Medicare B Update!
A Newsletter for Florida Medicare Part B Providers

New Format for Your *Medicare B Update!*

Connecticut and Florida Issues Will Be Combined

In an effort to better serve providers and suppliers in Connecticut and Florida, your Medicare carrier, First Coast Service Options, Inc. (FCSO), is changing your Medicare Part B publication. Beginning with the 2003 Healthcare Common Procedure Coding System (HCPCS) and Medicare Physician Fee Schedule Database (MPFSDB) Special Issue *Medicare B Update!* that will be published in late November 2002, Connecticut and Florida information will be provided in a single publication. Readers will continue to receive the same accurate, timely information as before; however, individual issues will no longer be produced for each state.

Clear Identification of State-Specific Content

Each article in the combined publication will clearly indicate whether the topic is applicable to both Connecticut and Florida, Connecticut only, or Florida only. Articles common to both states will appear at the beginning of the publication. Within common articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., will be state-specific as appropriate. Content specific to Connecticut will be next, followed by content specific to Florida. Connecticut and Florida local medical review policy (LMRP) summaries will be maintained in separate sections.

Publication Format

You will continue to see information presented in essentially the same format as before, but in four distinct sections.

The new *Update!* will begin with content applicable to both states, as noted above. Within this section, information will be categorized under the same headings with which you are familiar-claims, coverage/reimbursement, electronic media claims, and general information.

The two state-specific sections may include some or all of the above topics, dependent upon information being applicable to one site but not the other. Local and focused medical review will *always* be state-specific, as will educational resources.

Indexes to the year's previous issues of the *Update!* plus important addresses, phone numbers, and Web sites are listed for each state in the back of the publication.

We are excited about this consolidation, which will allow us to improve our publication and enhance other areas of provider education. We greatly appreciate your continued support!

Highlights In This Issue...

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

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 _____
  _____
  _____

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Vol. 16, No. 1
First Quarter 2003

Publications Staff
Bill Angel
Shari Bailey
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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:

Medicare Part B Publications
P.O. Box 45270
Jacksonville, FL 32232-5270

A Physician's Focus

"This and That"

Consolidation of Publications

This is the last Florida-only issue of the *Medicare B Update!* you will ever receive. Please note the cover article that announces the consolidation of our Florida and Connecticut Medicare publications. All future publications will contain information for providers in both states. The first combined publication will be the special issue for the 2003 HCPCS update, which you should receive in late November. The combined issue for the second quarter of 2003 will be organized into three basic sections. The first section will contain articles common to both states, the second, articles and policies that relate to Connecticut, and the third, articles and policies that relate to Florida. This consolidation will allow us to improve our publications and enhance other areas of provider education.

Noncoverage of Self-Administered Drugs

My last article was devoted to impending changes in Medicare noncoverage for drugs that are usually self-administered. These changes are a result of legislation intended to increase the number of drugs that could qualify as "not usually self-injected" and therefore, be covered by Medicare. For example, "Avonex" was noncovered under the old rules, but under the new rules *is* covered. 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." Our process and list of affected drugs are posted on our provider education Web site, *www.floridamedicare.com*.

There were few changes to the drugs we had already classified as "self-administered." Under the new rules, drugs that are usually self-administered for combined indications and routes of administration cannot be covered for any indication or route of administration. An example of this is insulin. Under the old rules, Medicare paid for insulin given intravenously to a patient for ketoacidosis in an emergency situation. Under the new rules, insulin cannot be covered for any outpatient administration, even if given intravenously in an emergency.

Clinical Trials and Investigational Device Exemptions (IDE)

Medicare usually does not cover investigational services. There are two exceptions: some Category B Investigational Devices are covered, and the routine services associated with "deemed" clinical trials are covered.

Category B Investigational Devices may receive coverage at the discretion of the local contractor. All services associated with providing IDE services must be billed with modifier QA attached to the procedure code. Likewise, all services billed for clinical trials must have modifier QV attached.

These modifiers apply to both Part A and B providers. Reviews of claims data indicate that many times modifiers are not used. This is inappropriate billing, which results in payment errors and may create repayment situations. All physicians engaged in investigational services are urged to review related articles published in the following issues of the *Medicare B Update!* which can also be found on our provider education Web site, *www.floridamedicare.com*:

Second Quarter 2001 (page 18)
Fourth Quarter 2001 (page 18)
Second Quarter 2002 (page 43)
Fourth Quarter 2002 (page 46)

And please remember to attach those modifiers.

Sincerely

Sidney R. Sewell, MD
Medical Director

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 2003	Mid-November 2002	January 1, 2003
Second Quarter 2003	Mid-February 2003	April 1, 2003
Third Quarter 2003	Mid-May 2003	July 1, 2003
Fourth Quarter 2003	Mid-August 2003	October 1, 2003

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 $70 (order form on page 46). 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.

Advance Beneficiary Notices (ABNs)

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. ABNs advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket, and to be more active participants in their own health care treatment decisions. An ABN must meet the following requirements:

- The ABN must be on an approved Form CMS-R-131 (see "New Patient Liability Notice" below)
- 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.
- The ABN should be maintained with the patient's medical record.

New Patient Liability Notice

Form CMS-R-131 is the new approved ABN, ***required for services provided on or after October 1, 2002***. Form CMS-R-131 was developed as part of the Centers for Medicare & Medicaid Services' (CMS) Beneficiary Notices Initiative (BNI), and was approved by OMB (Office of Management and Budget) on June 18, 2002. The new ABNs are designed to be more beneficiary-friendly, more readable and understandable, with patient options more clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users, following the guidance in CMS Program Memorandum (PM) AB-02-114.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI Web site at *www.cms.hhs.gov/medicare/bni*.

ABN Modifiers

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** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

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.

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

Annual Updating of ICD-9-CM Codes Must 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. Effective for claims processed on or after October 1, 2002, ICD-9-CM diagnosis codes must be processed using date of service instead of date of receipt.

Information concerning this change was communicated in the Fourth Quarter 2002 *Medicare B Update!* (page 13). Additional language has since been provided by the Centers for Medicare & Medicaid Services (CMS) regarding the ICD-9-CM grace period.

The 90-day grace period will still apply. Medicare carriers will accept old and new codes for dates of service October 1, 2002, through December 31, 2002. See the two examples below:

- Diagnosis code 771.8 is a valid code for dates of service prior to the release of the 2003 annual ICD-9-CM code update. (The ICD-9-CM update is effective each October 1.) With the 2003 update, it becomes a truncated diagnosis because more specific 5-digit codes have been created. Medicare will continue to correlate 771.8 for services performed prior to October 1, 2002. If correlated to services performed on or after October 1, 2002, (and the claim is submitted after the grace period) the claim will be returned as unprocessable, as the diagnosis was truncated at the time the service was performed.
- For claims submitted before January 1, 2003, with dates of service October 1, 2002 through December 31, 2002, providers may continue to report the 4-digit diagnosis code 771.8. This 3-month grace period is intended to give providers sufficient time to obtain and integrate the updated 2003 ICD-9-CM codes into their billing systems. If a claim is received on or after January 1, 2003, and 771.8 is correlated to a service performed on or after October 1, 2002, the claim will be returned as unprocessable.

This instruction does not change the number of diagnosis codes that are normally processed today (up to four in the header plus the line item).

Source: CMS Transmittal B-02-063, CR 2108

Item 32 of Form CMS-1500

Form CMS-1500 is the standard form providers use for submitting claims to Medicare Part B contractors. Effective for claims processed on or after October 1, 2002, the Medicare Carriers Manual (MCM) is revised to no longer allow "SAME" to be entered in Item 32 of Form CMS-1500 when the address is the same as in Item 33. Per Part 3, Section 4020.2 and Part 4, Section 2010.2 of the MCM, enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.

Providers of service (namely physicians) must identify the supplier's name, address, ZIP code and provider identification number (PIN) when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier. This item is completed whether the supplier personnel performs the work at the physician's office or at another location.

Source: CMS Transmittals 1751 and 26, CR 1658

Claims Delayed but Not Denied or Finalized

Since transitioning to the Multi-Carrier System (MCS), Florida Medicare has received a high volume of duplicate claims. Research reveals that in many cases, claims are re-filed before the initial claim finalized. The delay in finalization of the initial claim may be due to system issues that are being aggressively addressed.

Providers are encouraged to obtain claim status prior to re-filing. **Once it is determined that a claim has been accepted in our processing system, there is no need to re-file another claim. The re-filed claim will deny as a duplicate and the initial claim will continue processing to finalization.**

To minimize duplicate claim denials, please visit our provider education Web site at *www.floridamedicare.com* and refer to the MCS Issues Matrix in the Part B section to determine if potential system problems are causing your claim to be delayed.

Requirements for Reporting Dates–Paper Claims

As a reminder, if birth dates are furnished in Form CMS-1500 items 3, 9b, and 11a, these items *must* contain 8-digit birth dates. 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 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.

For more information concerning Form CMS-1500 completion requirements, refer to the Fourth Quarter 2002 *Medicare B Update!* (pages 6-11).

Correct Coding Initiative

Version 9.0 of the Correct Coding Initiative (CCI) will be implemented January 1, 2003, 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/correct_coding.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.

Source: CMS Transmittal B-02-058, CR 2309

COVERAGE/REIMBURSEMENT

DIABETIC SERVICES

Payment to Registered Dietitians for Diabetes Outpatient Self-Management Training (DSMT) Services

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DSMT when the services are furnished by a certified provider who meets certain quality standards. The DSMT program educates beneficiaries in successful self-management of diabetes. The program includes education about self-monitoring of blood glucose, diet and exercise, and an insulin treatment plan developed specifically for the patient who is insulin-dependent. The program also motivates patients towards self-management of their diabetes.

All suppliers and providers who may bill for other Medicare services or items and who represent a DSMT program accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Effective October 11, 2002, for services rendered on or after January 1, 2002, registered dietitians can be reimbursed for DSMT, providing all other DSMT requirements/certification are met.

Registered dietitians are eligible to bill on behalf of an entire DSMT program as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. Dietitians can be part of a multi-disciplinary team in the DSMT program.

DSMT, when billed by a registered dietitian, is payable at 85% of the Medicare Physician Fee Schedule amount, subject to coinsurance and deductible. Assignment is mandatory.

Prior to rendering services, registered dietitians must submit their DMST certificate to:

Medicare Registration–ADA
P.O. Box 2078
Jacksonville, FL 32231-0048

Registered dietitians should contact Florida Medicare if they have received denials of any claims submitted on behalf of a DSMT program.

Source: CMS Transmittal B-02-062, CR 2386

DIAGNOSTIC TESTS

ICD-9-CM Coding for Diagnostic Tests—Additional Instruction to Determine the Reason for the Test

An article based on the Centers for Medicare & Medicaid Services (CMS) transmittal AB-01-144, change request (CR) 1724 was published in the First Quarter 2002 *Medicare B Update!* (pages 9-12). Since that time, CMS has issued CR 2167, which updates the Medicare Carriers Manual with the information in CR 1724. However, CR 2167 includes language that provides additional instruction to determine the reason for the test.

The information that follows is in addition to that listed under "Instruction to Determine the Reason for the Test" on page 10 of the First Quarter 2002 *Update!*

- In the event the physician's interpretation of the test result is not clear or ambiguously stated in the patient's medical record, contact either the attending physician or the physician that performed the test for clarification. This may result in the reporting of symptoms or a confirmed diagnosis.
- If the test (i.e., lab test) has been performed and the results are back, but the patient's physician has not yet reviewed them to make a diagnosis, or there is no physician interpretation, then code the symptom or the diagnosis provided by the referring physician.
- In the event the individual responsible for reporting the codes for the testing facility or the physician's office does not have the report of the physician interpretation at the time of billing, the individual responsible for reporting the codes for the testing facility or the physician's office should code what they know at the time of billing. Sometimes reports of the physician's interpretation of diagnostic tests may not be available until several days later, which could result in delay of billing. Therefore, in such instances, the individual responsible for reporting the codes for the testing facility or the physician's office should code based on the information/reports available to them, or what they know, at the time of billing.

Source: CMS Transmittal 1769, CR 2167

Revised Guidelines for Purchased Diagnostic Tests and Purchased Interpretations of Diagnostic Tests

Sections 3060 and 15048 of the Medicare Carriers Manual (MCM) provide specific rules governing Medicare coverage of purchased diagnostic tests and purchased interpretations of such tests. The Centers for Medicare & Medicaid Services (CMS) recently issued Transmittal 1751 (Change Request 1658), which revises these sections of the MCM. **These revisions are effective October 1, 2002.**

Payment to Physician for Purchased Technical Component of Diagnostic Tests

A physician or a medical group may submit the claim and, if assignment is accepted, receive Part B payment for the technical component (modifier TC) of diagnostic tests which the physician or group purchased from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests, or may be a different physician or group. An example of the latter is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not mark up the charge for a test from the purchase price and must accept as full payment for the test (even if assignment is not accepted) the lowest of:

- The fee schedule amount if the supplier had billed directly,
- The physician's actual charge, or
- The supplier's net charge to the purchasing physician or group.

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare Program. No formal reassignment is necessary.

Billing Requirements:

- In item 24 (line 1), enter the *CPT*/HCPCS code with modifier TC in first modifier position with the charge for the technical component.
- In item 24 (line 2), enter the *CPT*/HCPCS code and modifier 26 with the charge for interpretation.
- In item 20, check the "Yes" box and enter the outsider supplier's charge.
- In item 32, enter the supplier's name, address, ZIP code, and provider number.

Payment to Supplier of Diagnostic Tests for Purchased Interpretations

A person or entity that provides diagnostic tests may submit the claim, and, if assignment is accepted, receive Part B payment, for diagnostic test interpretations which that person or entity purchased from an independent physician or medical group if:

- The tests are initiated by a physician or medical group that is independent of the person or entity providing

the tests and of the physician or medical group providing the interpretations.
- The physician or medical group providing the interpretations does not see the patient.
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare Program. No formal reassignment is necessary.

The purchaser must keep on file the name, the provider identification number, and address of the interpreting physician. The rules permitting claims by a facility or clinic for services of an independent contractor physician on the physical premises of the facility or clinic are set forth in MCM sections 3060.2 and 3060.3C.

Questionable Business Arrangements

There are two requirements for all diagnostic tests under section 1861(s)(3) of the Act, as implemented by 42 CFR 410.32 and MCM sections 15021 and 2070. The test must be ordered by the treating practitioner, and the test must be supervised by a physician.

However, attempts may be made to establish arrangements that continue to allow physicians to profit from other's work or by creating the appearance the physician has performed or supervised his/her technicians who are employed, contracted, or leased. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used, and hiring out their staff to the physicians to meet the supervision requirement. Such arrangements may constitute an attempt to circumvent the prohibition against marking up purchased diagnostic tests. Another arrangement to circumvent the purchased diagnostic service provision is for the ordering physician to reassign his/her payment for the interpretation of the test to the supplier. The supplier, in turn, bills for both the test and the interpretation and pays the ordering physician a fee for the interpretation. This arrangement violates section 1842(b)(6) of the Act, which prohibits Medicare from paying benefits due the person that furnished the service to any other person, subject to limited exceptions discussed in MCM section 3060.D. In addition, this arrangement could constitute a violation of section 1128 B (b) of the Act, which prohibits remuneration for referrals (i.e., kickbacks).

Violations of section 1128B (b) of the Act may subject the physician or supplier to criminal penalties or exclusion from the Medicare and Medicaid Programs. Illegal remuneration for referrals can be found even when the ordering physician performs some service for the remuneration.

Source: CMS Transmittal 1751, CR 1658

DRUGS AND BIOLOGICALS

Medicare Payment Allowance for Injectable Drugs

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

The quarterly drug update was installed in the Florida Medicare processing system from October 2, 2002 through October 11, 2002. This update is effective for services rendered on or after January 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
A9500	117.85	111.96	J0630	38.41	36.49	J1056	25.64	24.36
A9502	115.92	110.12	J0640	17.47	16.60	J1060	4.42	4.20
A9504	460.00	437.00	J0670	1.99	1.89	J1070	5.15	4.89
A9505	41.82	39.73	J0692	8.13	7.72	J1110	30.29	28.78
A9507	2122.90	2016.76	J0702	3.89	3.70	J1165	0.64	0.61
A9508	48.00	45.60	J0706	3.24	3.08	J1170	1.04	0.99
A9510	55.20	52.44	J0715	5.41	5.14	J1180	9.01	8.56
A9600	933.00	886.35	J0720	10.13	9.62	J1190	226.08	214.78
A9605	987.79	938.40	J0725	3.40	3.23	J1205	10.49	9.97
J0130	513.02	487.37	J0735	55.16	52.40	J1250	9.38	8.91
J0151	223.19	212.03	J0744	13.69	13.01	J1260	17.81	16.92
J0205	37.53	35.65	J0760	7.07	6.72	J1320	2.41	2.29
J0282	20.09	19.09	J0770	54.15	51.44	J1325	18.06	17.16
J0285	14.59	13.86	J0895	14.81	14.07	J1327	15.39	14.62
J0290	2.04	1.94	J0900	1.64	1.56	J1390	1.29	1.23
J0330	0.13	0.12	J0945	0.95	0.90	J1440	185.90	176.60
J0390	19.69	18.71	J1000	0.84	0.80	J1441	314.07	298.37
J0456	24.68	23.45	J1020	2.54	2.41	J1565	827.50	786.13
J0585	4.66	4.43	J1030	4.63	4.40	J1590	0.91	0.86
J0587	8.79	8.35	J1050	35.44	33.67	J1600	13.51	12.83

Code	PAR	NONPAR
J1610	45.60	43.32
J1620	201.98	191.88
J1630	7.22	6.86
J1631	26.70	25.37
J1645	15.44	14.67
J1650	5.53	5.25
J1655	3.82	3.63
J1720	2.03	1.93
J1730	122.95	116.80
J1742	261.82	248.73
J1790	2.46	2.34
J1820	5.14	4.88
J1825	234.00	222.30
J1850	0.49	0.47
J1910	14.92	14.17
J1950	508.48	483.06
J1956	17.39	16.52
J1960	3.76	3.57
J1980	8.23	7.82
J2010	3.31	3.14
J2020	38.33	36.41
J2060	3.14	2.98
J2150	2.96	2.81
J2175	0.72	0.68
J2180	4.61	4.38
J2210	3.88	3.69
J2260	22.59	21.46
J2270	0.67	0.64
J2352	154.45	146.73
J2370	2.13	2.02
J2405	6.09	5.79
J2430	265.87	252.58
J2440	3.56	3.38
J2540	0.34	0.32
J2545	109.08	103.63
J2550	0.57	0.54
J2590	0.56	0.53
J2650	0.69	0.66
J2680	13.68	13.00
J2700	0.80	0.76
J2710	0.61	0.58
J2720	1.01	0.96
J2725	24.40	23.18
J2730	102.96	97.81
J2760	32.59	30.96
J2765	1.53	1.45
J2770	105.12	99.86
J2792	20.55	19.52
J2795	0.16	0.15
J2950	0.39	0.37
J2995	93.20	88.54
J2997	35.63	33.85
J3030	50.60	48.07
J3070	4.00	3.80
J3140	0.44	0.42
J3240	566.68	538.35
J3245	462.16	439.05
J3250	1.55	1.47
J3265	2.53	2.40
J3280	4.97	4.72
J3302	0.27	0.26
J3303	1.00	0.95
J3320	26.80	25.46
J3365	511.50	485.93
J3475	0.29	0.28
J3485	1.01	0.96
J7040	9.71	9.22
J7190	0.88	0.88
J7191	2.04	2.04
J7192	1.26	1.26
J7194	0.37	0.37
J7198	1.47	1.47
J7308	100.94	95.89
J7330	15162.00	14403.90
J7340	31.53	29.95
J7500	1.25	1.25
J7502	5.22	4.96
J7507	3.15	2.99
J7508	15.75	14.96
J7509	0.50	0.50
J7510	0.04	0.04
J7513	425.11	403.85
J7515	1.38	1.31
J7516	26.40	25.08
J7517	2.68	2.55
J7520	7.13	6.77
J7525	118.80	112.86
J8510	1.99	1.89
J8520	2.95	2.80
J8521	9.82	9.33
J8560	45.26	43.00
J8600	2.38	2.26
J8610	3.41	3.24
J9000	29.31	27.84
J9001	378.34	359.42
J9045	135.97	129.17
J9060	42.47	40.35
J9062	212.32	201.70
J9065	53.39	50.72
J9070	5.98	5.68
J9090	23.81	22.62
J9092	95.27	90.51
J9093	5.98	5.68
J9094	11.64	11.06
J9096	48.86	46.42
J9097	97.75	92.86
J9100	6.27	5.96
J9110	25.52	24.24
J9120	13.87	13.18
J9140	22.45	21.33
J9150	80.33	76.31
J9160	1210.30	1149.79
J9170	328.36	311.94
J9180	719.78	683.79
J9181	10.45	9.93
J9182	104.50	99.28
J9185	326.69	310.36
J9190	3.04	2.89
J9200	136.04	129.24
J9201	121.01	114.96
J9206	151.81	144.22
J9208	150.38	142.86
J9209	33.21	31.55
J9212	4.10	3.90
J9214	13.50	12.83
J9230	12.01	11.41
J9245	416.77	395.93
J9260	4.75	4.51
J9265	163.12	154.96
J9266	1427.38	1356.01
J9270	93.80	89.11
J9280	121.65	115.57
J9290	413.29	392.63
J9300	2101.88	1996.79
J9320	136.71	129.87
J9340	116.97	111.12
J9350	729.76	693.27
J9355	54.94	52.19
J9360	2.79	2.65
J9380	136.37	129.55
J9600	2603.67	2473.49
Q0136	12.79	12.15
Q2008	1.09	1.04
Q2009	9.84	9.35
Q2010	33.67	31.99
Q2011	1.03	0.98
Q2013	15.11	14.35
Q2014	15.78	14.99
Q2017	240.63	228.60
Q2018	62.07	58.97
Q2021	131.96	125.36
Q3002	28.21	26.80
Q3003	391.23	371.67
Q3004	29.94	28.44
Q3007	105.27	100.01
Q3011	162.53	154.40
Q3030	142.50	135.38
Q9920	12.79	12.15
Q9921	12.79	12.15
Q9922	12.79	12.15
Q9923	12.79	12.15
Q9924	12.79	12.15
Q9925	12.79	12.15
Q9926	12.79	12.15
Q9927	12.79	12.15
Q9928	12.79	12.15
Q9929	12.79	12.15
Q9930	12.79	12.15
Q9931	12.79	12.15
Q9932	12.79	12.15
Q9933	12.79	12.15
Q9934	12.79	12.15
Q9935	12.79	12.15
Q9936	12.79	12.15
Q9937	12.79	12.15
Q9938	12.79	12.15
Q9939	12.79	12.15
Q9940	12.79	12.15
90375	72.85	69.21
90378	712.64	712.64
90657	4.01	4.01
90658	8.02	8.02
90659	8.02	8.02
90675	139.76	132.77
90703	8.32	7.90
90740	203.78	203.78
90743	55.76	55.76
90744	24.36	24.36
90746	68.38	68.38

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

Most claims for DMEPOS are processed by the durable medical equipment regional carriers (DMERCs). The DMERC that serves Florida is Palmetto Government Benefits Administrators (www.palmettogba.com) *The articles that follow are intended to provide information to those providers who bill to the DMERC, as well as to local carriers. For more information concerning contractor jurisdiction for a specific service, refer to the Third Quarter 2002* Medicare B Update! *(pages13-21).*

Billing Prosthetics and Orthotics - HCPCS Updates

The codes listed below were added to the Healthcare Common Procedure Coding System (HCPCS) effective October 1, 2002. These codes fall under the fee schedule category for prosthetics and orthotics, and replace codes L5660, L5662, L5663, and L5664, which are invalid for Medicare use effective October 1, 2002.

Code	Descriptor
K0556	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
K0557	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
K0558	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)
K0559	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)

In addition, suppliers may be inappropriately billing socket design codes L5647 (for a below knee prosthesis) and L5652 (for an above knee prosthesis) each time a replacement socket insert (codes L5660, L5662, L5663, or L5664) is furnished. The socket design code (L5647 or L5652) should only be billed at the time the initial prosthesis is furnished to the patient, and not every time a replacement socket insert is furnished. Suppliers billing in such a manner should discontinue this practice immediately.

Source: CMS Transmittal AB-02-104, CR 2245

Durable Medical Equipment Ordered with Surrogate Unique Physician Identification Numbers (UPIN)

Section 1833(q) of the Social Security Act requires that all physicians who meet the section 1861(r) definition of a physician must have a UPIN. All claims for services ordered or referred by a physician must include the name and UPIN of the ordering/referring physician.

A physician or supplier who bills Medicare for a service or item must show the name and UPIN of the ordering/referring physician on the claim form, if that service or item was the result of an order or referral from a physician. If the ordering physician is also the performing physician, the physician must enter his/her name and assigned UPIN as the ordering physician. If the ordering/referring physician is not assigned a UPIN, the biller may use a surrogate UPIN.

A physician or supplier who submits a claim for a service or item is responsible for ensuring that the name and UPIN of the ordering/referring physician is obtained and submitted on Form CMS-1500. Physician names and UPINs can be found in the UPIN directory. If the physician's UPIN has not yet been issued, a surrogate UPIN is to be used only until an individual UPIN has been assigned. Surrogate UPINs are used under these conditions:

- **OTH000**: To be used when the ordering/referring physician has not yet been assigned and does not qualify for one of the other surrogate UPINs. When OTH000 is used, ensure that it is not being over utilized. Notify the suppliers, physicians, or billers if their use of surrogates is excessive. If surrogate UPINs are over utilized, the Part B contractor via the UPIN Registry will confirm that a UPIN has not been assigned to the ordering/referring physician. If a UPIN has been assigned, the physician will be notified of the assigned UPIN. If a UPIN has not been assigned, the physician will be notified of the need to file an application for a UPIN and sent an application form.
- **RES000**: To be used by physicians meeting the description of "intern," "resident," or "fellow."
- **VAD000**: To be used by physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs.
- **PHS000**: To be used by physicians serving in the Public Health Service, including the Indian Health Service.
- **RET000**: To be used by retired physicians who have not been issued a UPIN. (Retired physicians who have been assigned a UPIN must use the assigned UPIN.)

It is a goal of the Centers for Medicare & Medicaid Services (CMS) to assign a UPIN to every physician/health care practitioner and group practice that meets the Medicare definition.

Source: CMS Transmittal AB-02-125, CR 2268

Change in Jurisdiction for Topical Hyperbaric Oxygen Chamber

Effective for dates of service on or after January 1, 2003, jurisdiction for processing claims for code A4575 (Topical hyperbaric oxygen chamber, disposable) will change from local carriers to durable medical equipment regional carriers (DMERCs).

Source: CMS Transmittal B-02-044, CR 2177

LABORATORY/PATHOLOGY

Claims Processing Requirements for Clinical Diagnostic Laboratory Services Based on the Negotiated Rulemaking

The Centers for Medicare & Medicaid (CMS) recently issued Program Memorandum (PM) AB-02-129 that provides instructions on how providers should bill the date of service for specimen collection. Additionally, this PM provides clarification to providers on diagnosis to procedure guidelines and clarification of the use of the term "screening" or "screen."

Policy Guidelines

These changes are **effective for services furnished on or after November 25, 2002**, and apply to every diagnostic clinical laboratory service payable under Medicare Part B. Neither the place where the service was performed, nor the type of contractor that will process the request for payment has any effect on the applicability of these policies. A clinical laboratory service done in a hospital laboratory, independent laboratory, physician/practitioner office laboratory, or other type of CLIA (Clinical Laboratory Improvement Amendment) approved laboratory service is subject to these administrative policies.

This instruction does not affect the requirement that all physician claims must have a diagnosis. If a physician submits a claim for a service performed in a physician office laboratory, that claim is considered a physician claim and must meet the requirements for physician claims. In addition, claims for laboratory services that may be denied for reasons of medical necessity should be submitted with modifier GA, GZ, or GY, as appropriate.

Implementation Guidelines for Date of Service Requirement

Effective for diagnostic clinical laboratory services collected on and after November 25, 2002, **the provider of service must report the date of service based on the date the specimen was collected.** Providers should not report the date of service when the specimen was processed. Additional date of service requirements are provided below:

- **Date of service must be reported as the date of specimen collection.**
- The person obtaining the specimen must furnish the date of collection for the specimen to the entity billing Medicare.
- For specimen collections that span more than a 24-hour period, the date of service should be reported as the date the collection began.
- For laboratory tests that require a specimen from stored collections, the date of service must be defined as the date the specimen was obtained from the archives.

Grace Period

Effective November 25, 2002, Medicare will consider granting a grace period for the date of service requirement of up to 12 months (for claims with dates of service on or after November 25, 2002) to accommodate any provider system changes required by the policy changes or clarifications resulting from the provisions of this rule.

Entities that want to request a grace period to permit additional time to implement computerized system changes must send a request in writing on or before November 25, 2002 to the following address:

Medicare Part B Customer Service Operations
Attn: CDL Approval—6C
P. O. Box 2078
Jacksonville, FL 32231-0048

The request for a grace period *must* include all five documentation elements to be considered:

1. A description of the nature of the system changes not able to be implemented timely.
2. A description of the actions the entity has taken to implement timely.
3. A work plan with a timeline providing a detailed description of the tasks that the entity shall undertake to accomplish full implementation.
4. The dates when tasks shall be performed.
5. The date that the entity will be able to implement fully.

Medicare will review the information submitted and respond to the requester advising the revised implementation date. If an entity requests and is granted a grace period, and then does not meet the requirements as outlined in their extension request, subsequent claims will be returned as unprocessable.

Matching of Diagnosis to Procedure

If there is local medical review policy (LMRP) or national coverage determination (NCD) for one or more diagnostic clinical laboratory services submitted on a claim, the claim will be reviewed based on *all* diagnosis codes submitted for making a medical necessity determination.

> **Note**: Even though a claim matches diagnosis to procedure in accordance with an NCD, other rules of adjudication may apply (e.g., utilization parameters), which could result in denial.

Physicians who submit claims for tests done in a physician office laboratory are still subject to the requirement for an ICD-9-CM diagnosis on a claim.

Clarification of the Use of the Term "Screening" or "Screen"

The final rule clarifies that effective February 21, 2002, the use of the term "screening" or "screen" in *CPT* code descriptor does not necessarily describe a test performed in the absence of signs and symptoms of illness, disease, or condition.

Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered except when there is a statutory provision that explicitly covers a tests for screening as described.

If a person is tested to rule out or to confirm a suspected diagnosis because the patient has signs and/or symptoms, this is considered a diagnostic test, not a screening test. The Medicare contractor has discretionary authority to make reasonable and necessary scope of benefit determinations.

Source: CMS Transmittal AB-02-129, CR 2169

Questions and Answers Related to Implementation of National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services

The Centers for Medicare & Medicaid Services (CMS) recently issued Program Memoranda (PM) AB-02-087 and AB-02-110 to provide instructions related to implementation of 23 NCDs for clinical diagnostic laboratory services established under negotiated rulemaking published in the *Federal Register* on November 23, 2001 (66 FR 58788). These PMs are available on the CMS Web site at *http://cms.hhs.gov/manuals/memos/comm_date_dsc.asp*.

CMS awarded a contract to Computer Sciences Corporation (CSC) to develop diagnosis-to-procedure edit tables to be used by each shared system to process claims for these services covered by the 23 NCDs, similar to the procedure-to-procedure editing performed by the Correct Coding Edits Initiative (CCI). This will ensure services covered by the 23 NCDs are processed consistently, no matter which contractor processes the claim(s). The complete NCDs covering the following services may be found in PM AB-02-110:

- Culture, Bacterial, Urine
- Human Immunodeficiency Virus Testing (Prognosis including monitoring)
- Human Immunodeficiency Virus Testing (Diagnosis)
- Blood Counts
- Partial Thromboplastin Time
- Prothrombin Time
- Serum Iron Studies
- Collagen Crosslinks, Any Method
- Blood Glucose Testing
- Glycated Hemoglobin/ Glycated Protein
- Thyroid Testing
- Lipids
- Digoxin Therapeutic Drug Assay
- Alpha-fetoprotein
- Carcinoembryonic Antigen
- Human Chorionic Gonadotropin
- Tumor Antigen by Immunoassay - CA125
- Tumor Antigen by Immunoassay CA 15-3/CA 27.29
- Tumor Antigen by Immunoassay CA 19-9
- Prostate Specific Antigen
- Gamma Glutamyl Transferase
- Hepatitis Panel/Acute Hepatitis Panel
- Fecal Occult Blood

Since publication of these PMs, CMS has received numerous questions related to implementation of the NCDs. The questions and answers below are to clarify information in the PMs:

Q The NCDs become effective on November 25, 2002. How is this applied?

A The effective date of the NCDs is for services furnished on or after November 25, 2002. The NCDs will be applied on a date of service basis.

Q Since implementation of the system edits to apply the NCDs will be delayed until January 1, 2003, should laboratories hold claims with dates of service on or after November 25, 2002 until then?

A No, it is not necessary for laboratories to hold claims until January 1, 2003. Medicare claims processing contractors have been instructed to review their local medical review policies (LMRP) to ensure that they do not conflict with the NCDs by November 25, 2002. If there is no conflicting LMRP for the test in your area, the claim should not be edited, and in most cases, will be paid. Laboratories should identify claims that are not appropriate for payment under the new NCDs by using the GA, GZ, or GY modifiers, as appropriate. Contractors may conduct postpayment review of laboratory claims that are subject to the NCDs to ensure appropriate payment. As a result, erroneously paid claims may be adjusted and erroneous payments may be recovered.

Q PM AB-02-110 states that laboratories should use the GZ modifier for claims where the diagnosis is in the list of ICD-9-CM codes denied. The GZ modifier is for services that are not medically necessary. Is this the correct modifier?

A Most of the items in the list of ICD-9-CM codes denied are not covered for statutory reasons other than medical necessity. Labs should use the GY modifier for items that are not covered for reasons other than medical necessity. For items in the list of ICD-9-CM codes that do not support medical necessity, use the GA modifier for cases where an advance beneficiary notice (i.e., a waiver of liability statement) is on file or the GZ modifier when there is not an advance beneficiary notice on file.

Q The NCD for urine culture includes in the list of* CPT *codes tests that can be performed to identify bacteria for urine and other purposes. Specifically,* CPT *codes 87184 and 87186 are for sensitivity studies and are not specific to urine. Concern was raised with editing these* CPT *codes generally with the diagnosis listed in the covered list.

A It is true that *CPT* codes for sensitivity testing are not specific to urine. Editing of these *CPT* codes with the list of covered diagnosis is likely to result in inappropriate denial of these services when they are performed on specimens other than urine. The edit module will not edit for these *CPT* codes. Rather, they will return a "not applicable" response from the edit module. Contractors are free to edit these codes locally either on a prepayment or postpayment basis.

Q What happens to those codes not included in one of the three lists?

A Every single ICD-9-CM code falls into one of the three lists. Each of the 23 NCD policies has a section that states the codes covered for that policy, the codes denied for that policy, and the codes that (generally) do not support medical necessity. Two of the lists will list specific codes while the third list consists of a default category consisting of any ICD-9-CM codes not listed in the other two.

Q How will the edit module treat claims where the diagnosis is in the list of ICD-9-CM codes that do not support medical necessity?

A Some contractors have the ability to use an electronic indicator on the claims to show that there is documentation submitted with the claim. Where the indicator is not present, a deny response will be issued, unless the claim is accompanied by an override code. Where the indicator is present on the claim, the edit module will send back a suspend response. Contractors may not deny these suspend claims unless they have reviewed the documentation and made a determination that the documentation does not support medical necessity of the service. Contractors may pay suspend response claims without review of the documentation. In cases where the contractor does not currently have the capability to use an electronic documentation indicator, contractors should either instruct laboratories to submit claims hard copy or develop some other mechanism for the laboratories to notify the contractor that documentation should be associated with the claim. Contractors will then make a decision to either pay the claim without review of the documentation or review the documentation and make a decision based on the evidence supplied. If the decision is to pay the claim, the contractor should use the override code to indicate such so that the edit module will send a pass response. Claims sent to the edit module without the override indicator or the documentation indicator will receive a deny response. See the specifications for the edit module for additional information regarding the record layout for transmitting this information to the edit module and appropriate values.

Q How should contractors correct any claims that were denied in error due to failure to override the edit module?

A Contractors should reopen claims as authorized by the regulations.

Q How will the edit module handle multiple services with a date code that spans the effective date of the NCDs?

A If the through date of the claim is on or after the effective date, all services on the claim will be edited. In order to avoid claims being edited by the module inappropriately, a provider may split the claim into two bills—one for services prior to the effective date and one for services on or after the effective date. Carriers may also allow providers to split the services onto individual claim lines as well, if their systems allow the claims to be appropriately processed this way.

Q The laboratory final rule makes an exception to the date of service for specimens that have been stored. The date of service for stored specimens is the date the specimen is removed from archives. Sometimes, a laboratory may store a specimen for a day or two before testing. How long does a specimen need to be stored in order to qualify for this exception?

A The final rule did not define the period of time a specimen needs to be stored in order to qualify for this exception. In the absence of national instructions, contractors have the discretion to further clarify the criterion for this exception. The intent of the exception was to recognize long storage periods that occurred prior to testing. Contractors can address the exact length of time on an individual basis.

Source: CMS Transmittal AB-02-134, CR 2383

SURGERY

Coverage and Billing for Percutaneous Image-Guided Breast Biopsy

Percutaneous image-guided breast biopsy is a method of obtaining a breast biopsy through a percutaneous incision by employing image guidance systems. Image guidance systems may be either ultrasound or stereotactic. For services furnished on or after January 1, 2003, Medicare will cover percutaneous image-guided breast biopsy using stereotactic or ultrasound imaging for the following breast lesions:

- **Nonpalpable Breast Lesions** - These lesions are covered for a radiographic abnormality that is nonpalpable and is graded as a Breast Imaging Reporting and Data System (BIRADS) III (probably benign), IV (suspicious abnormality) or V (abnormality).
- **Palpable Breast Lesions** - Coverage also includes palpable lesions that are difficult to biopsy using palpation alone. Contractors have discretion to determine what types of palpable lesions are difficult to biopsy using palpation.

Applicable *CPT* Codes for Percutaneous Image-Guided Breast Biopsy

19102 [biopsy of breast;] percutaneous needle core, using imaging guidance
19103 percutaneous automated vacuum assisted or rotating biopsy device, using imaging guidance
10022 fine needle aspiration; with imaging guidance

Note: For imaging guidance performed in conjunction with *19102*, *19103* see codes *76095*, *76096*, *76360*, *76393* and *76942*.

Source: CMS Transmittal AB-02-128, CR 2232

Local and Focused Medical Review

This section of the *Medicare B Update!* features summaries of new and revised medical policies developed as a result of either 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 accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), full-text local medical review policies (LMRPs) no longer included in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs on our provider education Web site, *www.floridamedicare.com*. Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs; the date the LMRP is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, *www.floridamedicare.com;* click on the yellow "Join our electronic mailing list" bar and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP, contact Medical Policy at:

Medical Policy
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

Phone: (904) 791-8465

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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.

Local Medical Review Policy Reconsideration Process

The local medical review policy (LMRP) reconsideration process is a vehicle by which interested parties can request a revision to a Florida Medicare Part B LMRP. First Coast Service Options, Inc. (FCSO), the Florida Medicare carrier, will gladly consider all requests for LMRP reconsideration received from Medicare beneficiaries who reside (or receive care) in Florida, or from providers who do business in Florida. Additionally, Florida Medicare Part B will review requests received from other interested parties and, at its discretion, reconsider LMRPs based on such requests.

Individuals utilizing the LMRP reconsideration process can request the carrier modify any section of an existing LMRP. Generally, requests for policy modification will involve requests that information be added to an LMRP or that information be deleted from an LMRP. For example, one might request that changes be made to the "Indications and Limitations" section of an LMRP, or one might request that additional diagnoses be added to the "Diagnoses that Support Medical Necessity" section of an LMRP.

All LMRP reconsideration requests must be submitted in writing and must clearly state the specific revisions/modifications the requestor is seeking. Requests must include a justification supported by evidence, which may materially affect the policy's content or basis. Copies of published evidence (e.g., peer-reviewed medical literature, published studies, etc.) must be included with the revision request.

Once the carrier receives a written request for an LMRP reconsideration, the carrier will, within 30 days, determine if the request is valid (i.e., satisfies the requirements outlined above). If the request is invalid, Florida Medicare Part B will respond, in writing, to the requestor explaining why the request was invalid. If the request is valid, Florida Medicare Part B will, within 90 days, of the day the request was received, make a final LMRP reconsideration decision and notify the requestor of the decision along, with the rationale for the decision. Decisions made by Florida Medicare Part B may include one of the following:

- retirement of the policy
- no revision of the policy
- revision to a more restrictive policy, or
- revision to a less restrictive policy

If the decision is either to retire the LMRP or make no revision to the LMRP, then within 90 days of the day the request was received, Florida Medicare Part B will inform the requestor of its decision and the rationale for the decision. If the decision is to revise the LMRP, the normal process for LMRP development will be followed.

Requests for LMRP reconsideration should be sent to the following address, fax, or email:

First Coast Service Options, Inc., Medicare Part B
ATTN: Medical Policy Department, LMRP Reconsideration
P.O. Box 2078
Jacksonville, Florida 32231-0048

FAX: 904-791-8006

EMAIL: *medical.policy@fcso.com*

Note: the LMRP reconsideration process applies only to finalized, active, Florida Medicare Part B LMRPs. These LMRPs are posted to the Florida carrier's provider education Web site at *www.floridamedicare.com*. The LMRP Reconsideration Process does not apply to the following:

- National Coverage Decisions (NCD)*, coverage provisions in the Medicare Carriers Manual, Coverage Issues Manual, *Federal Register*, Code of Federal Regulations, etc. (*information concerning the process for requesting modification of a NCD can be found at *www.cms.hhs.gov/coverage/8a1.asp*)
- draft LMRPs
- template LMRPs
- retired LMRPs
- individual claim determinations
- bulletins, articles, or training materials, and
- any instance in which no LMRP exists (for example, a request to develop a LMRP)

Widespread Probe Reviews

Progressive Corrective Action (PCA) is a concept designed by the Centers for Medicare & Medicaid Services (CMS) for Medicare contractors to use when deploying resources and tools to conduct medical review activities. PCA ensures medical review activities are targeted at identified problem areas, and corrective actions imposed are appropriate for the severity of the infraction of Medicare rules and regulations.

The decision to conduct medical review will be driven by data analysis. Data analysis is the starting point in PCA to determine aberrancies in billing patterns that might suggest improper billing or payment. Based on in-depth data analysis, a widespread probe review (service-specific review) may be indicated to aid in the development of local medical review policy. A widespread probe review generally will not exceed 100 claims distributed among the identified provider universe. All providers subject to a widespread probe review will be notified in writing that a probe review is being conducted, and will be notified in writing of the results. Providers or facilities will be asked to provide all documentation applicable to the claims in question.

The widespread probe review process was developed according to guidelines found in CMS Program Memorandum AB-00-72, dated August 7, 2000.

2003 ICD-9-CM Coding Changes

The 2003 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2002. Updated diagnosis 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. All claims for services rendered on or after January 1, 2003 *must* be billed with the updated 2003 ICD-9-CM codes.

Please remember, 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 (see the Fourth Quarter 2002 *Medicare B Update!* [page 13]).

Florida Medicare has reviewed all Local Medical Review Policies (LMRPs) for procedure codes with specific diagnosis criteria that are affected by the 2003 ICD-9-CM update. The following table lists the LMRPs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2003 ICD-9-CM update:

2003 ICD-9 Part B LMRP Changes

LMRP Title	Publications Listing	2003 Changes
29540 Strapping	1st Quarter 2002 *Update* (page 41)	-Add 454.8 (Varicose veins of the lower extremities with other complications) for procedure code 29580
36470 Sclerotherapy of Varicose Veins	Jan/Feb 1999 *Update!* (page 19)	-Add 454.8 (Varicose veins of the lower extremities with other complications)
48554 Pancreas Transplantation	Jul/Aug 1999 *Update!* (page 26) Nov/Dec 1999 *Update!* (page 31)	-Remove "congestive" from the descriptors for 404.03, 404.13, and 404.93
70450 Computerized Tomography Scans	1st Quarter 2002 *Update!* (page 48) June 2001 Special Issue *Update!* page 16	-Add 765.20-765.29 (Weeks of gestation) for procedure codes 70450, 70460, and 70470 -Change 770.8 to 770.81-770.89 (Other respiratory problems after birth) for procedure codes 70450, 70460, and 70470 -Change 780.9 to 780.91-780.99 (Other general symptoms) for procedure codes 70450, 70460, and 70470
70551 Magnetic Resonance Imaging of the Brain	2nd Quarter 2001 *Update!* (page 69)	-Change 780.9 to 780.91-780.99 (Other general symptoms)
71010 Chest X-Ray	1st Quarter 2002 *Update!* (page 48) 1st Quarter 2001 *Update!* (page 66)	-Change 277.00-277.01 to 277.00-277.09 (Cystic fibrosis) -Remove "congestive" from the descriptors for 404.00-404.01, 404.03, 404.11, 404.13, 404.91, and 404.93
76075 Bone Mineral Density Studies	1st Quarter 2002 *Update!* (page 51)	-Change descriptor for 627.2 to read *Symptomatic* menopausal or female climacteric states
78460 Myocardial Perfusion Imaging	1st Quarter 2002 *Update!* (page 54)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) -Add 414.12 (Dissection of coronary artery) -Change descriptor for 428.0 to read Congestive heart failure, *unspecified* -Add 428.20-428.23 (Systolic heart failure), 428.30-428.33 (Diastolic heart failure), and 428.40-428.43 (Combined systolic and diastolic heart failure)
78472 Cardiac Blood Pool Imaging	1st Quarter 2002 *Update!* (page 56)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart)
80061 Lipid Profile/Cholesterol Testing	1st Quarter 2002 *Update!* (page 58) 3rd Quarter 2001 *Update!* (page 68) Jan/Feb 1999 *Update!* (page 30)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) -Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
82435 Chloride	2nd Quarter 2001 *Update!* (page 79)	-Change descriptor for 428.0 to read Congestive heart failure, *unspecified*

LMRP Title	Publications Listing	2003 Changes
82784 Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, each	Mar/Apr 1997 *Update!* (page 59)	-Change 414.0 to 414.00-414.06 (Coronary atherosclerosis)
82947 Blood Glucose Testing	3rd Quarter 2001 *Update!* (page 69)	-Change 357.8 to 357.81-357.89 (Other inflammatory and toxic neuropathy)
83735 Magnesium	Jul/Aug 2000 *Update!* (page 53) May/Jun 2000 *Update!* (page 42)	-Change descriptor for 428.0 to read Congestive heart failure, *unspecified*
84100 Serum Phosphorus	3rd Quarter 2002 *Update!* (page 54) 1st Quarter 2001 *Update!* (page 72)	-Remove "congestive" from the descriptors for 404.03 and 404.13
85007 Complete Blood Count	1st Quarter 2002 *Update!* (page 63) 4th Quarter 2001 *Update!* (page 61)	-Change 780.9 to 780.91-780.99 (Other general symptoms)
85610 Prothrombin Time (Postphlebetic syndrome)	Jul/Aug 1997 *Update!* (page 36) Oct 1996 Special Issue *Update* (page 36)	-Change 459.1 to 459.10-459.19
86706 Hepatitis B Surface Antibody and Surface Antigen	4th Quarter 2002 *Update!* (page 63)	-Remove "congestive" from the descriptors for 404.03 and 404.13
87621 Human Papillomavirus DNA Assay, Amplified Probe Technique	Jul/Aug 2000 *Update!* (page 53)	-Change 795.0 to 795.00-795.09 (Nonspecific abnormal Papanicolaou smear of cervix)
88141 Pap Smears	4th Quarter 2001 *Update!* (page 64)	-Change descriptor for 627.2 to read *Symptomatic* menopausal or female climacteric states -Change 795.0 to 795.00-795.09 (Nonspecific abnormal Papanicolaou smear of cervix)
92973 Interventional Cardiology	2nd Quarter 2002 *Update!* (page 20) 1st Quarter 2002 *Update!* (page 64)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) -*Change descriptor for diagnosis range 414.01-414.03 (Coronary atherosclerosis of native coronary artery, autologous and nonautologous biological bypass graft(s)) ***Not related to 2003 ICD-9-CM update**.
93000 Electrocardiography	4th Quarter 2002 *Update!* (page 68)	-Change 277.00-277.01 to 277.00-277.09 (Cystic fibrosis)
93224 Electrocardiographic Monitoring for 24 Hours (Holter Monitoring)	1st Quarter 2002 *Update!* (page 66)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart)
93303 Transthoracic and Doppler Echo-cardiography and Doppler Color Flow Velocity Mapping	4th Quarter 2001 *Update!* (page 71)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) for procedure codes 93307, 93308, 93320, 93321, and 93325 -Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart for procedure codes 93307, 93308, 93320, 93321, and 93325 -Remove "congestive" from the descriptors for 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 for procedure codes 93320, 93321, and 93325
93312 Transesophageal Echocardiogram	2nd Quarter 2001 *Update!* (page 90)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) -Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
93350 Stress Echocardiography	1st Quarter 2002 *Update!* (page 68)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) -Add 414.12 (Dissection of coronary artery) -Change descriptor for 428.0 to read Congestive heart failure, *unspecified* -Add 428.20-428.23 (Systolic heart failure), 428.30-428.33 (Diastolic heart failure), and 428.40-428.43 (Combined systolic and diastolic heart failure)

LMRP Title	Publications Listing	2003 Changes
93501 Cardiac Catheterization	1st Quarter 2002 *Update!* (page 70) Mar/Apr 2000 *Update!* (page 46)	-Remove "congestive" from the descriptors for 402.01, 402.11, and 402.91 for procedure codes 93526, 93527, 93528, and 93529
93701 Cardiac Output by Electrical Bioimpedance	2nd Quarter 2002 *Update!* (page 21) Nov/Dec 1999 *Update!* (page 29)	-Remove "congestive" from the descriptors for 402.11, 402.91, 404.11, 404.13, 404.91, and 404.93
93925 Duplex Scan of Lower Extremity Arteries	Sept/Oct 2000 *Update!* (page 22) Jan/Feb 1997 *Update!* (page 44)	-Add 823.40-823.42 (Torus fracture)
93965 Noninvasive Evaluation of Extremity Veins	2nd Quarter 2001 *Update!* (page 96) Jul/Aug 2000 *Update!* (page 59)	-Add 454.8 (Varicose veins of the lower extremities with other complications) -Change descriptor for 454.9 to read *Asymtomatic* varicose veins of lower extremities -Change 459.1 to 459.10-459.19 (Postphlebetic syndrome)
94760 Non-invasive Ear or Pulse Oximetry for Oxygen Saturation	4th Quarter 2002 *Update!* (page 77) Sept/Oct 2000 *Update!* (page 22) Mar/Apr 2000 *Update!* (page 48)	-Remove "congestive" from the descriptors for 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 -Change descriptor for 428.0 to read Congestive heart failure, *unspecified* -Add 428.20-428.23 (Systolic heart failure), 428.30-428.33 (Diastolic heart failure), and 428.40-428.43 (Combined systolic and diastolic heart failure)
94799 Pulmonary Rehabilitation Services	Sept/Oct 2000 *Update!* (page 22) Nov/Dec 1998 *Update!* (page 7) Jul/Aug 1998 *Update!* (page 58) Mar/Apr 1998 *Update!* (page 51)	-Change 277.00-277.01 to 277.00-277.09 (Cystic fibrosis)
95816 Electroencephalography (EEG)	2nd Quarter 2001 *Update!* (page 98)	-Change 780.9 to 780.91-780.99 (Other general symptoms) for procedure code 95819
A0425 Ground Ambulance Services	4th Quarter 2002 *Update!* (page 28)	-Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
A4644 Low Osmolar Contrast Media (LOCM)	Sept/Oct 2000 *Update!* (page 23) Jan/Feb 2000 *Update!* (page 30) Nov/Dec 1998 *Update!* (page 7) Jul/Aug 1998 *Update!* (page 44)	-Remove "congestive" from the descriptors for 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 404.00, 404.01, 404.03, 404.10, 404.11, 404.13, 404.90, 404.91, and 404.93 -Change descriptor for 428.0 to read Congestive heart failure, *unspecified*
G0030 Positron Emission Tomography (PET) Scan	2nd Quarter 2002 *Update!* (page 29)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) for procedure codes G0030-G0047
J0150 Adenosine (Adenocard, Adenoscan)	1st Quarter 2002 *Update!* (page 27)	-Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) for procedure codes J0150 and J0151 -Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart for procedure code J0151
J1561 Intravenous Immune Globulin	4th Quarter 2002 *Update!* (page 37) 3rd Quarter 2002 *Update!* (page 33)	-Change 357.8 to 357.81 (Chronic inflammatory demyelinating polyneuritis [CIDP])

Changes in Adjudication Procedures for Ambulance Claims

First Coast Service Options, Inc. (FCSO) recently conducted a review of appeals generated by medical review. Data showed that ambulance services account for a large volume of these appeals. This data, coupled with feedback from provider inquiries and recent changes in ambulance coding and fee schedules, has led FCSO to determine the most appropriate course of action would be to phase out current prepayment medical review adjudication procedures for ambulance services, with the exception of air ambulance and specialty care transportation. **This change is effective for services processed on or after July 31, 2002.**

In conjunction with this change, a shift in FCSO's medical review strategy for ambulance services will also occur. Local medical review policy (LMRP) for ambulance services related to coding for basic life support, advanced life support, and specialty care transportation will be developed. To clarify coverage, coding, and documentation expectations to the ambulance provider community, when the LMRP is finalized, FCSO will undertake an educational initiative, in partnership with the Florida Ambulance Association. Once this educational phase is completed, medical review will be initiated to targeted providers requiring additional education through the Progressive Corrective Action (PCA) process. For more information concerning PCA, please refer to the Third Quarter 2001 *Medicare B Update!* (page 35).

Ambulance suppliers should continue to submit claims according to current instructions; no change to your process is necessary. The medical review prepayment process for air and specialty care transport will not be affected by this change. Ambulance claims previously denied for lack of medical necessity must continue to be appealed through the normal review process.

Temporary Suspension of Utilization Screens for Laboratory Services

On May 29, 2002, First Coast Service Options, Inc. (FCSO) inactivated utilization screens for certain laboratory services while a study is conducted to determine effectiveness of these screens. This study was conducted between June 1, 2002, and approximately August 26, 2002. When analyzed, decisions will be made to reactivate the screens, reactivate the screens with modifications, or leave the screens inactivated. The decisions will be published in future issues of the *Medicare B Update!* and on the Web site *www.floridamedicare.com*.

Screens for the following laboratory services were inactivated:

- B12 (Cyanocobalamin)
- Parathormone
- Hepatitis B Antigen
- Ferritin
- Aluminum
- Calcium
- Iron
- Hepatitis B Antibody
- Phosphorus Inorganic
- Magnesium*

*__Note__: The screen for magnesium was not inactivated until July 12, 2002. FCSO has adjusted claims for magnesium services denied for overutilization between May 29, 2002, and July 12, 2002.

With the exception for magnesium noted above, providers must request reviews for claims denied for overutilization while the screens were active.

Intracoronary (Intravascular) Brachytherapy

Recurrent coronary stenosis is a major limitation of coronary stenting. One of the major causes of in-stent restenosis following coronary angioplasty is excessive neointimal formation, an exaggerated healing response to the balloon/stent injury to the coronary vessel that causes narrowing of the stented area. Intracoronary brachytherapy involves the application of radiation therapy in the management of in-stent restenosis of the coronary artery. The angiographic data at six to nine months show significant reductions in the restenosis rate (>50%) in patients treated with brachytherapy.

Delivery of intracoronary brachytherapy is performed by a multidisciplinary team consisting of a cardiologist, radiation therapist, and/or a medical physicist. The two major types of radiation utilized for intracoronary brachytherapy are beta and gamma radiation. Beta radiation emits electrons, which penetrate only a few millimeters and offers the advantage of a shorter treatment time (2-5 minutes) because of its higher energy, increased tissue absorption and shorter penetration that reduces radiation exposure to surrounding tissue and personnel. Gamma radiation emits photons that penetrate tissues deeply, offers the advantage of higher penetration and uniform delivery to all blood vessel layers, and is not shielded by stents. Gamma radiation is given for 15-20 minutes and requires medical personnel to leave the room to avoid exposure to radiation.

Currently there is no specific *CPT* or HCPCS code for intracoronary brachytherapy, therefore, the team involved with the planning and delivery of this technology will bill separately. The cardiologist is expected to bill *CPT* code 92974 (*transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy*) in addition to the primary procedure code (percutaneous transluminal coronary balloon angioplasty). The radiation therapy component will be billed by the radiation therapist utilizing procedure codes in the 77000 section of the *CPT*. These may include brachytherapy isodose calculation (codes 77326-77328) remote afterloading high intensity brachytherapy (codes 77781-77784), and other radiation treatment delivery services.

Based on the above information, Florida Medicare considers intracoronary (intravascular) brachytherapy medically reasonable and necessary for the treatment of in-stent restenosis of a native coronary artery when the FDA approved device is used according to the FDA approved labeling.

Oral Surgery: Widespread Probe Review Results

A widespread probe review was performed on procedure codes *70355 (Orthopantogram), 88305 (Level IV surgical pathology, gross and microscopic examination), 99203 (Office or other outpatient visit for the evaluation and management of a new patient…),* and *99213 (Office or other outpatient visit for the evaluation and management of an established patient…).* The results are as follows:

Procedure codes 70355, 88305, and 99213 were chosen for focused medical review for FY2001 based on the January through September 2001 data revealing a total of $977,207.03 was paid to specialty 19 (Dentist/Oral Surgery) for codes other than dental codes ("D" codes). Based on the conclusions of the findings, the performance of these services were considered a widespread problem, therefore, a recommendation to perform a widespread probe and a possible revision to the local medical review policy (LMRP) was made. A widespread probe of 104 claims from 18 providers for the period from July 1, 2001, to December 31, 2001, was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed and determine the medical conditions for which the services were being performed. The Dental LMRP, national coverage guidelines, and previous *Medicare B Update!* articles were used in reviewing the services.

Results of the review are as follows:

- 91 of the services were allowed as billed, and 13 services were denied. Of the denied services, eight were denied as noncovered services and five were denied as no documentation was received to support that the services were performed.
- 41% of the services billed were for orthopantogram (70355), 39% of the services billed were for evaluation and management services (99213), and 20% of the services billed were for surgical pathology (88305).
- The majority of the services billed by specialty 19 (oral surgery, dentist only) were covered services according to the guidelines in the Dental LMRP.

An article will be published in a future issue of the *Medicare B Update!* clarifying dental services and explain that any items or services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are noncovered per the Dental LMRP.

G0030: Positron Emission Tomography (PET) Scans

Policy Revision

The local medical review policy (LMRP) for PET scans has been revised to reflect information in CMS Program Memorandum AB-02-065.

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

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

J1561: Intravenous Immune Globulin (IVIG)

Policy Revision

The local medical review policy (LMRP) for IVIG has been revised to reflect information in CMS Program Memoranda AB-02-060 and AB-02-093, **effective for services processed on or after October 1, 2002**.

Intravenous immune globulin is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

The full-text of this LMRPis available on the provider education Web site *www.floridamedicare.com.*

J1745: Infliximab (Remicade™)

Policy Revision

The local medical review policy (LMRP) for Infliximab (Remicade™) was published in the Fourth Quarter 2001 *Medicare B Update!* (pages 39-40).

Effective for services processed on or after October 9, 2002, ICD-9-CM codes 696.0 (Psoriatic arthropathy) and 720.0 (Ankylosing spondylitis) have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

J9212: Interferon

Policy Revision

The local medical review policy (LMRP) for Interferon was published in the June 2001 *Medicare B Update! Special Issue* (pages 9-11). Since that time, the Centers for Medicare & Medicaid Services (CMS) Transmittal AB-02-072, CR 2200, indicated drugs delivered by intramuscular injection should be presumed to be *not* usually self-administered by the patient, and specifically named Avonex (J1825).

Therefore, **effective for dates of service on or after August 1, 2002**, HCPCS code J1825 has been removed from the "Indications and Limitations of Coverage and/or Medical Necessity" and "Reasons for Denials" sections of the LMRP for Interferon.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

J9999: Antineoplastic Drugs

Policy Revision

The local medical review policy (LMRP) for antineoplastic drugs was published in the First Quarter 2002 Medicare *B Update!* (pages 31-36). Since that time, several drugs in the policy have received additional indications based on literature evaluations and/or Compendia updates. Therefore, the LMRP has been revised to include the following indications, **effective for services processed on or after October 28, 2002**:

HCPCS Code/Descriptor/ICD-9-CM Code

J9170 Docetaxel-Pancreatic carcinoma (ICD-9-CM codes 157.0-157.9)
J9201 Gemcitabine-Testicular germ cell tumor (ICD-9-CM codes 186.0-186.9)
J9310 Rituximab-Idiopathic Thrombocytopenia Purpura (ICD-9-CM code 287.3)

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

NCSVCS: The List of Medicare Noncovered Services

Policy Revision

The List of Medicare Noncovered Services local medical review policy (LMRP) has been revised to reflect the deletion of procedure codes 82379 and J3520 from Local Noncoverage; the addition of procedure code 66999 to Local Noncoverage; and the addition of procedure codes 90882 and G0252 to National Noncoverage.

Local Noncoverage

Deletions

*82379** *Carnitine (total and free), quantitative, each specimen*

J3520 Edetate disodium, per 150 mg (chemical endarterectomy)

Additions

*66999** *Deep Sclerectomy with or without Collagen Implant*

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

National Noncoverage

Additions

90882 *Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.* (This service is already nationally noncovered by Medicare.)

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) (This service is nationally noncovered per CMS Program Memorandum AB-02-065.)

Note: J3520 is already in the National Noncoverage section of the policy, per Coverage Issues Manual Sections 35-64 and 45-20.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

VISCO: Viscosupplementation

Policy Revision

Based on CMS Transmittal AB-02-82, CR 2230, the "*CPT*/HCPCS Codes" section of the local medical review policy (LMRP) for viscosupplementation was changed, **effective for services rendered on or after July 1, 2002, processed on or after October 1, 2002**.

In the pathological joint, synovial fluid is more abundant and less viscous (i.e., the concentration of hyaluronan is decreased). Viscosupplementation attempts to return synovial fluid to its pre-pathological state. Hyaluronic preprations (Hyalgan ®, Synvisc® Hylan G-F 20, and Supartz™) are drugs used for viscosupplementation of the knee's synovial space for those patients with mild to moderate osteoarthritis of the knee. The appropriate HCPCS codes for hyaluronic preprations are:

J7320 Hylan G-F 20, 16mg, for intra-articular injection
Q3030 Sodium Hyaluronate, per 20 to 25mg dose, for intra articular injection

An article concerning this change in coding was published in the Fourth Quarter 2002 *Medicare B Update!* (page 28). The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

00001: Independent Diagnostic Testing Facility (IDTF)

Policy Revision

The local medical review policy (LMRP) for IDTF was published in the Third Quarter 2002 *Medicare Part B Update* (pages 37-52). Since that time, the Centers for Medicare & Medicaid Services (CMS) Transmittal AB-02-112, CR 2282 changed the physician supervision requirements for procedure codes 92270, 92275, 92285, and 92286. The following chart identifies the level of physician supervision required, **effective for services performed on or after January 1, 2002, processed on or after October 1, 2002**.

***CPT* Code**	**Physician Supervision**
92270	1
92275	1
92285	1
92286	1

A physician supervision level of "1" indicates that the procedure must be performed under the general supervision of a physician.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

10060: Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures

Policy Revision

The local medical review policy (LMRP) for incision and drainage of abscess of skin, subcutaneous and accessory structures was published in the First Quarter 2002 *Medicare B Update* (pages 37-38). **Effective for claims processed on or after September 9, 2002**, diagnosis code 681.02 for onychia and paronychia of the finger has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

00103: Anesthesia Services (Ocular Procedures)

Policy Revision

The local medical review policy (LMRP) for Anesthesia Services (Ocular Procedures) was published in the Fourth Quarter 2001 *Medicare B Update!* (pages 54-57). Based on CMS Transmittal 1766, CR 2224, the following statement has been added to the "Coding Guidelines" section of the policy, **effective July 1, 2002**:

> Payment can be made under Part B to a teaching Certified Registered Nurse Anesthetist (CRNA) who supervises a single case involving a student nurse anesthetist where the CRNA is continuously present. The CRNA reports the service using the usual "QZ" modifier. Full payment cannot be made under Part B to a teaching CRNA who supervises two concurrent cases involving student nurse anesthetists. No payment is made under Medicare Part B for the service provided by a student nurse anesthetist.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

11730, 11750, 11765: Widespread Probe Review Results

Based on information obtained from statistical medical data analysis presented to the Program Safeguard Change Group on March 13, 2002, services for toenail avulsion, excision, and wedge excision of the skin of the nail fold (procedure codes 11730, 11750, and 11765) were found to be aberrant. This analysis examined services rendered from January 1, 2001, to June 30, 2001. Utilizing this data, a widespread probe review of Florida Medicare providers was conducted to review medical documentation on a randomly selected sample of beneficiaries on whom these three procedures were performed during that period. The purpose of the review was to gather information on billing frequency, correct use of codes 11730, 11750, and 11765, and appropriate documented indications given for each of these procedures.

As a result of the information obtained from this widespread probe review, a local medical review policy (LMRP) will be developed to identify indications, limitations, and utilizations parameters for procedure codes 11730, 11750, and 11765. The LMRP coding guidelines will indicate that claims for these services should be submitted with the appropriate modifier to identify the specific digit.

20600: Arthrocentesis

Policy Revision

The local medical review policy (LMRP) for arthrocentesis was published in the September/October 2000 *Medicare B Update!* (pages 24-29). **Effective for claims processed on or after October 28, 2002**, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy, for *CPT* code 20605:

715.12	Osteoarthrosis of upper arm, localized, primary
715.22	Oteoarthrosis of upper arm, localized, secondary
715.32	Osteoarthrosis of upper arm, localized, not specific whether primary or secondary
715.92	Osteoarthrois of the upper arm, unspecified whether generalized or localized
716.12	Traumatic arthropathy of the upper arm
716.52	Unspecified polyarthropathy or polyarthritis of the upper arm
716.82	Other specified arthropathy of the upper arm
716.92	Arthropathy of the upper arm, unspecified
719.02	Effusion of joint of the upper arm
719.22	Villonodular synovitis of the upper arm
719.42	Pain in joint of the upper arm

In addition, diagnosis codes 715.06 and 715.86 have been deleted from the "ICD-9-CM Codes that Support Medical Necessity" section of the policy for *CPT* 20610, as these are invalid ICD-9-CM codes.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*.

20974: Osteogenic Stimulation

Policy Revision

The local medical review policy (LMRP) for osteogenic stimulation was published in the Second Quarter 2002 *Medicare B Update* (pages 44-46). **Effective for claims processed on or after October 28, 2002**, the following diagnosis codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy:

For *CPT* code 20974

724.9	other unspecified back disorders

For *CPT* code 20975

724.9	other unspecified back disorders
909.3	late effect of complications of surgical and medical care
V45.4	arthrodesis status

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*.

29540: Strapping

Policy Revision

The local medical review policy (LMRP) for strapping was published in the First Quarter 2002 *Medicare B Update* (pages 41-43). Since that time, diagnosis code 459.81 (venous peripheral insufficiency, unspecified) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy, **effective for claims processed on or after September 9, 2002**.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*.

36245: Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterizations

A recent study was performed by the New York peer review organization (PRO) in conjunction with the Centers for Medicare & Medicaid Services (CMS) PRO staff in response to a carrier referral related to payments for potential medically unnecessary diagnostic procedures performed in conjunction with primary cardiac catheterizations. The study focused on a review of Medicare beneficiaries who underwent renal arteriogram during inpatient admission for cardiac catheterization. The NY carrier medical director, through claims data, determined a number of physicians were billing for both cardiac catheterization and a renal arteriogram on the same day. Because the carrier and fiscal intermediary do not have jurisdiction over inpatient quality of care and medical necessity for the inpatient portion of the service, a collaborative team was formed to address these issues from a more global standpoint. Both Part A and B data were extracted to identify if there were any significant billing/performing patterns visible. The study focused on more than 1,000 inpatient medical records of Medicare beneficiaries admitted to the top 30 hospitals for cardiac catheterization, who, based on analysis of the data, also underwent extracardiac arteriography, particularly renal arteriograms. The study focused on the following:

- Were cardiologists performing the renal arteriograms?
- Were the renal arteriograms carried out at the same time as the cardiac catheterization?
- Were the renal studies medically necessary?
- Did this pattern of performance constitute poor quality of care?

Preliminary findings demonstrated that medical necessity for the renal arteriogram was not substantiated by documentation in the medical record. They also identified quality of care concerns related to performing a medically unnecessary invasive procedure associated with high risk.

The study group, NY PRO/CMS/Contractor, have been presenting their findings to the medical community, especially cardiologists, and at hospitals on both a local and regional level. The hope is that a follow-up study will demonstrate more appropriate use of renal artery arteriography consistent with current medical evidence post provider education.

The data analysis staff noted the following on initial review:

- A total of $2,875,602.52 was paid to all performing providers in Florida, from January through September 2001, who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization. A total of 8953 renal arteriograms, by 261 providers, were billed for the same time frame.
- A total of $9,894, accounting for 53 services, was paid to the seven performing providers in Connecticut, from January through September 2001, who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization.

This contractor will be performing a widespread medical review across Connecticut and Florida, which may result in specific medical necessity guidelines, PRO referrals and/or provider education. Please assure that when billing these services (*CPT* 36245 with *CPT* 93512 or 93526), the renal arteriogram is both medically necessary and performed in accordance with the intention of the *CPT* Editorial Panel.

61862: Deep Brain Stimulation

Policy revision

The local medical review policy (LMRP) for deep brain stimulation was published in the January/February 1999 *Medicare B Update!* (page 22). Based on CMS Transmittal AB-02-112, CR 2282, **effective for dates of service on or after January 1, 2002, processed on or after October 1, 2002,** a revision to the policy has been made. The policy has been revised to expand coverage from *unilateral* to *bilateral* deep brain stimulation.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

67221: Ocular Photodynamic Therapy (OPT) with Verteporfin

Policy Revision

The local medical review policy (LMRP) for OPT with vertiporfin has been revised to reflect information in CMS Transmittal 157, CR 2335, for Coverage Issues Manual Section 35-100.

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

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

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

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

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

66761: Widespread Probe Review Results

Procedure code *66761 (Iridotomy/iridectomy by laser surgery [eg, for glaucoma] [one or more sessions])* was chosen for focused medical review for fiscal year (FY) 2001 because it was paid at a higher rate per 1,000 Medicare enrollees than was paid nationally. This code has been consistently aberrant over the past several years. The Florida carrier ranks fourth in the nation for allowed dollars for this procedure. Based on the conclusions of the findings, a recommendation was made to develop a local medical review policy (LMRP) with diagnosis criteria, for the carrier to determine if a procedure performed prophylactically should be covered, and under what circumstances. A widespread probe review of 102 claims from 20 providers for the period of January 1, 2001, to June 30, 2001, was performed. The purposes of the review were to determine the extent to which this procedure is being performed prophylactically and when it is medically necessary.

Results of the review are as follows:

- Medical necessity of the iridectomy procedure was established for 98 of 102 services.
- Four services had to be re-coded as *65855 (Trabeculoplasty by laser surgery, one or more sessions [defined treatment series]).*
- A majority of services were billed with diagnosis code 365.02, Anatomical narrow angle, borderline glaucoma (63 services), followed by 365.20, Primary angle-closure glaucoma, unspecified (20 services).
- 33 of the beneficiaries had been receiving an eye medication (miotic) on a regular basis prior to the procedure.
- All medical records supported the presence of narrow angles or applicable circumstances per gonioscopic exam that required a medically necessary iridectomy (or trabeculoplasty).

- The majority of beneficiaries received an iridectomy procedure of the other eye within one week, which were also deemed medically reasonable and necessary.
- According to medical literature, in general, for those patients diagnosed with glaucoma, medicine (both topical eye drops and oral medications), laser procedures, and operative procedures are all utilized in an attempt to preserve vision. The "Primary Angle Closure" guideline by the American Academy of Ophthalmology indicates that miotics may aggravate papillary block and, when used chronically, may increase the risk of synechial angle closure, especially if cataract formation increases lens-iris contact. The Web site *eyemdlink.com* indicates for primary open angle glaucoma patients, the treatment is a peripheral iridectomy or peripheral iridotomy. Repeat procedures may be necessary, as over time, some iridectomies close due to the normal healing process. The performance of an iridectomy is warranted for those with documented angle closure or narrow angles with accompanying elevated intraocular pressures, visual acuity changes or visual disturbances (e.g., halos, blurry vision, pain, etc.). The alternative to performance of the iridectomy procedure is development of an acute angle closure and possible blindness. Therefore, the iridectomy procedures performed by the providers in this widespread probe review are considered medically reasonable and necessary. No further policy action is needed at this time.

70450: Widespread Probe Review Results

Procedure code *70540 (Magnetic resonance [eg, proton] imaging, orbit, face, and neck: without contrast material[s])* was chosen for focused medical review for fiscal year (FY) 2001 based on January through June 2000 data revealing a carrier to nation ratio of allowed dollars of 3.44, with a maximum potential savings of $815,629. This trend continued in the last six months of 2000. An interesting finding noted was 35% of the time procedure code 70540 was performed, an MRI of the brain was also performed.

Based on the conclusions of the findings, the performance of this service was considered a widespread problem; therefore, a recommendation to perform a widespread probe and the development of a local medical review policy was made. A widespread probe of 100 claims from 20 providers for the period April 1, 2001, to September 30, 2001, was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, determine the medical conditions for which the service was being performed, and to determine if the additional studies were medically necessary.

Results of the review are as follows:

- Of the 100 claims reviewed, 98 claims were allowed as billed; two were denied due to lack of an order for the service.
- The majority of the services were performed for complaints of hearing loss, both chronic and acute, as well as both bilateral and unilateral. The services were also performed for complaints of dizziness and various visual disturbances, both chronic and new onset.
- Evidence that the results of the tests were used acutely in the management of the patient's care was not generally found.
- Incidentally, for the 100 claims reviewed, an MRI of the brain (70551-70553) was also performed on 77 beneficiaries in addition to procedure code 70540. Medical necessity for the performance of an MRI of the brain was very vague in most instances.
- Based on documentation submitted, it was difficult to establish an accurate timeframe of occurrence of symptoms and what other diagnostic interventions had been performed.

A local medical review policy, which will include MRI codes 70540, 70542, and 70543 will be developed in the near future. A policy is needed to address the indications for coverage and define the criteria for performing an MRI of the orbit, face, and neck both with contrast and without. Additionally, the criteria will be defined for the appropriateness of performing an MRI of the brain in addition to an MRI of the orbit, face, and neck.

76375: Widespread Probe Review Results

Procedure code *76375 (Coronal, Sagittal, Multiplanar, Oblique, 3-Dimensional and/or Holographic Reconstruction of Computerized Tomography, Magnetic Resonance Imaging, or other Tomographic Modality)* was chosen for Focused Medical Review, because it was paid in Florida at an exceedingly higher rate per 1,000 Medicare enrollees than was paid nationally. Based on limited information available in the current medical literature to define the service, a widespread probe review of 100 claims from 19 providers was performed for services from July 1, 2000, to December 31, 2000. The purpose of the review was to determine if services billed to Medicare were documented as having been performed, determine which tomographic modality the reconstruction code was performed with, and evaluate rationales that warrant the additional views.

Results of the review revealed the following:

- Code 76375 was billed with computerized tomography (CT) scans, MRIs, MRAs, Myocardial Perfusion Imaging, and Radiation Oncology services. The majority of reconstruction services performed were for CT scans and a MRA of the head and/or neck.
- The *Current Procedural Terminology (CPT)* instructs providers to bill code 76375 for coronal, sagittal, and/or oblique views in addition to the base CT code.
- Prior to January 1, 2001, providers were instructed to bill CT Angiography using the base CT code in addition to the reconstruction code 76375. As of January 1, 2001, new procedure codes were established for CT Angiography. Information provided in the July 2001 *cpt Assistant* indicates CT Angiography includes three-dimensional or volume-rendered reconstructions. Therefore, code 76375 should not be billed separately for CT Angiography studies.
- Many radiation oncology codes were billed on the same day as 76375. Based on *CPT*, procedure code 77295 includes three-dimensional reconstruction; therefore, code 76375 should not be paid in addition to 77295. Clarification was received after the review regarding additional radiation oncology codes. Based on the information received from the Code Utilization and Application Subcommittee of the ACR/ASTRO Joint Economics Committee, it is inappropriate to bill code 76375 in addition to codes 77315, 77328, and 77412-77416. These codes include such descriptors as "rotational beam" or "special spatial reconstruction."
- According to the September 2001 *cpt Assistant*, magnetic resonance angiography (MRA) entails 2-D or 3-D, time-of-flight or phase contrast gradient echo sequences sensitive to blood flow covering the anatomic region of interest. The images are processed to produce maximum intensity projections (MIPs). Post processing of source images to create the MIP images is included in these codes; thus the separate reconstruction code, 76375, should not be reported for MRA examinations.
- The majority of reconstruction services were not ordered by the referring physician. It appeared the radiologist performed this service to eliminate overlapping structures, rotate vessels into different obliquities to find the best view for detecting the abnormality, and to visualize the abnormality from different visual planes, which confirms the accuracy of the diagnosis.
- Medical necessity of the base service was established for many of the services. Some MRA services were denied when performed for noncovered national indications.

Based on the above information, code 76375 is included in all CT Angiography services, all MRA services, all myocardial perfusion imaging services, and the following radiation oncology services: 77295, 77315, 77328, and 77412-77416. Therefore, billing separately for code 76375 in addition to these codes is not appropriate. In addition, the referring provider is expected to indicate when additional views and/or a reconstruction is needed and included in the order for the base procedure.

76375: New Data Findings Surfaced

The Comprehensive Data Analysis (CDA) team has recently become aware of a second specific Florida Medicare program vulnerability. The code description for 76375 indicates this service is a reconstruction of a computerized tomography (CT), magnetic resonance imaging (MRI), or other tomographic modality. It is an add-on code and must be billed with a primary CT, MRI, or other tomographic modality. Florida claims history data demonstrates this service is being billed as a stand-alone procedure without a qualifying primary procedure. Please evaluate your billing procedures for the presence of this billing error and implement any necessary changes. The CDA team will continue to determine all causes of this payment error and propose corrective actions.

76536: Widespread Probe Review Results

Procedure code *76536 (Ultrasound, soft tissues of head and neck [eg, thyroid, parathyroid, parotid], B-scan and/or real time with image documentation)* was chosen for focused medical review for fiscal year (FY) 2001 based on January through June 2000 data, which revealed a carrier to nation ratio of allowed dollars of 2.38, with a maximum potential savings of $326,135. Based on the conclusions of the findings, the performance of this service was considered a widespread problem; therefore, a recommendation to perform a widespread probe and a possible local medical review policy was made. A widespread probe of 100 claims from 20 providers for the period from May 1, 2001, to October 31, 2001, was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed and determine the medical conditions for which the service was being performed.

Results of the review are as follows:

- 78 of the services were allowed as billed and 22 services were denied. Of the denied services, five were denied based on lack of medical necessity, seven were denied as not sufficiently documented, and ten were denied for no records received.
- 80% of the ultrasound, soft tissues of head and neck (*CPT* code 76536) were for thyroid ultrasounds, 5% were for carotid ultrasounds, and 5% were for nasal ultrasounds.
- Approximately 30% of the thyroid ultrasounds were performed on patients with thyroid nodule(s) or thyroid mass.
- Approximately 25% of the thyroid ultrasounds were performed on patients with enlarged thyroids.
- Approximately 15% of the thyroid ultrasounds were performed as follow-up to a previous performed thyroid ultrasound.
- Approximately 15% of the thyroid ultrasounds were performed on patients with various other thyroid symptoms and/or diseases.

A local medical review policy, which will include diagnostic ultrasounds of the head and neck (*CPT* codes 76506, 76511, 76512, 76513, 76516, 76519, 76529, and 76536), will be developed in the near future. A policy is needed to address the indications for coverage and define the criteria for performing the different ultrasounds (i.e., defining the use of *CPT* code 76506 versus 76536).

78306: Widespread Probe Review Results

Based on data from January through June 2000, *CPT* code *78306 (Bone and/or joint imaging: whole body)* was chosen for focused medical review. The review revealed a carrier-to-nation ratio of allowed dollars of 1.93 with a maximum potential savings of $1,271,365. This trend continued in the last six months of 2000. Findings indicated performance of this service was considered a widespread problem; therefore, recommendation was made to perform a widespread probe review and a possible local medical review policy (LMRP). A widespread probe review of 100 claims from 20 providers was performed for the period April 1, 2001, to September 30, 2001, to determine if the services billed to Medicare were documented as having been performed, and to determine the medical conditions for which the service was being performed.

Results of the review revealed the following:

- Approximately 66% of whole body scans performed were on patients with cancer or a previous history of cancer to evaluate for metastasis to the bone. Some of these patients had a history of cancer several years prior to the bone scan being performed.
- Approximately 30% of whole body scans performed were on patients with skeletal pain, musculoskeletal disorders, or status post/rule out fractures/compressions. Several signs and symptoms experienced by patients were limited to a specific body area, questioning use of a whole body scan instead of a limited scan.
- The remainder of the bone scans performed was on patients with abnormalities identified on other imaging and/or function studies.
- 86 services were allowed as billed, three services were changed to another bone scan code based on the service provided as documented on the radiology report, and 11 services were denied (one based on lack of medical necessity; 10 for no records received).
- 15 of the 20 providers reviewed performed only interpretation of the whole body scan.

Based on the findings of the widespread probe review, a LMRP will be developed for *CPT* codes 78300, 78305, 78306, 78315, and 78320. This policy will identify indications and limitations of coverage, and define criteria for performing the different bone scan techniques (e.g., limited versus whole body scan, three-phase study).

78460: Myocardial Perfusion Imaging

Policy Revision

The local medical review policy (LMRP) for myocardial perfusion imaging was published in the First Quarter 2002 *Medicare B Update!* (pages 54-55). Since that time, based on CMS Transmittal AB-02-112, CR 2282, a revision to the policy has been made, **effective for dates of service on or after January 1, 2002, processed on or after October 1, 2002.** Procedure codes 78478 and 78480 are no longer considered secondary codes.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

85651: Sedimentation Rate, Erythrocyte

Policy Revision

The local medical review policy (LMRP) for sedimentation rate, erythrocyte, was published in the Third Quarter 2002 *Medicare B Update!* (pages 55-56). **Effective for claims processed on or after October 28, 2002**, diagnosis codes 362.34 (amaurosis fugax), 379.91 (ocular pain), and 784.0 (headache) were added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

87536: HIV-1 Viral Load Testing

Policy Revision

The local medical review policy (LMRP) for HIV-1 viral load testing has been effective since December of 1997. **Effective for claims processed on or after October 7, 2002**, the "ICD-9-CM Diagnosis Codes That Support Medical Necessity" section of the LMRP has been expanded to include the following diagnosis codes:

ICD-9-CM Code	Description
079.53	Human immunodeficiency virus, type 2 (HIV-2)
647.60-647.64	Infectious and parasitic conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, other viral diseases
795.71	Nonspecific serologic evidence of human immunodeficiency virus (HIV)
V08	Asymptomatic human immunodeficiency virus (HIV) infection status

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com.*

88108: Widespread Probe Review Results

The following is based on information collected from First Coast Service Options, Inc.'s (FCSO) Connecticut Medicare operation. FCSO believes this information is valuable to Medicare providers in Florida as well.

Procedure code *88108 (Cytopathology, concentration technique, smears and interpretation [eg, Saccomanno technique])* was identified as aberrant for Connecticut during fiscal year (FY) 2001 based on July through December 2001 data. The data revealed a carrier to nation ratio of allowed dollars of 8.73 for procedure code 88108. Based on the conclusions of the findings and the continued growth rate of the number of services being performed, a recommendation was made to perform a widespread probe and develop a local medical review policy. A widespread probe of 105 claims for code 88108 for the period of July 1, 2001, to December 31, 2001, was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, determine if the services were coded correctly, and identify the types of specimens requiring the concentration technique.

The results of the widespread probe review revealed the following:

- 113 services were reviewed for procedure code 88108. All services were allowed as billed.
- The cytopathology reports submitted by 13 of the providers supported that a smear and interpretation were performed, however, did not specifically document the concentration technique used to prepare the slide for review and interpretation.
- The remaining cytopathology/hematopathology reports indicated that a thin prep or cytospin technique was utilized to prepare the slide for interpretation. These techniques are classified as concentration techniques.
- Four providers billed procedure code 88108 with bone marrow aspirate/clot/biopsy specimens documented under the flow cytometry section of the hematopathology report. The report indicated that a cytospin smear was performed. In addition to billing cytopathology, these providers also billed multiple other pathology codes including flow cytometry (code 88180).
- The majority of providers billed other pathology services on the same claim as procedure code 88108.
- Procedure code 88108 was billed more than once per beneficiary only when a separate specimen was obtained requiring cytopathology.

The Laboratory Test Handbook (Jacobs, *et.al*., 1996) indicates that body fluid cytology billed under procedure code 88108 includes fresh body fluid from a variety of sources. Cytology is used to establish the presence of primary or metastatic neoplasms; aid in the diagnosis of rheumatoid pleuritis; systemic lupus erythematosus; myeloproliferative and lymphoproliferative disorders; viral, fungal, and parasitic infestation of serous cavities; fistulas involving serous cavities; infection of the lung;

and to establish the nature of a cystic process. Further uses may exist depending on the specimen.

According to the coding committee, a cytology examination is already included in the work values for flow cytometry procedure codes. Therefore, the provider should not be billing separately for cytopathology (procedure codes 88106-88108) when it is performed (on the flow cytometry sample) as part of a flow cytometry request.

Based on the above analysis, it is expected that documentation submitted to support cytopathology services clearly indicate the technique utilized to prepare the specimen for review and interpretation. For example, if a ThinPrep preparation or cytospin is performed, this must be indicated in the report. In addition, it is not appropriate to bill procedure codes 88106-88108 when the cytologic evaluation is performed (on the flow cytometry sample) as part of a flow cytometry request.

92567: Tympanometry

Policy Revision

The local medical review policy (LMRP) for Tympanometry was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 67-68). **Effective for claims processed on or after October 28, 2002**, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy:

386.11	Benign paroxysmal positional vertigo
386.12	Vestibular neuronitis
386.19	Other peripheral vertigo
386.2	Vertigo of central origin
386.30-386.35	Labyrinthitis
387.0-387.9	Otosclerosis
388.30-388.32	Tinnitus
389.10-389.18	Sensorineural hearing loss
389.2	Mixed conductive and sensorineural hearing loss

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*.

93025: Microvolt T-wave Alternans

Policy Revision

The local medical review policy (LMRP) for Microvolt T-wave Alternans (Microvolt TWA) was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 71-72). Since that time, Florida Medicare received medical literature supporting the use of Microvolt TWA in patients with acute myocardial infarction.

Therefore, **effective for claims processed on or after September 23, 2002**, diagnosis range 410.00-410.92 was added to the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP. In addition, the language in the "Coding Guidelines" section was changed to read, "Florida Medicare considers an electrocardiogram (procedure code 93000-93010) and the sensors/electrodes (procedure code 99070) used in the performance of the test an integral part of Microvolt TWA, and therefore, are not to be billed separately. Additional national correct coding relationships may exist."

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*.

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

Policy Revision

The local medical review policy (LMRP) for Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 72-75). **Effective for claims processed on or after July 1, 2002**, the statement regarding the noncoverage of transtelephonic monitoring of a pacer cardioverter-defibrillator was removed from the "Reasons for Denial" section of the policy.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*.

ELECTRONIC MEDIA CLAIMS

Health Insurance Portability and Accountability Act–Administrative Simplification (HIPAA-AS) Update

The administrative simplification provisions of HIPAA require that Medicare, and all other health insurance payers in the United States, comply with the EDI standards established by the Secretary of Health and Human Services for specified healthcare transactions. The implementation guides for each transaction are available electronically at *www.wpc-edi.com*.

835-Electronic Remittance Advice

Testing

General testing, while not required but recommended, has begun and is scheduled to continue through October 2003. Testing will occur on a first-come, first-serve basis. Due to the large number of senders who will be testing, Medicare EDI encourages senders to begin their testing early. Senders who wait until the last few months of testing may not have enough time to prepare for the 4010 migration. **Medicare will switch to exclusive use of the ANSI X12N 835 Version 4010 as of October 2003.**

If you currently receive electronic remittance advice, you may sign up to test the 4010 Medicare Part B Electronic Remittance Advice. Please contact Elizabeth Templeton via telephone at (904) 791-6895, or via email at *elizabeth.templeton@fcso.com*.

If you do not currently receive electronic remittance advice, but would like to, you will need to complete an Electronic Data Request Form. You can obtain this form from the *www.floridamedicare.com* Web site, in the EDI section under the "Forms" subheading. Alternately, you may call the Marketing Team at (904) 791-8767.

New senders have asked if they have to accept the 4010 version of the remittance advice. Effective October 1, 2002, if one of the following situations is true, new senders must elect to receive version 4010 of the remittance advice:

- A facility or provider applies for a new sender code (and does not currently receive remittance advice electronically) and the facility's or provider's support vendor has already been approved to receive ANSI 835 version 4010.
- A sender applies for a new sender code and their support vendor is a new support vendor (with no existing Medicare clients).
- A sender's support vendor has already been approved to receive ANSI 835 version 4010.

Gap Filling Data Elements

Beginning October 1, 2002, First Coast Service Options, Inc. (FCSO), will "gap fill" required elements of the X12 835 Version 4010 in those situations where the claim received for processing lacked data or contained data that does not meet the data attribute or length requirements necessary for preparation of a HIPAA-AS-compliant electronic remittance advice (ERA). FCSO will "gap fill" affected alphanumeric elements in the ERA with a value of "G" and data elements with the processing system cycle data.

New and Revised Healthcare 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 complete list of remark codes is available at *www.wpc-edi.com/HIPAA*. The list is updated each March, July, and November. The list may be downloaded from this Web site to obtain the most current set of approved remark codes.

New Healthcare 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 *www.wpc-edi.com/HIPAA*.

For Additional Information

Medicare B submitters who would like additional information about testing the ANSI 835 4010 should contact Elizabeth Templeton via telephone at (904) 791-6895, or via email at *elizabeth.templeton@fcso.com*.

837 Inbound Claims Transaction

Some frequently asked questions (FAQ) have surfaced in the course of helping vendors/senders prepare their testing. You may find the answers helpful as you prepare your 4010 837 testing.

SEGMENT / LOOP	Question	Answer
ISA06	What is the value needed?	Your individual Mailbox Number
1000A/ NM109	What is the value needed?	Your individual Sender Code
1000A; 2310A,B,C 2420A,B,C	What value must I use in the NM108?	As XX is not a valid code for Medicare, you must use either 24 or 34 and the appropriate value in NM109.
1000A; 2310B,C; 2420A,B	Where do I put the Medicare Provider Number?	You must use the REF segment in that loop with a "1C" in the REF01 and the Medicare Provider Number in the REF02.
2310A; 2420E	Where do I put the UPIN	You must use the REF segment in that loop with a "1G" in the EF01 and the UPIN in REF02.
2000C	What do I put in the 2000C loop for Medicare?	The 2000C loop is not valid for Medicare. The patient is always the subscriber and therefore the file will reject if you submit a 2000C loop.
	If I am a new sender, what versions may I use?	Effective October 1, 2002, if one of the following situations is true, new senders **must** transmit claims via ANSI X12 4010 837 format: A facility or provider applies for a new sender code (and does not currently submit claims electronically) A sender applies for a new sender code and their support vendor is a wholly new support vendor (with no existing Medicare clients) A sender's support vendor has already been approved to submit ANSI X12 4010 837.

For Additional Information

Medicare B submitters who would like additional information about testing the ANSI 837 4010 should contact Floyd Rosenberger via telephone at (904) 791-6055, or via email at *floyd.rosenberger@fcso.com*.

270/271 Eligibility Inquiry/Response Transactions

The purpose of this section is to acquaint you with certain aspects of the new X12N 270/271 version 4010 transactions (Healthcare Eligibility Benefit Inquiry /Response). The 270/271 will be supported as a real time transaction, not accepted in a batch mode, by Medicare. The 270/271 Implementation Guide adopted for national use under HIPAA can be obtained at *www.wpc-edi.com/HIPAA*.

Any provider that prefers to obtain eligibility data in an EDI format but that does not want to use the 270/271 version 4010 may contract with a clearinghouse to translate the information on their behalf; however, that provider would be liable for those clearinghouse costs. Provider, clearinghouse, and vendor testing is not required prior to production use, but will be conducted if requested. There will not be a charge for such testing.

Providers desiring to obtain home health benefit period information must use the 270/271 to obtain the HHA data elements. ARU eligibility queries will continue to be accepted; however, additional data elements that will be available in the version 4010 271 will not be added to the ARU.

Electronic formats for the request and receipt of eligibility data other than via the 4010 270/271, will not be used after October 16, 2003. Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for use of HIPAA standard, Medicare will not furnish in-depth training on the use and interpretation of the standards implementation guides.

Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse or through standard development organizations.

Testing

Currently testing for 270/271 is scheduled to begin on or about January 2, 2003. We will begin accepting requests for testing on December 1, 2002. The following information will be returned in the 271 eligibility data response as applicable:

- Carrier Number
- Provider Number
- Requester ID
- Date and Time stamp
- Surname
- First Initial
- HICN
- Zip Code
- Date of birth
- Date of death
- Sex code
- Applicable date
- Current Part B entitlement date
- Current Part B termination date
- HMO ID code
- HMO option code
- HMO entitlement date
- HMO termination date
- Other program entitlement
    - Workers compensation
    - Black Lung
- MSP data (can occur up to five times):
    - MSP code
    - MSP effective date
    - MSP termination date
    - MSP insurer's name
    - MSP insurer's address
    - MSP insurer's city, state/zip
- Lifetime reserve days
- Part A Spell data:
    - Hospital days remaining
    - Co-insurance hospital days remaining
    - SNF days remaining
    - Co-insurance days remaining
    - Date of earliest billing action
    - Date of latest billing action
- Part B Spell data:
    - Most recent Part B year
    - Part B cash deductible remaining
    - Part B physical/speech therapy limit remaining
    - Part B occupational therapy limit remaining
- Hospice period number
- Hospice start date
- Hospice termination date
- Pap risk indicator
- Pap date
- Mammography risk indicators
    - Mammography date
    - Screening risk indicator
    - Technical or professional
    - Recent dates
- Glaucoma risk indicators
    - Technical or professional
    - Recent dates
- Colorectal risk indicator
    - Technical or professional
    - Recent dates
- Prostate risk indicator
    - Technical or professional
    - Recent dates
- Pelvic risk indicator
    - Technical or professional
    - Recent dates
- ESRD first code
- ESRD effective date
- Transplant indicator
- HHEH data (current two episodes):
    - HHEH start date
    - HHEH end date
    - HHEH date of earliest billing action
    - HHEH date of latest billing action
- HHEB data:
    - HHBP start date

For further information regarding the 270/271 for Medicare Part B or to be set up for the 270/271 transactions, please contact Floyd Rosenberger at (904) 791-6055 or via email at *floyd.rosenberger@fcso.com*

PC-ACE Pro32®

PC-ACE Pro32® continues to be involved with testing the Medicare ANSI 4010 production version of the program with a few select number of existing senders. We anticipate the product to be available to all existing PC-ACE Pro32® users in mid-October. Senders who have elected to download the program will be notified via email, and customers electing a CD will be notified via mail. If you have not migrated from the DOS version of PC-ACE to PC-ACE Pro32®, you should contact Technical Support **immediately** at (904) 355-0313.

Source: CMS Transmittal B-02-05, CR 2223

GENERAL INFORMATION

FRAUD AND ABUSE

TriCenturion Selected as Program Safeguards Contractor for Florida

The Health Insurance Portability and Accountability Act of 1996 includes a provision that authorizes the Centers for Medicare & Medicaid Services (CMS) to enter into contracts with organizations other than traditional Medicare contractors to perform Medicare program safeguards activities (i.e., medical reviews, fraud investigations, cost report audits, and data analysis). The organizations that enter into contracts with CMS to perform these activities are known as Program Safeguards Contractors (PSC). In response to this change, First Coast Service Options, Inc. (FCSO), Palmetto Government Benefits Administrators, and Trailblazer Health Enterprises entered into a partnership to form a new company called TriCenturion, LLC. In 1998, TriCenturion submitted a proposal and was selected by CMS, along with 12 other companies, to become a PSC. Since then, TriCenturion has successfully performed program safeguards work for CMS.

In early 2002, CMS began moving the fraud investigations functions from the traditional Medicare contractors to the PSCs. Beginning January 2003, the fraud investigations functions for Medicare Part A in Florida and Medicare Part B in Connecticut and Florida will be performed by TriCenturion. This transition of functions from FCSO should not affect Medicare providers nor people with Medicare in either state, as FCSO will continue to accept and review allegations of suspected inappropriate activities to rule out billing errors, processing errors, or misunderstandings of information. TriCenturion will concentrate its efforts on investigating alleged fraudulent activities, proactively identifying potential fraud through data analysis, and working with federal and state agencies to protect the Medicare Trust Fund. Therefore, FCSO's customers who wish to report allegations or complaints of suspected fraudulent or abusive activities may still report them to the FCSO addresses and/or telephone numbers listed in this publication (see page 47).

TriCenturion is currently operating as the fraud investigations PSC for six states and the District of Columbia (Part A–Colorado, New Mexico, Texas; Part B–Delaware, District of Columbia, Maryland, Texas, Virginia,), and as the durable medical equipment regional PSC for ten northeastern states (Region A). In addition to Connecticut and Florida, TriCenturion was recently named the fraud investigations PSC for Medicare Parts A and B in South Carolina, and for home health services for 16 states, including Florida, South Carolina and Texas.

TriCenturion will maintain a close working relationship with FCSO to coordinate program safeguard activities for Florida and Connecticut. It will be hiring many qualified FCSO employees and will have an increased regional presence with offices in Meriden, Connecticut, and Jacksonville, Miami, and Palm Harbor, Florida.

HOME HEALTH CONSOLIDATED BILLING

Annual Update of Procedure Codes Used for Home Health Consolidated Billing Enforcement

In April 2001, the Centers for Medicare & Medicaid Services (CMS) established the process of periodically updating the lists of *Current Procedural Terminology* (*CPT*) and Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). Services appearing on this list submitted on claims to Medicare fiscal intermediaries and carriers (including durable medical equipment regional carriers), will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse primary home health agencies that have opened such episodes during the episode periods. Items incident to physician services, as well as supplies used in institutional settings, are not subject to HH consolidated billing.

Updates of the HH consolidated billing code list will occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., "K" codes). These temporary codes may describe services subject to consolidated billing, in addition to the permanent list of HCPCS codes that is updated annually.

This notification is the first quarterly HH consolidated billing update for calendar year 2003. It incorporates new temporary codes, as well as the annual update of all HCPCS codes and *CPT* codes subject to consolidated billing. Updates for the remaining quarters of the calendar year will occur as needed prior to the next annual update, due to creation of new temporary codes representing services subject to HH consolidated billing.

New coding identified in each update describes the same services used to determine applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because services subject to HH consolidated billing are being redefined.

Section 1895 of the Social Security Act codifies the HH PPS.

Comprehensive List of Codes Subject to Home Health Consolidated Billing January 2003 Update

Therapy Codes

G0193	G0194	G0195	G0196	G0197	G0198	G0199	G0200
G0201	G0279	G0280	G0281	G0282	G0283	0019T	0020T
64550	90901	90911	92506	92507	92508	92510	92526
92601	92602	92603	92604	92605	92606	92607	92608
92609	92610	92611	92612	92614	92616	95831	95832
95833	95834	95851	95852	96000	96001	96002	96003
96105	97001	97002	97003	97004	97012	97014	97016
97018	97020	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97150	97504	97520	97530	97532
97533	97535	97537	97542	97545	97546	97601	97602
97703	97750	97799					

Supply Codes

A4212	A4310	A4311	A4312	A4313	A4314	A4315	A4316
A4319	A4320	A4321	A4322	A4323	A4324	A4325	A4326
A4327	A4328	A4330	A4331	A4332	A4333	A4334	A4335
A4338	A4340	A4344	A4346	A4347	A4348	A4351	A4352
A4353	A4354	A4355	A4356	A4357	A4358	A4359	A4361
A4362	A4364	A4365	A4367	A4368	A4368	A4369	A4371
A4372	A4373	A4375	A4376	A4377	A4378	A4379	A4380
A4381	A4382	A4383	A4384	A4385	A4387	A4388	A4389
A4390	A4391	A4392	A4393	A4394	A4395	A4396	A4397
A4398	A4399	A4400	A4402	A4404	A4405	A4406	A4407
A4408	A4409	A4410	A4413	A4414	A4415	A4421	A4422
A4455	A4458	A4460	A4462	A4481	A4622	A4623	A4625
A4626	A4649	A4656	A4657	A4712	A4930	A5051	A5052
A5053	A5054	A5055	A5061	A5062	A5063	A5071	A5072
A5073	A5081	A5082	A5093	A5102	A5105	A5112	A5113
A5114	A5119	A5121	A5122	A5126	A5131	A6010	A6011
A6020	A6021	A6022	A6023	A6024	A6154	A6196	A6197
A6198	A6199	A6200	A6201	A6202	A6203	A6204	A6205
A6206	A6207	A6208	A6209	A6210	A6211	A6212	A6213
A6214	A6215	A6219	A6220	A6221	A6222	A6223	A6224
A6228	A6229	A6230	A6231	A6232	A6233	A6234	A6235
A6236	A6237	A6238	A6239	A6240	A6241	A6242	A6243
A6244	A6245	A6246	A6247	A6248	A6251	A6252	A6253
A6254	A6255	A6256	A6257	A6258	A6259	A6261	A6262
A6266	A6402	A6403	A6404	A6405	A6406	A6410	A7043
A7501	A7502	A7503	A7504	A7505	A7506	A7507	A7508
A7509	K0581	K0582	K0583	K0584	K0585	K0586	K0587
K0588	K0589	K0590	K0591	K0592	K0593	K0594	K0595
K0596	K0597						

Source: CMS Transmittal AB-02-137, CR 2402

Additional Remark Code for Claims of Therapy Services Possibly Subject to Home Health Consolidated Billing

There may be situations in which a beneficiary is under a home health plan of care, but the Common Working File (CWF) does not yet have a record of either a request for anticipated payment (RAP) or a home health claim for the episode of care. To help inform therapy providers that the services they performed may be subject to consolidated billing, the following remark code will be provided on the remittance advice for the conditions noted.

Remark Code	Message
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

This message will appear on a remittance advice when CWF indicates the service is payable, and all three of the following conditions are true:

1. The place of service is "12 home."
2. The HCPCS code is a therapy code subject to home health consolidated billing.
3. The CWF has not returned a message indicating the presence of a RAP.

Source: CMS Transmittal B-02-050, CR 2258

SKILLED NURSING FACILITY (SNF)

Physicians Rendering Services To Patients in a Covered Part A Skilled Nursing Facility (SNF) Stay

If a patient is in a covered Medicare Part A SNF stay, payments for certain services are included in reimbursement to the SNF. For a complete list of procedure codes included in a SNF stay and more information pertaining to SNF consolidated billing, please refer to the CMS Web site at *www.cms.hhs.gov/medlearn/snfcode.asp*.

First Coast Service Options, Inc. (FCSO) has identified situations where SNFs are sending Medicare patients to a physician's office to have diagnostic tests performed. The Part B carrier is responsible for paying only the professional component (modifier 26) of these tests to the physician. However, physicians are billing these as global services (without a modifier), resulting in denial of their claim. The Centers for Medicare & Medicaid Services (CMS) specifies contractors use remark code N73 "a SNF is responsible for payment of outside providers who furnished these services/supplies to residents" and reason code 109 "claim not covered by this payer/contractor–you must send the claim to the correct payer/contractor" for such denials.

Because the technical component in this situation is included under the consolidated billing provision, both entities (SNF and physician) are encouraged to make reimbursement arrangements among themselves, so the physician can receive payment.

In addition, situations have been noted where claims have been received from and paid to physicians before receiving the SNF services. This creates an overpayment for the doctor. Per instructions from CMS Transmittal AB-02-023 dated February 12, 2002, the contractor is required to demand refunds that have been disbursed inappropriately in these cases.

Psychotropic Drug Use in Skilled Nursing Facilities (SNF)

In response to concerns expressed by the Senate Special Committee on Aging, the Office of Inspector General (OIG) studied the extent to which psychotropic drugs are being used in nursing homes as inappropriate chemical restraints. The OIG found that, in general, these drugs are being used appropriately. Where there are problems, they are related to inappropriate dosage, chronic use, lack of documented benefit to the resident, and unnecessary duplicate drug therapy. This article explains Medicare's guidelines for psychotropic drug use in SNFs including the definition of an unnecessary drug, justification for drug use outside guidelines, and antipsychotic drugs.

Definition of an Unnecessary Drug

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose (including duplicate drug therapy);
- For excessive duration;
- Without adequate monitoring;
- Without adequate indications for its use;
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the above reasons.

Note: When a resident receives duplicate drug therapy, an evaluation should be completed for accumulation of the adverse effects.

Note: Adequate indications for use means that there is a valid clinical reason for the resident to receive the drug based on some, but not necessarily all, of the following:

- Resident assessment;
- Plan of care;
- Reports of significant change;
- Progress notes;
- Laboratory reports;
- Professional consults;
- Drug orders; or
- Observation and interview of the resident.

Justification for Drug Use Outside Guidelines

A drug used outside these guidelines must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. Some examples of evidence that would support a justification as to why a drug is being used outside these guidelines, but in the best interest of the resident, may include:

- A physician's note indicating that the dosage, duration, indication, and monitoring are clinically appropriate and the reasons as to why they are clinically appropriate. The note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using a drug outside the guidelines.
- A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) confirming the physician's judgment that use of a drug outside the guidelines is in the best interest of the resident.
- Documentation of a physician, nursing, or other health professional indicating that the resident is being monitored for adverse consequences or complications of the drug therapy;
- Documentation confirming that previous attempts at dosage reduction have been unsuccessful;
- Documentation (including MDS documentation) showing the resident's subjective or objective improvement or maintenance of function while taking the medication;
- Documentation showing that the resident's decline or deterioration has been evaluated by the interdisciplinary team to determine whether a particular drug, a particular dose, or duration of therapy may be the cause; and
- Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, or monitoring.

Guidelines for Use of Antipsychotic Drugs

SNFs must ensure, based on a comprehensive assessment of the resident, that:

I. When an antipsychotic drug has not been used in the past, it is not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following specific conditions:

- Schizophrenia;
- Schizo-affective disorder;
- Delusional disorder;
- Psychotic mood disorders (including mania and depression with psychotic features);
- Acute psychotic episodes;
- Brief reactive psychosis;
- Schizophreniform disorder;
- Atypical psychosis;
- Tourette's disorder;
- Huntington's disease;
- Organic mental syndromes (now called delirium, dementia, and amnestic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors which:

A. Have been quantitatively and objectively documented. This documentation is necessary to assist in:
- Assessing whether the resident's behavioral symptom is in need of some form of intervention.
- Determining whether the behavioral symptom is transitory or permanent.
- Relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine).
- Ruling out environmental causes (e.g., excessive heat, noise, overcrowding).
- Ruling out medical causes (e.g., pain, constipation, fever, infection).

B. Are persistent;

C. Are not caused by preventable reasons; and

D. Cause the resident to:
- Present a danger to himself/herself or to others;
- Continuously scream, yell, or pace and results in an impairment of functional capacity; or
- Experience psychotic symptoms (e.g., hallucinations, paranoia, delusions) that are not exhibited as dangerous behaviors or as screaming, yelling, or pacing but result in distress or impairment of functional capacity.

- Short-term (7 day) symptomatic treatment of hiccups, nausea, vomiting, or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if the only indication is one or more of the following:

- Wandering;
- Poor self care;
- Restlessness;
- Impaired memory;
- Anxiety;
- Depression (without psychotic features);
- Insomnia;
- Unsociability;
- Indifference to surroundings;
- Fidgeting;
- Nervousness;
- Uncooperativeness; or
- Agitated behaviors that do not represent danger to the resident or others.

II. Unless clinically contraindicated, gradual dose reductions of the antipsychotic drug and behavioral interventions are considered in an effort to discontinue the drug. Close supervision should be provided when gradual dose reductions are carried out. If the gradual dose reduction causes an adverse effect on the resident and is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the daily dose to determine whether symptoms can be controlled by a lower dose or the drug can be altogether eliminated.

Note: Behavior interventions is a modification of the resident's behavior or environment, including staff approaches to care, to the largest degree possible to accommodate the behavioral symptoms.

Note: Clinically contraindicated means that gradual dose reductions or behavioral interventions need not be undertaken if:

- The resident has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) that have been stabilized with a maintenance dose of a antipsychotic drug without incurring significant side effects and has one of the following specific conditions:

  - Schizophrenia;
  - Schizo-affective disorder;
  - Delusional disorder;
  - Psychotic mood disorders (including mania and depression with psychotic features);
  - Acute psychotic episodes;
  - Brief reactive psychosis;
  - Schizophreniform disorder;
  - Atypical psychosis;
  - Tourette's disorder; or
  - Huntington's disease.

- The resident has organic mental syndrome, and gradual dose reductions have been attempted twice in one year that resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to previous dose reduction was necessary; or

- The resident's physician provides a justification as to why the continued use of the drug and the dose of the drug are clinically appropriate. This justification should include:

  - A diagnosis that includes a description of the symptoms (not simply a diagnostic label or code);
  - A discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be the result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor);
  - A description of the justification for the choice of a particular treatment or treatments; and
  - A discussion of why the present dose is necessary to manage the resident's symptoms.

Source: CMS Transmittal AB-02-143, CR 2318

GENERAL INFORMATION

Claims for Medicare Beneficiaries in State or Local Custody under a Penal Authority

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare Program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

The Centers for Medicare & Medicaid Services (CMS) presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of modifier QJ:

QJ — Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 CFR 411.4(b)

Effective January 1, 2003, local carriers and durable medical equipment regional carriers (DMERCs) must deny claims identified by the Common Working File (CWF) as noncovered under 42 CFR 411.4(a) and 411.4(b). These noncovered charges will be adjudicated with Remark Code N103: "Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt."

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) the conditions of 42 CFR 411.4(b) were met, or (2) the beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

Source: CMS Transmittal AB-02-097, CR 2022

New Telephone Hours of Operation for the Medicare Parts A & B Beneficiary and Provider Customer Service Call Centers

Effective October 1, 2002, there are new extended telephone hours of operation in the Medicare Customer Service Call Centers:

- The new hours of operation for the **Beneficiary Part A & B** Call Center are 9:00 a.m. to 4:30 p.m.; Monday through Friday, in Eastern and Central time zones (excluding holiday closings).
- The new hours of operation for the **Provider Part A** Call Center are 9:00 a.m. to 4:30 p.m.; Monday through Friday, in Eastern and Central time zones (excluding holiday closings).
- The new hours of operation for the **Provider Part B** Call Center are 9:00 a.m. to 3:30 p.m.; Monday through Friday, in Eastern and Central time zones (excluding holiday closings).

New Changes for Florida Medicare Part B Provider Customer Service Call Center

In order to better serve you, effective October 28, 2002, our services associates can provide you with information for up to three inquiries. This includes any telephone reviews that you may need performed. With this change, our service associates will be better able to quickly access and respond to all inquiries.

For information on how the Integrated Voice Response (IVR) system can assist you, please refer to the Fourth Quarter 2002 *Medicare B Update!* (page 87).

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 health care 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.cms.hhs.gov/medicare/edi/hipaadoc.asp* and *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 June 30, 2002.

New Remark Codes

Code	Current Narrative
N113	You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115	This decision is based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is reasonable and necessary. A copy of this policy is available at *www.LMRP.net*.
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Modified Remark Codes

Code	Current Narrative
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim either within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: · If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or · If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you

may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42 CFR 411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later). You may make the request through any Social Security office or through this office.

MA01 (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, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later, 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 (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 the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. Decisions made by a QIO must be appealed to that QIO within 60 days. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

N103 Social Security records indicate that this beneficiary was a prisoner when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

Additionally, the following codes were modified before February 28, 2002, but were not included in Transmittal AB-02-067 (CR 1959), which was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 89-91).

Code	Current Narrative
MA49	Missing/Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50	Missing/Incomplete/invalid Investigational Device Exemption number for FDAapproved clinical trial services.
MA51	Missing/Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA82	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	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 accurately the group's name, address, zip code and their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee 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*/.

In most cases, reason code additions, modifications and retirements are requested by non-Medicare entities, Medicare may occasionally request changes. If the request comes from Medicare, it may be included in a Medicare instruction in addition to the regular code update program memorandum. Code changes requested by entities other than Medicare would not be routinely included in a Medicare instruction as part of a policy change, but modification or retirement of an existing code could impact Medicare. CMS will issue a PM on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update PM, and will establish the deadline for Medicare contractors to implement the reason and remark code changes applicable to Medicare that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors also can discontinue use of retired codes in prior versions. Contractors and shared system maintainers must modify their maps or programming as necessary by the date the specified electronic version or a higher numbered version is implemented or earlier if the replacing code is available for the earlier version(s), if a retired code is being used.

The committee approved the following reason code changes in June 2002:

New Reason Codes

Code	Current Narrative
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provide contracted/negotiated rate expired or not in file
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

Modified Reason Codes

Code	Current Narrative
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure/revenue code is inconsistent with the provider type/specialty (taxonomy).
108	Payment adjusted because rent/purchase guidelines were not met.

Source: CMS Transmittal AB-02-142, CR 2395

THE PATIENT FRIENDLY ADVISORY

Easy Resources to Help your Patients with their Medicare Questions

New Rules for the Medicare Appeals Process

The Centers for Medicare & Medicaid Services (CMS) has announced several changes to the Medicare appeals process effective October 1, 2002. These changes are a result of the Benefits Improvement and Protections Act of 1997.

People with Medicare have the right to appeal Medicare's decision about a healthcare payment or service. They may appeal if:

- They don't agree with the amount that is paid
- A service is not covered and they think it should be
- A service is stopped before they think it should be

Previously, your patients had 60 days to file Part A appeal requests and 6 months to file Part B appeal requests. The new time frames for both Part A and Part B appeal requests is 120 days.

To help explain this change to your patients, we have included a flyer that you can copy and distribute to your patients. Remember, you can refer your patients to 1-800-MEDICARE (1-800-633-4227), or for the hearing and speech impaired, 1-877-486-2048 for the TTY/TTD line, for more information and answers to their Medicare questions. Or, for those who have access to the Internet, refer them to *www.medicare.gov*.

New Rules for the Medicare Appeals Process

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or a Medicare managed care plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Appeal Rights under the Original Medicare Plan

If you are enrolled in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

New Appeals Timeframes

The timeframes for requesting an appeal changed as of October 1, 2002. If you disagree with any claims decisions on either Part A or Part B of your Medicare Summary Notice, you can request an appeal up to 120 days from the date shown on the front of your Medicare Summary Notice. Previously, Part A and Part B claims had different timeframes for appeals.

Interim Timeframe until January 1, 2003

Since it may take a few months to make the necessary changes in your Medicare contractor's computer systems, there is an interim timeframe until January 1, 2003. If your Medicare Summary Notice is dated September 30, 2002, or earlier, you will have 60 days to file Part A appeal requests and 6 months to file Part B appeal requests. If your Medicare Summary Notice is dated between October 1, 2002, and December 31, 2002, you will have 120 days to file Part A appeal requests and 6 months to file Part B appeal requests.

Appeals Instructions

Don't worry if you are concerned you may not remember these new time frames for appeals. The instructions on how to appeal will always be listed on the back of your Medicare Summary Notice. You can also call 1-800-MEDICARE (1-800-633-4227), or for the hearing and speech impaired, call 1-877-486-2048 for the TTY/TTD line, for more information and answers to your Medicare questions. Those who have access to the Internet may go to *www.medicare.gov*.

EDUCATIONAL RESOURCES

Medicare Education and Outreach—Calendar of Upcoming Events

Below is a calendar for upcoming Medicare Education and Outreach events during the month of December, 2002. Calendars for future events will be posted to our provider education Web site, *www.floridamedicare.com*. Please refer to the symbol legend below to determine the type of event listed. Please note; the events with the legend (T) will not have a city listed because it is a teleconference and you are required to call in.

When you find a listing you are interested in, please refer to our Web site or fax a request for more information to (904) 791-6035.

Legend:

(W) **Workshop**: Cost-based event that includes interaction, exercises, and in depth information.

(E) **Expo**: Cost-based multi-specialty event that includes concurrent classes, workshops, and interactive sessions.

(T) **Teleconference**: *Free* telephone session that deals with limited issues of a predetermined subject, and questions and answers.

(SS) **Specialty Seminar**: Cost-based seminar providing in-depth material about a specific specialty.

(BB) **Building Blocks**: *Free* seminar that gives overviews and general information on chosen subjects. *Note: These sessions do not include exercises and in-depth information.*

(M) **Meeting**: Free quarterly advisory meeting consisting of providers, representatives from various medical organizations, billing staff, and others.

For further information, including subject matter and registration, please see our Web site *www.floridamedicare.com*, call our registration hotline at (904) 791-8103, check your *Medicare B Update!* or fax questions to (904) 791-6035. *Customized on-site sessions are available for a fee. Call (904) 791-8114.*

December 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4 (W) "Basic Skills for Beginners" Part B: Ft. Lauderdale (M) PCOM Advisory Part A: Jacksonville	5 (W) "Beyond the Basics" Part B: Ft. Lauderdale	6 (M) PCOM Advisory Part B: Miami	7
8	9	10	11	12 (T) "Topic to be announced" Part A	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

ORDER FORM – 2003 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 ***2003*** (back issues for subscription requests received after January 2003 will be sent upon receipt of order).	700395	$70.00
q	**2003 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 2003 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2003. 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!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies. ***Available mid-November 2002***.	700400	$20.00

Subtotal $ _____

Tax (*add % for your area*) $ _____

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 *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* are available **free of charge** online at *www.floridamedicare.com*.

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

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

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***