

# Medicare B Update!

## Second Update to the 2002 Medicare Physician Fee Schedule Database

This special issue is to provide changes included in the second update to the 2002 Medicare Physician Fee Schedule Database (MPFSDB). *Unless otherwise noted*, these changes are effective for services rendered on or after January 1, 2002, processed on or after July 1, 2002.

### New Codes Effective for Services Performed on or After July 1, 2002

Information concerning coverage and billing for the diagnosis and treatment of peripheral neuropathy with loss of protective sensation in people with diabetes (HCPCS codes **G0245-G0247**) was published in the Third Quarter 2002 *Medicare B Update!* (pages 22-23).

Coverage and billing instructions for home prothrombin time international normalized ratio (INR) monitoring for anticoagulation management (HCPCS codes **G0248-G0250**) are provided in this issue on page 3.

Codes G0245-G0250 are carried on the MPFSDB with a status of "R" (Restricted coverage. Special coverage instructions apply.). Allowances for these new codes are listed below.

Code	Participating Fee Schedule			Nonparticipating Fee Schedule			Limiting Charge		
	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0245	59.72	63.50	66.23	56.73	60.33	62.92	65.24	69.37	72.36
	44.65	47.29	49.48	42.42	44.93	47.01	48.78	51.66	54.06 *
G0246	34.95	37.11	38.55	33.20	35.25	36.62	38.18	40.54	42.12
	22.62	23.85	24.84	21.49	22.66	23.60	24.71	26.06	27.14 *
G0247	38.77	41.69	43.89	36.83	39.61	41.70	42.36	45.55	47.95
	27.47	29.53	31.32	26.10	28.05	29.75	30.01	32.26	34.22 *
G0248	96.68	104.23	107.92	91.85	99.02	102.52	105.62	113.87	117.90
G0249	68.60	74.01	76.70	65.17	70.31	72.87	74.95	80.86	83.79
G0250	9.55	10.12	10.58	9.07	9.61	10.05	10.43	11.06	11.56

\* These amounts apply when service is performed in a facility setting.

Continued inside...

### Also in this issue:

New CLIA Waived Tests .....	2
Coverage and Billing for Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management .....	3
Notice of Interest Rate for Medicare Overpayments and Underpayments .....	3
2002 Gap-Filled Clinical Laboratory Procedure Fee .....	3



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

**Additional Changes Effective for Services Performed on or After April 1, 2002**

HCPCS code **G0251** (Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment) is added, and is carried on the MPFSDB with a status of "I" (Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services.).

HCPCS codes **Q3019** (ALS vehicle used, emergency transport, no ALS service furnished) and **Q3020** (ALS vehicle used, non-emergency transport, no ALS service furnished) are added for use by Ambulance suppliers. For more information, refer to the April 2002 Special Issue *Medicare B Update!* "Implementation of the Ambulance Fee Schedule," available free of charge online at [www.floridamedicare.com](http://www.floridamedicare.com).

**Policy Indicator Revisions**

The following changes are effective for services rendered on or after January 1, 2002, processed on or after July 1, 2002.

- The bilateral procedure indicator for *Current Procedural Terminology (CPT)* codes **19000, 19001, 19120, 19125, and 19290** has been changed to "0" (150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, payment is based for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.).
- The bilateral procedure indicator for *CPT* codes **37609 and 63030** has been changed to "1" (150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), payment is based for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code).
- The multiple procedure indicator for *CPT* code **50320** has been changed to "0" (No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.).
- The procedure status for *CPT* code **90887** has been changed to "B" (Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient)).

**Informational Clarifications**

*CPT* code **76085** (computer aided detection, screening) is identified as an add-on service that can only be used in conjunction with *CPT* code 76092 (screening mammogram). Because *CPT* code 76092 is not subject to the Part B deductible, code 76085 is also not subject to the Part B deductible.

In the 2001 MPFSDB the professional/technical component (PC/TC) indicator was inadvertently changed from a '1' to a '2' for *CPT* code **95824**, and the related professional and technical portions of this service were deleted. The PC/TC indicator has subsequently been changed back to a '1' and the professional and technical portions of *CPT* code 95824 have been reinstated, effective January 1, 2002.

Source: CMS Transmittal AB-02-058, CR 2161

**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 April 12, 2002. The *Current Procedural Terminology (CPT)* codes for these new tests must have the modifier QW to be recognized as a waived test.

- Forefront Diagnostics Drugfree@Home THC/COC Test Kit, Effective July 27, 2001, *CPT* code: 80101QW; and
- GDS Technology STAT-Site M<sub>Hgb</sub> Test System, Effective: February 11, 2002, *CPT* code: 85018QW

TEST NAME	MANUFACTURER	CPT CODE(S)	USE
Forefront Diagnostics Drugfree@Home COC Test Kit	Forefront Diagnostics, Inc.	80101QW	Screening test for the presence/detection of THC/cannabinoids (THC) and cocaine metabolites in urine
GDS Technology STAT-Site M <sub>Hgb</sub> Test System	GDS Technology	85018QW	Monitors hemoglobin level in blood

Source: CMS Transmittal AB-02-070, CR 2163

## Coverage and Billing for Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management

Use of the 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 prothrombin time compared to the mean prothrombin time for a group of normal individuals.

For services furnished 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.

### HCPCS Codes

- G0248 Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician, includes: demonstration use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results and documentation of a patient ability to perform testing.
- G0249 Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.
- G0250 Physician review; interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service).

### ICD-9-CM Diagnosis Code

V43.3 Organ or tissue replaced by other means; heart valve.

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

### Claims Requirements

This is a CLIA waived diagnostic test and it is not covered as durable medical equipment. Therefore, claims submitted to DMERCs will not be paid. Home INR monitoring is covered under the physician fee schedule. The cost of the device and supplies are included in the payment for G0249 and therefore, are not separately billable to Medicare. Additionally, G0250 should be billed no more than once every four weeks, since the code descriptor is per four tests.

Claims for home INR monitoring are to be submitted on health insurance claim Form CMS-1500 or electronic equivalent. Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge.

Source: CMS Transmittal AB-02-064, CR 2071

## Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR) or the current value of funds rate (5 percent for calendar year 2002). The Secretary of the Treasury has notified the Department of Health and Human Services that the PCR has been changed to **11.75 percent**, effective May 8, 2002. The notice of the PCR was published in the *Federal Register* (see Vol. 67, No. 89, dated May 8, 2002). Therefore, the PCR will remain in effect until a new rate change is published. For previous rates, please refer to the Third Quarter 2002 *Medicare B Update!* (page 66).

Source: CMS Transmittal AB-02-068, CR 1898

## 2002 Gap-Filled Clinical Laboratory Procedure Fee

The gap-filled fee for clinical laboratory procedure 82274 for 2002 is \$5.60 (all Florida localities).



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