group Number:   |   |  |  |  |  |

### Seminar dates, times and locations

Registrant

Provider's Medicare

Address:

E-mail:

City, State, Zip Code:

Phone Number: ( )

Fax (

)

Fax completed form to (904) 791-6035, attention: Michelle Jackson

Centers for Medicare & Medicaid Services Formerly Health Care Financing Administration

# **BEYOND THE BASICS WORKSHOP**

# FOR

# **MEDICARE PART B PROVIDERS**

## Presented by First Coast Service Options, Inc. Your Florida Medicare Contractor

### **Designed for Experienced Office Personnel!**

Medicare Beyond the Basics is an interactive workshop meant for the intermediate or seasoned Medicare biller. It features hints and tools for ensuring clean claims, a "modifier" tutorial that includes usage aids, a HIPAA privacy overview, Hot Topics and new changes, incident-to exercises, and group exercises to solve difficult coding scenarios.

Have your questions answered by the Medicare experts.

Register today for one of the sessions listed below!

| Date                          | Location               |
|-------------------------------|------------------------|
| February 27, 2002             | Hyatt Regency Tampa    |
| 8:30 a.m. – 4:30 p.m.         | Two Tampa City         |
| Registration deadline 2/20/02 | Tampa, FL              |
| March 21, 2002                | Embassy Suites PGA     |
| 8:30 a.m. – 4:30 p.m.         | 4380 PGA Boulevard     |
| Registration deadline 3/14/02 | Palm Beach Gardens, FL |

All sessions include a continental breakfast and afternoon snack.

Lunch will not be provided

# Don't Delay – Register Today – Only \$249

Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration)

# PROVIDER EDUCATION & TRAINING (PET) ADVISORY MEETING

Presented by First Coast Service Options, Inc. Your Florida Medicare Contractor

March 8, 2002

| Time:  | 9:00 a.m. to 12 noon              |
|--------|-----------------------------------|
| Place: | First Coast Service Options, Inc. |
|        | 532 Riverside Ave.                |
|        | Jacksonville, FL                  |
| Cost:  | Free                              |

The Medicare Education and Outreach department will host its PET Advisory Group Meeting on March 8, 2002.

The PET Advisory Group is a panel of representatives from state medical societies, provider offices, billing organizations and consulting firms that meets every quarter to:

- Review new and existing Medicare education programs
- Recommend changes to these programs
- Alert Medicare to problems or concerns affecting providers
- Network with other professionals interested in Medicare
- Disseminate information from the advisory group to the organizations represented

#### Please complete the registration form below

| Registrant's Name:  |  |  |  |  |  |
|---|--|--|--|--|--|
| Company's Name:   |  |  |  |  |  |
| Position or Title:  |  |  |  |  |  |
| Address:  |  |  |  |  |  |
| City, State, Zip Code:  |  |  |  |  |  |
| Phone Number:         ()         Fax:         ()  |  |  |  |  |  |
| E-mail:   |  |  |  |  |  |
| Deadline for registration March 4, 2002<br>Fax completed form to (904) 791-6035, attention: Michelle Jackson<br>Centers for Medicare & Medicaid Services<br>Formerly Health Care Financing Administration |  |  |  |  |  |

# MEDICARE EDUCATION AND OUTREACH SURVEY FORM

To ensure that we include material addressing your issues and concerns, we are seeking your input for upcoming events Please complete <u>one survey form for each event</u> you plan to attend. (Note: A separate survey is provided for the Ultimate Medicare Expo scheduled for May 16-17, 2002.)

#### CHECK ONE:

- Building Blocks for Beginners (Part A)
- Building Blocks for Beginners (Part B)
- Basic Skills Workshop (Part A)
- Basic Skills Workshop (Part B)
- Beyond the Basics (Part B)
- ABN Workshop (Part B)
- MSP Workshop (Part A)

- PET Advisory Group Meeting
- SNF/PPS Specialty Seminar
- ARNP/PA Specialty Seminar
- Provider Enrollment Specialty Seminar
- Teleconference Part A (SNP/PPS)
- **Teleconference Part B (HIPAA)**
- **Teleconference Part B (ASC)**

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

Claims submission: (e.g., claim filing questions, denials)

Electronic Claims Submission:

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

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

Other: (e.g., your specialty)

What type of provider or facility do you represent? Part A \_\_\_\_\_ Part B \_\_\_\_\_

Field: (e.g., general practice, cardiology, podiatry): \_\_\_\_\_

Fax your completed survey (one per event) to (904) 791-6035 no later than **three weeks** before the event to allow sufficient time for your questions/concerns to be considered.

| M                | EDICARE I  | EDUCA  | FION & OU       | utreach <b>B</b>                    | EVENT <b>R</b> eg | ISTR    | ATION FORM                |  |  |  |
|------------------|--|--|-----------------|-------------------------------------|-------------------|---------|---------------------------|--|--|--|
| PLEA             | SE complet   | e all po   | rtions of this  | is form.                            |                   |         |                           |  |  |  |
|                  | DO NOT include your Medicare Provider Number on this form.   |  |                 |                                     |                   |         |                           |  |  |  |
|                  | y one form<br>o are you?   |  | son, per-reg    | gistration, pl                      | ease.             |         |                           |  |  |  |
|                  | Jare you   | •  |                 |                                     |                   |         |                           |  |  |  |
| Na               | me   |  |                 |                                     |                   |         |                           |  |  |  |
| Tit              | Title/Position Company/Organization  |  |                 |                                     |                   |         |                           |  |  |  |
| Co               |  |  |                 |                                     |                   |         |                           |  |  |  |
| Ad               | dress  |  |                 |                                     |                   |         |                           |  |  |  |
| Cit              |  |  |                 |                                     | State             |         | Code                      |  |  |  |
|                  |  |  | )               |                                     | Fax Number        | -       |                           |  |  |  |
|                  | ail Address  |  |                 |                                     |                   |         |                           |  |  |  |
|                  |  |  | want to att     | 4 19                                |                   |         |                           |  |  |  |
| Am               | ent Date<br>count Enclos   | ed   | \$              |                                     |                   |         |                           |  |  |  |
| Cit              | ·  |  |                 | (abla)                              |                   |         | State                     |  |  |  |
| Ma<br>you<br>ord | il this form<br>r check or n<br>er payable t<br>o <b>rtant!</b>  | with<br>noney  | events), or     |                                     | r Part A events   | s)      | 756240 (for Part B        |  |  |  |
|                  | Seating IsPlease submit your registration form and mail your payment (if applicable) as soon<br>as possible. Seating for most events is limited. |  |                 |                                     |                   |         |                           |  |  |  |
|                  | ng Your<br>nfirmation  | Be sure to bring your event confirmation notice with you to the event. It will<br>be treated as proof of registration and payment (if applicable) when you sign in<br>at the event and receive your materials. |                 |                                     |                   |         |                           |  |  |  |
| Sul              | ostitutions  | •  |                 | l an event, you<br>ration of the e  | -                 | nly on  | e person to substitute in |  |  |  |
|                  | und  | Refund   | s are available | e if your writte                    | en request is re  |         |                           |  |  |  |
| Pol<br>Ou        | icy<br>estions?  |  |                 | is a \$20 refund<br>hotline at (904 |                   | e per p | DEISON.                   |  |  |  |
| ¥."              |  |  | 0               |                                     | ,                 |         |                           |  |  |  |

**3** Fax your completed form to (904) 791-6035.

Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration)

# FLORIDA MEDICARE EDUCATION AND OUTREACH MEDICARE PART B RESOURCE MANUAL ORDER FORM

**INSTRUCTIONS:** Complete all portions of this form and follow the payment instructions outlined in #3 below.

| 1. TELL US                    | ABOUT YO  | URSELF. PLEASE PRINT                                 |  |       |  |  |  |
|-------------------------------|---|--|--|-------|--|--|--|
| Name                          |   | ne la            |  |       |  |  |  |
| ٦                             | itle/Positio  | n  |  |       |  |  |  |
| Company/                      | Organizatio   | n  |  |       |  |  |  |
|                               | Addres  | is list  |  |       |  |  |  |
| City, State, Zip Code         |   | le   |  |       |  |  |  |
| Phone Number                  |   | er ( ) - Extension:                                  |  |       |  |  |  |
| Fax Number                    |   | er ( ) -   |  |       |  |  |  |
| E-I                           | Mail Addres   | s  |  |       |  |  |  |
| 2. PLEASE                     |   | THE MATERIALS YOU WOULD LIKE TO PURCHASE.            |  |       |  |  |  |
| QUANTITY                      |   | TITLE  | PRICE (EA.)  | TOTAL |  |  |  |
|                               | Medica<br>Includes<br>Notice; A<br>Claims; I<br>Coding;<br>Surgery;<br>Patients<br>Appeals,<br>C; Medic<br>Primary<br>Efficienc | \$80.00  | \$   |       |  |  |  |
|                               |   |  | Sub-Total  | \$    |  |  |  |
|                               |   |  | Add 7%<br>Tax  | \$    |  |  |  |
|                               |   |  | Total  | \$    |  |  |  |
| 3. PLEASE SUBMIT YOUR PAYMENT |   |  |  |       |  |  |  |
| PAYMENT                       |   |  | <ul> <li>Payable to First Coast Service Options, Inc. #756240</li> <li>Mail to Medicare Education and Outreach, Attn: Phyllis Brooks, 17<br/>Tower, P.O. Box 2078, Jacksonville, FL 32231</li> </ul> |       |  |  |  |
| 10                            |   | Tour order will be shipped within tour to six weeks. |  |       |  |  |  |

# FLORIDA MEDICARE EDUCATION AND OUTREACH MEDICARE PART B INDIVIDUAL MODULE ORDER FORM

**INSTRUCTIONS:** Complete all portions of this form and follow the payment instructions outlined in #3 below.

| 1. TELL US ABOUT YOURSELF. PLEASE PRINT  |                               |  |   |   |          |             |           |        |               |    |
|--|-------------------------------|--|---|---|----------|-------------|-----------|--------|---------------|----|
|  | Name                          |  |   |   |          |             |           |        |               |    |
|  | Title/Position                |  |   |   |          |             |           |        |               |    |
| Company  | /Organization                 |  |   |   |          |             |           |        |               |    |
|  | Address                       |  |   |   |          |             |           |        |               |    |
| City, St   | tate, Zip Code                |  |   |   |          |             |           |        |               |    |
| Р  | hone Number                   | (  | )   | -   |          |             | Exte      | nsion: |               |    |
|  | Fax Number                    | (  | )   | -   |          |             |           |        |               |    |
| E·   | -Mail Address                 |  |   |   |          |             |           |        |               |    |
|  |                               |  |   |   |          | -           |           | -      | -             |    |
| BELOW THE LIST. EACH MODULE COSTS \$35.00. (Modules for Advanced Beneficiary Notice*         Advanced Beneficiary Notice*         Ambulance Regulations         Anesthesia         ARNP/PA Guidelines*         Cardiology         Chiropractic         CPT Coding*         Dermatology         Electronic Media Claims (EMC)*         E/M Coding*         E/M Documentation*         Focused Medical Review*         Medical Review*         Nephrology         QUANTITY |                               |  | erstand Mo  | Oncology         Orthopedics         Pathology         PC-ACE™ for HCFA-1500*         Podiatry         Primary Care*         payments*         Provider Enrollment*         Radiology         Rehabilitation Services |          |             |           |        |               |    |
|  | ·                             |  |   |   |          |             |           |        | Sub-Total     | \$ |
|  |                               |  |   |   |          |             |           |        | Add 7%<br>Tax |    |
| Total \$   |                               |  |   |   |          |             | \$        |        |               |    |
| 3. PLEASE  | 3. PLEASE SUBMIT YOUR PAYMENT |  |   |   |          |             |           |        |               |    |
|  | <b>U</b> IN                   | ubmit th   | ne complet  | ed form v   | with you | ur check o  | r money c | order: |               |    |
| PAYMENT •  |                               | Payable to First Coast Service Options, Inc. Account #756240 |   |   |          |             |           |        |               |    |
| •  |                               |  | <i>Mail to</i> Medicare Education and Outreach, Attn: Phyllis Brooks, 17 Tower, P.O. Box 2078, Jacksonville, FL 32231 |   |          |             |           |        |               |    |
|  | Y                             | our ord  | er will be s  | hipped w  | ithin fo | ur to six w | eeks.     |        |               |    |

### **ORDER FORM – 2002 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<br>ORDERED | ІТЕМ   | ACCOUNT<br>NUMBER | COST<br>PER ITEM |
|-------------------|--|-------------------|------------------|
|                   | <i>Medicare B Update!</i> Subscription – One copy of the <i>Update!</i> is sent free of charge to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the twelvemonths prior to the release of each issue. Non-provider entities or providers who need additional copies at other office locations may purchase an annual subscription. This subscription includes all issues published during calendar year 2002 (back issues sent upon receipt of order).  | 756245            | \$75.00          |
|                   | <b>2002 Fee Schedule</b> – One copy of the <i>Medicare Part B Physician and</i><br><i>Non-Physician Practitioner Fee Schedule</i> is sent free of charge in mid-<br>November to individual providers and Professional Association (PA)<br>groups who bill at least one claim to Medicare Part B of Florida for proc-<br>essing during the preceding six months. The Fee Schedule contains calen-<br>dar year 2002 payment rates for all Florida localities. These fees apply to<br>services performed between January 1 and December 31, 2002. These<br>items include the payment rates for injectable drugs, but <i>do not</i> include<br>payment rates for clinical lab services, mammography screening, or<br>DMEPOS items. Note also that revisions to fees may occur; these revi-<br>sions will be published in future editions of the <i>Medicare B Update!</i> Non-<br>provider entities or providers who need additional copies at other office<br>locations may purchase additional copies. | 756250            | \$20.00          |
|                   | <b>Procedure-to-Diagnosis Relationship Report</b> – 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.  | 756245            | \$20.00          |
| Subtotal          | \$ Mail this form with payment to:   |                   |                  |
| Tax (7%)          | \$ First Coast Service Options, Inc.<br>Medicare Publications  |                   |                  |
| Total             | P.O. Box 45280<br>\$ Jacksonville, FL 32232-5280   |                   |                  |
| Contact Nar       | ne:  |                   |                  |
| Provider/Offi     | ce Name:   |                   |                  |
| Phone :           | FAX Number:  |                   |                  |
| Mailing Add       | ess:   |                   |                  |
| City:             | State: Zip:  |                   |                  |
|                   | Please make check/money order payable to: BCBSFL- FCSO Account # (<br>(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPT   |                   | ve)              |

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

**Note:** The *Medicare B Update!* and 2002 *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* are available **free of charge** online at **www.floridamedicare.com**.

# Reader Survey-Medicare B Update!

Please complete the questions below and return your reply to us by March 15, 2002. Your opinion matters, so we want to hear from you!

#### **Overall Satisfaction**

**On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied**, how satisfied are you with the publication overall? Please *circle* the number that best applies.

5 4 3 2 1

Using the same scale, please rate the *Medicare B Update!* in the following areas:

#### Accuracy

- "When I read the *Medicare B Update!* I feel comfortable that the information presented is accurate."
   5 4 3 2 1
- 2) "When I read the *Medicare B Update!* I am confident that the information is up-to-date."
   5 4 3 2 1

#### Clarity

- 3) "Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare B Update!* clear."
   5 4 3 2 1
- 4) "Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare B Update!* easy to read."

5 4 3 2 1

#### Value

5) "The *Medicare B Update!* assists me in performing my job." 5 4 3 2 1

#### Layout/Format

6) "The *Medicare B Update!* is arranged in a manner that makes it easy to find the information I need." **5 4 3 2 1** 

#### Web site

If you have been to our provider Web site -**www.floridamedicare.com**- within the last 4 weeks - again using the same scale, how would you rate the site?

5 4 3 2 1

If you have not been to our Web site, we would like to know why.

#### Comments/Feedback -

What else could we do to improve the publication and/or Web site for you?

Please cut out this page and mail it to the address below.

Medicare Communication and Education. Publications - 18T Reader Survey P.O. Box 2078 Jacksonville, FL 32231-0048

Or you may fax your survey to (904) 791-6292.

Thank you for taking the time to complete this survey!

#### 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

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: (866) 454-9007 Interactive Voice Response (IVR): (877) 847-4992

#### ЕМС

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

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

DME, Orthotic or Prosthetic Claims Palmetto GBA Medicare (803) 735-1034

*MEDICARE PART A* **Toll-Free:** (877) 602-8816

#### WEB SITES

PROVIDER Florida www.floridamedicare.com

Centers for Medicare & Medicaid Services www.hcfa.gov or www.cms.hhs.gov

#### BENEFICIARY Florida

www.medicarefla.com

Centers for Medicare & Medicaid Services www.medicare.gov

