Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Highlights In This Issue...

This issue is available only on the Web site
www.floridamedicare.com

Features

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 _____
  _____
  _____

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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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

A Physician's Focus

"What do you mean the drug is self-administered?"

The Centers for Medicare & Medicaid Services (CMS) recently issued a program memorandum that provides direction to contractors on how to determine whether an injectable drug should be classified as usually self-administered. The process is still evolving, so additional information may become available before the date of implementation, which at this writing is August 1, 2002. The best way to get the latest information is to monitor our Web site, *www.floridamedicare.com*.

This is a very important issue because Medicare does not cover injectable drugs that are self-administered. The Benefits Improvement and Protection Act of 2000 (BIPA) uses the phrase "not usually self-administered by the patient" when defining these drugs. The prior statutory language was "which cannot…be self administered."

Using the new definition, if a drug is self administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage and Medicare will not pay for it. Each Medicare contractor is required to post to its Web site the process it uses to determine which drugs are self-administered. Florida Medicare will post our document in the near future. The following are some of the criteria to be used in formulating this process:

1. Oral drugs, suppositories, and topical medications are all considered to be usually self-administered by the patient.
2. Absent evidence to the contrary, intravenous drugs should be presumed to be not usually self-administered.
3. Absent evidence to the contrary, drugs given intramuscularly should be presumed to be not usually self-administered.
4. Absent evidence to the contrary, drugs given subcutaneously should be presumed to be usually self-administered.
5. The determination will be made on a drug-by-drug basis and not on a beneficiary-by-beneficiary basis.
6. Each contractor's list of self-administered drugs will be posted on their Web site and will not be subject to the local medical review policy (LMRP) process.
7. Our current list of self-administered drugs will not change until each drug is subjected to this process.
8. Our process will include the opportunity for comment by interested parties before final decisions are reached.
9. Providers will be given notice 45 days before a drug is noncovered.

Medicare will no longer pay for training or emergency use of drugs that are usually self-administered. Providers may charge beneficiaries for excluded drugs. Beneficiaries and participating providers will have appeal rights for denied payments.

Remember, this is a "heads up" notice, and changes may be made prior to implementation. Monitor our Web site for posting of the process and list of drugs.

Sincerely,

Sidney R. Sewell, M.D.
Medical Director

Source: CMS Transmittal AB-02-072, CR 2200

ADMINISTRATIVE

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
Fourth Quarter 2002	Mid-May 2002	July 1, 2002
Fourth Quarter 2002	Mid-August 2002	October 1, 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 98). 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 also 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.

*__Note__: Because this issue of the *Update!* is not available in hard copy format, the date it is posted to the Web site is considered the notice date. Please see articles on pages 27 and 88-89 for more information.

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 treatment and 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 (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 patient's diagnosis, the frequency of the service was in excess of accepted standards of medical practice, etc.).
- The notice must be signed and dated by the patient indicating the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for 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 modifier GA with the service or item. The ABN 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.

> **Note:** Modifier GZ may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

CLAIMS

Claims Returned as Unprocessable—Form CMS-1500 Completion Requirements

Form CMS-1500 is the basic claim form prescribed by the Centers for Medicare & Medicaid Services (CMS) for claims for Medicare Part B services. Section 3005 of the Medicare Carriers Manual (MCM), which provides instructions regarding unprocessable claims, is revised effective October 1, 2002. Specific information concerning how these revisions affect providers and suppliers is furnished below.

Overview of Revisions

- Section 3005 "Unprocessable Claims," has been renamed from "Incomplete or Invalid Claims," and is generally revised to update the section to reflect new requirements since the last revision. An initial sentence has been added to clarify the instruction that applies to assigned claims, as indicated in the transmittal sheet of the previous revision, but not in the body of that instruction.
- Reference to both the provider identification number (PIN) and the unique physician identification number (UPIN) along with the national provider identifier (NPI) has been reinstated, because NPI has not yet been implemented. The previous instruction refers to NPI and does not refer to the PIN and UPIN in current use. The requirement to use the NPI will be effective when that project is implemented. CMS will provide notification when that has occurred.
- Reference to HCFA in the HCFA-1500 and other forms has been changed to reflect the change of the agency acronym to CMS.
- In several places in the instruction where the terms "reject" or "return/reject" were found, they have been changed to "return."
- The term "field" has been changed to "item" or "items" in order to conform to the term found on the reverse side of the paper Form CMS-1500.
- Section 3005.3, "Data Element Requirements Matrix," refers to the matrix at section 3999, which specifies required and conditional standard data elements that are minimal requirements for processing a Part B claim. A crosswalk is provided to relate Form CMS-1500 items (hardcopy) to fields/records in the National Standard Format (NSF) 3.01 (electronic) and the Accredited Standards Committee (ASC) X12N 837 Professional Version 4010X098 implementation guide for use when the Health Insurance Portability and Accountability Act (HIPAA) is implemented.
- Section 3005.4, "Data Element Requirements," is revised to require that for item 32 of Form CMS-1500 or electronic equivalent, a ZIP code is to be included whenever an address is reported. This reflects the requirements currently set forth in MCM Part III, section 4020.
- In accordance with section 4317 of the Balanced Budget Act of 1997, the requirement that non-physician practitioners report ICD-9-CM codes is required under paragraph C, "Conditional Data Element Requirements."
- As previously implemented, X-ray dates(s) are no longer required for chiropractic claims.
- A laboratory identification number must be reported in item 23 of Form CMS-1500 for each claim for laboratory services submitted by any laboratory performing tests covered by Clinical Laboratory Improvements Amendments of 1988 (CLIA).
- The reference to using the word "SAME" as an alternative to providing a name and address or PIN of the provider or facility in item 32 of Form CMS-1500 when the place of service (POS) is the patient's home or physician's office has been deleted. For certain services where the POS indicated on the claim is the patient's home or the physician's office, item 32 need not be completed. Certain other services, such as purchased diagnostic tests, now require a valid name, address, and ZIP code in item 32. When an address is furnished in item 32, a ZIP code is now required. (**Note**: this was previously published in the February 2002 *Medicare B Update!* Special Issue – "Conversion to Medicare's Multi-Carrier System.")

Unprocessable Claims

The instructions in section 3005 apply to Part B assigned claims. For unassigned claims, submitted by beneficiaries (Form CMS-1490S) that are incomplete or contain invalid information, carriers will suspend and develop the claim. If corrections are not received on such unassigned claims within the suspense period, or if corrections are inaccurate, the claim is denied with appeal rights.

Terminology

Unprocessable Claim - Any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.
Incomplete Information - Missing, required, or conditional information on a claim (e.g., no UPIN / PIN or NPI when effective).
Invalid Information - Complete required or conditional information on a claim which is illogical, incorrect (e.g., incorrect UPIN/PIN or NPI when effective), or no longer in effect (e.g., an expired number).
Required - Any data element that is needed in order to process a claim (e.g., date of service).

Conditional - Any data element that must be completed if other conditions(s) exist (e.g., if the insured is different from the patient, then the insured's name must be entered on a claim).
Not Required - Any data element that is not needed by Medicare to process a claim (e.g., patient status).
Return as Unprocessable - Returning a claim as unprocessable does not mean a claim received with incomplete or invalid information is physically returned. The term "return as unprocessable" is used to refer to the processes utilized for notifying the supplier or provider of service that their claim cannot be processed and must be corrected or resubmitted. A claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied, and, as such, is not afforded appeal rights.

Data Element Requirements Matrix

The matrix (MCM Section 3999, Exhibit 10) specifies data elements that are required and conditional. These standard data elements are minimal requirements for processing a Part B claim. A crosswalk is present to relate Form CMS-1500 items (hardcopy) to fields/ records in the NSF 3.01 (electronic) and the ASC X12N 837 Professional Version 4010X098 implementation guide for use when HIPAA is implemented. A copy of the matrix is provided on pages 10-11.

Note: the matrix is not a comprehensive description of requirements that need to be met in order to submit a compliant transaction.

Data Element Requirements

Requirements for Reporting Dates–Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for specific items on Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

  Form CMS-1500 Items Affected by These Reporting Requirements:
  Item 3 - Patient's Birth Date
  Item 9b - Other Insured's Date of Birth
  Item 11a - Insured's Date of Birth

  Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24a), when dates are provided, either a 6-digit date or 8-digit date may be provided. If 8-digit dates are furnished for any of items 11b, 14, 16, 18, 19, or 24a (excluding items 12 and 31), note the following:

- All completed date items, except item 24a, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;
- Item 24a must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24a will penetrate the dotted, vertical lines used to separate month, day, and year. All 8-digit dates reported must stay within the confines of item 24a;
- Do not compress or change the font of the "year" item in item 24a to keep the date within the confines of item 24a. If a continuous number is furnished in item 24a with no spaces between month, day, and year, there is no need to compress the "year" item to remain within the confines of item 24a;
- The "from" date in item 24a must not run into the "to" date item, and the "to" date must not run into item 24b;
- Dates reported in item 24a must not be reported with a slash between month, day, and year; and
- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24a (excluding items 12 and 31), an 8-digit date must be furnished for *all* completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24a. The same applies to those who wish to submit 6-digit dates for any of these items.

Claims that do not adhere to these requirements will be returned as unprocessable.

Requirements for Reporting Dates–Electronic Claims

All electronic claims that do not include an 8-digit date (CCYYMMDD) when a date is reported will be returned as unprocessable.

Required Data Element Requirements

A claim will be returned as unprocessable to a provider or supplier of service:

1. If a claim lacks a valid Medicare health insurance claim number (HICN) in item 1A or contains an invalid HICN in item 1A.
2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card.
3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists.
4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12.
5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A.
6. If a claim lacks a valid place of service code in item 24B or contains an invalid place of service code in item 24B.
7. If a claim lacks a valid *CPT* or HCPCS procedure code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete *CPT* or HCPCS procedure code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D.
8. If a claim lacks a charge for each listed service.

9. If a claim does not indicate at least one day or unit in item 24G.
10. If a claim lacks a signature from a provider of service or supplier, or their representative.
11. If a claim does not contain in item 33:
    a. A billing name, address, ZIP code, and telephone number of a provider of service or supplier.
    AND EITHER
    b. A valid PIN (or NPI when effective) number or, for DMERC claims, a valid NSC (National Supplier Clearinghouse) number for the performing provider of service or supplier who is not a member of a group practice.
    OR
    c. A valid group PIN (or NPI when effective) number or, for DMERC claims, a valid NSC number for performing providers of service or suppliers who are members of a group practice.

Conditional Data Element Requirements

Universal Requirements

The following instruction describes some "conditional" data element requirements applicable to all assigned Part B claims submitted on Form CMS-1500 (hardcopy or electronic equivalent). This instruction is minimal and does not include all "conditional" data element requirements that are universal for processing a Part B claim.

A claim will be returned as unprocessable to a provider or supplier of service:

a. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name and/or UPIN (or NPI when effective) is not present in item 17 or 17A.
b If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or UPIN (or NPI when effective) of the supervising physician is not entered in items 17 or 17A.
c. For diagnostic tests subject to purchase price limitations:
    (1) If a "YES" or "NO" is not indicated in item 20.
    (2) If the "YES" box is checked in item 20 and the purchase price is not entered under the word "$CHARGES."
    (3) If the "YES" box is checked in item 20 and the purchase price is entered under "$CHARGES," but the supplier's name, address, ZIP code, and PIN are not entered in item 32 when billing for purchased diagnostic tests.
d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either a ICD-9CM code is missing, incorrect, or truncated; or a narrative diagnosis was not provided on an attachment.
e. If modifiers "QB" and "QU" are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient's home or the physician's office, the name, address, and ZIP code of the facility where the services were furnished are not entered in item 32.
f. If a performing physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner is a member of a group practice and does not enter his/her PIN (or NPI when effective) in item 24K and the group practice's PIN (or NPI when effective) in item 33.
g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete.
h. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a payer or plan identification number (use PlanID when effective) is not entered in item 11C, or the primary payer's program or plan name when a payer or plan ID (use PlanID when effective) does not exist.
i. If a HCPCS modifier must be associated with a HCPCS procedure code or if the HCPCS modifier is invalid or obsolete.
j. If a date of service extends more than one day and a valid "to" date is not present in item 24A.
k. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment.
l. If the name, address, and ZIP code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32.

Claim Specific Requirements

The following instruction describes some "conditional" requirements which are claim specific, and necessary for processing a Part B claim submitted on form CMS-1500 (hardcopy) or the NSF or ASC X12N 837 (electronic) format. This instruction is minimal and does not include all "conditional" data element requirements. Not all "conditional" data elements apply to Medicare. The ASC X12N 837 implementation guide states when each conditional data element is required; if the condition applies, it must be used. Items from Form CMS-1500 have been provided. These items are referred to as records and fields, segments or data elements on electronic claims. Refer to "Data Element Requirements Matrix," above, for a crosswalk between Form CMS-1500 items (hardcopy) and records and fields on the NSF (electronic) and for the ASC X12N 837 Professional Version 4010X098 implementation guide.

> **Note**: Some claim types covered by Part B are not included in these instructions. Also, the "SAME" requirement listed below only applies to paper claims.

A claim will be returned as unprocessable to a provider or supplier of service:

a. For chiropractor claims:
    1. If the X-ray date is not entered in item 19 for claims with dates of service prior to 01/01/2000. Entry of an X-ray date is not required for claims with dates of service on or after 01/01/2000.
    2. If the initial date "actual" treatment occurred is not entered in item 14.

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC [ambulatory surgical center]) and the group's name, address, ZIP code, and PIN (or NPI when effective) number is not entered in item 33 or their personal PIN (or NPI number when effective) is not entered in item 24K.
c. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP code of the location where the order was accepted is not entered in item 32.
d. For physicians who maintain dialysis patients and receive a monthly capitation payment:
   1. If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's PIN (or NPI when effective) is not entered in item 24K.
   2. If the name, address, and ZIP code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32.
e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when effective) is not present in item 19.
f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, or clinical nurse specialist was used and his/her name and/or UPIN (or NPI when effective) is not present in items 17 or 17A.
g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his/her name and/or UPIN (or NPI when effective) is not present in items 17 or 17A.
h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP code of the location where services were performed is not entered in item 32.
i. For independent laboratory claims:
   1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound").
   2. If the name, address, and ZIP code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office.
j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their six-digit, FDA-approved certification number in item 32 when billing the technical or global component.
k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, or clinical nurse specialist are used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A.
l. For portable X-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name and/or UPIN (or NPI when effective) are not entered in items 17 or 17A.
m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist's name and/or UPIN (or NPI when effective) if appropriate are not entered in items 17 or 17A.
n. For outpatient services provided by a qualified, independent physical or occupational therapist:
   1. If the UPIN (or NPI when effective) of the attending physician is not present in item 19.
   2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19.
o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP code, and PIN (or NPI when effective) where the laboratory services were performed in item 32, if the services were performed at a location other than the patient's home.
p. For all physician and non-physician specialty (PAs, NPs, CNSs, CRNAs, CNM, CP, CSW) claims, if an ICD-9-CM code in item 21 is missing, invalid, or truncated.
q. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998.
r. For investigational devices billed in an FDA-approved clinical trial if an IDE (investigational device exemption) number is not present in item 23.
s. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23.

Source: CMS Transmittal 1750, CR 1968

Data Element Requirements Matrix

MCM Section 3999, Exhibit 10

* Key to status column:

R = Required - information which MUST always be on a claim.
C = Conditional - information which is required on a claim if certain conditions exist.
NR = Not Required - information which is either optional or is not required in order to process a claim.

CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID:

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	Medicare Status (Required or Conditional) *
1A	DA0 - 18.0	Loop 2010BA 2-015-NM109	Insured I.D. Number	Subscriber Primary Identifier	R
2	CA0 - 04.0	Loop 2010BA 2-015-NM103	Patient Name	Subscriber Last Name	R
	CA0 - 05.0	Loop 2010BA 2-015-NM104		Subscriber First Name	R
4	DA0 - 19.0	Loop 2330A 2-325-NM103	Insured Name	Other Insured Last Name	C
	DA0 - 20.0	Loop 2330A 2-325-NM104		Other Insured First Name	C
6	DA0 - 17.0	Loop 2000B 2-005-SBR02 Loop 2320 2-290-SBR02	Patient Relationship to Insured	Individual Relationship Code	C
7	DA2 - 04.0	Loop 2330A 2-332-N301	Insured's Address	Other Insured Address Line 1	C
	DA2 - 06.0	Loop 2330A 2-340-N401		Other Insured City	C
	DA2 - 07.0	Loop 2330A 2-340-N402		Other Insured State	C
	DA2 - 08.0	Loop 2330A 2-340-N403		Other Insured Zip Code	C
	DA2 - 09.0	Not Used	Insured Telephone Number		NR
8	CA0 - 17.0	Not Used	Patient Status		NR
	CA0 - 18.0	Not Used	Patient Student Status		NR
	CA0 - 19.0	Not Used	Patient Employment Status		NR
11	DA0 - 10.0	Loop 2320 2-290-SBR03	Insured's Policy Group Number	Insured Group or Policy Number	C
	DA0 - 05.0	Loop 2320 2-290-SBR09		Source of Payment	R
	DA0 - 06.0	Loop 2320 2-290-SBR05		Insurance Type Code	R
11C	DA0 - 11.0	Loop 2320 2-290-SBR04	Insurance Plan or Program Name	Other Insured Group Name	C
12	DA0 - 16.0	Loop 2300 2-130-CLM10	Patient Signature Source	Patient Signature Source Code	R
	EA0 - 13.0	Loop 2300 2-130-CLM09	Release of Information Indicator		R
14	EA0 - 07.0	Loop 2300 2-135-DTP03(439)	Date of Current Illness, etc.	Accident Date	C
	GC0 - 05.0	Loop 2300 2-135-DTP03(454) OR Loop 2400 2-455-DTP03(454)		Initial Treatment Date	C
15	EA0 - 15.0	Not Used	Patient Has Same/Similar Illness	Same/Similar Symptom Indicator	NR
	EA0 - 16.0	Loop 2300 2-135-DTP03(438) OR Loop 2400 2-455-DTP03(438)		Onset of Similar Symptoms or Illness	NR
		Loop 2300 2-135-DTP03(431) OR Loop 2400 2-455-DTP03(431)	Date of current illness or injury	Onset of current illness or injury	C
17	EA0 - 24.0	Loop 2310A 2-250-NM103 OR Loop 2420F 2-500-NM103	Name of Referring Provider	Referring Provider Last Name	C
	EA0 - 25.0	Loop 2310A 2-250-NM104 OR Loop 2420F 2-500-NM104		Referring Provider First Name	C
			OR		
	FB1 - 06.0	Loop 2420E 2-500-NM103		Ordering Provider Last Name	C
	FB1 - 07.0	Loop 2420E 2-500-NM104		Ordering Provider First Name	C
			OR		
17A	FB1 - 09.0	Loop 2420E 2-525-REF02 (1G or 1C)	UPIN/PIN of Ordering Provider	Ordering Provider Secondary Identifier (UPIN)	C
			OR		
	FB0 - 09.0	Loop 2420E 2-250-NM109(XX)		Order Provider Primary Identifier (UPIN) C	
			OR		
	EA0 - 20.0	Loop 2310A 2-250-NM109(XX) OR Loop 2420F 2-500-NM109(XX)		Referring Provider Primary Identifier (UPIN)	C
			OR		
	EA0 - 21.0	Loop 2310A 2-271-REF02(1G) OR		Referring Provider Secondary Identifier (UPIN)	C
	FB1 – 13.0	Loop 2420F 2-525-REF02(1G)			
			OR		
19	EA1 - 16.0	Loop 2310E 2-250-NM109(XX) OR Loop 2420D 2-500-NM109(XX)	Reserved for Local Use	Supervising Provider Primary Identifier (PIN)	C
	FB1 - 21.0	Loop 2310E 2-260-REF02(1G/1C) OR Loop 2420D-2-525-REF02(1G/1C)		Supervising Provider Secondary Identifier (PIN)	C
	GC0 - 06.0	Loop 2300 2-135-DTP03(455) OR Loop 2400 2-455-DTP03(455) OR		X-Ray Date	C

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	Medicare Status (Required or Conditional) *
	EA0 - 48.0	Loop 2300 2-135-DTP03(304) OR Loop 2400 2-455-DTP03(304)		Date Last Seen	C
	EA0 - 50.0	Loop 2300 2-220-CRC03(IH)		Homebound Indicator	C
	EA1 - 25.0	Loop 2300 2-135-DTP03(090/091)		Assumed and Relinquished Care Dates	C
	FA0 - 40.0	Loop 2400 2-450-CRC02(70)		Hospice Employed Provider Indicator	C
20	FB0 - 05.0	Loop 2400 2-488-PS102	Outside Lab	Purchased Service Charge	C
21	EA0 - 32.0	Loop 2300 2-231-HI01-02(BK)	Diagnosis	Principal Diagnosis Code	C
	EA0 - 33.0	Loop 2300 2-231-HI02-02(BF)		Diagnosis Code	C
	EA0 - 34.0	Loop 2300 2-231-HI03-02(BF)		Diagnosis Code	C
	EA0 - 35.0	Loop 2300 2-231-HI04-02(BF)		Diagnosis Code	C
22			Medicaid Resubmission Code		NR
23	DA0 - 14.0	Loop 2300 2-180-REF02(G1) OR Loop 2400 2-470-REF02(G1)	Prior Authorization Number	Prior Authorization or Referral Number	C
	FA0 - 34.0	Loop 2300 2-180-REF02(X4) OR Loop 2400 2-470-REF02(X4)	CLIA ID Number	CLIA Certification Number	C
	EA0 - 53.0	Loop 2310D 2-271-REF02(LU)	Care Plan Oversight (CPO) Number	CPO Number	C
	EA0 - 54.0	Loop 2300 2-180-REF02(LX)		Investigational Device Number	C
24A	FA0 - 05.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (From date)	Service Date	R
	FA0 - 06.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (To Date)	Service Date	C
24B	FA0 - 07.0	Loop 2300 2-130-CLM05-1 OR Loop 2400 2-370-SV105	Place of Service Place of Service Code	Facility Type Code	R
24C	FA0 - 08.0	Not Used	Type of Service	Type of Service Code	NR
24D	FA0 - 09.0	Loop 2400 2-370-SV101-2 (HC)	Procedures, Services, etc.	Procedure Code	R
	FA0 - 10.0	Loop 2400 2-370-SV101-3		Procedure Modifier 1	C
	FA0 - 11.0	Loop 2400 2-370-SV101-4		Procedure Modifier 2	C
	FA0 - 12.0	Loop 2400 2-370-SV101-5		Procedure Modifier 3	C
	FA0 - 36.0	Loop 2400 2-370-SV101-6		Procedure Modifier 4	C
24G	FA0 - 18.0	Loop 2400 2-370-SV104 (UN)	Days or Units of Service OR	Units of Service	R
	FA0 - 19.0	Loop 2400 2-370-SV104 (MJ)		Anesthesia/Oxygen Minutes	R
24H	FB0 - 22.0	Loop 2400 2-370-SV112	EPSDT Family Plan	Family Planning Indicator	NR
24I	FA0 - 20.0	Loop 2400 2-370-SV109	EMG	Emergency Indicator	NR
24J	FB0 - 21.0	Loop 2400 2-370-SV115	COB	Co-pay Status Code	NR
24K	FA0 - 23.0	Loop 2310B 2-250-NM109(XX) OR Loop 2420A 2-500-NM109(XX)	Reserved for Local Use	Rendering Provider Primary Identifier (PIN)	C
	BA0 - 09.0	Loop 2310B 2-271-REF02(1C) OR Loop 2420A 2-525-REF02(1C)		Rendering Provider Secondary Identifier (PIN)	C
27	EA0 - 36.0	Loop 2300 2-130-CLM07	Accept Assignment	Medicare Assignment Code	NR
31	EA0 - 37.0	Loop 2300 2-130-CLM06	Provider Signature Indicator	Provider or Supplier Signature Indicator	R
32	EA0 - 39.0	Loop 2310D 2-250-NM103	Facility Name and Address	Laboratory or Facility Name	C
	EA1 - 04.0	Loop 2310D 2-250-NM109(XX) OR Loop 2420C 2-500-NM109(XX) Loop 2310D 2-250-REF02(1C) OR Loop 2420C 2-525-REF02(1C)	OR	Laboratory or Facility Primary Identifier (PIN) Laboratory or Facility Secondary Identifier (PIN)	C
	FB0 - 11.0	Loop 2310C 2-250-NM109(XX) OR Loop 2400 2-488-PS101 Loop 2310C 2-271-REF02(1C) OR Loop 2400 2-488-PS101		Purchased Service Provider Primary Identifier (PIN) Purchased Service Provider Secondary Identifier (PIN)	C
	FA0 - 31.0	Loop 2300 2-180-REF02(EW) OR Loop 2400 2-470-REF02(EW)		Mammography Certification Number	C
33	BA0 - 19.0	Loop 2010AA 2-015-NM103(85,1)	Provider's Billing Name & Address	Provider Last Name	R
	BA0 - 20.0	Loop 2010AA 2-015-NM104	OR	Provider First Name OR	R
	BA0 - 18.0	Loop 2010AA 2-015-NM103(85,2)		Payer Organization Name	R
	BA1 - 13.0	Loop 2010AA 2-025-N301		Pay-To Provider Address 1	R
	BA1 - 15.0	Loop 2010AA 2-030-N401		Pay-To Provider City Name	R
	BA1 - 16.0	Loop 2010AA 2-030-N402		Pay-To Provider State Code	R
	BA1 - 17.0	Loop 2010AA 2-030-N403		Pay-To Provider Zip Code	R
	BA1 - 18.0	Loop 2010AA 2-040-PER04		Communication Number	R
	BA0 - 09.0	Loop 2010AA 2-015-NM109(XX)	OR Provider's Billing Name & Address	Billing Provider Primary Identifier (PIN)	R
	BA0 - 02.0 CA0 - 28.0	Loop 2010AA 2-035-REF02(1C)		Billing Provider Secondary Identifier (PIN)	C

Correct Coding Initiative

Version 8.3 of the Correct Coding Initiative (CCI) will be implemented October 1, 2002, and 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 National Correct Coding Initiative
AdminaStar Federal
P. O Box 50469
Indianapolis, IN 46250-0469
Fax: (317) 841-4600

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 *http://www.ntis.gov/products/families/cci/index.asp*

Providers can find additional information at CMS' Frequently Asked Questions online: *http://cms.hhs.gov/medlearn/ncci.asp.* As a reminder, Florida Medicare is not liable for information provided and/or published by AdminaStar Federal and/or NTIS.

Customer Service Representative Responses to Provider CCI Questions

Medicare provider customer service representatives (CSRs) are responsible to provide accurate and complete information and truly want to give answers to customer questions. However, supplying the right Healthcare Common Procedure Coding System (HCPCS) codes and CCI modifiers for specific claims is beyond the scope of their work. The HCPCS contains more than 12,000 codes, 7,000 of which describe physician procedures from all specialties and require specialized training to be able to describe. In contrast, the average individual practitioner only uses 150-300 of these codes to describe his/her services. Therefore, it is Medicare's expectation that the responsibility to supply the correct code on the Medicare claim lies with the practitioner or the provider. CSRs *are* able to give the definitions or explain the use of the CCI modifiers.

Source: CMS Transmittal B-02-036 CR 2187
CMS Transmittal AB-02-079 CR 2113

Correct Use of Modifier 59, "Distinct Procedural Service"

The description for modifier 59 in the American Medical Association's (AMA's) *Current Procedural Terminology* (*CPT*) for 2002 states: "Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used..."

For example, when two procedures are performed on the same day and one is bundled into the other (per a Correct Coding Initiative [CCI] relationship) ***and*** neither procedure was performed as a component of the other, it would be appropriate to use modifier 59 on the potentially denied (bundled per CCI) service. A specific example would be: if *CPT* code 11040 was bundled (destined to be denied) with 11041 and both procedures were performed on different anatomical sites, it would be appropriate to bill 11040-59 and 11041. Providers should refer to CCI to determine if a service is considered a component of another (sometimes called a "lesser" or "minor" procedure).

To further quote *CPT* 2002, "Modifier 59 was added to report instances when distinct and separate multiple services are provided to a patient on a single date of service. As the description indicates, some examples of common uses of this modifier may include separate sessions or patient encounters, different procedures or surgeries, surgery directed to different sites or organ systems, surgery directed to separate incision/excision or separate lesions, or treatment to separate injuries. When performing laboratory services, modifier 59 should be used to report procedures that are distinct or independent, such as performing the same procedure (which uses the same procedure code) for a different specimen. As indicated in the guidelines, this modifier should not be used when a more descriptive modifier is available."

For more information, please refer to the AMA's *CPT Assistant* Volume 12, Issue 6, June 2002.

Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

The 2003 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2002. Providers may begin using the updated ICD-9-CM codes for claims submitted on or after October 1, 2002. The Centers for Medicare & Medcaid Services (CMS) has posted the new, revised, and deleted ICD-9-CM codes to their Web site, as a courtesy for providers. The address is *http://www.cms.hhs.gov/medlearn/icd9code.asp*. The updated diagnostic codes *must* be used for all services billed on or after January 1, 2003.

A 90-day grace period is provided, during which Florida Medicare will accept both old and new ICD-9-CM codes, for claims received October 1 through December 31, 2002. This grace period is to allow providers sufficient time to obtain and integrate the updated ICD-9-CM codes into their billing systems. *For claims received on or after January 1, 2003, the latest version of the ICD-9-CM codes must be used.*

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

American Medical Association (800) 621-8335	Medicode Publications (800) 999-4600	St. Anthony's Publishing (800) 632-0123

ICD-9-CM and other coding materials may also be obtained from local medical publishing and consulting firms.

It is very important for providers to use the most current version of the ICD-9-CM coding book and to code to the highest level of specificity.

Annual Updating of ICD-9-CM Codes Will Be Date of Service Driven

According to the rules of the Health Insurance Portability and Accountability Act (HIPAA), national code sets must be date of service compliant. In order for Medicare carriers and standard systems to be HIPAA compliant, all carriers and standard systems must be able to process the annual update of ICD-9-CM codes based on date of service instead of date of receipt. Medicare carriers must become compliant in that diagnosis codes must be processed using date of service and not date received.

Therefore, **effective for claims processed on or after October 1, 2002**, Florida Medicare will edit for the validity of diagnosis codes based on the date of service of the procedure code to which the diagnosis code is correlated.

Providers need to be aware of this change, as well as software vendors who use ICD-9-CM codes in their product. Providers and their billing staff must understand that the diagnosis on the claim should be the diagnosis that was valid at the time the procedure was performed.

Source: CMS Transmittal AB-02-085, CR 2194
CMS Transmittal B-02-027, CR 2108

Filing Tips for Paper Claim Submissions

While filing claims electronically is the preferred method (it's quicker and more cost-effective), Florida Medicare understands there are times when it is necessary to file paper claims. Paper claims must be submitted on an approved red-and-white Form CMS-1500.

The Optical Character Recognition (OCR) department offers the following tips for more efficient processing of paper claims:

- Do not staple claims or attachments. OCR scanner operators have to remove staples from claims and documentation, which increases processing time.
- When making copies of documentation, ensure documentation is clean and legible.
- Ensure copier lid is down. Leaving the lid up causes "black out" on pages where the documentation is smaller than the paper size. When black-out is on a claim or attachment, the scanner sees this as half of a claim. The system cannot read a half-page claim; this causes the scanner to stop. The operator then has to restart the scanner, increasing processing time. Closing the copier lid produces a "clean" copy the scanner can read.

Request for Review Form

For providers' convenience, a Request for Review Form has been posted to our provider Web site, *www.floridamedicare.com*. The form is located in the "Forms" section, under Written Communications. It is also available upon written request or by contacting our Provider Call Center toll-free at (866) 454-9007.

Florida Medicare prefers providers use this form when requesting a review; however, Form CMS-1964 (Request For Review Of A Medicare Part B Claim) may alternatively be used. Form CMS-1964 may be obtained from the CMS Web site at *www.cms.hhs.gov/forms/cms1964.pdf*.

Providers *should not* request copies of Form CMS-1964 from the Superintendent of Documents at the United States Government Printing Office.

Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

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

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

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

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

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

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

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

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

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

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

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

Frequency of Vaccinations

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

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

Billing for Additional Services

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

provider may bill for additional reasonable and necessary services in addition to the administration of PPV, influenza virus, and or hepatitis B vaccines.

Nonparticipating Physicians and Suppliers

Pneumococcal, hepatitis B, and influenza virus vaccines fall into the category of drugs and biologicals, therefore, effective for services provided on or after February 1, 2001, the mandatory assignment provision of section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) applies. Nonparticipating physicians and suppliers (including local health facilities) may collect payment from the beneficiary for the administration codes, but must submit an unassigned claim on the beneficiary's behalf. Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

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

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

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

CPT/HCPCS Codes

The following *CPT* codes are used for billing vaccines:

90657	90658	90659
90723	90732	90744
90746	90747	90748

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

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

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

Billing Requirements

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

Diagnosis Codes

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

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

Reimbursement Guidelines

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

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

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

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

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

Simplified Roster Bills

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

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

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

Entities which submit claims on roster bills (and therefore must accept assignment) may not collect any "donation" or other cost-sharing of any kind from Medicare beneficiaries for PPV or influenza vaccinations. However, the entity may bill Medicare for the amount which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

Provider Enrollment Criteria. All individuals and entities that will submit PPV and influenza benefit claims to Medicare on roster bills must complete the Provider/Supplier Enrollment Application, Form CMS-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process. Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV and influenza virus vaccinations.

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

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

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

Sample rosters and samples of modified CMS Form-1500s are available to view, print, or download from our provider Web site – *www.floridamedicare.com* – in the "Forms" area.

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

COVERAGE/REIMBURSEMENT

ANESTHESIA

Anesthesia Codes to be Added to Common Working File (CWF) Edits

The Centers for Medicare & Medicaid Services (CMS) Change Request (CR) 1764, Transmittal AB-01-159, issued November 1, 2001, inadvertently omitted anesthesia services from CWF edits implemented on April 1, 2002. This resulted in incorrect denials for anesthesia services provided to beneficiaries in a Part A skilled nursing facility (SNF) stay who received services with dates of service on or after April 1, 2001, submitted after April 1, 2002. To resolve this issue, by July 1, 2002, CWF has added the anesthesia codes listed below to its edits, allowing them to be separately payable by the carrier. New claims submitted on or after July 1, 2002, will be processed correctly. Previously denied claims can be resubmitted on or after July 1, 2002.

For more information concerning CR 1764 and SNF consolidated billing, please refer to articles published in the Second Quarter 2002 (page 87) and Third Quarter 2002 (page 68) issues of the *Medicare B Update!*

CPT Codes

00100	00350	00600	00848	00940	01380	01636	01852
00102	00352	00604	00851	00942	01382	01638	01860
00103	00400	00620	00860	00944	01390	01650	01905
00104	00402	00622	00862	00948	01392	01652	01916
00120	00404	00630	00864	00950	01400	01654	01920
00124	00406	00632	00865	00952	01402	01656	01922
00126	00410	00634	00866	01112	01404	01670	01924
00140	00450	00635	00868	01120	01420	01680	01925
00142	00452	00670	00869	01130	01430	01682	01926
00144	00454	00700	00870	01140	01432	01710	01930
00145	00470	00702	00872	01150	01440	01712	01931
00147	00472	00730	00873	01160	01442	01714	01932
00148	00474	00740	00880	01170	01444	01716	01933
00160	00500	00750	00882	01180	01462	01730	01951
00162	00520	00752	00902	01190	01464	01732	01952
00164	00522	00754	00904	01200	01470	01740	01953
00170	00524	00756	00906	01202	01472	01742	01960
00172	00528	00770	00908	01210	01474	01744	01961
00174	00530	00790	00910	01212	01480	01756	01962
00176	00532	00792	00912	01214	01482	01758	01963
00190	00534	00794	00914	01215	01484	01760	01964
00192	00537	00796	00916	01220	01486	01770	01967
00210	00540	00797	00918	01230	01490	01772	01968
00212	00542	00800	00920	01232	01500	01780	01969
00214	00544	00802	00922	01234	01502	01782	01990
00215	00546	00810	00924	01250	01520	01810	01995
00216	00548	00820	00926	01260	01522	01820	01996
00218	00550	00830	00928	01270	01610	01830	01999
00220	00560	00832	00930	01272	01620	01832	
00222	00562	00840	00932	01274	01622	01840	
00300	00563	00842	00934	01320	01630	01842	
00320	00566	00844	00936	01340	01632	01844	
00322	00580	00846	00938	01360	01634	01850	

Source: CMS Memorandum dated May 21, 2002

AUDIOLOGY

Payment for Services Furnished by Audiologists

Effective for services processed on or after **July 7, 2002,** the medical coverage determinations for audiology tests have been made similar and comparable to ophthalmology tests as outlined in section 2320 of the Medicare Carriers Manual and section 3157 of the Medicare Intermediary Manual.

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

Diagnostic services performed by a qualified audiologist and meeting the above requirements are payable as "other diagnostic tests." The payment for these services is determined by the reason the tests were performed, rather than the diagnosis or the patient's condition. Payment for these services is based on the physician fee schedule amount except for audiology services furnished in a hospital outpatient department which are paid under the outpatient prospective payment system. Nonhospital entities billing for the audiologist's services may accept assignment under the usual procedure or, if not accepting assignment, may charge the patient and submit an unassigned claim on their behalf.

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

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

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

Claims for diagnostic services performed by a qualified audiologist must include the name and UPIN (unique provider identification number) of the ordering physician in items 17 and 17a of Form CMS-1500 (or electronic equivalent). There is no provision for direct payment to audiologists for therapeutic services.

Source: CMS Transmittal AB-02-080, CR 2073

DERMATOLOGY

Coverage of Photodynamic Therapy for Actinic Keratosis (AK)

The Coverage Issues Manual, Section 35-101, states the following, effective for services performed on and after November 26, 2001: "Various options exist for treating AKs. Clinicians should select an appropriate treatment based on the patient's medical history, the lesion's characteristics, and on the 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 photodynamic therapy (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. Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics."

The Centers for Medicare & Medicaid Services (CMS) has noted that some contractors may be covering the PDT portion of the treatment, but denying coverage of the associated drug, Levulan® Kerastick ™ (ALA). This is not appropriate, since removal of AKs by PDT requires that a photosensitive drug be applied to the skin and then activated by a light source, in this case the BLU-U™. The application of the BLU-U™ light to the skin without the presence of ALA would have no clinical effect. Furthermore, the Food and Drug Administration specifically approved this drug/device combination to be used together for this purpose.

When Florida Medicare covers PDT, the ALA drug is covered as well. For more information, please refer to the Third Quarter 2001 *Medicare B Update!* (page 42).

Source: CMS Memorandum dated May 8, 2002

DRUGS AND BIOLOGICALS

Medicare Payment Allowance for Injectable Drugs

Providers who bill Medicare for injectable drugs should be aware of updated payment allowances so they may adjust their fees accordingly:

These allowances are effective for services rendered on or after January 1, 2002 that are ***processed on or after July 1, 2002.***

Please remember that assignment must be accepted for these services, as mandated by the Benefits Improvement and Protection Act of 2000 (BIPA).

Code	PAR	NONPAR	Code	PAR	NONPAR	Code	PAR	NONPAR
J0120	4.91	4.66	J1980	7.90	7.50	J9355	54.93	52.18
J0150	37.71	35.82	J1990	26.20	24.89	J9390	99.28	94.32
J0170	2.26	2.15	J2060	6.36	6.04	Q0136	12.78	12.14
J0207	427.34	405.97	J2260	51.57	48.99	Q2003	2.27	2.16
J0275	20.31	19.29	J2321	10.40	9.88	Q2005	404.83	384.59
J0300	2.61	2.48	J2352	145.84	138.55	Q2006	380.00	361.00
J0360	14.25	13.54	J2355	256.63	243.80	Q2010	33.66	31.98
J0635	13.82	13.13	J2460	0.98	0.93	Q2011	1.02	0.97
J0635	13.82	13.13	J2510	9.04	8.59	Q2017	240.61	228.58
J0690	4.94	4.69	J2515	0.74	0.70	Q2018	94.86	90.12
J0694	10.36	9.84	J2545	101.44	96.37	Q2019	1538.42	1461.50
J0697	6.42	6.10	J2910	15.93	15.13	Q3002	29.12	27.66
J0698	10.95	10.40	J2940	45.56	43.28	Q3007	72.82	69.18
J0702	4.97	4.72	J3030	50.91	48.36	Q3011	176.66	167.83
J0706	3.15	2.99	J3105	5.57	5.29	Q9920	12.78	12.14
J0713	9.67	9.19	J3245	462.15	439.04	Q9921	12.78	12.14
J0743	15.87	15.08	J3265	2.52	2.39	Q9922	12.78	12.14
J0744	15.22	14.46	J3280	4.96	4.71	Q9923	12.78	12.14
J0745	1.20	1.14	J3305	142.50	135.38	Q9924	12.78	12.14
J0835	16.75	15.91	J3360	3.36	3.19	Q9925	12.78	12.14
J0850	702.33	667.21	J3420	0.23	0.22	Q9926	12.78	12.14
J1000	4.20	3.99	J3430	2.39	2.27	Q9927	12.78	12.14
J1020	2.46	2.34	J3475	0.56	0.53	Q9928	12.78	12.14
J1030	4.73	4.49	J3480	0.27	0.26	Q9929	12.78	12.14
J1040	5.18	4.92	J3485	1.00	0.85	Q9930	12.78	12.14
J1050	33.91	32.21	J7190	0.91	0.85	Q9931	12.78	12.14
J1056	24.12	22.91	J7501	59.84	59.84	Q9932	12.78	12.14
J1060	4.23	4.02	J7504	290.31	290.31	Q9933	12.78	12.14
J1070	4.92	4.67	J7515	1.30	1.24	Q9934	12.78	12.14
J1080	19.29	18.33	J7520	7.12	6.76	Q9935	12.78	12.14
J1190	199.22	189.26	J8600	2.37	2.25	Q9936	12.78	12.14
J1200	0.80	0.76	J9015	699.20	664.24	Q9937	12.78	12.14
J1260	20.00	19.00	J9031	171.48	162.91	Q9938	12.78	12.14
J1270	5.22	5.50	J9045	123.60	117.42	Q9939	12.78	12.14
J1327	14.82	14.08	J9060	42.45	40.33	Q9940	12.78	12.14
J1390	1.32	1.25	J9062	212.31	201.69	90376	75.83	72.04
J1436	70.30	66.78	J9185	311.12	295.56	90657	4.15	4.15
J1440	187.91	178.51	J9190	2.88	2.74	90658	8.31	8.31
J1450	90.86	86.32	J9211	466.59	443.26	90659	8.31	8.31
J1455	12.13	11.52	J9216	337.78	320.89	90675	142.97	139.76
J1563	85.50	81.23	J9217	611.56	580.98	90703	7.65	7.27
J1610	67.82	64.43	J9245	416.76	395.92	90732	13.10	13.10
J1644	0.39	0.37	J9280	96.94	92.09	90744	28.77	28.77
J1820	4.75	4.51	J9290	413.28	392.62	90746	69.54	69.54
J1910	14.34	13.62	J9293	266.18	252.87	90747	196.99	196.99
J1950	500.59	475.56	J9310	475.00	451.25			
J1956	19.65	18.67	J9320	120.46	114.44			

Payment Limit for Drugs and Biologicals

This article is to advise providers that instructions provided to contractors in the Centers for Medicare & Medicaid Services' (CMS) Change Request 745, Transmittal AB-00-110, dated April 3, 2000, continue unchanged. This transmittal specifies that carriers pay drugs and biologicals based on the lower of the billed charge or 95 percent of the average wholesale price (AWP) as described below.

Drugs and biologicals not paid on a cost or prospective payment basis are paid based on the lower of the billed charge or 95 percent of the AWP as reflected in sources such as the Red Book, Price Alert, or Medispan. Examples of drugs that are paid on this basis include, but are not limited to, drugs furnished incident to a physician's service, immunosuppressive drugs furnished by pharmacies, drugs furnished by pharmacies under the durable medical equipment benefit, covered oral anticancer drugs, and drugs furnished by independent dialysis facilities that are not included in the end stage renal disease composite rate payment.

For a single-source drug or biological, the AWP equals the AWP of the single product. For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or biological or the lowest brand name product AWP. A "brand name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological. After determining the AWP, it is multiplied by 0.95. This is the new drug payment allowance limit.

Source: CMS Transmittal AB-02-075 CR 2123

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

Contractor Jurisdiction for Pleurx Pleural Catheters and Pleurx Pleural Drainage Kits

The Centers for Medicare & Medicaid Services (CMS) has determined that since Pleurx pleural catheters are implanted prostheses, claims for catheters should be billed to the Medicare Part A fiscal intermediary. However, since the drainage kits are an external accessory to the implanted catheter, claims for the kit's supplies should be billed to the local Medicare Part B carrier. Therefore, the Part B carrier, not the DMERC, is responsible for processing claims for the Pleurx pleural drainage kits, including service areas. CMS anticipates that HCPCS codes will be established for the catheter and vacuum bottle, effective January 1, 2003.

Source: CMS Region IV Memorandum, July 1, 2002

EVALUATION & MANAGEMENT

Revision to HCPCS Codes for Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

Instructions concerning coverage and billing for diagnosis and treatment of peripheral neuropathy with loss of protective sensation (LOPS) in people with diabetes was published in the Third Quarter 2002 *Medicare B Update!* (pages 22-23). Since then, HCPCS codes G0245 and G0246, for reporting the services under this new coverage, have been revised to describe them more accurately as evaluation and management codes. HCPCS codes G0246 and G0247 have been revised to indicate that they are physician services. The new descriptions are as follows (revisions in *italics*):

G0245 Initial physician evaluation *and management* of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), which must include:

1. The diagnosis of LOPS.
2. A patient history.
3. A physical examination that consists of at least the following elements:
   (a) Visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) Evaluation of a protective sensation,
   (c) Evaluation of foot structure and biomechanics,
   (d) Evaluation of vascular status and skin integrity, and
   (e) Evaluation and recommendation of footwear.
4. Patient education.

G0246 Follow-up *physician* evaluation *and management* of a diabetic patient with diabetic sensory neuropathy resulting in a LOPS to include at least the following:

1. A patient history.
2. A physical examination that includes:
   (a) Visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) Evaluation of protective sensation,
   (c) Evaluation of foot structure and biomechanics,
   (d) Evaluation of vascular status and skin integrity, and
   (e) Evaluation and recommendation of footwear.
3. Patient education.

G0247 Routine foot care *by a physician* of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:
1. local care of superficial wounds,
2. debridement of corns and calluses, and
3. trimming and debridement of nails.

For more information concerning coverage and billing for diagnosis and treatment of peripheral neuropathy with LOPS in people with diabetes, please refer to the local medical review policy beginning on page 32 of this issue.

Source: CMS Transmittal AB-02-096, CR 2269

HEMATOLOGY

Coverage and Billing for Intravenous Immune Globulin (IVIg) for the Treatment of Autoimmune Mucocutaneous Blistering Diseases

Effective for services performed on or after October 1, 2002, IVIg is covered for treatment of the following biopsy-proven conditions:

- Pemphigus vulgaris, ICD-9-CM code: 694.4, pemphigus
- Pemphigus foliaceus, ICD-9-CM code: 694.4, pemphigus
- Bullous pemphigoid, ICD-9-CM code: 694.5, pemphigoid
- Mucous membrane pemphigoid (a.k.a., Cicatrical pemphigoid), ICD-9-CM code: 694.6, Benign mucous membrane pemphigoid
  — ICD-9-CM code: 694.60; Without mention of ocular involvement
  — ICD-9-CM code: 694. 61; With ocular involvement
- Epidermolysis bullosa acquisita, ICD-9-CM code: 694.8, Other specified bullous dermatoses

Patients must meet at least one of the following criteria:

- Failed conventional therapy. Contractors have the discretion to define what constitutes failure of conventional therapy;
- Conventional therapy is contraindicated. Contractors have the discretion to define what constitutes contraindications to conventional therapy; or
- Have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents. In these situations, IVIg therapy would be given along with conventional treatment(s) and the IVIg would be used only until conventional therapy could take effect.

Note: In addition, IVIg for the treatment of autoimmune mucocutaneous blistering disease must be used only for short-term therapy and not as a maintenance therapy. Again, contractors have the discretion to decide what constitutes short-term therapy.

CPT/HCPCS Codes

Use the following code(s) for intravenous immune globulin for the treatment of autoimmune mucocutaneous blistering diseases:

J1563 Injection, immune globulin, intravenous, 1 g
90780 *Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour.*
90781 *Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour up to 8 hours.*

The HCPCS code (J1563) will be payable at 95% of the average wholesale price. As with all drugs and biologicals, assignment is mandatory. Deductible and coinsurance apply.

Source: CMS Transmittal AB-02-093 CR 2192

LABORATORY/PATHOLOGY

New CLIA Waived Tests

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), effective June 17, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

- Enterix InSure™ Fecal Occult Blood Test, effective: January 1, 2002, *CPT* code: 82274QW;
- Alatex Scientific Peace of Mind Multiple Drugs of Abuse Test, effective: February 21, 2002, *CPT* code: 80101QW;
- Metrika A1c Now for Prescription Home Use (K020234), effective: March 8, 2002, *CPT* code: 83036QW; and
- Metrika A1c Now for Professional Use (K020235), effective: March 8, 2002, *CPT* code: 83036QW.

In addition, the *CPT* code for the Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick) has been changed from 82044QW to 83518QW, Effective: June 3, 2002. Effective June 17, 2002, the *CPT* codes for the Boehringer Mannheim Chemstrip Micral and the Roche Diagnostics Chemstrip Micral (urine dipstick) have also been changed from 82044QW to 83518QW, since both tests use methodologies that are similar to the Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick).

TEST NAME	MANUFACTURER	*CPT* CODE(S)	USE
Boehringer Mannheim Chemstrip Micral	Boehringer Mannheim	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease
Roche Diagnostics Chemstrip Micral (urine dipstick)	Roche Diagnostics Corporation	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease
Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick)	Diagnostic Chemicals Limited (USA)	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease
*Enterix InSure™ Fecal Occult Blood Test	Enterix, Inc.	82274QW	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening) by immunoassay
*Alatex Scientific Peace of Mind Multiple Drugs of Abuse Test	Advantage Diagnostics Corporation, Ltd.	80101QW (This test may not be covered in all instances.)	Screening test for the presence/detection of cannabinoids (THC), cocaine metabolites, methamphetamines, morphine, and phencyclidine (PCP) in urine
*Metrika A1c Now for Prescription Home Use (K020234)	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
*Metrika A1c Now for Professional Use (K020235)	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes

* Newly added waived test system

Source: CMS Transmittal AB-02-091, CR 2263

PHYSICAL/OCCUPATIONAL THERAPY

Group Therapy Services (*CPT* Code 97150)

Medicare may pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be, performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

Source: MCM Section 15302; CMS Transmittal 1753, CR 2126

Payment for the Services of Therapy Students under Medicare Part B

Services performed by a therapy student may not be billed to Medicare Part B or to a Medicare beneficiary. Only the services of the therapist may be billed and reimbursed under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Medicare Part B may pay for medically necessary direct (one-to-one) patient contact services of the physician or therapist. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room."

Therapists may bill and be reimbursed for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

Therapy Assistants as Clinical Instructors

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

Services Provided Under Part A and Part B

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

Under the skilled nursing facility prospective payment system (SNF PPS), payments are based upon the case mix or resource utilization group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determine the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

Source: MCM Section 15304;
CMS Transmittal 1753, CR 2126

RADIOLOGY

Positron Emission Tomography (PET) Scans—Coverage Requirements for Breast Cancer and Revised Coverage Conditions for Myocardial Viability

Positron emission tomography (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 (radiopharmaceuticals) such as 2-[F-18] Fluoro-D-Glucose (FDG), that are administered intravenously to the patient.

Coverage of FDG PET for Breast Cancer

Effective for dates of service on or after October 1, 2002, Medicare will cover FDG PET as an adjunct to other imaging modalities for staging and restaging for locoregional, recurrence, or metastasis. Monitoring treatment of a locally advanced breast cancer tumor and metastatic breast cancer when a change in therapy is contemplated is also covered as an adjunct to other imaging modalities. The baseline PET study for monitoring should be done under the code for staging or restaging.

Limitations

Medicare continues to have a national noncoverage determination for initial diagnosis of breast cancer and initial staging of axillary lymph nodes.

Effective for dates of service on or after October 1, 2002, Medicare coverage now includes PET as an adjunct to standard imaging modalities for:

- staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis
- monitoring for women with locally advanced and metastatic breast cancer when a change in therapy is contemplated.

Coverage for Myocardial Viability

FDG PET is covered for the determination of myocardial viability following an inconclusive single-photon emission computed tomography (SPECT) test from July 1, 2001, through September 30, 2002. Only full ring scanners are covered as the scanning medium for this service from July 1, 2001 through December 31, 2001. However, as of January 1, 2002, full and partial-ring scanners are covered for myocardial viability following an inconclusive SPECT.

Beginning October 1, 2002, Medicare will cover FDG PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization, and will continue to cover FDG PET when used as a follow-up to an inconclusive SPECT. However, if a patient received a FDG PET study with inconclusive results, a follow-up SPECT is not covered. FDA full and partial-ring PET scanners are covered.

Limitations

In the event a patient receives a SPECT with inconclusive results, a PET scan may be performed and covered by Medicare. However, a SPECT is not covered following a FDG PET with inconclusive results.

The referring physician as part of the beneficiary's medical record should maintain documentation that these conditions are met. Conditions and coverage guidelines for both conditions are summarized in the following table:

Clinical Condition	Effective Date	Coverage
*Breast Cancer	October 1, 2002	As an adjunct to standard imaging modalities, staging distant metastasis or restaging patients with locoregional recurrence or metastasis; and as an adjunct to standard imaging modalities for monitoring response to treatment for locally advanced and metastatic disease to determine if therapy should be changed.
Myocardial Viability	July 1, 2001 to September 30, 2002	Covered only following inconclusive SPECT.
Myocardial Viability	October 1, 2002	Primary or initial diagnosis prior to revascularization, or following an inconclusive SPECT.

* **Note**: for breast cancer, monitoring is allowed when a change in treatment is contemplated.

General Conditions of Coverage by Allowable Type of FDG PET Scanner

Allowable Type of FDG PET System			
Covered Clinical Condition	Prior to July 1, 2001	July 1, 2001 through December 31, 2001	On or after January 1, 2002
Breast Cancer	Not covered	Not covered	Effective October 1, 2002, full and partial ring
Myocardial Viability Primary or initial diagnosis prior to revascularization (Continued coverage following an inconclusive SPECT is also allowed)	Not covered	Not covered	Effective October 1, 2002, full and partial ring

HCPCS Codes for Breast Cancer PET Scans Performed on or after October 1, 2002

G0252 PET imaging, *full and partial-ring PET scanners only,* for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes), not covered by Medicare

G0253 PET imaging for breast cancer, *full and partial-ring PET scanners only,* staging/restaging of local regional recurrence or distant metastases, i.e., Staging/restaging after or prior to course of treatment

G0254 PET imaging for breast cancer, *full and partial-ring PET scanners only,* evaluation of response to treatment, performed during course of treatment

CPT/HCPCS Codes for Myocardial Viability PET Scans performed on or after October 1, 2002

G0230 PET imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study; *full- and partial-ring PET scanners only* (should continue to be billed following an inconclusive SPECT)

78459 *Myocardial imaging, positron emission tomography (PET), metabolic evaluation (should be used for determination of myocardial viability as a primary or initial diagnostic study prior to revascularization)*

Source: CMS Transmittal AB-02-065, CR 2138

VISION CARE

Medicare Coverage of Rehabilitation Services for Beneficiaries with Vision Impairment

A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical and should be performed by an occupational or physical therapist. (Physical therapy and occupational therapy assistants cannot perform such evaluations.)

Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or AIDS.

Coverage and Limitations

In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare physician, and implemented by approved Medicare providers (occupational or physical therapists) or incident to physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services:

- Mobility
- Activities of daily living
- Other rehabilitation goals that are medically necessary

The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning – is not covered. For example, a person with an ICD-9-CM diagnosis 369.08 (profound impairment in both eyes, i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less) would generally be eligible for, and may be provided, rehabilitation services under *CPT* code 97535, (self care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

Services may be provided by a physician as defined in sections 1861(r)(1) and (4) of the Social Security Act, a qualified occupational therapist, or a qualified physical therapist. Services furnished by an employee of the physician may only be provided incident to the physician's professional services, must be furnished under the physician's direct personal supervision, and must meet other incident to requirements provided in section 2050 of the Medicare Carriers Manual. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as other therapy services.

Applicable *CPT* Therapeutic Procedures

The following list contains examples that are not meant to limit the provision of other medically necessary services:

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility

97116 gait training (includes stair climbing)

97532 Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

97535 Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instruction in use of assistive technology/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

97537 Community/work reintegration (e.g., shopping, transportation, money management, avocational activities and/or work environment modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes

Note: Community reintegration when performed in conjunction with other therapeutic procedures such as gait training and self-care/home management training is bundled into the payment for those other services. Therefore, these services are not separately reimbursable by Florida Medicare.

ICD-9-CM Codes for Vision Impairment that Support Medical Necessity

The following are appropriate diagnoses to use for the therapeutic procedures specified above:

BE = Better Eye LE = Lesser Eye

368.41	Scotoma central area
368.45	Generalized contraction or constriction
368.46	Homonymous bilateral field defects
368.47	Heteronymous bilateral field defects
369.01	BE – total impairment LE – total impairment
369.03	BE – near-total impairment LE – total impairment
369.04	BE – near-total impairment LE – near-total impairment
369.06	BE – profound impairment LE – total impairment
369.07	BE – profound impairment LE – near-total impairment
369.12	BE – severe impairment LE – total impairment
369.13	BE – severe impairment LE – near-total impairment
369.14	BE – severe impairment LE – profound impairment
369.16	BE – moderate impairment LE – total impairment
369.17	BE – moderate impairment LE – near-total impairment
369.18	BE – moderate impairment LE – profound impairment
369.22	BE – severe impairment LE – severe impairment
369.24	BE – moderate impairment LE – severe impairment
369.25	BE – moderate impairment LE – moderate impairment

Definition of Levels of Vision Impairment:

Moderate – best-corrected visual acuity is less than 20/60

Severe *(legal blindness)* – best corrected visual acuity is less than 20/160, or visual field is 20 degrees or less

Profound *(moderate blindness)* – best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less

Near-total (*severe blindness)* – best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less

Total *(total blindness)* – no light perception.

Source: CMS Transmittal AB-02-078; CR 2083

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**

Medical Policy Table of Contents

Local Medical Review Policies

Provider Notification of Local Medical Review Policy (LMRP)

Medicare contractors are required to offer a 45-day notice period for LMRPs. This period typically begins by publishing LMRP through contractors' bulletins. However, a recent memorandum from the Centers for Medicare & Medicaid Services (CMS) directs contractors to discontinue printing and mailing bulletins between July 1, 2002, and September 30, 2002.

This article is to notify providers that **the 45-day notice period for all LMRPs will now begin on the date the LMRP is posted to our Web site** (*www.floridamedicare.com*).

Source: CMS Memorandum dated June 28, 2002

Coding Changes for Sodium Hyaluronate

The Centers for Medicare & Medicaid Services (CMS) has established the new payment code Q3030 (sodium hyaluronate, per 20 to 25 mg dose, for intra articular injection). This code is effective July 1, 2002, for claims with dates of service on or after that date. The current code for this drug, J7316, will be discontinued as of July 1, 2002, with a 90-day grace period.

Due to systems limitations, CMS will not be able to accept the new code for payment until October 1, 2002. Therefore, services submitted with the Q3030 will be denied until October 1, 2002. Providers may hold their claims and submit them using the Q3030 starting October 1, 2002. Alternatively, they may continue to submit them using the J7316 through September 30, 2002. Should there be a payment differential between J7316 and Q3030, starting October 1, 2002, providers may contact their carriers and request that an adjustment be made for claims with dates of service from July 1, 2002, through September 30, 2002.

Source: CMS Transmittal AB-02-082, CR 2230

A0425: Ground Ambulance Services

Revision Overview: Policy revised to reflect information in CMS Program Memoranda AB-01-165 and AB-02-036.

Policy Number
A0425

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Ground Ambulance Services

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Medicare Carriers Manual, Sections 2120.1-2124.H, 2125, 3102, 5116, 5215
Program Memorandum, B-00-09 (Change Request 1065)
Program Memorandum, AB-01-165 (Change Request 1555)
Program Memorandum, AB-02-036 (Change Request 2047)

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
04/01/2002

Revision Ending Date
03/31/2002

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

The ambulance and crew must meet specific requirements outlined in the Medicare Carriers Manual. The transportation must be medically reasonable and necessary as outlined in the Medicare Carriers Manual. This requires that other means of transportation be medically contraindicated, in other words, that the patient cannot be safely transported by any other means. The origin and destination requirements outlined in the Medicare Carriers Manual must be met.

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

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

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

- The patient's condition necessitated emergency care and resulted from an acute injury or illness in which the patient was left in an unstable condition. Examples include a patient that has had a major bone compound

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

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

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

Physician Certification
When a nonemergency transport is scheduled (repetitive and nonrepetitive) or unscheduled, the ambulance supplier must obtain a written order from the patient's attending physician certifying that the medical necessity requirements are met. The signed physician certification must be obtained from either the physician, physician-assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the attending physician or by the hospital or facility who has personal knowledge of the beneficiary's condition when the supplier is unable to obtain the attending physician's signature.

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

CPT/HCPCS Section & Benefit Category
Ambulance

CPT/HCPCS Codes
A0420 Ambulance waiting time (ALS or BLS), one – half (1/2) hour increments

Waiting Time Table

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

A0424 Extra ambulance attendant, ALS or BLS (requires medical review)
A0425 Ground mileage, per statute mile
A0426 Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0427 Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-emergency)
A0428 Ambulance service, basic life support, non-emergency transport (BLS)
A0429 Ambulance service, basic life support, emergency transport (BLS-emergency)
A0433 Advanced life support, level 2 (ALS 2)
A0434 Specialty care transport (SCT)
A0999 Unlisted ambulance service
Q3019 Ambulance service, advance life support (ALS) vehicle used, emergency transport, no ALS level service furnished
Q3020 Ambulance service, advance life support (ALS) vehicle used, non-emergency transport, no ALS level service furnished

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

250.20-250.23	Diabetes with hyperosmolarity (severe diabetic complication)
250.30-250.33	Diabetes with other coma
251.0	Hypoglycemic coma
255.4	Corticoadrenal insufficiency
293.0	Acute delirium
298.8	Other and unspecified reactive psychosis (psychosis requiring restraints)
345.3	Grand mal status
410.00-410.92	Acute myocardial infarction
411.0-411.89	Other acute and subacute forms of ischemic heart disease
413.0-413.9	Angina pectoris
414.10-414.19	Aneurysm of heart
415.11-415.19	Pulmonary embolism and infarction
426.0-426.9	Conduction disorders
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure (severe)
430-434.91, 436	Cerebrovascular disease (severe cerebral vascular problems)
441.00-441.9	Aortic aneurysm and dissection
442.0-442.9	Other aneurysm
493.01, 493.11, 493.21, 493.91	Asthma with status asthmaticus
518.0	Pulmonary collapse
518.4	Acute edema of lung, unspecified
518.5	Pulmonary insufficiency following trauma and surgery
518.81	Acute respiratory failure
518.82	Other pulmonary insufficiency, not elsewhere classified
519.00-519.09	Tracheostomy complications
531.00-531.21, 531.40-531.61, 532.00-532.21, 532.40-532.61, 533.00-533.21, 533.40-533.61, 534.00-534.21, 534.40-534.61, 535.01, 535.11, 535.21, 535.31, 535.41, 535.51, 535.61	Diseases of esophagus, stomach, and duodenum (severe gastrointestinal complication)
578.9	Hemorrhage of gastrointestinal tract, unspecified
669.10-669.14	Shock during or following labor and delivery
669.90-669.94	Unspecified complication of labor and delivery
719.49	Pain in joint, multiple sites (severe joint pain causing immobility)
780.01	Coma
780.2	Syncope and collapse
780.31-780.39	Convulsions
785.50-785.59	Shock without mention of trauma
786.09	Other symptoms involving respiratory system and other chest symptoms (severe respiratory distress)
786.50-786.59	Chest pain
789.00-789.09	Abdominal pain (severe)
799.0	Asphyxia
799.1	Respiratory arrest
800.00-804.99	Fracture of skull
805.00-809.1	Fracture of neck and trunk
820.00-823.92	Fracture of femur, patella, tibia, and fibula
835.00-835.13	Dislocation of hip
850.1-854.19	Intracranial injury, excluding those with skull fracture
860.0-869.1	Internal injury of thorax, abdomen, and pelvis
871.0-871.9	Open wound of eyeball
925.1-929.9	Crushing injury
948.00-948.99	Burns classified according to extent of body surface involved
952.00-952.9	Spinal cord injury without evidence of spinal bone injury
958.4	Traumatic shock
959.01-959.3, 959.6-959.8	Injury, other and unspecified (severe injuries to include those with open fractures, unstable fractures where movement could result in further injury, moderate to heavy bleeding, traumatic amputations, incapacitating pain)
960.0-979.9	Poisoning by drugs, medicinal, and biological substances
980.0-989.9	Toxic effects of substances chiefly nonmedicinal as to source
991.6	Hypothermia (severe with decreased level of consciousness)
993.3	Caisson disease
994.0	Effects of lightening
994.1	Drowning and nonfatal submersion
994.7	Asphyxiation and strangulation
994.8	Electrocution and nonfatal effects of electric current
995.0	Other anaphylactic shock
995.60-995.69	Anaphylactic shock due to adverse food reaction
999.4	Anaphylactic shock due to serum

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

Diagnoses that Support Medical Necessity

N/A

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

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denials

Ambulance services will be denied when the patient's condition does not warrant its use either because the patient could have been safely transported by another means of transportation, independent of whether or not it

was available, or if the patient's condition did not require the skills of specially trained staff or equipment due to an acute condition or injury. A denial will also occur if all the requirements identified in the Medicare Carriers Manual are not met (e.g., ambulance and crew requirements, physician certification, bed confined).

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

Origin and destination modifiers are to be used with codes A0425-A0434 and Q3019-Q3020. The first position alpha code equals origin and the second position alpha code equals destination. The origin and destination codes are:

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

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

Effective for services performed on or after January 01, 2001, HCPCS code A0434 (Specialty Care Transport) will be reviewed on a prepayment basis. All claims submitted with HCPCS code A0434 must include documentation as outlined in the "Documentation Requirements" to support medical necessity and the need for specialty care transport.

Documentation Requirements

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

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

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

Documentation is required to be submitted on a prepayment basis when billing HCPCS code A0434.

Utilization Guidelines

N/A

Other Comments

Terms defined:

- Basic Life Support (BLS) – Basic life support (BLS) means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from state to state. for example, only in some states is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.
- Basic Life Support (BLS) – Emergency – The Basic Life Support – Emergency category is the provision of BLS services, as specified above, in the context of an emergency response.

  Emergency response means responding immediately at the BLS or ALS 1 level of service to a 911 call, or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.
- Advanced Life Support, Level 1 (ALS 1) – Advanced life support, level 1, (ALS 1) means transportation by ground ambulance, medically necessary supplies and services, and an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

  Advanced life support assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

  Advanced life support intervention means a procedure that is, in accordance with state and local laws, beyond the scope of authority of an emergency medical technician-basic (EMT-Basic).

  Advanced life support personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also qualified in accordance with state and local laws to perform essential advanced techniques and to

administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with state and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

- Advanced Life Support, Level 1 (ALS 1) – Emergency – The Advanced Life Support, Level 1 – Emergency Response category is defined as the provision of ALS 1 services as specified above, in the context of an emergency response.

  Emergency response means responding immediately at the BLS or ALS 1 level of service to a 911 call or the equivalent in areas without a 911 system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

- Advanced Life Support, Level 2 (ALS 2) – The Advanced Life Support, Level 2 category is:

1. Three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate), and transportation, medically necessary supplies and services, or
2. The provision of at least one of the following ALS procedures:
   Manual defibrillation/cardioversion
   Endotracheal intubation
   Central venous line
   Cardiac pacing
   Chest decompression
   Surgical airway
   Intraosseous line

- Specialty Care Transport (SCT) – When medically necessary, for a critically injured or ill beneficiary, a level of inter-facility service provided by a ground ambulance vehicle, including medically necessary supplies, that is at a level of service beyond the scope of the EMT-paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

Sources of Information and Basis for Decision
N/A

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

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	4	PCR B2002-109
Start Date of Comment Period:		N/A
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		04/01/2002

G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes

Revision Overview: Original policy.

Policy Number
G0245

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 50-8.1
Program Memorandum AB-02-042, (Change Request 2060, dated April 01, 2002, and Change Request 2296, dated July 17, 2002)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
07/01/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Peripheral neuropathy is the most common factor leading to amputation in people with diabetes. In diabetes, peripheral neuropathy is an anatomically diffuse

process primarily affecting sensory and autonomic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal, or chemical sources. When foot lesions are present, the reduction in autonomic nerve functions may also inhibit wound healing.

Indications and Limitations of Coverage and/or Medical Necessity

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet. Foot exams for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 01, 2002, Medicare covers, as a physician service, an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of five tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

CPT/HCPCS Section & Benefit Category

Procedures/Professional Services

CPT/HCPCS Codes

G0245 G0246 G0247

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

250.60 250.61 250.62 250.63 357.2

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

N/A

Coding Guidelines

Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.

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

Utilization Guidelines

Each physician or physician group, of which that physician is a member, may only receive reimbursement once for G0245 for each beneficiary. However, should that beneficiary need to see a new physician, that new physician may also be reimbursed once for G0245 for that beneficiary as long as it has been at least six months from the last time G0245 or G0246 was paid for the beneficiary, regardless of who provided the service.

Other Comments

N/A

Sources of Information and Basis for Decision

N/A

Advisory Committee Notes

N/A

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2002

Revision History

Revision Number Original	PCR B2002-146
Start Date of Comment Period:	N/A
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	07/01/2002

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.

G0248: Home Prothrombin Time International Normalized Ratio (INR) Monitoring

Revision Overview: Original policy.

Policy Number
G0248

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Home Prothrombin Time International Normalized Ratio (INR) Monitoring

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 50-56
Program Memorandum AB-02-064 (Change Request 2071, dated 05/02/02)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
07/01/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Warfarin is the oral anticoagulant most frequently used to control and prevent thromboembolic disorders. The goal of anticoagulant therapy is to administer the lowest possible dose of anticoagulant to prevent clot formation or expansion. The required degree of anticoagulation continues to evolve as studies provide more information about the efficacy and safety of lower doses. The prothrombin time (PT) is the primary assay used in monitoring warfarin therapy. The standardized use of the International Normalized Ratio (INR) allows physicians to determine the level of anticoagulation in a patient independent of the laboratory reagents used. The INR is the ratio of the patient's population time compared to the mean prothrombin time for a group of normal individuals. The current therapeutic INR goal for patients with mechanical prosthetic heart valves is 2.5-3.5.

The monitoring of a patient's INR level to maintain patients within the therapeutic range is accomplished in a physician's office, anticoagulant clinics, or home monitoring. Patient self-testing and self-management through the use of a home INR monitor may be used to improve the time in therapeutic rate for a select group of patients. This policy addresses coverage of home monitoring of INR levels.

Indications and Limitations of Coverage and/or Medical Necessity
Effective for services performed on or after July 1, 2002, Medicare will cover the use of home prothrombin time INR monitoring for anticoagulation management for patients with mechanical heart valves on warfarin. The monitor and the home testing must be prescribed by a physician and the following patient requirements must be met:

- Must have been anticoagulated for at least three months prior to use of the home INR device;
- Must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
- Self testing with the device is limited to a frequency of once per week.

Note: Porcine valves are not covered, so Medicare will not make payment on home INR monitoring for patients with porcine valves.

CPT/HCPCS Section & Benefit Category
Pathology and Laboratory/Hematology and Coagulation

CPT/HCPCS Codes
G0248 G0249 G0250

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
V43.3

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
The cost of the device and supplies are included in the payment for G0249, and therefore, are not separately billable to Medicare.

Documentation Requirements
Medical record documentation maintained in the patient's file must support the coverage requirements are met. In addition, the documentation must support that the procedure was performed. This information is normally found in the office/progress notes, hospital records, and test results.

Utilization Guidelines
HCPCS code G0250 is per 4 tests, therefore, this code should only be billed no more than once every 4 weeks.

Other Comments
N/A

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

Advisory Committee Notes
N/A

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-115
Start Date of Comment Period:	N/A
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	07/01/2002

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.

J0470: Chelation Therapy

The local medical review policy (LMRP) for chelation therapy (J0470) was previously published in the Second Quarter 2002 *Medicare Part B Update!* (pages 38-40). Since that time, coverage for one of the procedure codes in that LMRP, J0895 (Deferoxamine Mesylate [Desferal]), has been expanded to include the treatment of chronic iron overload due to transfusion-dependent anemias. ICD-9-CM code 275.0 (Disorders of iron metabolism) must be used for those patients with secondary iron overload from multiple transfusions who do not meet the definition for ICD-9-CM code 285.0 (Sideroblastic anemia).

> **Note:** Desferal is not indicated for the treatment of primary hemochromatosis, since phlebotomy is the method of choice for removing excess iron in this disorder.

Effective Date
This revision is effective for services processed on or after June 24, 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.

J0587: Botulinum Toxin Type B (Myobloc™)

Revision Overview: Original policy.

Policy Number
J0587

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Botulinum Toxin Type B (Myobloc™)

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description

Botulinum toxin type B (Myobloc™) is an injectable neurotoxin that is produced by fermentation of the bacterium *Clostridium botulinum* type B. Myobloc™ acts at the neuromuscular junction to produce flaccid paralysis, thereby reducing the severity of abnormal head position and neck pain associated with cervical dystonia.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider botulinum toxin type B (Myobloc™) medically reasonable and necessary when provided for its Food and Drug Administration (FDA) approved use for treatment of cervical dystonia. Myobloc™ is indicated and approved to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

CPT/HCPCS Section & Benefit Category

Drugs and Biologicals

CPT/HCPCS Codes

J0587

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

333.83 723.5

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.

Treatment of wrinkles using botulinum toxin type B (Myobloc™) is considered to be cosmetic and is not covered.

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

When billing for injections of botulinum toxin type B (Myobloc™) for covered conditions/diagnoses, the following guidelines should be used. Failure to report this procedure according to these guidelines may result in a denial of a claim.

When reporting *CPT* code J0587, botulinum toxin type B (Myobloc™), a detailed description of the procedure must also be submitted with the claim before consideration for payment may be made.

To bill medically necessary electromyography guidance, in addition to botulinum toxin type B (Myobloc™), report the following procedure code(s):

CPT Code	Descriptor	Corresponding Chemodenervation/ Injection Code
95860	Needle electromyography, one extremity with or without related paraspinal areas	64614
95861	Needle electromyography, two extremities with or without related paraspinal areas	64614
95867	Needle electromyography, cranial nerve supplied muscles, unilateral	31513, 31570, 31571, 64612, 64613
95868	Needle electromyography, cranial nerve supplied muscles, bilateral	31513, 31570, 31571, 64612, 64613
95869	Needle electromyography; thoracic paraspinal muscles	64614
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	64613, 64614, 64640

Due to the short shelf life of the botulinum toxin type B (Myobloc™), Medicare will reimburse the unused portion of this drug only when the vial is not split between patients. The exact dosage of the drug given and the exact amount of the discarded portion of the drug must be documented in the patient's medical record.

Scheduling of more than one patient is encouraged to prevent wastage of botulinum toxin type B (Myobloc™). If a vial is split between two patients, the billing in these instances must be for the exact amount of botulinum toxin type B (Myobloc™) used on each individual patient. Show the exact amount given for each patient in Item 24G of the 1500 claim form. For electronic media claim (EMC) billings, document the units injected in the units service field, FAO.18. Medicare would not expect to see billing for the full fee amount for botulinum toxin type B (Myobloc™) for each beneficiary when the vial is split between two or more patients.

Documentation Requirements

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

Utilization Guidelines

N/A

Other Comments
N/A

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

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

Carrier Advisory Committee Meeting held on August 25, 2001.

Start Date of Comment Period
08/17/2001

End Date of Comment Period
10/01/2001

Start Date of Notice Period
08/01/2002

Revision History
Revision Number	Original PCR B2002-124
Start Date of Comment Period:	08/17/2001
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

J1561: Intravenous Immune Globulin
To provide clarification regarding coverage for HIV-associated thrombocytopenia, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the local medical review policy for intravenous immune globulin has been revised, effective July 29, 2002. Please note the following changes:

b) Idiopathic Thrombocytopenic Purpura (ITP) and HIV-associated Thrombocytopenia

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

ITP is the most common cause of thrombocytopenia in HIV disease, the mechanism of which is thought to be similar to individuals who are HIV negative. Antiretroviral therapy may be used for the initial long term management of HIV-associated thrombocytopenia for those individuals who do not meet the coverage criteria listed below. The use of IVIG for HIV-associated thrombocytopenia must meet the medical necessity criteria set forth below and must be billed using ICD-9 code 287.5 (Thrombocytopenia, unspecified.)

IVIG is indicated for ITP and HIV-associated Thrombocytopenia under the following circumstances:

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

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

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

J2820: Sargramostim (GM-CSF, Leukine®)
Revision Overview: Original policy.

Policy Number
J2820

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Sargramostim (GM-CSF, Leukine®)

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Granulocyte Macrophage Colony Stimulating Factor (GM-CSF) is an antineutropenic, hematopoietic growth factor, which supports survival, clonal expansion, and differentiation of hematopoietic progenitor cells. GM-CSF is also capable of activating mature granulocytes and macrophages. This drug is not a cancer chemotherapy agent.

The drug appears to elicit the pharmacologic effects usually produced by endogenous human GM-CSF. Endogenous GM-CSF is a multilineage colony-stimulating factor that principally affects the proliferation, differentiation, and activation of granulocytes and macrophages by inducing partially committed progenitor cells to divide and differentiate in the granulocyte-macrophage pathways.

Endogenous GM-CSF acts on various progenitor target cells by binding to GM-CSF specific receptors on their cell surfaces. Biosynthetic GM-CSF principally affects cells in the granulocyte-macrophage lineage. In patients receiving low doses of biosynthetic GM-CSF, the leukocyte response is composed principally of neutrophils; at higher concentrations, the leukocyte response also involves proliferation of monocytes and eosinophils.

Indications and Limitations of Coverage and/or Medical Necessity

Indications
Florida Medicare will consider GM-CSF medically reasonable and necessary for the treatment of the following FDA approved indications when it is not self/caregiver administered:

- Promotion of myeloid engraftment following bone marrow transplant (BMT):
    - o For acceleration of myeloid recovery in patients with non-Hodgkin's lymphomas, acute lymphoblastic leukemia, and Hodgkin's disease undergoing autologous BMT.
    - o For acceleration of myeloid recovery in patients undergoing autologous or allogenic BMT following myeloablative chemotherapy for non-myeloid malignancies.
    - o For acceleration of myeloid recovery in patients undergoing allogenic BMT following myeloablative chemotherapy for myeloid malignancies.
    - o For treatment of failure or delay of myeloid engraftment following autologous or allogenic BMT, in the presence or absence of infection.
- Enhancement of peripheral blood progenitor cell (PBPC) collection when the bone marrow transplant procedure itself is a covered benefit.
- For acceleration of myeloid recovery in patients undergoing hematopoietic stem cell transplantation following myeloablative chemotherapy.
- To reduce the duration of neutropenia, following induction chemotherapy treatment of adults with acute myelocytic leukemia (AML).

Florida Medicare will consider GM-CSF medically reasonable and necessary for the treatment of the following off-label indications when it is not self/caregiver administered:

- Failure or delay of myeloid engraftment in patients who have undergone autologous or allogenic hematopoietic stem cell transplantation, in the presence or absence of infection.
- To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia.
- Acquired immunodeficiency syndrome (AIDS)-associated neutropenia caused by the disease (AIDS) itself or infection with opportunistic organisms (such as cytomegalovirus), or antiretroviral agents (zidovudine, ganciclovir).
- Intermittent administration of GM-CSF for a subset of patients with Myelodysplastic syndromes (MDS) who have severe neutropenia and recurrent infections.

Limitations
A physician is not to bill Florida Medicare for a supply of GM-CSF given to the patient for self-administration at home.

The following off-labeled uses of GM-CSF have not been shown to be safe and effective and are noncovered by Florida Medicare: aplastic anemia, hairy cell leukemia, severe chronic neutropenia which includes congenital (Kostmann's syndrome), idiopathic and cyclic.

Treatment of drug-induced neutropenia, except when associated with the use of antiretroviral agents is an off-labeled indication and noncovered by Florida Medicare.

There is no evidence that GM-CSF is an important benefit in patients with refractory or relapsed myeloid leukemia.

Therapeutic initiation of GM-CSF does not add significantly to the antibiotic treatment outcome of established febrile neutropenia.

CSFs should not be routinely used as adjunct therapy for the treatment of uncomplicated fever and neutropenia. Uncomplicated fever and neutropenia are defined as follows:

- Fever of $\leq$ 10 days in duration, *and*

- No evidence of pneumonia, cellulitis, abscess, sinusitis, hypotension, multi-organ dysfunction, or invasive fungal infection, *and*
- No uncontrolled malignancies.

There is inadequate data to support the use of GM-CSF for patients with afebrile neutropenia.

GM-CSF is contraindicated in patients with excessive leukemic myeloid blasts in the bone marrow or peripheral blood (≥ 10%).

In general, for previously untreated patients receiving a chemotherapy regimen, primary prophylactic administration of GM-CSF is not considered medically necessary.

Due to the potential sensitivity of rapidly dividing hematopoietic cells, GM-CSF should not be administered simultaneously with cytotoxic chemotherapy or radiotherapy or within 24 hours preceding or following chemotherapy or radiotherapy.

There is no evidence of benefit from the use of GM-CSF to increase chemotherapy dose-intensity.

Dosage and Frequency
The following is the recommended dosage and frequency when administering this drug:

Myelosuppressive chemotherapy - recommended dose is 250 mcg/m²/day. Administered no earlier than 24 hours after cytotoxic chemotherapy and not in the 24 hours before administration of chemotherapy.

PBPC - recommended dose is 250 mcg/m²/day. For the mobilization phase, this dosing should continue through the period of PBPC collection. For the post transplantation phase, begin the dose immediately and continue until an ANC > 1500 cells/mm³ for 3 consecutive days is attained.

Myeloid Reconstitution after Autologous or Allogenic BMT - recommended dose following BMT is 250 mcg/ m²/day. Patients should not receive the drug until the post marrow infusion ANC is less than 500 cells/mm³. The drug should be continued until an ANC >1500 cells/mm³ for 3 consecutive days is attained.

BMT Failure or Engraftment Delay- recommended dose is 250 mcg/m²/day. Repeat dosage after 7 days off therapy if engraftment has not occurred. If engraftment still has not occurred, a third course of 500 mcg/ m²/day for 14 days may be tried after another 7 days off therapy. If there is still no improvement, it is unlikely that further dose escalation will be beneficial.

If the ANC exceeds 20,000 or the platelet count exceeds 500,000, GM-CSF treatment should be discontinued or the dose reduced by half. Excessive blood counts usually return to normal or baseline levels within 3 to 7 days following withdrawal of GM-CSF.

CPT/HCPCS Section & Benefit Category
Drugs and Biologicals

CPT/HCPCS Codes
J2820

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
238.7 288.0 V42.9 V58.1 V58.69 V59.8

Note: Please refer to coding guidelines for specific requirements regarding the billing of each of these ICD-9-CM codes.

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
The use of GM-CSF (Sargramostim, Leukine®) 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
Claims for GM-CSF should be billed using the following diagnosis codes:

238.7	(Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues) when GM-CSF is used for Myelodysplastic syndrome (MDS).
288.0	(Agranulocytosis) when GM-CSF is used for patients with AIDS-associated neutropenia.
V42.9	(Unspecified organ or tissue replaced by transplant) when GM-CSF is given to stem cell recipients (e.g., BMT).
V58.1	(Encounter for other and unspecified procedures and aftercare, chemo-therapy) when GM-CSF is used for febrile neutropenia resulting from myelosuppressive chemotherapy or following induction or consolidation chemotherapy treatment of adults with AML.
V58.69	(Long-term [current] use of other medications) when GM-CSF is used for a patient with AZT or Ganciclovir neutropenia.
V59.8	(Donors, other specified organ or tissue) when GM-CSF is used in priming for autologous peripheral stem cells (e.g., PBPC), as an adjunct to allogeneic and autologous progenitor-cell transplantation, or for neutrophil engraftment failure.

Documentation Requirements
Medical record documentation maintained by the physician must clearly indicate:

- The patient's current absolute neutrophil count (ANC);
- The patient's weight in kilograms;
- The administration and dosage of the GM-CSF;
- The actual indication for which the drug was given and accompanying symptomology (e.g., fever); and
- The patient's response to the treatment.

This information is usually found in the history and physical or the office/progress notes. The ANC may be reported in the patient's laboratory report.

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
The package insert instructions for dosage and duration of treatment should not be exceeded.

The guidelines recommended for adults are generally applicable to the pediatric age group.

Terms Defined:
Absolute neutrophil count (ANC) - a lab test done on blood which counts the neutrophils within the blood specimen. It is represented by the total WBC x % segmented neutrophils and bands. Normal ANC is considered 3000-7000/mm³.
Dose-intense chemotherapy - treatment given at higher doses or on a more frequent schedule than is conventional in an attempt to induce either more complete remissions or a greater cure rate.
Febrile neutropenia - generally designated as a temperature of approximately 38.5°C (~101°F) or greater, sustained for more than one hour, and developing concurrently with an ANC < 500/mm³.
GM-CSF primary administration - the use of GM-CSF before any occurrence of neutropenia or febrile neutropenia that may result from chemotherapy (i.e., beginning in the first cycle of treatment).
Myeloid - pertaining to, derived from, or resembling bone marrow.
Neutropenia - an abnormally small number of neutrophil cells in the blood (an ANC of < 1800/mm³).
Progenitor-cell support - refers to transplantation of hematopoietic cells derived from either bone marrow or the peripheral blood as a means to increase patient safety and tolerance of treatment when very high doses of chemotherapy are administered to increase remission rates and increase disease-free survival (DFS).
Severe chronic neutropenia - ANC less than 500/mm³.

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

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

Carrier Advisory Committee Meeting held on 01/19/2002.

Start Date of Comment Period
01/11/2002

End Date of Comment Period
02/25/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-134
Start Date of Comment Period:	01/11/2002
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

J3490: Zoledronic Acid (Zometa®)
Revision Overview: Original policy.

Policy Number
J3490

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Zoledronic Acid (Zometa®)

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Zoledronic Acid (Zometa®) is a bisphosphonic acid, which is an inhibitor of osteoclastic bone resorption. This class of drug, also known as a bisphosphonate, binds to the bone matrix, which decreases osteoclastic activity, prevents bone resorption and skeletal calcium release induced by various stimulatory factors released by tumors. Osteoclastic hyperactivity resulting in excessive bone resorption is the underlying pathophysiologic derangement in hypercalcemia of malignancy and metastatic bone disease.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider Zoledronic Acid (Zometa®) medically reasonable and necessary when provided to patients for the treatment of the following FDA approved indications:

- hypercalcemia of malignancy;
- multiple myeloma; and/or
- documented bone metastases from solid tumors in conjunction with standard antineoplastic therapy.

Note: Prostate cancer should have progressed after treatment with at least one hormonal therapy.

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

CPT/HCPCS Codes
N/A

Not Otherwise Classified Codes (NOC)
J3490

ICD-9-CM Codes that Support Medical Necessity
198.5 203.00-203.01 275.42

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.

The use of this drug for the treatment of osteoporosis is not FDA approved and is, therefore, not covered by Florida Medicare.

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
When billing for Zoledronic Acid (Zometa®), use HCPCS code J3490 and include the name of the drug and the appropriate ICD-9-CM diagnosis code, which indicates the medical condition being treated.

Infusion code 90780 should be used when this drug is administered. Chemotherapy administration codes should not be used.

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

Utilization Guidelines
N/A

Other Comments
N/A

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

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

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-137
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	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

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). Since that time, four existing drugs have received additional indications based on literature evaluation and/or Compendia updates:

HCPCS Code	Description	ICD-9-CM Diagnosis
J9201	Gemcitabine	Malignant neoplasm of gallbladder (156.0-156.9)
J9206	Irinotecan	Malignant neoplasm of esophagus, stomach, and pancreas (150.0-150.9, 151.0-151.9, and 157.0-157.9)
J9265	Paclitaxel	Malignant neoplasm of connective tissue and other soft tissue (171.0-171.9)
J9390	Vinorelbine	Malignant neoplasm of prostate (185)

Effective Date

These additions are effective for services processed on or after July 16, 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.

NCSVCS: The List of Medicare Noncovered Services

The List of Medicare Noncovered Services was published in the Second Quarter 2002 *Medicare B Update!* (pages 22-27). Since then, the following changes have been made to the local medical review policy.

Local Noncoverage

Deletions

- 95999GY+, Quantitative Sensory Testing (QST), is deleted from the Local Noncoverage list, based on information in LMRP 95900: Nerve Conduction Studies, effective for claims processed on or after July 29, 2002.
- 95999+, Current Perception Threshold Testing, is changed to G0255 Current Perception Sensory Nerve Conduction Threshold (sNCT) by the Centers for Medicare & Medicaid Services (CMS) Transmittal AB-02-066 (CR 2153). This is a noninvasive test that uses transcutaneous electrical stimulus to evoke a sensation. There is insufficient scientific or clinical evidence to consider this device reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Social Security Act. Effective for dates of service on or after October 1, 2002, this test will be nationally noncovered by Medicare. Therefore, 95999+ for Current Perception Threshold Testing is deleted from the Local Noncoverage list and added to the National Noncoverage list as G0255.

National Noncoverage

Additions

- G0255, Current Perception Sensory Nerve Conduction Threshold (sNCT), is added to the National Noncoverage list (please see above).
- J3520*, Edetate disodium, per 150 mg, is added to the National Noncoverage list based on Coverage Issues Manual (CIM) 35-64, 45-20.
- IV chelation therapy (chemical endarterectomy) is added to the National Noncoverage list (M0300*) based on CIM 35-64.

Corrections

- A correction to the coding of existing nationally noncovered Cellular Therapy from 99199*+ to M0075* (CIM 35-5).
- A correction to the coding of the existing nationally noncovered Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (CIM 35-13) from 20999*+ to M0076*.

Deletions

- A revision to The List of Medicare Noncovered Services policy (NCSVCS) referencing *CPT* code 90887 was published in the Third Quarter 2002 *Medicare B Update!* (page 30). CMS Transmittal AB-02-058 (CR 2161) changed the procedure code status of *CPT* code 90887 back to "bundled" effective for services rendered on or after January 1, 2002, processed on or after July 1, 2002. Therefore, *CPT* code 90887 has been deleted from the National Noncoverage list.

Advance Notice Statement

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

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

22520: Percutaneous Vertebroplasty

Revision Overview: The term "multi-disciplinary" was deleted, the statement regarding general anesthesia was revised, and an indication for those individuals with severe pain and debilitation requiring hospitalization for pain control and treatment was added.

Policy Number
22520

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Percutaneous Vertebroplasty

AMA *CPT* Copyright Statement

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
04/17/2000

Original Policy Ending Date
N/A

Revision Effective Date
07/22/2002

Revision Ending Date
07/21/2002

LMRP Description
Percutaneous vertebroplasty is a therapeutic, interventional neurosurgical and radiological procedure that consists of the percutaneous injection of a biomaterial, methyl methacrylate, into a lesion of a cervical, thoracic, or lumbar vertebral body. The procedure is utilized for pain relief and bone strengthening of weakened vertebral bodies.

The procedure is performed under fluoroscopic guidance, although some prefer the use of computed tomography (CT) with fluoroscopy for needle positioning and injection assessment. An intraosseous venogram is sometimes performed before cement injection to determine whether the needle is positioned within a direct venous anastomosis to the central or epidural veins, to minimize extravasation into venous structures. Conscious sedation with additional local anesthesia (1% lidocaine) is generally utilized; however, patients who experience difficulties with ventilation or are unable to tolerate prone position during the procedure may require general anesthesia or deep sedation with airway and ventilation support. The methyl methacrylate is injected into the vertebral body until resistance is met or until cement reaches the posterior wall. The procedure usually lasts from 1 to 2 hours, unless cement is injected into two or more vertebral bodies. The patient must remain flat for about three hours following the procedure.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the performance of a percutaneous vertebroplasty procedure medically reasonable and necessary for the following indications:

- Painful osteolytic vertebral body metastatic disease;
- Painful multiple myeloma involving the vertebral body;
- Painful and/or aggressive hemangioma;
- Painful, debilitating, osteoporotic vertebral collapse/compression fractures that have not responded to conservative medical treatment (e.g., 2-4 week period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic usage); and
- Severe pain and functional debilitation related to activities of daily living due to chronic vertebral collapse/compression fractures that require hospitalization for pain control and treatment. Conservative medical management is not considered appropriate for such patients. It is expected that this circumstance will occur rarely to occasionally.

The decision to perform this procedure should take into consideration the following factors: the local and general extent of the disease, the spinal level involved, the severity of pain experienced by the patient, previous treatments and their outcomes, as well as the patient's neurological condition, general state of health, and life expectancy.

Percutaneous vertebroplasty is contraindicated in coagulation disorders due to the large diameter of the needles used for injection.

Relative contraindications to performance of a percutaneous vertebroplasty are extensive vertebral destruction, significant vertebral collapse (i.e., vertebra reduced to less than one-third its original height), neurological symptoms related to compression, and when there is no neurosurgical backup for emergency decompression in the event a neurological deficit develops during the injection of methyl methacrylate.

CPT/HCPCS Section & Benefit Category
Surgery/Musculoskeletal System
Radiology/Diagnostic Radiology

CPT/HCPCS Codes
22520 22521 22522 76012 76013

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

170.2	198.5	203.00-203.01
228.09	238.6	733.13
805.00-805.9		

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

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
CPT code 22520 and/or 22521 should only be billed one time, regardless of the number of injections to the one vertebral body.

If more than one vertebra is injected, *CPT* code 22522 may be billed in accordance with the multiple surgery billing guidelines.

Documentation Requirements
Medical record documentation (e.g., office/progress notes, procedure notes) maintained by the provider must indicate the medical necessity for performing this service. The documentation must also support that the service was performed.

When the service is performed for painful, debilitating, osteoporotic vertebral collapse/compression fractures, documentation must support that conservative treatment has failed, unless the patient experienced severe pain and functional limitation in performing activities of daily living due to chonic vertebral collapse/compression fractures and required hospitalization for pain control and treatment. Under those circumstances, documentation must support the severity of pain and functional limitations related to performance of activities of daily living requiring hospitalization.

Utilization Guidelines
N/A

Other Comments
N/A

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

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the Florida Radiological Society, Inc.

Carrier Advisory Committee Meeting held on November 13, 1999.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	2	PCR B2002-140
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		07/22/2002

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.

22899: Kyphoplasty

Revision Overview: Original policy.

Policy Number
22899

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Kyphoplasty

AMA *CPT* Copyright Statement

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
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Balloon kyphoplasty is a minimally invasive surgical procedure for the reduction and internal fixation of vertebral body compression fractures (VCFs). The procedure is similar to vertebroplasty in that there is percutaneous placement of tools for insertion of the bone cement polymethylmethacrylate (PMMA). However, balloon kyphoplasty involves the inflation of a balloon tamp which creates a cavity into which the PMMA is injected under low pressure.

The physician makes a small incision in the patient's back to allow access into the fractured vertebral body. A small orthopedic balloon is placed through transpedicular or extrapedicular approaches to the vertebral body and inflated. The balloon is then deflated and removed, leaving a space within the vertebral body. The space is then injected with PMMA to support the bone and help prevent further collapse. There are instances when two balloons, rather than one, may be placed bilaterally via the transpedicular or extrapedicular approaches (T9-L5 fractures). The procedure is performed under fluoroscopic guidance.

Balloon kyphoplasty may be done under local or general anesthesia, generally takes about an hour per fracture, and the patient is observed for four hours afterward (some patients may require an overnight hospital stay). Balloon kyphoplasty is generally used for more recent VCFs (less than 10 weeks). It has been used in VCFs due to primary osteoporosis, secondary osteoporosis, multiple myeloma, and osteolytic metastatic disease.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the performance of a balloon kyphoplasty procedure medically reasonable and necessary for the following indications:

- Painful osteolytic vertebral body metastatic disease;
- Painful multiple myeloma involving the vertebral body;
- Painful, debilitating osteoporotic VCFs that have not responded to conservative medical treatment (e.g., 2-4 week period of immobilization such as restricted activity/bracing and analgesia/scheduled narcotic usage); and
- Severe pain and functional debilitation related to activities of daily living due to chronic VCFs that require hospitalization for pain control and treatment. Conservative medical management is not considered appropriate for such patients. It is expected that this circumstance will occur rarely to occasionally.

The decision to perform this procedure should take into consideration the following factors: the local and general extent of the disease, the spinal level involved, the severity of pain experienced by the patient, previous treatments and their outcomes, as well as the patient's neurological condition, general state of health, and life expectancy. It is expected that only those skilled in this procedure/technique will perform it. Rapid access to emergency equipment and personnel is required for balloon kyphoplasty.

The balloon kyphoplasty procedure is contraindicated in non-painful stable VCFs, clinically improving VCFs, osteomyelitis, uncorrectable coagulopathy, allergy to the PMMA, retropulsed fracture fragment(s) or tumor mass causing significant spinal canal compromise, or when it is technically not feasible (e.g., vertebra plana).

CPT/HCPCS Section & Benefit Category
Surgery/Musculoskeletal System
Radiology/Diagnostic Radiology

CPT/HCPCS Codes
N/A

Not Otherwise Classified Codes (NOC)
22899 76499

ICD-9-CM Codes that Support Medical Necessity
170.2 198.5 203.00-203.01
238.6 733.13 805.2
805.4

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
Procedure code 22899 should be billed one time per vertebra, regardless of the number of injections or balloon tamps into a single vertebra. Each additional vertebral body should be billed on a separate line item using procedure code 22899-51. The professional radiological supervision and interpretation services associated with the performance of kyphoplasty should be billed with procedure code 76499-26.

Open biopsy of vertebral body and methylmethacrylate application (procedure codes 20250, 20251 and 22851) are included in the kyphoplasty procedure and are not separately reimbursable.

For electronic claim submission of the kyphoplasty procedure, place the words "kypho" and "thoracic" or "lumbar" (depending on the vertebral body level) in the narrative record. Additionally, for the professional radiological supervision and interpretation services associated with the performance of the kyphoplasty, place the word "fluoro" or "CT" in the narrative record.

For paper claim submission of the kyphoplasty procedure, place the words "kypho" and "thoracic" or "lumbar" (depending on the vertebral body level) in item 19 of Form CMS-1500. Additionally, for the professional radiological supervision and interpretation services associated with the performance of the kyphoplasty, place the word "fluoro" or "CT" in item 19 of Form CMS-1500.

In summary, we expect to see one of the following in item 19 or the narrative record:
- kypho/thoracic/fluoro
- kypho/lumbar/fluoro
- kypho/thoracic/CT
- kypho/lumbar/CT

For example, a claim for a kyphoplast**y** procedure performed on 3 vertebrae in the lumbar region (unilaterally or bilaterally) under fluoroscopic guidance, should be billed as follows:
- 22899
- 22899-51
- 22899-51
- 76499-26

Documentation Requirements
Medical record documentation (e.g., office/progress notes, procedure notes) must indicate the medical necessity for performing this service. The documentation must also support that the service was performed.

When the service is performed for painful, debilitating, osteoporotic VCFs, documentation must support that conservative treatment has failed, unless the patient experienced severe pain and functional limitation in performing activities of daily living due to chronic VCFs and required hospitalization for pain control and treatment. Under those circumstances, documentation must support the severity of pain and functional limitations related to performance of activities of daily living requiring hospitalization.

Utilization Guidelines
N/A

Other Comments
N/A

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

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

Carrier Advisory Committee Meeting held on January 19, 2002.

Start Date of Comment Period
01/11/2002

End Date of Comment Period
02/25/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-139
Start Date of Comment Period:	01/11/2002
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

35475: Percutaneous Transluminal Angioplasty (PTA) with Carotid Stenting—Correction

Effective for services provided on or after January 1, 2002, in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials, carotid stent placement should be billed with procedure code 35475. This procedure code, 35475, was incorrectly identified as procedure code 35474 in the Second Quarter 2002 issue of the *Medicare B Update!* (page 43).

69220: Mastoidectomy Cavity Debridement

Revision overview: Original policy.

Policy Number
69220

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Mastoidectomy Cavity Debridement

AMA *CPT* Copyright Statement
CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such

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
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
A mastoidectomy cavity is created as a result of ear operations such as radical mastoidectomy, modified radical mastoidectomy, atticotomy, fenestration operation, temporal bone resection, etc. Such operations are performed to eradicate disease of the middle ear and mastoid. An automastoidectomy may also occur as a result of a cholesteatoma. Complications may occur postoperatively or any time after the creation of the cavity and necessitate debridement of the cavity.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the debridement of the mastoidectomy cavity medically reasonable and necessary under the following circumstances:

For patients who have undergone any of the following surgical procedures: a radical mastoidectomy, a modified mastoidectomy, atticotomy, fenestration operation, temporal bone resection, or developed an automastoidectomy (as a result of cholesteatoma), resulting in the formation of a mastoid cavity, and present with any of the following signs/symptoms:

- Persistent earache
- Ear drainage
- Excess crusting
- Ear pressure
- New onset of hearing loss
- Dizziness
- New onset of facial muscle weakness

Simple debridement (69220)
A simple debridement of the mastoidectomy cavity (routine cleaning) is considered medically reasonable and necessary for those presenting with dry debris or excess crusting of the mastoidectomy cavity. It is generally expected that a simple debridement of the mastoidectomy cavity would be performed no more than once every three months. However, the frequency at which a simple debridement of the mastoidectomy cavity is performed is dependent on the clinical presentation of the individual patient.

Complex debridement (69222)
A complex debridement of the mastoidectomy cavity is considered medically reasonable and necessary for those presenting with any of the following conditions: lack of previous meatoplasty or stenosis of the ear canal, bleeding, recurrent cholesteatoma, granulation tissue, presence of labyrinthine fistula, absence of tympanic membrane, active infection, inadequate lowering of the facial ridge, presence of cholesteral granuloma cysts, severe pain, severe vertigo or increased vertigo during debridement, or an uncooperative patient (e.g., young child).

The frequency at which a complex debridement of the mastoidectomy cavity is performed is dependent on the clinical presentation of the individual patient. For example, debridement of the mastoidectomy cavity may be required on multiple visits at close intervals due to inter-current infection and the attempt to reduce mucolized surfaces and remove granulomatous tissue.

Note: It is inappropriate to bill either procedure code 69220 or 69222 for removal of impacted cerumen or debridement of the external auditory canal.

CPT/HCPCS Section & Benefit Category
Auditory System/Surgery

CPT/HCPCS Codes
69220 69222

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

381.00-381.03	383.00-383.02	389.03
381.10-381.19	383.1	389.08
381.20-381.29	383.30-383.33	389.10
381.3	385.30-385.9	389.11
382.00-382.01	386.19	389.12
382.1	386.40-386.48	389.18
382.2	387.9	389.2
382.3	388.60-388.69	389.8
382.4	388.70-388.72	
382.9	389.00	

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 (e.g., office/progress notes, procedure notes) maintained by the performing provider must indicate the medical necessity for performing the service. It is expected that the following information will be clearly documented in the medical record to support the mastoidectomy cavity debridement code billed:

- Documentation of previous radical mastoidectomy, modified radical mastoidectomy, atticotomy, fenestration operation, temporal bone resection, or development of an automastoidectomy (as a result of a cholesteatoma);
- the extent of the current disease pathology necessitating debridement; and
- the method utilized for debridement, including any anesthesia (when applicable).

Utilization Guidelines
The frequency at which a debridement of the mastoidectomy cavity is performed is dependent on the clinical presentation of the patient. However, it is generally expected that a simple debridement of the mastoidectomy cavity would be performed no more than once every three months.
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
Terms defined:
Atticotomy – a surgical operation to remove cholesteatoma from the ear. It is a form of limited mastoidectomy.
Cholesteatoma – a skin-lined sac containing debris from dead skin cells that grows from the eardrum into the mastoid bone eroding normal structures in its path. Left untreated, it can carry infection to the brain, causing meningitis and cerebral abscess. Treatment is by means of mastoidectomy.
Mastoidectomy – an operation to remove some or all of the air cells in the bone behind the ear (the mastoid process of the temporal bone) when they have become infected or invaded by cholesteatoma.

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

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

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-138
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

71010: Chest X-Ray

The local medical review policy (LMRP) for chest X-ray (71010) was published in the First Quarter 2002 *Medicare B Update!* (pages 48-51). Since that time, ICD-9-CM diagnosis code 236.9, listed under *Neoplasms*, has been updated for specificity to 236.90 – 236.99, effective for services processed on or after August 5, 2002.

In addition, an error has been noted in the "ICD-9-CM Codes That Support Medical Necessity" section on page 49 of the above issue. ICD-9-CM diagnosis code 553.3 was inadvertently omitted from the list of codes covered for *Diseases of the Digestive System*. This code has been allowed in the chest X-ray LMRP since June 1994. Florida Medicare apologizes for any inconvenience this may have caused.

71250: Computerized Axial Tomography of the Thorax

Revision Overview: CT scans are utilized for a number of conditions, which can incorporate several diagnoses. Since the ICD-9-CM codes associated with the many indications for CT of the thorax can be numerous and the ability to identify every appropriate diagnosis code for this service would result in an extensive diagnosis list, the policy was revised deleting the diagnoses list. In addition, indications for coverage were added to the policy.

Policy Number
71250

Contractor Number
00590

Contractor Name
First Coast Service Options, Inc.

Contractor Type
Carrier

LMRP Title
Computerized Axial Tomography of the Thorax

AMA *CPT* Copyright Statement

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

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
07/30/2001

Original Policy Ending Date
N/A

Revision Effective Date
07/01/2002

Revision Ending Date
06/30/2002

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

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

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

Note: Posterior and lateral views of the chest represent the basic screening tool in identifying abnormalities involving the thorax. It is expected that the chest X-ray is used to evaluate patients who present with signs and/or symptoms suggestive of chest pathology prior to proceeding to a CT scan. However, in limited circumstances, a CT of the Thorax may be used as a primary diagnostic tool if the documentation supports that the initial test was reasonable and necessary and the medical literature supports the CT scan as the primary diagnostic test for the condition being evaluated.

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

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

CPT/HCPCS Section & Benefit Category
Radiology/Diagnostic Radiology

CPT/HCPCS Codes
71250 71260 71270

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
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
N/A

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

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

Utilization Guidelines
N/A

Other Comments
N/A

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

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

Carrier Advisory Committee Meeting held on May 13, 2000.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	2	PCR B2002-118
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		07/01/2002

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.

77280: Therapeutic Radiology Simulation-Aided Field Setting

Revision Overview: To provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guidelines, for these services.

Policy Number
77280

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Therapeutic Radiology Simulation-Aided Field Setting

AMA *CPT* Copyright Statement

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
09/23/2002

Revision Ending Date
09/22/2002

LMRP Description
Following treatment planning, simulation is utilized to actually direct the treatment beams to the specific treatment volume determined. Simulation is usually performed on a dedicated simulator, but can be performed on other pieces of equipment such as a radiation therapy treatment unit, virtual reality-based 3D simulation system or other dedicated diagnostic X-ray, magnetic resonance, ultrasound, or nuclear medicine equipment that has been modified to localize treatment volumes in order to define the area that requires treatment.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider therapeutic radiology simulation-aided field testing medically reasonable and necessary for patients with documented cases of neoplasm for whom a radiation therapy treatment course needs to be established. The complexity of simulation is based on the number of ports of entry, treatment volumes, and the inclusion and type of treatment devices. However, the number of films taken per treatment volume, the modality from which images for simulation are obtained, and the use of fluoroscopy are not determinants of complexity. Portal changes based on unsatisfactory initial simulation(s) are not reported as additional simulations. However, additional simulations may be required during treatment in order to account for changes in ports due to changes in treatment volume. Minor changes in port size, without substantial changes in treatment volume, do not warrant an additional charge or a higher level of complexity.

77280 Therapeutic radiology simulation-aided field setting; simple

If any or all of the following factors are present, the simulation will remain simple:

- single treatment volume with either a simple port or parallel opposed ports (2), with simple or no blocking;
- block verification simulation; and/or
- subsequent simulations (e.g., orthogonal films) for brachytherapy source verification (radioactive or dummy).

77285 Therapeutic radiology simulation-aided field setting; intermediate

If any of the following factors are present, the simulation will be considered intermediate:

- simulation of three or more converging ports, or two separate treatment volumes; and/or
- multiple blocks, if clinically necessary.

77290 Therapeutic radiology simulation-aided field setting; complex

If any and/or all of the following factors are present, the simulation will be considered complex:

- three of more treatment volumes;
- rotation or arc therapy;
- complex blocking, custom made shielding blocks based on clinical necessity;
- any use of contrast media (e.g., body cavity, GI tract, or intravascular) to define anatomic structures and treatment volume, or for initial brachytherapy simulation;
- tangential ports with multiple devices; and/or
- custom immobilization devices.

77295 Therapeutic radiology simulation-aided field setting; three-dimensional

Three-dimensional simulations and treatment is clinically warranted if one or more of the following exists:

- the volume of interest is irregular and in close proximity to normal structures that must be protected;
- the volume of interest is in such a location that its parameters can only be defined by MRI or CT;
- multiple or conformal portals are necessary to cover the volume of interest with close margins and protect immediate adjacent structures;
- beam's eye view of multiple portals must be established for conformal treatment delivery;
- an immediately adjacent area has been irradiated and abutting portals must be established with high precision;
- three-dimensional reconstruction of the tumor volume and the critical structure volume in brachytherapy cases is used to develop dose volume histograms (DVH) for the tumor and critical structures.

This procedure involves three-dimensional, computer-generated reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scan and/or MRI data in preparation for non-coplanar or coplanar therapy. This simulation utilizes documented three-dimensional beam's eye view volume-dose displays of multiple or moving beams. Documentation must include a hard copy of computer-generated, three-dimensional tumor volume and critical structure or critical area reconstruction and three-dimensional representation of dose distribution in the form of dose clouds and/or dose volume histograms (DVH) of volume of interest and critical structures with evidence of review by physician.

The typical course of radiation therapy will consist of between one and three simulations. However, no more than one simulation should be reported per day. Frequency in excess of three simulations may require supporting documentation.

CPT/HCPCS Section & Benefit Category

Radiology/Radiation Oncology

CPT/HCPCS Codes

77280 77285 77290 77295

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
Procedure code 77295 may be billed once per treatment course per treatment volume. *CPT* 77295 includes those activities necessary to perform a three-dimensional treatment plan, including digitally reconstructed radiographs of the beam's eye view, and either cross-sectional reconstructions of the dose distributions in three dimensions, or a review of the dose-volume histograms of the resultant treatment. In most circumstances, the anatomy and the planning tumor volume for the highest dose regions will not change throughout the treatment course. Therefore, in general, a single 77295 activity and reimbursement shall suffice. If more than one set of beams utilizing different beam and gantry angles is used to treat a larger "nodal" volume and a smaller "cone-down" volume, and both sets of treatments are planned off of the same CT dataset, two sets of beam's eye view portals can be generated. Only one set of dose-volume histograms is necessary for documentation in this case, the dose-volume histograms representing the cumulative dose distributions from the two plans. Therefore, only one 77295 charge is appropriate.

In those uncommon circumstances where there is a substantial change in either patient anatomy or tumor conformation where a second CT dataset is required to produce an accurate, efficacious, and safe "cone-down" plan, a second 77295 charge may be appropriate. When the physician deems this to be the case, the medical necessity for the second 77295 simulation must be documented.

Procedure code 77295 precludes the use of teletherapy isodose plan (77305-77315) for the same volume. CPT code 77295 is not appropriately reported for two-dimensional or multiple two-dimensional beam's eye view plans without three-dimensional, computer-generated reconstruction. Dose volume histogram is part of 77295 and is not to be billed separately. Simulation procedures (77280-77290) may be performed if medically necessary to prepare the patient for treatment planning and to ensure accurate treatment delivery. The professional components of 76375 (3-D reconstruction) and 76370 (computerized axial tomographic guidance for placement of radiation therapy fields) are included in *CPT* code 77295. The technical component of 76370 may be charged by the provider of the technical service, which may be the radiation oncologist in the freestanding setting. To bill the professional component of the CT codes, a complete diagnostic interpretation is required.

Documentation Requirements
Documentation of simulation requires a written record of the procedure, hard copy or electronically archived images, and evidence of image review by the physician, including signature or initials and date of review. Electron ports or clinical simulations may also be documented photographically.

For procedure code 77295, documentation requires a computer-generated graphic, permanent record including the following elements:

- three-dimensional tumor volume;
- appropriate critical normal structures; and
- a reconstruction and three-dimensional representation of dose distribution in the form of dose clouds and/or dose volume histograms of the volume of interest and appropriate critical structures with evidence of review by the physician designated by signature or initials and date.

Utilization Guidelines
The typical course of radiation therapy will consist of between one and three simulations. However, no more than one simulation should be reported per day. Frequency in excess of three simulations may require supporting documentation.

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 numerous societies.

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	3	PCR B2002-127
Start Date of Comment Period:		05/10/2002
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		09/23/2002

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.

77300: Basic Radiation Dosimetry Calculation

Revision Overview: To provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding for basic radiation dosimetry calculations.

Policy Number
77300

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Basic Radiation Dosimetry Calculation

AMA *CPT* Copyright Statement

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
09/23/2002

Revision Ending Date
09/22/2002

LMRP Description
Basic radiation dosimetry calculation (*CPT* code 77300) is a mathematical computation of the amount of radiation being received at a tumor site or other independent calculations and is only performed when requested by the radiation oncologist. This is performed either by the radiation oncologist, a qualified medical radiological physicist, a qualified medical treatment planning dosimetrist, or a qualified radiation therapy technologist under the technical supervision of the radiation oncologist.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider basic radiation dosimetry calculation to be medically necessary for each treatment field (area), for off-axis dose calculations, or because of a change in one of the initial calculation parameters (e.g., port size or shape, depth dose, blocking factor, tumor dose). Recalculation of previously determined dose points by the same methodology does not justify additional dosimetry charges.

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.

The typical course of radiation therapy will consist of one to six dosimetry calculations, depending on the complexity of the case. Radiation treatments to the head/neck, prostate, or for Hodgkin's disease may require eight or more calculations.

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
The calculation of different projections for the same site are considered to be included as one calculation if all treatment parameters other than beam angle are the same. For example, in a four-port box treatment of the pelvis, the anterior and posterior opposed ports and the right and left lateral opposed ports are treated. If the anterior and posterior ports are identical in size, shape, and depth, they are considered to be one calculation. The same holds true for the lateral ports. If two entirely separate sets of calculations are performed in AP or lateral opposed fields because of irregular fields that require variable blocking, weighting, or depth, two separate calculations should be reported.

Both external beam and brachytherapy require specific calculations to be made before or during the course of therapy. For external beam, code 77300 is used to report dosimetry calculations. However, multiple points of calculation within an isodose plan should not be reported independently or individually. For brachytherapy, code 77300 may be reported when an independent calculation is performed exclusive of the isodose plan.

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 of 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
- evidence that the calculations were reviewed, signed, and dated by a physician.

Utilization Guidelines
The typical course of radiation therapy will consist of one to six dosimetry calculations, depending on the complexity of the case. Radiation treatments to the head/neck, prostate, or for Hodgkin's disease may require eight or more calculations.

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 numerous societies

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number:	2	PCR B2002-126
Start Date of Comment Period		05/10/2002
Start Date of Notice Period		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date:		09/23/2002

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.

77301: Intensity Modulated Radiation Therapy (IMRT)
Revision Overview: Original policy.

Policy Number
77301

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Intensity Modulated Radiation Therapy (IMRT)

AMA *CPT* Copyright Statement

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
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Intensity Modulated Radiation Therapy (IMRT) is a new technology; a computer-based method of planning for, and delivery of patient specific, spatially modulated beams of radiation to solid tumors within a patient. IMRT planning and delivery uses a new approach for obtaining the highly conformal dose distributions needed to irradiate complex targets positioned near, or invaginated by, sensitive normal tissues, thus improving the therapeutic ratios. IMRT delivers a more precise

radiation dose to the tumor while sparing the surrounding normal tissues by using non-uniform radiation beam intensities determined by various computer-based optimization techniques.

The computer based optimization process is referred to as 'inverse planning.' Inverse planning develops a dose distribution based on the input of specific dose constraints for the planned treatment volume (PTV) and nearby clinical structures, and is the beginning of the IMRT treatment planning process. The gross tumor volume (GTV), the PTV and surrounding normal tissues must be identified by a contouring procedure, and the optimization must sample the dose with a grid spacing of one centimeter (1cm) or less.

IMRT uses non-uniform and customized fluence distributions in treatment delivery. Delivery of IMRT requires use of a multi-leaf collimator (MLC) with leaves that project to a nominal 1cm or less at the treatment unit isocenter. The MLC may be in a dynamic (DMLC) or segmented mode (SMLC) to create the three-dimensional, intensity-modulated dose distribution. Since other delivery techniques are available and new ones may be developed, the exact delivery method is not restricted as long as the particular technique chosen has the ability to model the highly modulated intensity patterns that result from the planning process described above. However, use of simple one-dimensional ramp intensity distributions is excluded, because the inverse planning process is not expected to produce these intensity patterns. IMRT delivery imposes a more stringent requirement than conventional radiation therapy in terms of accounting for patient position and organ motion. Methods that account for organ motion include, but are not limited to: 1) use of published studies on organ movement when developing the PTV, 2) image guided adaptive radiotherapy (e.g., ultrasound guided or portal image guided setup with implanted fiducial markers), and 3) respiratory gating of diaphragm movement for thoracic and upper abdominal sites.

Indications and Limitations of Coverage and/or Medical Necessity

The decision process for using IMRT requires an understanding of accepted practices that take into account the risks and benefits of such therapy compared to conventional treatment techniques. While IMRT technology may empirically offer advances over conventional or three-dimensional conformal radiation, a comprehensive understanding of all consequences is required before applying this technology.

IMRT is not a replacement therapy for conventional radiation therapy methods. Florida Medicare will consider IMRT reasonable and necessary in instances where sparing the surrounding normal tissue is essential and the patient has at least one of the following conditions:

1. Important dose limiting structures adjacent to but outside the PTV are sufficiently close and require IMRT to assure for safety and morbidity reduction.
2. An immediately adjacent volume has been irradiated and abutting portals must be established with high precision.
3. GTV margins are concave or convex and in close proximity to critical structures that must be protected to avoid unacceptable morbidity.
4. Only IMRT techniques would decrease the probability of grade 2 or grade 3 radiation toxicity, as compared to conventional radiation in greater than 15 percent of radiated similar cases.

IMRT is indicated for primary brain tumors, brain metastasis, prostate cancer, lung cancer (with special provision for organ motion), pancreas cancer and other upper abdominal sites (with special provision for organ motion), spinal cord tumors, head and neck cancer, adrenal tumors, pituitary tumors, and situations in which extremely high precision is required.

CPT/HCPCS Section & Benefit Category

Radiology/Radiation Oncology

CPT/HCPCS Codes

77301
77418

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

142.0-142.9	158.0-158.9	194.0
144.0-144.9	160.0-160.9	194.1
145.0-145.9	162.0-162.9	195.0-195.8
146.0-146.9	163.0-163.9	198.3
147.0-147.9	164.0-164.9	225.1
148.0-148.9	171.0-171.9	225.2
149.0-149.9	174.0-174.8	227.3
150.0-150.9	175.0-175.9	227.4
153.0-153.9	185	227.6
154.0-154.8	190.0-190.9	747.81
155.0-155.2	191.0-191.9	
156.0-156.9	192.0-192.9	
157.0-157.9	193	

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 Code(s)

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

Noncovered Diagnoses

N/A

Coding Guidelines

N/A

Documentation Requirements
Medical record documentation maintained by the provider must indicate the medical necessity for IMRT, and include all of the following:

1. The prescription must define the goals and requirements of the treatment plan, including the specific dose constraints for the target(s) and nearby critical structures.
2. A statement by the treating physician documenting the special need for performing IMRT on the patient in question, rather than performing conventional or three-dimensional treatment planning and delivery.
3. Signed IMRT inverse plan that meets prescribed dose constraints for the PTV and surrounding normal tissue using a treatment delivery technique to produce the various intensity maps required.
4. The target verification methodology must include the following:
   a. Documentation of the CTV and PTV.
   b. Documentation of immobilization and patient positioning.
   c. Means of dose verification and secondary means of verification.
5. The monitor units (MUs) generated by the IMRT treatment plan must be independently checked before the patient's first treatment.
6. Documentation of fluence distributions re-computed in a phantom is required.
7. Documentation is required to account for structures moving in and out of high and low dose regions created by respiration. Voluntary breath holding *is not* considered appropriate and the solution for movement can best be accomplished with gating technology.

Utilization Guidelines
N/A

Other Comments
N/A

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

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from oncologist and radiology societies.

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	Original	PCR B2002-125
Start Date of Comment Period:		05/10/2002
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Original Effective Date		09/23/2002

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.

77332: Treatment Devices, Design and Construction
Revision Overview: To provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guidelines, for these services.

Policy Number
77332

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Treatment Devices, Design and Construction

AMA *CPT* Copyright Statement

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
09/23/2002

Revision Ending Date
09/22/2002

LMRP Description
Many different types of treatment devices are used in the successful delivery of radiation oncology treatments. Examples include: beam-shaping devices, custom-fabricated patient-immobilization devices, beam-

modification devices, and equipment used to shield critical structures. Their use is determined by the clinical judgment of the radiation oncologist, based on patient anatomy and disease state. They are fabricated as the direct result of physician work and supervision. During the course of fractionated radiation therapy, the accuracy of their use is the direct responsibility of the treating physician.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will consider treatment devices, design, and construction to be medically reasonable and necessary for patients with a documented diagnosis of a neoplasm, who require custom-designed and fabricated devices during the course of radiation therapy. Multiple treatment devices may be charged during a course of therapy if documentation substantiates multiple treatment fields, the use of custom-made devices, and/or the necessity of replacement devices.

Treatment devices, designs, and construction are broken down into the following three levels of complexity: simple, intermediate and complex.

77332 Treatment devices, design and construction; simple (simple block, simple bolus)

Simple Block
Treatment blocks made in the form of squares, rectangles, circles, and other irregular, multi-use shapes that are placed by hand on the blocking tray each day at the time of the patient's setup constitute simple blocks. The physician selects the shape and designs the placement of these blocks with the intent to protect certain areas of a radiation port during treatment. No special fabrication is necessary for these blocks.

Simple Bolus
The use of bolus material to modify the radiation beam as it transitions from air to tissue constitutes a simple treatment device. These pre-made, reusable articles are typically used with other treatment devices. Bolus material is billable only in the situation where it is used as the only treatment device for a particular radiation port, i.e., no other, more complex treatment devices are being used. When more complex treatment devices are used, the bolus charge becomes subordinate to the more complex charge, with no charge being submitted for the bolus material.

Passive, Multi-Use Devices
Passive restraints, pillows, straps, sandbags, amorphous devices, and other minor devices are widely used in radiation oncology. Their reimbursement is blended into treatment delivery and they are not billable as separate treatment devices.

77333 Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)

Blocks
A pre-cast or pre-made standard-shaped block used from patient to patient, where there is no particular custom fabrication to the patient's individual anatomy, constitutes an intermediate device.

Stents
A pre-fabricated stent used to modify a patient's anatomy for the proper delivery of a radiation dose is billed as an intermediate treatment device.

Bite Blocks
A custom-fabricated bite block for manipulation of the oral cavity and oropharyngeal anatomy is billed as an intermediate treatment device.

Special Bolus
Custom fabrication of bolus material to compensate for tissue defects is billed as an intermediate treatment device.

77334 Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)

Irregular Blocks
A custom-fabricated cast block designed specifically for one patient constitutes a complex treatment device. These devices require direct input from the physician for design, selection, placement, and daily reproduction.

Immobilization Devices
Treatment devices may be used for patient immobilization to accurately reproduce the anatomic isocenter on a daily basis. These include any of the thermal plastic devices, solidifying polymers, or vacuum devices. These devices are fabricated under the supervision of a physician and are specifically designed for an individual patient's treatment course.

Wedges
Wedges, or treatment devices that shape the profile of a treatment beam to compensate for an angular plane of entry, are mechanical devices usually affixed to the machine head, and are considered complex treatment devices. They are billable in this fashion only when used alone. In the more common circumstance, when they are used in conjunction with other complex treatment devices on the same port, only a single complex treatment device may be billed. An exception to this rule is when the wedge has been specifically fabricated for a particular patient's situation.

Compensators
Custom-fabricated compensators designed to eliminate dose inhomogeneities secondary to irregular surface contours are billed as complex treatment devices. When custom designed for a particular port, it may be billed individually and in addition to other complex treatment devices that may be used.

Eye Shields
Eye shields are multiple-use devices whose application is highly complex and precise. They are used under initial direct supervision of the radiation oncologist and are clinically placed for each treatment. When used, they are billed as complex treatment devices.

The purpose of the device(s), the risks involved by its use or non-use, and the complexity of its design determine the complexity level. The choice to custom-make a device for a given patient is justified only for clinical necessity and should be documented for patients treated with palliative intent. The code for complex devices

(77334) is reserved for those cases in which a highly complex irregular port is designed for the protection of sensitive vital tissues. In addition, a complex device is unique to that particular patient and port. Examples of complex devices are a mantle port block or those for head and neck treatments with multiple areas protected. Pre-made, multiple-patient use, generic cast blocks (e.g., beam-splitter block, two- or four-corner pelvis blocks, midline spinal cord blocks) do not constitute custom blocks.

The typical course of radiation therapy may consist of up to five professional charges for devices. Prostate and head/neck treatments may require eight devices. Frequency in excess of these values may require supporting documentation.

Products used for patient comfort (e.g., pillows, pads, cushions) should not be charged as treatment devices.

CPT/HCPCS Section & Benefit Category
Radiology/Radiation Oncology

CPT/HCPCS Codes
77332
77333
77334

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
If the blocks can be designed from the same simulation image and are identical in shape except opposed in location (mirror images), this should be regarded as a single design of a set of blocks. Such an example is the design of AP and PA blocks for parallel opposed beams in which the patient does not move and the gantry of the treatment unit is rotated 180 degrees to the opposed port. For these blocks, a single charge is made for their design and professional supervision. A separate technical charge is made for the fabrication of each individual device. An example of this charging structure is a treatment plan involving a four-field box to the pelvis. In this example, one professional charge is made for the AP and PA blocks and another for the right and left lateral blocks, but four technical treatment device charges should be made for the fabrication of each of the AP, PA, right lateral, and left lateral blocks.

Minor port changes should not necessitate additional device charges. However, significant changes in the shape of the port(s), beam direction, or size (i.e. boosts) may require additional device charges. Modern linear accelerators with multi-leaf collimation can create shielding that is equivalent to a complex fabricated block. Independent jaw motion to a single static position or pre-programmed motions of the jaw to simulate half-beam blocks are coded as simple treatment devices. Use of an independent jaw (as in dynamic wedge) or multi-leaf collimator to substitute for a complex treatment device is coded as a complex device (77334).

The same principles for determining the level of complexity apply to the design of a wedge, compensator, or bolus. The professional reimbursement applies to the work associated with the supervision of the design and construction for all of the devices utilized to modify photon fluence for each portal or symmetrical pair of portals. If a patient has some combination of a wedge, compensator, bolus, or port block covering the same treatment portal, this should be reported as a single complex treatment device rather than a separate charge for each item. If beam-modification devices of two separate levels of complexity are utilized for the same treatment port, only the one of highest complexity will be billable. However, a technical charge may be assessed for the construction of each device, at the appropriate level of complexity. Only in the most unique situation are separate charges made (e.g.,two or more devices that were unique and specially designed for an individual port).

Restraining and custom positioning devices (e.g.,thermo-plastic face and body masks, Styrofoam body casts, bite-block head holders) and beam-modification devices may be billed separately for the same volume of interest, but the professional reimbursement for only one restraining device may be billed for each volume of interest treated. That is to say, positioning and restraining devices may be charged separately from beam-modifying devices.

It is the physician's responsibility to ensure that the codes reported correspond to the level of professional activity provided. Documentation of physician participation in this aspect of the process of care is signified by the physician's signature and date in simulation images and port images.

Multiple services are allowed on the same day with appropriate documentation. Medically necessary changes in the beam geometry or port configuration periodically during a course of treatment may require the redesign and fabrication of new treatment devices. An individual treatment device is reported and charged only one time for the entire course of treatment, regardless of the number of times the device is actually used.

Devices will be billed at the beginning of the treatment course and then may be repeated later in the course of

treatment when additional or new devices are required due to a reduction of the treatment field. This reduction in treatment field is a result of a reduction of the target volume. In all levels of complexity, the physician must be directly involved in the design, selection, and initial placement of any of the devices.

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

- a signed and dated physician order for each different kind of custom device;
- physician's documentation of his/her input in terms of selection, design, and initial position/placement of these devices;
- specific notation indicating each custom-designed device for a particular application; and
- an explanation for the need for additional or revised devices during the course of therapy (i.e., specific treatment field modification, etc.).

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.

The typical course of radiation therapy may consist of up to five professional charges for devices. Prostate and head/neck treatments may require eight devices. Frequency in excess of these values may require supporting documentation.

Other Comments
Please note that the plural use of the word "devices" in the *CPT* definitions in no way implies any substantive meaning regarding reimbursement policy, but instead designates that there are many types of devices at each complexity level. It is erroneous to suggest that the plural "devices" implies that multiple devices can be charged once per treatment course.

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 May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	1	PCR B2002-136
Start Date of Comment Period:		05/10/2002
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		09/23/2002

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.

77336: Radiation Physics Consultation
Revision Overview: To provide further clarification regarding the indications and limitations of coverage, as well as appropriate coding guidelines, for these services.

Policy Number
77336

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Radiation Physics Consultation

AMA *CPT* Copyright Statement

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
10/16/1995

Original Policy Ending Date
N/A

Revision Effective Date
09/23/2002

Revision Ending Date
09/22/2002

LMRP Description

Under Medicare regulation, medical radiation physics services consist of specific tests, measurements, calculations, and fabrication of materials that are deemed necessary by the radiation oncologist, and ultimately selected and used by the radiation oncologist for the benefit of a patient undergoing radiation therapy. Often, these procedures are necessary for the development and implementation of a final treatment plan. Some procedures may be necessary only to verify or validate that the treatment plan is correct, or the ongoing treatment is being correctly applied. Under all circumstances, the physician is responsible for ordering the patient related physics services and ultimately placing them into clinical use.

Indications and Limitations of Coverage and/or Medical Necessity

Procedure Code 77336

Continuing medical physics consultation includes documented weekly checking of the patient's treatment chart by, or under the supervision of, a qualified medical physicist to assure that the treatment administered conforms to that prescribed by the radiation oncologist. It includes verification of accurate dose calculations, accurate data entry in the patient's chart, proper patient positioning and beam orientation, patient radiation safety, and correct summation of dose at the conclusion of treatment. Examination of the patient setup may be required to assure the correct placement of wedges or other beam modifiers.

The service also includes initial acceptance testing and commissioning and ongoing review of the performance of treatment equipment such as simulators (computed tomography and conventional simulators), linear accelerators, brachytherapy sources and devices, treatment device manufacturing equipment, and treatment planning computers. These tasks, performed by the qualified medical physicist, are essential in ensuring that the physician's prescription is being followed accurately throughout the course of radiation therapy. Documentation of physics services performed is essential. Documentation of calibration and maintenance of radiation therapy equipment is routinely kept within the radiation oncology department, and is not part of the treatment chart. These services are not considered special physics consultations, and are not to be billed as such.

Procedure Code 77370

The special medical radiation physics consultation code is used when the radiation oncologist makes a direct request to the qualified medical physicist for a special consultative report or for specific physics services on an individual patient. Such a request may be made when the complexity of the treatment plan is of such magnitude that a thorough written analysis is necessary to address a specific problem or when the service to be performed requires the expertise of a qualified medical physicist. The clinical indication that justifies the request for the special physics consultation should also be documented.

Examples of problems that might justify use of this code include:

- the complex interrelationships of electron and photon ports, intensity modulated radiation therapy, and complex dosimetric considerations in brachytherapy, including high dose rate remote afterloader applications, and interstitial radioactive seed implantation;
- analysis of customized beam modification devices and special blocking procedures (and their dosimetric evaluation) to protect critical organs during treatment; or
- analysis of the effects of previous radiation therapy with assessment of cumulative radiation dose to critical organs.

Computation of dose to the fetus of a pregnant patient undergoing radiation therapy may be reported using this code. Special brachytherapy equipment developed by the qualified medical physicist to treat a particular patient can also be reported with this code. The qualified medical physicist will spend a considerable amount of time and effort on behalf of a specific patient and will render a customized written report (which will form part of the patient's chart) to the radiation oncologist in reference to the problem or service being addressed. Documentation of the physician's request and the physics consultations should not be charged when a qualified medical physicist verifies the calculations performed by others or performs the duties of other members of the treatment team (e.g., dosimetrists).

A special medical radiation physics consult (code 77370) is generally required once per course of radiation therapy. However, additional medical physics work in support of a specific patient's treatment (e.g., total body irradiation, etc.) may require additional medical physics consultation. Frequency in excess of this value may require supporting documentation.

CPT/HCPCS Section & Benefit Category

Radiology/Radiation Oncology

CPT/HCPCS Codes

77336 77370

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
Continuing medical physics consultation (code 77336) is used to describe the ongoing medical physics assessment provided to all patients receiving radiation therapy. *CPT* code 77336 is a "weekly code," and is reported once for each week of external beam radiation treatments in which at least three fractions have been given, or once for each five treatments, in the event that more than one treatment is given per day. For radiation therapy treatment that is not administered in five weekly fractions (such as brachytherapy or stereotactic radiosurgery), or for a course of radiation therapy consisting of one or two fractions, code 77336 may be reported.

77336 *Continuing medical physics consultation* and 77370 *Special medical radiation physics consultation* are distinct, separately identifiable procedures. A special medical radiation physics consult (code 77370) is generally required once per course of radiation therapy. However, additional medical physics work in support of a specific patient's treatment (e.g., total body irradiation, etc.) may require additional medical physics consultation.

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

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated in writing to the requesting physician or other appropriate source.

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 numerous societies.

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	2	PCR B2002-133
Start Date of Comment Period:		05/10/2002
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		09/23/2002

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.

82607: Vitamin B-12 (Cyanocobalamin) Assay
Revision Overview: Policy revised to include frequency guidelines regarding vitamin B-12 assays.

Policy Number
82607

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Vitamin B-12 (Cyanocobalamin) Assay

AMA *CPT* Copyright Statement

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
04/17/2000

Original Policy Ending Date
N/A

Revision Effective Date
09/23/2002

Revision Ending Date
09/22/2002

LMRP Description
Vitamin B-12 (Cyanocobalamin), is a water soluble hematopoietic vitamin found in foods of animal origin. It is necessary for the metabolism of protein, fats, and carbohydrates. It is essential for normal blood formation and normal neural function. Causes of vitamin B-12 deficiency usually include the absence of intrinsic factor, which is vital for the absorption of vitamin B-12 by the gastrointestinal tract. Since vitamin B-12 is present in all foods of animal origin, dietary B-12 deficiency is rare. It is usually only seen in Vegans (strict vegetarians). Deficiency of vitamin B-12 leads to macrocytic anemia. The normal adult daily intake of vitamin B-12 is between 2.0 ug and 5.0 ug.

The serum vitamin B-12 assay is intended to measure the serum vitamin B-12 level. The measurement is used to diagnose anemia due to gastrointestinal malabsorption and inadequate dietary intake of vitamin B-12. The normal adult vitamin B-12 levels are between 150 pg/mL and 350 pg/mL.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider a vitamin B-12 assay level medically necessary for the following indications:

- To initially evaluate a patient presenting with signs and symptoms suggestive of vitamin B-12 deficiency. These patients could present with a megaloblastic anemia determined by other lab indices, peripheral neuropathy, and/or altered cerebral functioning such as dementia.
- To evaluate a patient with a previously identified gastrointestinal disease such as malabsorption syndromes, sprue, or a patient that has undergone gastric or ileal surgery and a vitamin B-12 deficiency is suspected.

Other than the initial vitamin B-12 assay, which is used to diagnose vitamin B-12 deficiency, it is not expected that the test would need to be repeated.

Note: Sequential vitamin B-12 testing is not necessary for the purpose of monitoring the effectiveness of vitamin B-12 therapy. Since vitamin B-12 is administered as a treatment for anemia, the tests that are usually ordered for monitoring are the complete blood count (CBC), the hematocrit (HCT), and the hemoglobin (HGB).

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

CPT/HCPCS Codes
82607
82608

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

266.2	294.8	558.9
281.0	298.9	579.0
281.1	311	579.1
281.3	357.4	579.2
285.8	555.9	579.3
285.9	558.3	579.9

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

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 (e.g., history and physical, progress notes) maintained by the ordering physician/referring physician must indicate the medical necessity for performing a vitamin B-12 assay. Additionally, a copy of the lab results should be maintained in the medical records.

If the provider of the services is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the vitamin B-12 level. The physician must state the clinical indication/medical necessity for the vitamin B-12 level in the order for the test.

Utilization Guidelines
The vitamin B-12 assay is used to diagnose vitamin B-12 deficiency. Since the assay is not used to monitor the effects of vitamin B-12 therapy, it is not expected to see repeated vitamin B-12 assays.

Other Comments
N/A

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

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

final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from numerous societies.

Carrier Advisory Committee Meeting held on August 25, 2001.

Start Date of Comment Period
08/17/2001

End Date of Comment Period
10/01/2001

Start Date of Notice Period
08/01/2002

Revision History

Revision Number:	2	PCR B2002-122
Start Date of Comment Period		08/17/2001
Start Date of Notice Period		08/01/2002 4th QTR 2002 *Update!*
Revised Effective Date		09/23/2002

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.

82728: Serum Ferritin; 83540: Iron—Revision to Policies

The following diagnosis code has been added to the "ICD-9 CM Codes that Support Medical Necessity" section of these policies:

238.4 Polycythemia vera

These revisions are effective for claims processed on or after July 1, 2002.

86706: Hepatitis B Surface Antibody and Surface Antigen

Revision Overview: According to the Coding Clinic guidelines, the combined diagnoses for patients with renal failure caused by hypertension should be billed with diagnosis codes in the 403 and 404 ranges. Therefore, the policy was revised to add the applicable diagnoses.

Policy Number
86706

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Hepatitis B Surface Antibody and Surface Antigen

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 50-17
Medicare Carriers Manual, Sections 2049.2, 2230.1, 2231.3C

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
12/20/1999

Original Policy Ending Date
N/A

Revision Effective Date
07/01/2002

Revision Ending Date
06/30/2002

LMRP Description
Hepatitis refers to inflammation of the liver. Approximately 50% of all acute viral hepatitis cases in the United States are type B. Hepatitis B is caused by the hepatitis B virus (HBV) which is spread by blood and serum-derived fluids through direct contact with these body fluids (such as transmission through parenteral, sexual, and perinatal modes). The incubation period for hepatitis B can be six weeks to six months with a slow onset. The most frequent presenting symptoms of acute viral hepatitis are low-grade fever, anorexia, fatigue, myalgia, and nausea followed one to two weeks later by jaundice. Dark urine and clay-colored stools present several days before jaundice. After the onset of jaundice, the liver enlarges and becomes tender. About 5% of patients infected with the hepatitis B virus develop what is coined the "serum-sickness syndrome." The syndrome includes the symptoms of jaundice, fever, rash, and arthralgia. Hepatitis B may be quite mild, while a few patients could rapidly progress to death suffering from acute necrosis of the liver. Some patients with hepatitis B (approximately 6%-10%) may progress to a persistent carrier status confirmed by the consistently present hepatitis B surface antigen in their blood. These patients are highly likely to transmit hepatitis B. Each case of hepatitis B is treated symptomatically.

Hepatitis B surface antigen (HBsAg) is the earliest indicator of an acute hepatitis B infection. It can be detected one to seven weeks before liver enzyme elevation or the onset of clinical symptoms. The serology of 50% of affected patients will be positive three weeks after acute onset, while at the seventeen week mark only 10% will remain positive. There is evidence of a "window" stage where the hepatitis B surface antigen has become negative and the patient has not yet developed the hepatitis B surface antibody. The chronic carrier state is indicated by the persistence of hepatitis B surface antigen over six months and longer (even years) while never seroconverting to hepatitis B surface antibody. The reference range is negative. The detection of the hepatitis B surface antigen establishes the presence of infection and implies infectivity.

Hepatitis B surface antibody (HbsAb or anti-HBs) is present in the serum of patients who have resolved a previous hepatitis B infection or have been vaccinated against hepatitis B. The disappearance of hepatitis B antigen with the appearance of hepatitis B antibody signals recovery from the hepatitis B infection, the status of noninfectivity and protection from recurrent hepatitis B infection. Hepatitis B surface antibody can be detected several weeks to several years after Hepatitis B antigen can no longer be detected. It may persist for life after the acute infection has been resolved. Since there are different serologic subtypes of the hepatitis B virus, it is possible for a patient to have an antibody for one subtype and be infected with another. Transfused individuals or hemophiliacs receiving plasma components may have false positive tests. Individuals vaccinated with HBV vaccine will have antibodies. The appearance of the hepatitis B antibody following vaccination signals successful vaccination against hepatitis B. The detection of hepatitis B surface antibody in the patient's serum can be performed by either the radioimmunoassay (RIA) or enzyme immunoassay (EIA) method. The reference range varies with the clinical circumstance.

Indications and Limitations of Coverage and/or Medical Necessity

Hepatitis B Surface Antibody
Florida Medicare will consider coverage for the Hepatitis B surface antibody (86706) for any of the following indications:

I. To confirm the resolution of a recent hepatitis B infection. The HBsAb is drawn one month after the diagnosis of acute hepatitis B is made. This test may be repeated monthly while seeking the disappearance of HBsAg and the appearance of HBsAb indicating immunity and recovery. If the HBsAg is still evident at the end of six months of testing, the patient is considered a persistent hepatitis B carrier. No further HBsAb would be considered reasonable and necessary.

II. After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the SOURCE is HBsAg-positive *and* the previously vaccinated exposed person is either a known responder or the response to vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination. EXCEPTION-Vaccinated persons who have not been tested within the past 24 months should undergo testing to determine immunity.

III. After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the SOURCE is not tested or unknown *and* the previously vaccinated exposed person's response to the vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination.

IV. Following the administration of the Hepatitis B vaccine series in order to determine adequate antibody response. Coverage for this indication is limited to two instances.

> To determine the antibody response of vaccination due to prophylaxis treatment following percutaneous and/or mucosal exposure; or
> To determine the antibody response of vaccination following a Medicare reimbursed vaccination furnished to a beneficiary who is at high or intermediate risk of contracting hepatitis B. See Intermediary Manual section 3157 for more information regarding this benefit.

It is recommended this testing occur between one to six months following the completion of the series. If the patient was given Hepatitis B immunoglobulin (HBIg) during this time period, the testing should be delayed until four to six months after the HBIg administration. Those beneficiaries who do not respond to the initial vaccination series, can receive up to three additional doses of vaccine at one to two month intervals. Serologic testing can occur following each dose.

V. To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with the Centers for Medicare & Medicaid Services' (CMS) National coverage policy. Further testing is dependent upon the initial result and the vaccination status. Please refer to the following table from the Coverage Issues Manual, section50-17.

Vaccination and Serologic Status	**Freq. of HBsAb Surveillance**
Unvaccinated	
Susceptible	Semiannually
HBsAg Carrier	None
HBsAb positive (*)	Annually
Vaccinated	
HBsAb positive (*)	Annually
HBsAb of 9 or less SRUs by RIA	Semiannually

* At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mlU/ml are recognized as conferring protection against hepatitis.

End-stage Renal Disease (ESRD) patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible.

Between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine. Once the response is confirmed as positive, there is no further need to perform semiannual HBsAb tests. If, during future annual HBsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. A booster dose, otherwise known as re-vaccination, requires the complete three-injection-series be repeated. Once again, between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine.

Hepatitis B Surface Antigen
Florida Medicare will consider coverage for the Hepatitis B surface antigen (87340) for any of the following indications:

I. To aid in the differential diagnosis of hepatitis when the patient presents with signs and symptoms of acute viral infection. If the initial HBsAg test is positive with the Anti-HBc-IgM being negative, both of these tests are repeated in two weeks. The results of the repeat tests aid in the differential diagnosis of acute HBV infection vs. chronic HBV carrier status. If the initial HBsAg test is positive with the Anti-HBc-IgM being positive, HBV infection is confirmed. The hepatitis B surface antigen test can be repeated monthly until negative. If, at the end of six months, the hepatitis B surface antigen remains positive, the beneficiary is diagnosed as a chronic HBV carrier and further hepatitis B surface antigen testing would not be reasonable or necessary.

II. To evaluate patients with chronic elevations (6 months or longer) of the following serum liver enzyme levels: alanine aminotransferase (ALT) and aspartane aminotransferase (AST) to rule out the diagnosis of Hepatitis B. It is expected that only one HBsAg test will be required in this clinical situation (ICD-9-CM code 790.4).

III. To evaluate patients with polyarteritis nodosa to determine if the illness is associated with replicating hepatitis B. In this instance HBsAg and HBeAg would be evaluated. It is expected that only one HBsAg test will be required (ICD-9-CM code 446.0).

IV. To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with CMS National coverage policy. Further testing is dependent upon the initial result as well as the vaccination status. Please refer to the following table from the Coverage Issue Manual, section 50-17.

Vaccination and Serologic Status	**Freq. of HBsAb Surveillance**
Unvaccinated	
Susceptible	Monthly
HBsAg Carrier	Annually
HBsAb positive (*)	None
Vaccinated	
HBsAb positive (*)	None
HBsAb of 9 or less SRUs by RIA	Monthly

* At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mlU/ml are recognized as conferring protection against hepatitis B.

ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose, all patients should be tested for HbsAb response to the vaccine. Once the response is confirmed, there is no further need to perform monthly HbsAg tests. If, during future annual HbsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. Monthly HbsAg can resume while awaiting the antibody response to this booster. Once the antibody titer confirms protection, no further HbsAg testing would be necessary.

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

CPT/HCPCS Codes
86706 87340

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
For procedure code 86706 (Hepatitis B surface antibody)

070.20-070.23	404.03	V01.7
070.30-070.33	404.12	V05.3
403.01	404.13	V45.1
403.11	585	V67.59
404.02		

Note: Billing for Hepatitis B Surface Antigen for ESRD beneficiaries requires dual diagnoses. Please submit code V45.1 ***and*** 403.01, 403.11, 404.02, 404.03, 404.12, 404.13, or 585 to report the approved indication.

For procedure code 87340 (Hepatitis B surface antigen)

070.20-070.23	570	782.4
070.30-070.33	573.1	783.0
070.6	573.2	787.02
070.9	573.3	789.1
403.01	585	790.4
403.11	719.40-719.49	791.9
404.02	729.1	792.1
404.03	774.4	V01.7
404.12	780.6	V02.61
404.13	780.79	V45.1
446.0	782.1	

Note: Billing for Hepatitis B Surface Antigen for ESRD beneficiaries requires dual diagnoses. Please submit code V45.1 ***and*** 403.01, 403.11, 404.02, 404.03, 404.12, 404.13, or 585 to report the approved indication.

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
Hepatitis B surface antigen and antibody tests are separately billable lab tests for hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis patients. Payment for these tests are not part of the composite rate of reimbursement.

To identify end-stage renal dialysis patients, bill ***both*** V45.1 ***and*** 403.01, 403.11, 404.02, 404.03, 404.12, 404.13, or 585 on the Medicare claim form. If both ICD-9-CM codes are not on the claim, the services will be denied as lacking medical necessity.

Documentation Requirements
For someone suspected of having been recently exposed to the hepatitis B virus, the medical record documentation must contain information regarding the beneficiary's vaccination status, and the suspected incident including an assessment of current signs and symptoms. It is expected that the initial and, if needed, subsequent hepatitis B lab test results (e.g., HBsAg, HBsAb, and/or Anti-HBc-IgM) be contained within the medical record. This information is usually found in the history and physical, office notes, test results, and/or progress notes.

Medical record documentation for ESRD beneficiaries receiving services through Medicare dialysis facilities must contain information regarding the method of dialysis, their hepatitis B vaccination status, and the results of their initial admission serology testing and all subsequent hepatitis B surface antigen and antibody tests.

If the provider of 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 test(s). The physician must state the beneficiary's vaccination status, as well as the clinical indication/medical necessity for the study in his/her order for the test(s).

Utilization Guidelines
It is expected that these services would be performed as indicated in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Other Comments
Terms defined:
Chronic hepatitis- persistently abnormal liver enzymes for at least six months duration.
End-stage Renal Disease (ESRD) - the term as defined by CMS reads the "stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life."
Person infected with HBV- the blood of this individual contains the hepatitis B surface antigen.
Person immune to HBV- the blood of this individual contains the hepatitis B antibody.
Person susceptible to HBV- the blood of this individual contains neither hepatitis B surface antigen nor antibody.

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

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the Florida Gastroenterologic Society, Florida Society of Nephrology and the Clinical Laboratory Management Association.

Carrier Advisory Committee Meeting held on August 29, 1998.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2002

Revision History

Revision Number	1	PCR B2002-104
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		07/01/2002

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.

87086: Urine Bacterial Culture

The local medical review policy for urine bacterial culture was published in the November/December 1999 issue of the *Medicare B Update!* (page 35). Since that time, diagnosis codes 791.0 (proteinuria) and 791.7 (other cells and casts in the urine) have been expanded to include diagnosis range 791.0-791.9. This range has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy. This revision is effective for claims processed on or after July 1, 2002.

90800: Psychiatric Services

The local medical review policy (LMRP) for Psychiatric Services was published in the Third Quarter 2002 *Medicare B Update!* (pages 57-58). Change Request 2161 (Transmittal AB-02-058) changed the procedure code status of *CPT* code 90887 back to a bundled status effective for services rendered on or after January 1, 2002, processed on or after July 1, 2002. Therefore, under the "Reasons for Denials" section of the LMRP, the statement referencing *CPT* code 90887 as a noncovered service was deleted and the procedure code was added to the list of bundled services.

92567: Tympanometry

Revision Overview: Original policy.

Policy Number
92567

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Tympanometry

AMA *CPT* Copyright Statement

CMS National Coverage Policy
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
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Tympanometry is a test used to evaluate the condition of the middle ear system. The test determines the functionality of the tympanic membrane by observing its response to waves of pressure, and measuring the pressure of the middle ear. The test is used to measure parameters of the middle ear and eardrum in an effort to determine whether there are dysfunctions that could ultimately affect the hearing of the patient or put one at risk for repeated infections. Tympanometry is regarded as an objective technique for obtaining reproducible measurements of the compliance (also referred to as "admittance") or mobility of the tympanic membrane and the pressure within the middle ear system. The measurements assist in assessing Eustachian tube function and in determining the continuity and mobility of the ossicular chain.

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

- To evaluate middle ear abnormalities suspected by clinical otoscopy
- To evaluate Eustachian tube patency
- To evaluate conductive hearing loss
- To evaluate perforations of the tympanic membrane
- To evaluate suspected fixation of the ossicular chain
- To evaluate middle ear function
- To evaluate lack of contact between conduction of the bones of the middle ear
- To document or follow persistent middle ear effusions

Tympanometry (impedance testing) is covered when testing is for the purpose of determining the appropriate medical or surgical treatment for disorders.

CPT/HCPCS Section & Benefit Category
Medicine/Special Otorhinolaryngologic Services

CPT/HCPCS Codes
92567

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
381.00-381.9 382.00-382.9 383.00-383.9
384.00-384.9 389.00-389.08*

* Tests for the ICD-9-CM codes 389.00-389.08 are covered only for an initial evaluation of a hearing problem.

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.

Tympanometry is considered noncovered when performed on a screening basis.

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 Medicare coverage of audiologists performing hearing tests, the audiologists must be "qualified audiologists" as defined in the Medicare Carriers Manual (MCM), Section 2070.3;

A qualified audiologist is an individual with a master's or doctoral degree in audiology who:

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

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

Documentation Requirements
Medical record documentation maintained by the performing physician 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 office/progress notes, hospital notes, and/or procedure report.

Utilization Guidelines
N/A

Other Comments
N/A

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

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

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
08/01/2002

Revision History

Revision Number	Original	PCR B2002-123
Start Date of Comment Period:		05/11/2001
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Original Effective Date		09/23/2002

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.

93000: Electrocardiography

Revision Overview: The term Dressler's Syndrome was deleted from and diabetes was added to indication #10 in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy. Coverage was expanded to allow an EKG to be performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities. The ICD-9-CM code range for diabetes was expanded to 250.00-250.93.

Policy Number
93000

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Electrocardiography

AMA *CPT* Copyright Statement
CPT codes, descriptions, and other data only are copyright 2001 American Medical Association (or such

CMS National Coverage Policy
Coverage Issues Manual, Section 50-15

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
08/19/1996

Original Policy Ending Date
N/A

Revision Effective Date
07/29/2002

Revision Ending Date
07/28/2002

LMRP Description
Electrocardiography (ECG, EKG) is the graphic tracing of the variations in electrical potential caused by the excitation of the heart muscle as detected at the body surface by electrodes placed on the patient's limbs and chest. The monitoring electrodes detect the electrical activity of the heart from a variety of spatial perspectives. The EKG lead system is composed of several electrodes that are placed on each of the four extremities and at varying sites on the chest. It provides information regarding rate, rhythm, myocardial injury, and conduction system.

The normal EKG pattern is composed of waves arbitrarily designated by the letters P, Q, R, S, and T. Through the analysis of these wave forms and time intervals, valuable information about the heart may be obtained. The EKG is used primarily to identify abnormal heart rhythms (arrhythmias or dysrhythmias) and to diagnose acute myocardial defects, ventricular hypertrophy, and/or strain.

Indications and Limitations of Coverage and/or Medical Necessity
Electrocardiograms are indicated for diagnosis and patient management purposes involving symptoms of the heart, pericardium, thoracic cavity, and system diseases which produce cardiac abnormalities.

Florida Medicare will consider an EKG medically necessary in any of the following circumstances:

1 Initial diagnostic workup for a patient that presents with complaints of symptoms such as chest pain, palpitations, dyspnea, dizziness, syncope, etc. which may suggest a cardiac origin.
2 Evaluation of a patient on a cardiac medication for a cardiac arrhythmia or other cardiac condition which affects the electrical conduction system of the heart (e.g., inotropics such as digoxin; antiarrhythmics such as Tambocor, Procainamide, or Quinidine; and antianginals such as Cardizem, Isordil, Corgard, Procardia, Inderal, and Verapamil). The EKG is necessary to evaluate the effect of the cardiac medication on the patient's cardiac rhythm and/or conduction system.
3 Evaluation of a patient with a pacemaker with or without clinical findings (history or physical examination) that suggest possible pacemaker malfunction.
4 Evaluation of a patient who has a significant cardiac arrhythmia or conduction disorder in which an EKG is necessary as part of the evaluation and management of the patient. These disorders may include, but are not limited to, the following: Complete Heart Block, Second Degree AV Block, Left Bundle Branch Block, Right Bundle Branch Block, Paroxysmal VT, Atrial Fib/Flutter, Ventricular Fib/Flutter, Cardiac Arrest, Frequent PVCs, Frequent PACs, Wandering Atrial Pacemaker, and any other unspecified cardiac arrhythmia.
5 Evaluation of a patient with known Coronary Artery Disease (CAD) and/or heart muscle disease that presents with symptoms such as increasing shortness of breath (SOB), palpitations, angina, etc.
6 Evaluation of a patient's response to a newly established therapy for angina, palpitations, arrhythmias, SOB, or other cardiopulmonary disease process.
7 Evaluation of patients after coronary artery revascularization by Coronary Artery Bypass Grafting (CABGs), Percutaneous Transluminal Coronary Angiography (PTCA), thrombolytic therapy (e.g., TPA, Streptokinase, Urokinase), and/or stent placement.
8 Evaluation of patients presenting with symptoms of a Myocardial Infarction (MI).
9 Evaluation of other symptomatology which may indicate a cardiac origin especially in those patients who have a history of an MI, CABG surgery or PTCA, *or* patients who are being treated medically after a positive stress test or cardiac catherization.
10 Pre-operative Evaluation of the patient when:
- undergoing cardiac surgery such as CABGs, automatic implantable cardiac defibrillator, or pacemaker, or
- the patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial ischemia such as Diabetes, history of MI, angina pectoris, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, valvular disease, or cardiomyopathy to name a few.
11 Evaluation of a patient's response to the administration of an agent known to result in cardiac or EKG abnormalities (for patients with suspected, or at increased risk of developing, cardiovascular disease or dysfunction). Examples of these agents are antineoplastic drugs, lithium, tranquilizers, anticonvulsants, and antidepressant agents.
12 When performed as a baseline evaluation prior to the initiation of an agent known to result in cardiac or EKG abnormalities. An example of such an agent is verapamil.

CPT/HCPCS Section & Benefit Category
Cardiovascular/Medicine

CPT/HCPCS Codes

93000 93005 93010

Not Otherwise Classified Codes (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

079.0-079.99	780.4	799.1
240.0-246.9	780.79	860.0-860.5
250.00-250.93	782.0	861.00-861.32
276.0-276.9	782.61-782.62	959.1
277.00-277.01	785.0	972.0-972.9
277.3	785.1	980.0-989.9
337.0	785.2	995.0-995.89
337.9	785.3	996.00-996.09
390-429.9	785.50-785.59	996.80-996.89
435.9	786.00	997.1
436	786.01	997.2
440.0-448.9	786.02	997.3
668.10-668.14	786.03-786.09	E933.1
710.0-710.9	786.50-786.59	E936.0-E936.3
714.0-714.9	786.6	E939.0-E939.9
745.0-745.9	789.01	V45.01-V45.09
746.00-747.9	789.02	V45.81-V45.82
780.02	789.06	V58.69
780.2	794.30-794.39	V58.83
780.31-780.39	799.0	V72.81

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

When billing subsequent electrocardiograms on the same day, use modifier 76 if repeated by the same provider or modifier 77 when repeated by a different provider.

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, the EKG strip and a copy of the test results should be maintained in the medical record.

If the provider of 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 the order for the test.

When using diagnosis code V72.81, the medical record must contain information supporting either of the two preoperative evaluation indications listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

If an EKG is being performed to evaluate a patient's response to the administration of an agent known to result in cardiac or EKG abnormalities for patients with suspected, or at increased risk of developing cardiovascular disease or dysfunction, then diagnosis code V58.69 or V58.83 should be used. The "E" diagnoses should be used when the patient is experiencing adverse effects to high risk medications.

Utilization Guidelines

N/A

Other Comments

N/A

Sources of Information and Basis for Decision

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

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the Florida Chapter of the American College of Cardiology.

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2002

Revision History

Revision Number	11	PCR B2002-141
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date		07/29/2002

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.

93025: Microvolt T-wave Alternans

Revision Overview: Original policy.

Policy Number
93025

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Microvolt T-wave Alternans

AMA *CPT* Copyright Statement

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
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Microvolt T-wave alternans (TWA) is an every other beat variation in the T-wave that is predictive of ventricular tachyarrhythmias associated with sudden cardiac death. Microvolt TWA is measured through sensors and electrodes placed in the standard 12-lead configuration as well as additional vector positions during a routine exercise stress test, pharmacologic stress test, or cardiac pacing. Sustained alternans with an onset of the heart rate less than 110 bpm for a minimum of 2.5 minutes with alternans voltage measured at > 1.9 microvolts and alternans ratio of >3 is considered a positive t-wave alternans.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider microvolt TWA medically reasonable and necessary when performed for a clinical condition associated with a high risk of ventricular tachyarrhythmias (e.g., ischemic cardiomyopathy, unexplained syncope with suspected or known heart disease, etc.) only when the results of the test will be used in the management of the patient. For example, the results of the microvolt TWA will determine whether a patient will undergo an invasive electrophysiological study or treatment with antiarrhythmics when the results are positive.

Microvolt TWA is not covered for the general assessment of a patient with atherosclerotic heart disease, pre-surgical evaluation, or other circumstances where the index of suspicion of ventricular tachycardia/fibrillation is low, or the knowledge of possible ventricular tachycardia/fibrillation will not alter the management of the patient. Also, the routine use of microvolt TWA as an add-on service to other cardiac evaluation tests such as electrocardiograms, stress testing, and electrophysiologic studies is not covered.

CPT/HCPCS Section & Benefit Category
Medicine/Cardiovascular

CPT/HCPCS Codes
93025

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
414.8, 425.0-425.9, 427.1, 427.41, 427.5, 428.1, 780.2

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
N/A

Coding Guidelines
The following services are considered bundled into the reimbursement of microvolt TWA, and therefore, are not to be billed separately: Electrocardiogram/Rhythm electrocardiogram (procedure codes 93000-93010, 93040-93042), and the sensors/electrodes (procedure code 99070) used in the performance of the test.

Documentation Requirements
Medical record documentation must clearly indicate the medical necessity of the service(s) being billed and that the results of the test are being used in the management of the patient. In addition, the documentation must support that the procedure was performed. This information is normally found in the office/progress notes, hospital records, and test results.

Utilization Guidelines
N/A

Other Comments
N/A

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

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the Florida Chapter of the American College of Cardiology.

Carrier Advisory Committee Meeting held on January 19, 2002.

Start Date of Comment Period
01/11/2002

End Date of Comment Period
02/25/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-106
Start Date of Comment Period:	01/11/2002
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

Revision Overview: Current information supports monitoring of pacer cardioverter-defibrillators transtelephonically, therefore, the noncoverage statements were deleted.

Policy Number
93724

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 50-1

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
03/19/2001

Original Policy Ending Date
N/A

Revision Effective Date
07/01/2002

Revision Ending Date
06/30/2002

LMRP Description
Electronic analysis of single and dual chamber pacemakers and pacing cardioverter-defibrillators involves the interrogation and testing of the programmable parameters of the device using electrocardiographic recordings with analysis of event markers and device response. Follow-up with electronic analysis after insertion of these devices is dictated by multiple factors, including other cardiovascular or medical problems, the device used, and evolving technology. The goals of routine monitoring of the pacemakers and cardioverter-defibrillators is to determine overall system function; optimize performance for maximal clinical effectiveness and system longevity; minimize complications; anticipate replacement of system components; and ensure timely intervention for clinical problems.

Indications and Limitations of Coverage and/or Medical Necessity
Electronic analysis to monitor the patient's pacemaker and/or cardioverter-defibrillator is medically necessary on a regular basis to evaluate the device. The frequency of follow-up is determined by the patient's attending physician who takes into account the condition and circumstances of the individual patient. If the monitoring

is done by some entity other than the patient's physician, such as a commercial monitoring service or hospital outpatient department, the physician's prescription for monitoring is required and must be renewed at least annually to assure that the frequency of monitoring is proper for the patient. When services are performed by entities other than the attending physician, such as monitoring services and pacemaker clinics, it is expected that the information obtained from these monitoring activities be communicated to the attending physician for use in the management of the patient's condition. This information must be documented in the patient's medical record.

Transtelephonic Monitoring of Cardiac Pacemakers (procedure codes 93733 and 93736)
Telephone monitoring of pacemakers is medically efficacious in identifying early signs of possible pacemaker failure, thus reducing the number of sudden pacemaker failures requiring emergency replacement. All systems which monitor the pacemaker rate (bpm) in both the free-running and/or magnetic mode are effective in detecting subclinical pacemaker failure due to battery depletion. More sophisticated systems are also capable of detecting internal electronic problems within the pulse generator itself and other potential problems. In the case of dual chamber pacemakers, such monitoring may detect failure of synchronization of atria and ventricles, and the need for adjustment and reprogramming of the device.

In order for transtelephonic monitoring services to be covered, the services must consist of the following elements:

- A minimum 30-second readable strip of the pacemaker in the free-running mode;
- Unless contraindicated, a minimum 30-second readable strip of the pacemaker in the magnetic mode; and
- A minimum 30 seconds of readable ECG strip.

National Medicare Frequency Guidelines
Frequency guidelines for transtelephonic monitoring (procedure codes 93733 and 93736) are divided into two categories: Guideline I which applies to the majority of pacemakers now in use and Guideline II which applies to pacemaker systems for which sufficient long-term clinical information exists to assure that they meet the standards of the Intersociety Commission for Heart Disease Resources (ICHD) for longevity and end-of-life decay. The two groups of guidelines are further divided into single and dual-chamber pacemakers. The frequency guidelines identified below represent the maximum frequency of transtelephonic monitoring that is expected to occur under routine follow-up. The frequency with which a patient is monitored may be changed for a number of reasons, such as a change in the patient's overall condition, a reprogramming of the patient's pacemaker, and the development of better information on the pacemaker's longevity or failure mode.

Guideline I	**Guideline II**
Single-chamber pacemaker	*Single-chamber pacemaker*
1st month - every 2 weeks	1st month - every 2 weeks
2nd through 36th month - every 8 weeks	2nd through 48th month - every 12 weeks
37th month to failure - every 4 weeks	49th through 72nd month - every 8 weeks
	After 72nd month - every 4 weeks
Dual-chamber pacemaker	*Dual-chamber pacemaker*
1st month - every 2 weeks	1st month - every 2 weeks
2nd through 6th month - every 4 weeks	2nd through 30th month - every 12 weeks
7th through 36th month - every 8 weeks	31st through 48th month - every 8 weeks
37th month to failure - every 4 weeks	After 48th month - every 4 weeks

Pacemaker Clinic Services
Pacemaker monitoring (procedure codes 93724, 93731-93732, 93734-93735) is covered by pacemaker clinics and may be done in conjunction with transtelephonic monitoring or as a separate service. The services rendered by a pacemaker clinic are more extensive than those currently possible by telephone. They include, for example, physical examination of patients and reprogramming of pacemakers.

The frequency of pacemaker clinic services is the decision of the patient's physician, taking into account the medical condition of the patient. The following monitoring guidelines apply to lithium-battery pacemakers (all pacemakers currently have lithium batteries):

- Single-chamber pacemakers – twice in the first 6 months following implant, then once every 12 months.
- Dual-chamber pacemakers – twice in the first 6 months, then once every 6 months.

Local Medicare Frequency Guidelines
Electronic analysis of a pacing cardioverter-defibrillator (procedure codes 93741-93744) is performed in an office or outpatient hospital setting. Procedure codes 93741-93744 involve the interrogation and evaluation of the pulse generator status in addition to evaluation of the programmable parameters, analysis of event markers and device response during periods of rest and activity. The monitoring of these complex devices requires more frequent monitoring then a single or dual chamber pacemaker. Therefore, Florida Medicare will allow routine electronic analysis of a pacing cardioverter-defibrillator (single and dual chamber) at one month following implantation and then every three months thereafter. More frequent testing may be necessary to evaluate patient symptomatology suggestive of pacing cardioverter-defibrillator involvement/origin. Transtelephonic monitoring of a pacer cardioverter-defibrillator is covered and should be billed with procedure code 93799 (Unlisted cardiovascular service or procedure).

The frequency of transtelephonic monitoring of a pacer cardioverter-defibrillator for asymptomatic patients is as follows: 1st month – every 2 weeks and every 4 weeks thereafter. More frequent testing may be necessary to evaluate patient symptomatology suggestive of pacing cardioverter-defibrillator involvement/origin.

CPT/HCPCS Section & Benefit Category
Medicine/Cardiovascular

CPT/HCPCS Codes

93724	93734	93742
93731	93735	93743
93732	93736	93744
93733	93741	

Not Otherwise Classified Codes (NOC)
93799

ICD-9-CM Codes that Support Medical Necessity

426.0-426.9	996.01	V53.31
427.0-427.9	996.04	V53.32
429.4	996.09	V53.39
780.2	V45.01	V67.9
785.1	V45.02	

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.

Transtelephonic monitoring of a pacer cardioverter-defibrillator is noncovered.

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
Procedure codes 93741-93744 are intended to be reported for postimplantation electronic analysis performed in an office or outpatient setting, and do not involve induction of an arrhythmia. It is not appropriate to bill for procedure codes 93741-93744 at the time of pacer cardioverter-defibrillator (procedure codes 33216, 33217, 33240, 33245, 33246, and 33249) insertion.

The pacemaker analysis codes 93731-93736 are intended to be reported for subsequent encounters separate from the insertion procedure. Therefore, it would be inappropriate to bill for the pacemaker analysis codes 93731, 93732, 93734, 93735, or 93736 at the time of single-chamber or dual-chamber pacemaker (procedure codes 33212-33213) insertion.

If the electronic analysis of the pacemaker, automatic implantable cardiac defibrillator or pacing cardioverter-defibrillator is being performed for routine follow-up of that device, then the appropriate "V" diagnosis should be billed.

Documentation Requirements
Medical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed and must demonstrate the medical necessity of the services performed in excess of the established frequency guidelines. In addition, the documentation must support that the service was performed. This information is normally found in the office/progress notes, hospital records, testing results.

Also, a physician's prescription for monitoring is required and must be renewed annually when the monitoring is performed by a commercial monitoring service or an outpatient hospital department. In addition, the documentation must indicate the date and type of device implanted.

For services performed by entities other than the attending physician, such as monitoring services and pacemaker clinics, it is expected that the medical record documentation will demonstrate how the information obtained is used in the management of the patient.

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

Utilization Guidelines
The frequency of transtelephonic monitoring of cardiac pacemakers and the frequency of monitoring of lithium-battery pacemakers in a pacemaker clinic are identified in the Coverage Issues Manual, Section 50-1. These guidelines are identified in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Local frequency guidelines for pacing cardioverter-defibrillators are identified in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Other Comments
N/A

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

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the Florida Chapter of the American College of Cardiology.

Carrier Advisory Committee Meeting held on November 11, 2000.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
08/01/2002

Revision History
Revision Number:	2	PCR B2002-116
Start Date of Comment Period		N/A
Start Date of Notice Period		08/01/2002
		4th QTR 2002 *Update!*
Revised Effective Date:		07/01/2002

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.

93784: Ambulatory Blood Pressure Monitoring (ABPM)

Revision Overview: Original policy.

Policy Number
93784

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Ambulatory Blood Pressure Monitoring (ABPM)

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 50-42
Program Memorandum Transmittal AB-01-188 (Change Request 1985, dated December 18, 2001)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Ambulatory Blood Pressure Monitoring (ABPM) involves the use of a FDA approved, non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted at the physician's office. ABPM must be performed for 24 hours to meet coverage criteria.

Indications and Limitations of Coverage and/or Medical Necessity
Ambulatory blood pressure monitoring is covered by Medicare (effective for services furnished on or after April 1, 2002) for beneficiaries with suspected "white coat hypertension."

"White coat hypertension" is defined as:

- Office blood pressure >140/90 mmHg on at least three separate clinic/office visits with two separate measurements made at each visit;
- At least two documented separate blood pressure measurements taken outside the office which are <140/90 mmHg; and
- No evidence of end-organ damage.

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

CPT/HCPCS Section & Benefit Category
Medicine/Cardiovascular

CPT/HCPCS Codes
93784 93786 93788*
93790

**CPT* code 93788 is not approved for Medicare payment.

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
796.2

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.

Testing on an institutionalized beneficiary will be denied.

Any testing period less than 24 hours will be denied.

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.

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 (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for assessment of suspected "white coat hypertension."

This includes documentation of:

1. Office blood pressure >140/90 on at least three separate clinic/office visits with two separate measurements made at each visit;
2. At least two documented separate blood pressure measurements taken outside the office which are <140/90 mmHg; and
3. No evidence of end-organ damage (e.g., central nervous system, renal, cardiac)

Additionally, a copy of the Ambulatory Blood Pressure Monitoring report, with the physician's signature, must be maintained in the medical record.

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 numerous societies.

Carrier Advisory Committee Meeting held on 05/18/2002

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History

Revision Number Original	PCR B2002-131
Start Date of Comment Period:	05/10/2002
Start Date of Notice Period:	08/01/2002
	4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

93975: Duplex Scanning—Revision to Policy

A revision has been added to the local medical review policy for duplex scanning to include evaluation of scrotal contents as an indication for medical necessity. Under the section "Indications and Limitations of Coverage and/or Medical Necessity" the following indication has been added:

- To evaluate patients with pain or swelling of scrotal contents which may be as a result of suspected obstruction in arterial inflow or venous outflow to the testicles or related structures. The use of duplex scanning of scrotal contents should only be performed after conventional diagnostic test, such as ultrasound, have proven to be "non-definitive."

The following codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section for procedure codes 93975 and 93976:

456.4 Scrotal varicies
608.2 Torsion of testis
608.83 Other specified disorders of male genital organ, vascular disorders

These revisions are effective for claims processed on or after July 01, 2002.

94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation

The latest revision to the ICD-9-CM diagnosis code list for the local medical review policy (LMRP) 94760 Noninvasive Ear or Pulse Oximetry for Oxygen Saturation was published in the September/October 2000 *Medicare B Update!* (page 22). Since that time, the following ICD-9-CM diagnosis codes have been added to the LMRP for procedure codes 94760, 94761, and 94762, effective for services processed on or after July 16, 2002:

391.8	402.91	404.13
398.91	404.01	404.91
402.01	404.03	404.93
402.11	404.11	428.1

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.

95900: Nerve Conduction Studies

The local medical review policy (LMRP) for Nerve Conduction Studies was previously published in the May/June 1998 *Medicare B Update!* (pages 49-51). The Centers for Medicare & Medicaid Services (CMS) Transmittal AB-02-066 (CR 2153) dated May 2, 2002, indicates that Current Perception Sensory Nerve Conduction Threshold (sNCT), procedure code G0255, is noncovered by Medicare, effective for dates of service on or after October 1, 2002 (see related article on page 42).

As a result, the "Coding Guidelines" section of the Nerve Conduction Studies LMRP (policy # 95900) has been revised to reflect this change. Please refer to our Web site, www.floridamedicare.com, on or after October 1, 2002, for the latest revision to the LMRP.

95250: Continuous Glucose Monitoring System (CGMS)

Revision Overview: Original policy.

Policy Number
95250

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Continuous Glucose Monitoring System (CGMS)

AMA *CPT* Copyright Statement

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
09/23/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
The Continuous Glucose Monitoring System (CGMS) is a sensor system that is designed to continuously and automatically monitor interstitial glucose values in subcutaneous tissue. This information is intended to supplement, not replace blood glucose information obtained using standard home glucose monitoring devices. The monitor records glucose values every 5 minutes, and should be worn for a maximum of 3 days. The information is downloaded and may be reviewed in both graphical and tabular formats. This information allows identification of patterns of glucose level excursions above or below the desired range, facilitating therapy adjustments, which may minimize these excursions.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will cover the CGMS for the following patients:

Type I or Type II diabetics who have:
- Been instructed by a healthcare professional in the management of diabetes, and
- Documented frequency of glucose self-testing an average of at least 4 times per day during the previous month, and
- Been on a program of multiple daily injections of insulin (at least 2 injections per day) with self-adjustment of their insulin dose based on self-testing results, and

- Met one or more of the following criteria while on the multiple daily injection regime:
    - Glycated hemoglobin (Hgb A1C) values <4 or >9
    - Unexplained large fluctuations in daily glucose values before meals
    - Unexplained frequent hypoglycemic attacks
    - Episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels.

Type I diabetics with an implanted insulin pump who have:

- Been instructed by a healthcare professional in the management of diabetes, and
- Documented frequency of glucose self-testing an average of at least 4 times per day during the previous month, and
- Met one or more of the following criteria since enrollment in the Medicare Program:
    - Glycated hemoglobin (Hgb A1C) values <4 or >9
    - Unexplained large fluctuations in daily glucose values before meals
    - Unexplained frequent hypoglycemic attacks
    - Episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels.

Type I or Type II diabetic woman who is newly pregnant or a woman who has developed gestational diabetes that requires insulin therapy.

For Medicare purposes, continuous glucose monitoring must be performed for a minimum of 24 hours to effectively show glucose trends. The recommended monitoring period is 72 hours. Monitoring for less than 24 hours is not considered medically reasonable or necessary.

CPT/HCPCS Section & Benefit Category
Medicine/Endocrinology

CPT/HCPCS Codes
95250

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

250.02	250.42	250.72
250.03	250.43	250.73
250.12	250.52	250.82
250.13	250.53	250.83
250.22	250.62	648.03
250.23	250.63	648.83

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.

The use of this code is intended for one-time or occasional use. Frequent use of continuous glucose monitoring will be denied as not reasonable and necessary.

Monitoring for less than 24 hours is not considered medically reasonable or necessary and therefore, will be denied.

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
Procedure code 95250 does not include reimbursement for data interpretation. The interpretation of this testing should be included in the evaluation and management services rendered to the patient at the time that the results are presented and the treatment options are discussed.

It is not appropriate to report code 95250 in conjunction with 99091 (Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, requiring a minimum of 30 minutes of time).

Documentation Requirements
Medical record documentation must substantiate the criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. This information may be included in the office progress notes, hospital records, and/or lab results section of the medical record.

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
The CGMS is intended for occasional rather than everyday use, and is to be used as a supplement to, and not a replacement for, standard invasive measurements.

Testing must be performed on a device that is approved by the Food and Drug Administration for continuous glucose monitoring.

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

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

final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from numerous specialties.

Carrier Advisory Committee Meeting held on May 18, 2002.

Start Date of Comment Period
05/10/2002

End Date of Comment Period
06/24/2002

Start Date of Notice Period
08/01/2002

Revision History
Revision Number	Original
Start Date of Comment Period:	PCR B2002-135 05/10/2002
Start Date of Notice Period:	08/01/2002 4th QTR 2002 *Update!*
Original Effective Date	09/23/2002

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.

97802: Medical Nutrition Therapy (MNT)

Revision Overview: Original policy.

Policy Number
97802

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Medical Nutrition Therapy (MNT)

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Program Memorandum B-01-48 (Change Request 1776, dated August 7, 2001)
Program Memorandum AB-02-059 (Change Request 2142, dated May 1, 2002)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
10/01/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Medical Nutrition Therapy (MNT) are services furnished by a registered dietitian or nutrition professional for patients with diabetes or renal disease. The services consist of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure patient compliance with the dietary plan.

Indications and Limitations of Coverage and/or Medical Necessity
Effective 01/01/2002 Medicare will cover medical nutrition therapy (MNT) performed by a registered dietitian or nutrition professional when provided in accordance with the criteria listed below:

For the purposes of this benefit, renal disease means chronic renal insufficiency; end stage renal disease when dialysis is not received; and the medical condition of a patient for 36 months after a kidney transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate [GFR] 13-50 ml/min/1.73 m2). Diabetes is defined as diabetes mellitus Type 1 (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency) and Type 2 (familial hyperglycemia), and gestational diabetes. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy. The diagnostic criterion for a diagnosis of diabetes is a fasting glucose greater than or equal to 126 mg/dl.

The following are the general conditions of coverage effective for services on or after January 1, 2002:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease for each episode of care and any reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. A treating physician means the primary care physician or specialist coordinating care for the patient with diabetes or renal disease. Nonphysician practitioners cannot make referrals for this service;

- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;
- Services may be provided either on an individual or group basis without restrictions;
- MNT services must be provided by a registered dietitian or nutrition professional meeting the criteria listed below.
- Reassessments and interventions are allowed within an episode of care when the referring physician determines there is a change of diagnosis or medical condition within such an episode of care that makes a change in diet necessary.

Effective for services on or after October 1, 2002:

- For a patient with a diagnosis of diabetes, Diabetes Self-Management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same patient. For a patient with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the patient may receive MNT services based on a change in medical condition, diagnosis, or treatment.

The following limitations apply for services on or after January 1, 2002:

- MNT services are not covered for patients receiving maintenance dialysis.
- Referral may only be made by the treating physician when the patient has been diagnosed with diabetes or renal disease as defined in this policy. Documentation must be maintained by the referring physician in the patient's medical record. Referrals must be made for each episode of care and any reassessments prescribed during an episode of care as the result of a change in medical condition or diagnosis.
- Additional hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary.
- For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. For the purpose of this benefit, registered dietitian or nutrition professional means a dietitian or nutrition professional nutritionist licensed or certified in a state as of December 21, 2000.

Professional Standards for Dietitians and Nutritionists:

Registered dietitian or nutrition professional is defined as a dietitian or nutritionist licensed or certified in a state as of December 21, 2000; or an individual whom, on or after December 22, 2000 meet the following criteria:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and
- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he/she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of the first two bullets of this section.

CPT/HCPCS Section & Benefit Category
Medicine/Medical Nutrition Therapy

CPT/HCPCS Codes
97802 97803 97804

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
250.00-250.93 585 V42.0

Diagnoses that Support Medical Necessity
N/A

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

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for 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
Procedure code 97802 is used only once per year, for the initial assessment of a new patient. Procedure code 97803 is used for all individual reassessments and all interventions after the initial visit and when there is a change in the patient's medical condition that affects the nutritional status of the patient. Procedure code 97804 is used for all group visits, initial and subsequent including when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending a group (2 or more individuals).

Note: The above codes can only be paid if submitted by a registered dietitian or nutrition professional who meets the specified requirements. These services cannot be paid "incident to" physician services.

Documentation Requirements

Referral may only be made by the treating physician when the patient has been diagnosed with diabetes or renal disease as defined in this policy. Documentation must be maintained by the referring physician in the patient's medical record. The documentation should contain evidence to substantiate that the patient's condition meets the criteria to receive MNT services. Nonphysician practitioners cannot make referrals for this service. An individualized assessment should be present in the patient's medical record. Components of the individualized assessment should include items such as the following:

- Relevant medical history, cultural influences, health beliefs and attitudes, diabetes or renal health knowledge, self-management skills and behaviors, readiness to learn, cognitive ability, physical limitations, and family support. The patient's progress should also be documented in the medical record.

Utilization Guidelines

Effective for services on or after October 1, 2002:

For purpose of this policy, this service is defined as a maximum of 3 hours that may be reimbursed in the initial episode of care. In subsequent years, patients may receive 2 hours of medical nutrition therapy (MNT) with a physician referral. The number of hours covered for diabetes is the same as the number of hours covered for renal disease.

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 January 19, 2002.

Start Date of Comment Period

01/11/2002

End Date of Comment Period

02/25/2002

Start Date of Notice Period

08/01/2002

Revision History

Revision Number	Original	PCR B2002-128
Start Date of Comment Period:		01/11/2002
Start Date of Notice Period:		08/01/2002
		4th QTR 2002 *Update!*
Original Effective Date		10/01/2002

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.

ELECTRONIC MEDIA CLAIMS

HIPAA Model Compliance Extension Plan and Instructions Now Available

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic healthcare transactions and code sets. October 16, 2002, is the deadline for covered entities such as health plans, clearinghouses and providers (such as physicians, dentists, hospitals, nursing homes and others) to comply with these new standards. However, in December 2001, the Administrative Simplification Compliance Act (ASCA, Public Law 107-105) gave covered entities not compliant by October 16, 2002, the opportunity to extend their compliance deadline by 1 year – to October 16, 2003. This extension opportunity is applicable to all HIPAA-covered entities other than small health plans (those with less than $5 million in annual receipts whose compliance date is already set for October 16, 2003). In order to qualify for this extension, covered entities must submit a compliance plan by October 15, 2002.

A model compliance plan and instructions on how to complete and submit it are available on the Centers for Medicare & Medicaid Services (CMS) Web site, *www.cms.hhs.gov/hipaa*. You can submit this online model plan electronically through the Web site or print and mail it. You can submit your own paper version of the plan as long as it provides equivalent information (covered entity and contact information; reasons for filing for the extension; HIPAA implementation budget information; and where you are in implementing and testing, including whether or not you plan to use a vendor). CMS strongly encourages electronic filing but if you must file on paper, you should send your form to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD. 21244-8040. The deadline for both electronic and paper submissions is October 15, 2002.

If you file electronically through the Web site, you will receive an electronic confirmation number acknowledging and granting your extension. If you file a paper version, you won't receive a confirmation, but if your paper plan consists of the required equivalent information, you may consider your extension granted.

The instructions give more details on how to complete the form; explanation of who should file for an extension; data you need to include; and where to get more information on definitions, frequently asked questions, etc.

For more information, submit questions to *askhipaa@cms.hhs.gov*.

Providers Using Medicare Supplied Billing Software

Medicare contractors will continue to provide electronic billing software for providers to submit their Medicare claims. The HIPAA-compliant version of this software will be available on or near July 15, 2002, from PC-ACE Pro32 ® Support of First Coast Service Options, Inc. (FCSO). Any providers who will continue to use the non-HIPAA version Medicare billing software at any time between October 16, 2002, and October 16, 2003, must submit a Compliance Extension Plan as described above.

Source: CMS Transmittal AB-02-071, CR 2168

GENERAL INFORMATION

FRAUD AND ABUSE

Medicare Fraud Alert

Contractors were notified of the following fraudulent activity in a recent communication from the Centers for Medicare & Medicaid Services.

A provider is reportedly traveling to various states purchasing medical practices from chiropractors. This provider renders services, submits claims to insurance carriers for these services, and sets up accounts receivables for the business. The claims are processed and paid by Medicare or other carrier; however, he does not close out the accounts receivables in his accounting records. The provider then sells the practice to another chiropractor and promotes to the purchaser that there are outstanding accounts receivables not satisfied with Medicare or other insurance carrier, when in fact, these claims were already processed and paid. The purchaser is encouraged to submit claims to carriers for the false outstanding accounts receivable. The purchasing chiropractor, relying on this provider's misrepresentation, is submitting duplicate claims for services already reimbursed by the carriers to the subject provider.

Need to Report Fraud?

If you encounter a similar or other suspected fraudulent activity, please call one of the telephone numbers listed below for help:

Medicare Part A Issues:
(877) 602-8816

Medicare Part B Issues:
Beneficiaries:
(800) 333-7586
(800) 754-7820
(Hearing impaired)
(904) 355-3680
(Duval County or outside Florida)

Providers (toll-free):
(866) 454-9007

If you prefer to report suspected fraudulent activity in writing, send your correspondence to:

Medicare Anti-Fraud Branch
First Coast Service Options, Inc.
P.O. 45087
Jacksonville, FL 32231

MEDICARE SECONDARY PAYER

Reporting the Obligated to Accept as Payment in Full (OTAF) amount on the X12N 837 Version 4010 When Submitting Medicare Secondary Payer (MSP) Claims

Effective October 16, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010) as adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), unless a one-year extension to comply with HIPAA version 4010 under the provisions of the Administrative Simplification Compliance Act is requested.

Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the OTAF amount. The OTAF amount is a payment (which is less than your charges) that you are obligated to accept or agreed to accept as payment in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare Program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

When physicians and suppliers migrate to the X12N 4010 837, the line level contract information (CN1) segment must be used to report the OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102.

If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment as described above, as well as line level reporting using the line level CN1 segment. Furnish line level primary payer data, including the OTAF amount, when available.

The chart below identifies the segments and data elements physicians and suppliers must use to report: (1) the submitted charges, (2) the primary payer paid amount, (3) the primary payer allowed amount, and (4) the OTAF amount at the claim and the service line levels.

	837/3051	NSF	837 v 4010	Comments
Claim Total Submitted Charge	2-130-CLM02	XA0-12	2300 CLM02	Must be equal to the sum of the lines. If the lines do not equal, return the claim to the physician or supplier.
Claim Primary Payer Paid Amount	2-300-AMT02 AMT01 = D	DA1-14	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines do not equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2-300-AMT02 AMT01= B6	DA1-11	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines do not equal, return the claim to the physician or supplier.
Claim OTAF Amount			2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines do not equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2-370-SV102	FA0-13	2400 SV102	None
Line Primary Payer Paid Amount	2-475-AMT AMT01 = D	FA0-35	2430 SVD02	None
Line Primary Payer Allowed Amount	2-475-AMT02 AMT01= B6	FB0-06	2400 AMT02 AMT01 = AAE	If there is no value in the Allowed Amount field, use the value in the Approved Amount field.
Line OTAF	2-475-AMT02 AMT01=CT	FA0-48	2400 CN102 CN101 = 09	None

Previously released instructions concerning the 837 HIPAA version 4010 may be found in the following publications (also available on our provider Web site, *www.floridamedicare.com*):

EDI HIPAA Flyer July 1, 2001
First Quarter 2002 *Medicare B Update!* (page 76)
EDI Flyer November 26, 2001
Third Quarter 2002 *Medicare B Update!* (pages 63-64)

Source: CMS Transmittal B-02-025, CR 2007

Sulzer Inter-Op Acetabular Shell Recall Settlement with CMS

The Centers for Medicare & Medicaid Services (CMS) and Sulzer Orthopedics have resolved a dispute concerning the application of the Medicare Secondary Payer (MSP) laws to a Sulzer recall of certain Inter-Op acetabular shells for hip implants. This article summarizes the dispute and its resolution and provides guidance to physicians and other suppliers on the actions the physicians and other suppliers need to take as a result.

In December 2000, Sulzer Orthopedics recalled approximately 17,500 Inter-Op acetabular shells used in connection with hip implant procedures. Sulzer advised providers, physicians and recipients that it would cover the cost of "unreimbursed medical expenses" related to the monitoring and possible replacement of the hip implants and related services. The MSP laws preclude Medicare payment for services when payment has been made, or can reasonably be expected to be made, under a liability insurance policy or plan (including a plan of self-insurance). The CMS considered Sulzer's initial assurance of payment for "unreimbursed medical expenses" to constitute a "reasonable expectation of payment under a liability insurance policy or plan" and held that Sulzer (and its insurers) were the primary payers for these services. Sulzer disagreed and takes the position that it is not subject to recovery under the MSP provisions.

The CMS and Sulzer agreed to try to resolve the dispute through negotiation. The CMS asked its Medicare contractors to advise providers and suppliers to hold claims while it determined whether the claims should be sent to Sulzer or the appropriate Medicare contractor for processing. If a physician or other supplier did not wish to await such guidance from CMS, it could submit a paper claim with the annotation that the claim was related to the Sulzer recall. Such claims were to be held by the Medicare contractors until CMS determined whether Medicare should process the claims.

The CMS and Sulzer have reached a final settlement regarding the processing of claims related to medical services provided to Medicare beneficiaries in conjunction with a revision of a recalled Inter-Op acetabular shell. Under the settlement, Medicare will process any claims for such services and should not look to Sulzer, its liability insurance plans, the Sulzer Class Action Settlement, or the Medicare beneficiaries for repayment of any claims in connection with the hip implant devices. Other Medicare payment and coverage rules for these services will be applied. The CMS has further agreed that Medicare will consider there to exist "good cause" for failure to submit an assigned physician or other supplier claim within 1 year of the date of service but filed before November 30, 2002, if the supplier submits a hard copy claim and includes with the claim a signed statement that the services delineated on the claim were related to a revision of a Sulzer Inter-Op acetabular shell that was recalled in December 2000; and the delay in submitting the claim was attributable to CMS's advice to hold claims. Physicians and other suppliers are encouraged to submit claims related to the Sulzer recall as soon as possible.

If a physician or other supplier submits an initial claim to Medicare for primary payment and receives such primary payment, under the terms of the settlement, physicians or other suppliers may bill Sulzer for Medicare deductibles, Medicare coinsurance and services not covered by Medicare under applicable Medicare coverage guidelines. If a physician or other supplier receives a payment from Sulzer, its liability insurance plans or the Sulzer Class Action Settlement, it may not bill Medicare on a secondary payer basis.

Physicians and other suppliers who want to submit claims to Florida Medicare Part B should clearly mark "Sulzer Settlement" in the detail line and send them to:

Attention: Sulzer Settlement
Medicare Part B
P.O. Box 2078
Jacksonville, FL 32231-0048

Source: CMS Memorandum dated May 20, 2002

HOME HEALTH CONSOLIDATED BILLING

Procedures Subject to Home Health Consolidated Billing

With the publication of program memorandum (PM) AB-01-65 in April 2001, the Centers for Medicare & Medicaid Services (CMS) established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). That instruction indicated the lists would be updated annually, in conjunction with the overall annual HCPCS code set update.

Update Process to List of Codes

CMS has determined that more frequent updates of the HH consolidated billing code lists are necessary. This is to reflect the creation of temporary HCPCS codes ('K' codes) throughout the course of a year that may describe services subject to consolidated billing. For example, such codes may be created at the request of durable medical equipment regional carriers (DMERCs), to reflect new technologies or clarify coding in support of local medical review policies. To account for any mid-year coding changes, CMS will update the HH consolidated billing code lists as frequently as quarterly. Some quarters there may be no update, if no new codes need to be reflected.

As with previous updates, the new coding identified in each update will describe the same services that were used to determine the HH PPS payment rates. Additional services not reflected in the HH PPS rates will not be added by these updates.

Current Update

The current update is to reflect a new set of 'K' codes for ostomy supplies that were published in PM AB-02-001. The following new 'K' codes replace codes currently on the HH consolidated billing code list. Each deleted code in the list below is replaced by two new codes:

Deleted Code and Description	New Code and Description
A4370: Skin barrier paste per oz	K0561: Non-pectin based ostomy paste
	K0562: Pectin based ostomy paste
A4374: Skin barrier extended wear	K0563: Ext wear ost skn barr <4sq"
	K0564: Ext wear ost skn barr >4sq"
A4386: Ost skn barrier w flng ex wr	K0565: Ost skn barr w flng <4sq"
	K0566: Ost skn barr w flng >4sq"
A5061: Pouch drainable w barrier at	K0567: 1 pc drainable ost pouch
	K0568: 1 pc cnvx drainabl ost pouch
A5123: Skin barrier with flange	K0570: Ostomy skn barr w flng <4sq"
	K0571: Ostomy skn barr w flng >4sq"

The following new 'K' codes are added to the HH consolidated billing code list, without a replacement:

K0569: 2 pc drainable ost pouch
K0574: Ostomy pouch filter
K0575: Ost pouch rustle free mat
K0576: Ostomy pouch comfort panel
K0577: Ostomy pouch odor barrier
K0578: Urinary pouch faucet/drain
K0579: Ost pouch absorbent material
K0580: Ost pouch locking flange

CMS has determined that the following codes published in PM AB-02-001 are **not** subject to HH consolidated billing.

K0572 Non-waterproof tape
K0573 Waterproof tape

The resulting list of 207 non-routine supply codes that follows replaces the previous list of 194. The list of 194 codes was provided in PM AB-01-65 and modified by PM AB-01-128. The list of 69 therapy codes that are subject to HH consolidated billing is not affected by this update. These lists were published in the First Quarter 2002 *Medicare B Update!* (pages 80-81).

Non-Routine Supply Codes

A4212	A4335	A4371	A4396	A5063	A6154	A6221	A6247	A7505
A4310	A4338	A4372	A4397	A5071	A6196	A6222	A6248	A7506
A4311	A4340	A4373	A4398	A5072	A6197	A6223	A6251	A7507
A4312	A4344	A4375	A4399	A5073	A6198	A6224	A6252	A7508
A4313	A4346	A4376	A4400	A5081	A6199	A6228	A6253	A7509
A4314	A4347	A4377	A4402	A5082	A6200	A6229	A6254	K0561
A4315	A4348	A4378	A4404	A5093	A6201	A6230	A6255	K0562
A4316	A4351	A4379	A4421	A5102	A6202	A6231	A6256	K0563
A4319	A4352	A4380	A4455	A5105	A6203	A6232	A6257	K0564
A4320	A4353	A4381	A4460	A5112	A6204	A6233	A6258	K0565
A4321	A4354	A4382	A4462	A5113	A6205	A6234	A6259	K0566
A4322	A4355	A4383	A4481	A5114	A6206	A6235	A6261	K0567
A4323	A4356	A4384	A4622	A5119	A6207	A6236	A6262	K0568
A4324	A4357	A4385	A4623	A5121	A6208	A6237	A6266	K0569
A4325	A4358	A4387	A4625	A5122	A6209	A6238	A6402	K0570
A4326	A4359	A4388	A4626	A5126	A6210	A6239	A6403	K0571
A4327	A4361	A4389	A4649	A5131	A6211	A6240	A6404	K0574
A4328	A4362	A4390	A5051	A6010	A6212	A6241	A6405	K0575
A4330	A4364	A4391	A5052	A6020	A6213	A6242	A6406	K0576
A4331	A4365	A4392	A5053	A6021	A6214	A6243	A7501	K0577
A4332	A4367	A4393	A5054	A6022	A6215	A6244	A7502	K0578
A4333	A4368	A4394	A5055	A6023	A6219	A6245	A7503	K0579
A4334	A4369	A4395	A5062	A6024	A6220	A6246	A7504	K0580

Source: CMS Transmittal AB-02-092, CR 2247

SNF CONSOLIDATED BILLING

Consolidating Billing (CB) for Skilled Nursing Facilities (SNF)—Important Information for Physicians

On November 1, 2001, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 1764, Transmittal AB-01-159, which implemented a number of Common Working File (CWF) crossover duplicate edits effective April 1, 2002. The logic behind one of the edits (Edit 7256) was flawed, and it was disabled on April 15, 2002. Between April 1, 2002, and April 15, 2002, a number of services were incorrectly rejected by CWF and denied by carriers.

If CWF had already received a claim for a facility payment, it would then reject the physician service as a duplicate based on the beneficiary health insurance claim number, date of service, and procedure code. The CR did not instruct CWF to program the edit to distinguish between the facility claim and the physician claim in order to allow both to be payable.

Resolution for Claims Incorrectly Rejected by CWF Duplicate Crossover Edit 7256

Carriers will reprocess any of these services that have not been finalized. *To correctly process and pay for services denied between April 1, 2002, and April 15, 2002, the services must be resubmitted by the provider*.

Source: CMS memo to Medicare Fiscal Intermediaries and Carriers dated May 14, 2002.

GENERAL INFORMATION

New Source of Provider Information Available on CMS Web site

The Centers for Medicare & Medicaid Services (CMS) released the first issue of *The CMS Quarterly Provider Update* on April 22, 2002. Future issues will be released the first work day of each subsequent calendar quarter. These quarterly updates will include all changes to Medicare instructions that affect providers, or may be of interest to them. They will provide a single source for national Medicare provider information and give providers advance notice on upcoming instructions and regulations.

The first release is a Web-based document and is available at *http://www.cms.hhs.gov/providerupdate*. For ease of use by individual providers, regulations and instructions are collated and sorted based on the interests of the user. Each update will include the full text of instructions to be implemented 90 or more days after its release. For example, instructions included in the April update have an implementation date of July 1, 2002 or later. The listings of regulations will be presented in two parts. One part will list all regulations CMS plans to publish within the next 90 days. The second part will include hyperlinks to the text of all regulations published in the previous quarter.

CMS' goal is to make it easier for providers to understand and comply with Medicare regulations and instructions and to give them time to review and react to upcoming program changes. To improve future issues of the update and ensure they are responsive to provider needs, a feedback form will be included with each issue. CMS encourages anyone accessing the update to use the feedback form to forward comments on its utility, organization, and format.

Source: CMS Transmittal AB-02-049, CR 1868

Customer Service Changes

On March 8, 2002, Florida Medicare transitioned to the Multi-Carrier System. The new system includes several enhancements to our Integrated Voice Response (IVR) unit that have proven beneficial to our provider community. One major enhancement is the IVR can now release check information for the last three checks. Check status may also be obtained by using the check date or number. In addition, patient eligibility is available through the IVR. Therefore, we have made changes to the roles and responsibilities of our customer service associates.

Effective July 29, 2002, our service associates no longer release check status information or patient eligibility. This information must be obtained via the IVR. This will allow service representatives more time to handle issues related to Medicare guidelines and processing procedures. For more information on the IVR, please refer to the December 2001 *Medicare B Update!* Special Issue (page 12). The toll-free number for the IVR is (877) 847-4992.

Edits for Debridement Services Adjusted

The Common Working File (CWF) implemented edits effective April 1, 2002, that identify and reject claims for therapy services for skilled nursing facility (SNF) beneficiaries unless submitted by the SNF. An error has been identified in an edit that is causing valid claims to reject.

Debridement services are a type of wound care that may be provided by either therapists or physicians. A separate procedure code has been developed to describe the type of debridement typically performed by therapists. The codes for both physicians and therapists were mistakenly used when constructing the therapy edit. As a result, payable physician services are being rejected.

Effective July 1, 2002, CWF removed procedure codes 11040, 11041, 11042, 11043, and 11044 from the therapy code edit and add them as separately payable codes not subject to consolidated billing. Florida Medicare will reprocess any denied claims for services submitted on or after April 1, 2002, through June 30, 2002, with dates of service on or after April 1, 2001, through June 30, 2002, for beneficiaries in either a Part A covered SNF stay or a non-covered SNF stay. New claims submitted on or after July 1, 2002, will process correctly.

Source: CMS memorandum dated July 1, 2002

The Do Not Forward (DNF) Initiative—Using "Return Service Requested" Envelopes for Remittance Advice

Carriers are instructed in section 4021 of the Medicare Carriers Manual to use "return service requested" envelopes when mailing checks to providers and suppliers. When the post office returns a "return service requested" envelope to the carrier, no additional checks may be generated for that provider or supplier until a properly completed change of address form is sent to the carrier. Upon verifying the new address, the carrier can again generate checks for the provider or supplier.

Because some providers or suppliers are paid through electronic funds transfer (EFT), there may be cases where a provider or supplier does not have a correct address on file, but the carrier continues to pay the provider or supplier through EFT.

Effective October 1, 2002, carriers will use "return service requested" envelopes for hardcopy remittance advices, in addition to using them for hardcopy checks, with respect to providers or suppliers who have elected to receive hardcopy remittance advices. When the post office returns a remittance advice due to an incorrect address, no additional EFT payments may be generated for that provider or supplier until a properly completed change of address form is sent to the carrier.

Previously, in order to release payment to providers or suppliers identified under the DNF Initiative, corrections were required only for the "pay to" address. However, effective October 1, 2002, corrections to *all* addresses (mailing address, physical address, and "pay to" address) are required before the carrier can again pay these providers or suppliers. Therefore, Florida Medicare will not release any payments to providers or suppliers identified under DNF until all addresses for that provider's location are received on the appropriate Form CMS-855, verified, and updated by the Medicare Registration department.

Source: CMS Transmittal B-02-023, CR 2038

No Newsletters Will Be Printed Between July and September 2002

In an effort to save funds that will be used to help providers better understand the Health Insurance Portability and Accountability Act (HIPAA) via HIPAA-specific educational outreach events, pamphlets, etc., the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to discontinue printing and mailing any bulletins or newsletters scheduled for distribution between July 1, 2002, and September 30, 2002. This decision affects two publications First Coast Service Options, Inc. (FCSO), your Medicare carrier for Florida, has scheduled during this period. The Fourth Quarter 2002 *Medicare B Update!* is scheduled for distribution in mid August, and a Special Issue *Update!* is planned for the Final Update to the 2002 Medicare Physician Fee Schedule Database (MPFSDB). The MPFSDB Special Issue was expected to be released in late August.

FCSO will develop these materials and post them to our provider Web site (*www.floridamedicare.com*). However, these issues will *not* be available in hard copy format. The Fourth Quarter 2002 *Update!* will be posted to the Web site by August 8, 2002. The exact posting date of the MPFSDB Special Issue is dependent upon the date CMS releases the update to carriers; however, this issue should be posted no later than September 1, 2002.

To receive quick, automatic notification when new issues of the *Medicare B Update!* are posted to the Web site, subscribe to our *eNews* mailing list. It's very easy to do; simply go to our Web site, click on the yellow "Join our electronic mailing list" bar and follow the prompts.

In the event additional publications become necessary during this time, these too will only be posted to the Web site; *eNews* notifications of these postings will be sent.

Frequently Asked Questions

Q What do I do if I don't have Internet access? How am I to receive and know what is updated?

A Public libraries have PCs with Internet access available for anyone to use. Providers who do not have Internet access might consider asking a colleague who does for assistance.

Q What is the rationale for this change?

A Funds initially intended for contractors' general provider education and training activities, including hard copy publications, have been re-allocated to help providers better understand HIPAA, via HIPAA–specific educational outreach events, pamphlets, etc.

Q Is Medicare going to waive any changes in updates to allow processing?

A No. Providers will be responsible for the information posted to the Web site, as if it were published in hard copy format.

Q Will the First Quarter 2003 issue be published at its regular scheduled timeframe?

A At this time, we anticipate a return to the normal publication schedule. The First Quarter 2003 issue is scheduled to be provided at least 45 days prior to January 1, 2003. However, beginning with the First Quarter 2003 issue, full-text local medical review policies will be available *only* on the Internet. Hard copy publications will provide a summary of policies or policy changes, with a reference to the full-text on the Web site.

Q Is Medicare trying to put us out of business? I don't want to buy a PC.

A You don't have to purchase a PC, but you will need to have access to one, for example, at a library (refer to question 1). Providing publications only on the Web site is simply a more cost-effective delivery method for the Medicare Program, allowing more funds to be utilized for implementation of HIPAA (refer to question 2).

Q Can a Customer Service Representative go on the Web, print the article and fax or mail it to my office?

A No. At this time, we feel our CSRs can better serve the provider community by concentrating on responding to specific issues. Refer to question 1 for information on obtaining the *Update!* if you do not have Internet access.

Q Is there an easy way to know when Medicare has posted something new to the Web site?

A To receive quick, automatic notification when new issues of the *Medicare B Update!* (and other items of interest) are posted to the Web site, providers may subscribe to our *eNews* mailing list. It's very easy to do; simply go to the Web site, click on the yellow "Join our electronic mailing list" bar and follow the prompts.

Additional Changes to the Standard Paper Remittance (SPR) Advice Notice

Information was provided in the Third Quarter 2002 *Medicare B Update!* concerning changes to the SPR effective April 1, 2002 (pages 69-72). Since then, an additional change is being made. **Effective July 1, 2002**, "AMOUNTS PAID TO THE BENEFICIARY" and "MSP AMOUNT" will now be reported at the line level.

Medicare Payment Policy for Bad Debts for Physicians' Services Paid Under a Fee Schedule

There is no payment for bad debts (unrecovered costs attributable to uncollectible deductible and coinsurance arising from covered services to beneficiaries considered in calculating payment to providers reimbursed on the basis of reasonable cost) with respect to services paid under the Medicare physician fee schedule. Under a fee schedule, payment is not based on incurred costs; rather, payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific provider's cost outlay for a service and does not embody the concept of unrecovered cost. Bad debts are allowable only to an entity to which payment is made based on reasonable cost.

Source: MCM Section 15002;
CMS Transmittal 1753, CR 2126

Remittance Advice Coding and Health Insurance Portability and Accountability Act (HIPAA) Transaction 835v4010 Completion Update

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for healthcare as established by the Secretary of Health and Human Services.

The X12N 835 version 4010-implementation guide has been established as the standard for compliance for remittance advice transactions. The implementation guide for that format is available electronically at *http://www.wpc-edi.com/hipaa/HIPAA_40.asp*.

New and Revised Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. The list of remark codes is updated continuously as needed, and both Medicare and non-Medicare entities can request new codes or modifications in the existing codes to address their business needs.

The list of remark codes is available at *http://www.wpc-edi.com/Remittance_40.asp*. The list is updated each March, July, and November. The list may be downloaded from this Web site during those three months to obtain the most current set of approved remark codes.

The following list summarizes additions and modifications made to the remark codes through February 28, 2002.

M81 Modification

Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity

MA01 Modification
(Initial Part B determination, Medicare carrier or intermediary)—If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your 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 the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)

MA02 Modification
(Initial Medicare Part A Determination)—If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a Peer Review Organization (PRO) must be appealed to that PRO.

MA03 Modification
(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 6 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.

MA49 Modification
Missing/Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.

MA50 Modification
Missing/Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.

MA51 Modification
Missing/Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.

MA81 Modification
Our records indicate neither a physician or supplier or practitioner signature is on the claim or on file.

MA82 Modification
Did not complete or enter the correct physician/physician assistant/nurse practitioner/clinical nurse specialist/supplier's billing number/NPI and/or billing name, address, city, state, zip code, and phone number.

MA112 Modification
Our records indicate that the performing physician/physician assistant/clinical nurse specialist/certified registered nurse anesthetist/anesthesia assistant/supplier/nurse practitioner is a member of a group practice; however, you did not complete or enter enter accurately the group's name, address, zip code and their carrier assigned individual and group PINs.

MA126 New Code
Pancreas transplant not covered unless kidney transplant performed.

N23 Modification
Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.

N70 Modification
Home health consolidated billing and payment applies.

N71 Modification
Your unassigned claim for a drug or biological or clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.

N73 Modification
A SNF is responsible for payment of outside providers who furnish these services/supplies to residents. Only the professional component of physician services can be paid separately.

N95 New Code
This provider type may not bill this service.

N96 New Code
Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.

N97 New Code
Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.

N98 New Code
Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.

N99 New Code
Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

N100 New Code
PPS code corrected during adjudication.

N101 New Code
Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the Provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item 32 on the claim form. You may bill only one site of service provider number per claim.

N102 **New Code**
This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.

N103 **New Code**
Social Security records indicate that this beneficiary was a prisoner when this claim was submitted. Medicare does not cover items and services furnished to beneficiaries while they are incarcerated, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated.

N104 **New Code**
This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at *www.cms.gov*.

N105 **New Code**
This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.

N106 **New Code**
Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.

N107 **New Code**
Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.

N108 **New Code**
This item/service was denied because the upgrade information was invalid.

N109 **New Code**
This claim was chosen for complex review and was denied after reviewing the medical records.

N110 **New Code**
This facility is not certified for film mammography.

N111 **New Code**
No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

N112 **New Code**
This claim is excluded from your electronic remittance advice.

New Health Care Claim Adjustment Reason Codes

The committee that maintains the healthcare claim adjustment reason codes, a non-CMS body, meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at *http://www.wpc-edi.com/hipaa/*.

A reason code may be retired if determined to be duplicative or no longer applicable. These changes are always effective with a specified 835 future version, and never retroactively. Remark and reason code changes, other than retirements, are not version specific. The reason code committee has indicated that future updates will identify which code should be used in lieu of the retired code.

The committee did not approve any reason code changes in October 2001.

In February 2002, the committee determined that reason codes 16, 17, and 125 will have an additional sentence added to their current descriptions that reads: Additional information is supplied using the "Remittance Advice Remark Codes" whenever appropriate.

Source: CMS Transmittal AB-02-067, CR 1959

THE PATIENT FRIENDLY ADVISORY

Help Your Patients Pay for Prescriptions

Paying for prescription drugs may be a key concern for your patients. The Original Medicare Plan does not cover prescription drugs except in a few cases, like certain cancer drugs. Many Medicare + Choice plans and some Medigap policies cover prescription drugs, but often cap coverage at certain dollar limits.

As a healthcare provider, you want your patients to not only take the medication you prescribe for their health condition, but also to comply with directions for correctly using it. The high cost of prescriptions can deter patients from purchasing and using their medications as directed. Too often we hear stories where a senior has chosen not to purchase an important medication due to cost, or purchased the prescription, but cut the dosage in half to make it last longer.

Help is available to assist people with Medicare to pay for their prescriptions. To help your patients, access the **Prescription Drug Assistance Programs database** at *www.medicare.gov***.** This Web site provides information on programs that offer discounts or free medication including state prescription drug assistance programs, programs sponsored by pharmaceutical companies, and disease-specific programs. The Prescription Drug Assistance Program also provides information on drug benefits offered through Medicare managed care plans and Medigap policies.

In Florida, the **Medicare Prescription Discount Program** enables beneficiaries to obtain prescription drugs at lower costs. This program requires Florida pharmacies (more than 3,300) that accept Medicaid to guarantee a discount no greater than the average wholesale price of the medication minus 9%. A dispensing fee of $4.50 is added to the total. This discount is available to all Florida residents presenting a Medicare card, regardless of income. In some instances, your patient's current pharmacy may already charge a price below this amount. Discounts may vary from pharmacy to pharmacy when there is more than one manufacturer for the prescribed drug. Different pharmacies may not stock the drug from the same manufacturer. It is important that your patients shop for the best prices for the medications they take.

The **Pharmaceutical Expense Assistance Program (PAPS)** is limited to those individuals who qualify for both Medicare and Medicaid (QMB - Qualified Medicare Beneficiary, SLMB - Specified Low-income Medicare Beneficiary plans) and who are not currently receiving a pharmacy benefit. This monthly benefit is limited to $80 per program participant. Applicants must be age 65 or over, have an annual income between 90-120% of the federal poverty level, and be eligible for both Medicare and Medicaid. The participant will pay a required co-pay of 10% per prescription.

The delay of adding prescription coverage to the federal Medicare Program has sparked an interest by the pharmaceutical companies to create their own discounts. Several companies offer substantial discounts on the medications they produce. A couple of programs offer one discount card that covers several pharmaceutical companies all at once. **These programs require that recipients be enrolled in Medicare and meet certain income level**s.

For more information about prescription drug assistance programs in Florida and for a list of companies that have a discount program, go to *http://www.elderaffairs.state.fl.us/*. Click on the SHINE (Serving the Health Insurance Needs of Elders) link, and open the prescription drug assistance fact sheet. You or your patients can also call the Elder Helpline at 1-800-963-5337 and ask for a SHINE Insurance Counselor. For general Medicare information, call 1-800 MEDICARE (1-800-633-4227).

EDUCATIONAL RESOURCES

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.

This Expo is packed with everything needed to help optimize Medicare providers' performance and offers PWM information needed to make informed healthcare decisions. In commemoration of September 11, we will feature a "Celebration of Life" presentation. Come and join us for this exciting event.

When:	September 10 & 11, 2002
Where:	Radisson Mart Plaza Hotel 711 NW 72nd Avenue Miami, FL 33126 (305) 261-3800
Registration:	Complete the registration form and the class schedules and fax to: (904) 791-6035

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.

Registration Information

For your convenience, we have designated specific times for registration and check in. *Take advantage of early registration on September 9, 2002.*

Date	Registration Time
September 9, 2002	3:00 pm – 7:00 pm
September 10, 2002	7:30 am – 8:45 am
September 11, 2002	7:30 am – 8:45 am

Commemoration Ceremony

Join us as we celebrate the courage and heroism exhibited one year ago by our fellow Americans.

September 11, 2002 (Day 2)
9:00 am – 9:30 am
Celebration of Life

ULTIMATE MEDICARE EXPO CLASS SCHEDULE September 10 -11, 2002 (Days 1 & 2)

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

REGISTRANT'S NAME: _____ **PROVIDER #:** _____

IMPORTANT CLASS SCHEDULE INSTRUCTIONS

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)

REGISTRATION DEADLINE 08/26/02

September 10 - DAY 1

7:30 – 8:45
Registration Check-in/Vendor visitation

9:00 – 9:15
General Session (All UME attendees)

9:30 – 12:00

- CMS-1500/EMC Workshop (B)
- Data Analysis/Progressive Corrective Action Process (PCA) (B)
- Global Surgery/Advanced Modifiers (B)
- HIPAA Privacy (A/B)
- UB-92/Direct Data Entry (DDE) Workshop (A)

1:30 – 3:00

- Advanced Modifiers (A)
- Anesthesia/Pain Management (B)
- Fraud and Abuse (A/B)
- Reimbursement Efficiency (B)
- Vision (B)

3:30 – 5:00

- Dermatology (B)
- E & M Coding (/B)
- Medical Review (A/B)
- Medicare Secondary Payer (A)
- Skilled Nursing Facility (A)

September 11 - DAY 2

7:30 – 8:45
Registration Check-in/Vendor visitation

9:45 – 11:15

- HOPPS (A)
- Inquiries, Appeals, & Overpayments (B)
- Medicare Secondary Payer Workshop (B)
- Primary Care (B)
- Rehabilitation Services (A)

11:15 – 12:30
Interactive Session (All UME Attendees)
Topic: Advanced Beneficiary Notices

1:30 – 3:00

- E & M Documentation (B)
- HIPAA Administrative Simplification Compliance Act (ASCA) (A/B)
- Orthopedics (B)
- Partial Hospitalization Program (A)
- Reimbursement Efficiency (A)

(A) – Part A Course or Workshop
(B) – Part B Course or Workshop
(A/B) – Part A & B Course

ULTIMATE MEDICARE EXPO REGISTRATION FORM
September 10 & 11, 2002

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

FOUR EASY STEPS TO REGISTER

NOTE: ALL REGISTRATIONS MUST BE RECEIVED BY 8/26/02

1. Fax both registration form and class schedule(s) to **(904) 791-6035**
2. Make checks payable to: **FCSO Account #700390**
3. Mail the forms (after you have faxed them) and payment to:
   UME Seminar Registration
   PO Box 45157
   Jacksonville, Florida 32232-5157
4. Bring your UME Confirmation notice to the event

Registrant's Name _____

Provider's Name _____

Medicare Billing Provider # _____ Sender Number: _____

Street Address _____

City, State, ZIP Code _____

Phone ( ) _____ Fax ( ) _____ E-mail: _____

Payment is being issued for:

Seminar/Material **UME Course Materials will be distributed at the event (upon arrival)*	Quantity	Price (each)	Total
Ultimate Medicare Expo (UME) ***Note: UME Course Materials are not included.***	N/A	**$299.00**	
UME Part A Handbook on CD* *(see course descriptions for a list of the courses included)* *After event, deadline to order is October 1, 2002.*		$75.00	
UME Part B Handbook on CD* *(see course descriptions for a list of the courses included)* *After event, deadline to order is October 1, 2002.*		$75.00	
UME Individual Course Material* *(All individual course material are included in the Part A or Part B handbook. Therefore, you do not have to order in addition to the Part A & Part B handbook*: _____		$30.00	

Method of payment: The only acceptable forms of payment are checks and money orders. Cash and credit cards are **NOT ACCEPTABLE** forms of payment.

If your organization is tax exempt, a copy of the tax-exempt statement should be included with your registration. Materials purchased are taxable.

To secure your registration all payments must be received prior to the registration deadline of 8/26/02.

Check (#_____) Money Order

Subtotal:
Add 7% tax for materials only:
Total:

Important Registration Information:

Cancellations and Refunds	Substitutions	Confirmation Notice	Hotel Information
Cancellation requests must be received in writing 14 days prior to the event. No refunds will be issued after that time. All refunds are subject to a $35.00 cancellation fee per person. (Rain checks will not be issued for cancellations. Additionally, rain checks issued for previous seminars may not be applied towards this event)	If you are unable to attend, your company may send **one substitute** to take your place for the **entire seminar**. Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event. **Remember:** Registration must be informed of all changes in advance.	A confirmation notice will be faxed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Outreach), please contact us at (904) 791- 8600.	**Radisson Mart Plaza Hotel** **711 NW 72nd Ave.** **Miami, FL 33126** **(305) 261-3800**

For additional information, please visit our Web site at www.floridamedicare.com, *or call our registration hotline at (904) 791-8103.*

FLORIDA MEDICARE EDUCATION AND OUTREACH
MEDICARE PART B
RESOURCE MANUAL ORDER FORM

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

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, State, Zip Code	
Phone Number	( ) - **Extension:**
Fax Number	( ) -
E-Mail Address	

2. PLEASE INDICATE HOW MANY MANUALS YOU WOULD LIKE TO PURCHASE.

QUANTITY	TITLE	PRICE (EA.)	TOTAL
	Medicare Part B Resource Manual **Includes our most popular subjects:** Advance Beneficiary Notice; ARNP/PA Guidelines; CMS-1500 Claims Filing; Comprehensive Data Analysis (*formerly Focused Medical Review)*; CPT Coding; Electronic Media Claims; Evaluation and Management Documentation and Coding; Fraud and Abuse; Global Surgery; HIPAA-AS; How to Help Patients Understand Medicare; ICD-9-CM Coding; Inquiries, Appeals, and Overpayments; Medical Review; Medicare Part C; Medicare Secondary Payer; Primary Care; Provider Enrollment; and Reimbursement Efficiency	$80.00	$
		Sub-Total	$
		Add 7% Tax	$
		Total	$

3. PAYMENT INFORMATION

SEND YOUR PAYMENT	Submit the completed form with your check or money order: § *Payable to* **First Coast Service Options, Inc. #700390** § *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 11 Tower, P.O. Box 45157, Jacksonville, FL 32232-5157** ***Your order will be shipped within four to six weeks.***

CMS
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FLORIDA MEDICARE EDUCATION AND OUTREACH
MEDICARE PART B
INDIVIDUAL MODULE ORDER FORM

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

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, State, Zip Code	
Phone Number	( ) - **Extension:**
Fax Number	( ) -
E-Mail Address	

2. PLEASE INDICATE THE INDIVIDUAL MODULES YOU WANT BY CLEARLY PRINTING THEIR NAMES IN THE SPACE BELOW. EACH MODULE COSTS $35.00. ***(Modules followed by * are included in a resource manual)***

Advanced Modifiers	**Electronic Media Claims (EMC)***	**Mental Health Services**
Advance Beneficiary Notice*	**E/M Coding***	**Nephrology**
Ambulance Regulations	**E/M Documentation***	**Oncology**
Anesthesia	**Fraud and Abuse***	**Orthopedics**
ARNP/PA Guidelines*	**Global Surgery***	**Pathology**
Cardiology	**HIPAA-AS***	**Podiatry**
Chiropractic	**How to Help Patients Understand Medicare***	**Primary Care***
CMS-1500 Claims Filing*	**ICD-9-CM Coding***	**Provider Enrollment***
Comprehensive Data Analysis* (formerly Focused Medical Review)	**Inquiries, Appeals, & Overpayments***	**Radiology**
	Medical Review*	**Rehabilitation Services**
CPT Coding*	**Medicare Part C***	**Reimbursement Efficiency: Part B***
Dermatology	**Medicare Secondary Payer***	**Vision**

QUANTITY	TITLE	PRICE (EA.)	TOTAL
		$35.00	
.		**Sub-Total**	$
		Add 7% Tax	
		Total	$

3. PAYMENT INFORMTION

SEND YOUR PAYMENT	Submit the completed form with your check or money order: § *Payable to* **First Coast Service Options, Inc. #700390** § *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 11 Tower, P.O. Box 45157, Jacksonville, FL 32232-5157** ***Your order will be shipped within four to six weeks.***

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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 BCBSFL - FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
q	***Medicare B Update!*** **Subscription –** One copy of the *Update!*is sent free of charge to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the twelve months prior to the release of each issue. Nonprovider 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).	700395	$75.00
q	**2002 Fee Schedule –** One copy of the *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* is sent free of charge in mid-November to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the preceding six months. The Fee Schedule contains calendar year 2002 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2002. These items include the payment rates for injectable drugs, but *do not* include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Non provider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	$20.00

Subtotal $ _____

Tax (7%) $ _____

Total $ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

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

Note: The *Medicare B Update!* and *2002 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* are available **free of charge** online at *www.floridamedicare.com*.

Index to Fiscal Year 2002 *Medicare B Update!*

The following is an index of articles published in the *Medicare B Update!* beginning October, 2001 (including special issues). A comprehensive index covering all issues published since January 1997 is available on the Web site *www.floridamedicare.com*.

*** Signifies a SPECIAL ISSUE *UPDATE!***

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* Special Issue *Updates!*

*** Signifies a SPECIAL ISSUE *UPDATE!***

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 32232-5001

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 32231-4141

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 32231-0020

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

MISCELLANEOUS

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

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

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

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

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 32232-5087

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

For Seminar Registration Only (*not* toll-free)**:**
(904) 791-8103

EMC

Format Issues & Testing:
(904) 354-5977 option 5
Start-Up & Front-End Edits/Rejects:
(904) 791-8767 option 4
Electronic Funds Transfer
(904) 791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Marketing:
(904) 791-8767 option 4
New Installations:
(new electronic senders; change of address or phone number for senders):
(904) 791-8608
Help Desk:
(Confirmation/Transmission):
(904) 905-8880 option 1

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.cms.hhs.gov or *www.hcfa.gov*

BENEFICIARY

Florida
www.medicarefla.com

Centers for Medicare & Medicaid Services
www.medicare.gov

MEDICARE B UPDATE!

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

*** ATTENTION BILLING MANAGER***