Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education Web sites, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *www.connecticutmedicare.com* or *www.floridamedicare.com*, click on the "Join our Electronic Mailing List FCSO eNews" bar and follow the prompts. The *FCSO eNews* is sent at least every other week, more frequently as required.

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. Publications issued beginning in 1997 are available at no cost from our provider education Web sites: *www.connecticutmedicare.com* and *www.floridamedicare.com*.

Routing Suggestions:

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

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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 Connecticut and 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

Comprehensive Error Rate Testing (CERT)

First Coast Service Options. Inc. (FCSO) is a traditional Medicare contractor with claims processing responsibility as a carrier (Medicare Part B) in Connecticut and Florida, and as a fiscal intermediary (Medicare Part A) in Florida. Other Medicare contractors that pay claims include the durable medical equipment regional carriers (DMERC) and the regional home health and hospice intermediaries (RHHI). The Centers for Medicare & Medicaid Services (CMS) also utilizes contractors that do not have direct claims processing responsibility such as quality improvement organizations (QIO) and program safeguards contractors (PSC). PSCs focus on certain aspects of the Medicare program such as specific types of medical review and fraud detection and prevention. One PSC, AdvanceMed of Richmond, Virginia, has responsibility for CERT- the comprehensive error rate testing program.

Error rates are not new to the Medicare program. The Office of the Inspector General (OIG) has been reporting error rates based on medical reviews for services during 1996-2002. A national error rate has been reported based on a sample of claims paid by contractors during part of a given year. The paid claims of 50 beneficiaries were reviewed for selected contractors. Some 5,000-8,000 claims were reviewed yearly. The error rates reported ranged from 13.8% in 1996 to 6.3% in 2002.

The CERT will produce several error rates based on medical reviews done by the CERT contractor for services performed in 2001 forward. Because of the different methodology and definitions, comparison to previously reported OIG rates will not be valid. A much larger sample, approximately 200 claims processed monthly by each contractor, will be requested from physicians and providers in the respective contractor's jurisdiction. Eventually, some 200,000 paid or denied claims will be assessed per year, and all contractors that pay claims will be included in the process. Several error rates will be reported, including:

- *paid claims error rate* (dollars paid incorrectly / total dollars paid),
- *claims processing error rate* ([claim lines paid incorrectly + claim lines denied incorrectly] / total claim lines processed), and
- *provider compliance rate* (dollar value of claims submitted correctly / dollar value of total claims submitted).

The findings will be used to develop and supplement programs and processes directed at improving claims processing and provider billing practices. The goal is to pay claims correctly.

A major problem noted in preliminary reports is the failure of physician offices and other providers to respond to requests for medical records. FCSO data from AdvanceMed shows 30-75% of line item errors are due to failure to submit documentation. If you do not provide documentation, AdvanceMed will determine that your claim was paid in error and the contractor will request a refund for that claim. If you submit the documentation and an error is noted, you are only liable for the amount in error and no further assessment or audit will be done. Documentation will only be requested on previously processed claims.

The CERT program may take a few years to develop benchmarks. However, CERT will have the most benefit for the Medicare program if physicians and providers submit documentation when requested. If one or more of your claims are sampled, a letter from AdvanceMed will provide the details regarding the needed information and the name of a contact person. The CERT Web site *is www.psccert.org*. FCSO looks forward to using the CERT program to improve payment of claims for physicians and providers.

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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

The *Medicare B Update!* is a comprehensive magazine published quarterly by First Coast Service Options, Inc. (FCSO) for all Part B providers in Connecticut and Florida. In accordance with notification requirements established by the Centers for Medicare & Medicaid Services, approximate delivery dates for fiscal year 2004 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2004	**Mid-November 2003**	**January 1, 2004**
Second Quarter 2004	Mid-February 2004	April 1, 2004
Third Quarter 2004	Mid-May 2004	July 1, 2004
Fourth Quarter 2004	Mid-August 2004	October 1, 2004

Important notifications that require communication in between these dates will be posted to the FCSO Medicare provider education Web sites, *www.connecticutmedicare.com* and *www.floridamedicare.com*. In some cases, additional unscheduled special issues may be published.

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain it from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form in the Third Quarter 2003 issue).

Distribution of the *Update!* in hardcopy format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to either Connecticut or Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us.*

For additional copies, providers may purchase a separate annual subscription for $70. All issues published since 1997 may be downloaded from the Internet, free of charge.

FCSO Medicare Part B uses the same mailing address for *all* correspondence, and cannot designate that 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.

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into four distinct sections. Following the table of contents, a letter from the Carrier Medical Director, and an administrative information section, the *Update!* begins with content applicable to both states, as noted above. Within this section, information is categorized under claims, coverage/reimbursement, electronic media claims, or general information. Information in these sections is categorized as follows. The **claims** section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information. The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present 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. The section pertaining to **electronic media claim** (EMC) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA). The **general information** section includes fraud and abuse, provider registration, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

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 medical review** and **comprehensive data analysis** will *always* be state-specific, as will the **educational resources** section.

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.

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. **The date the *Update!* is posted to the Web site is considered the notice date**, 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 the following section, "New Patient Liability Notice").
- 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 ABN. 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 January 1, 2003***. 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

Addition of Three New Diagnosis Codes to be Effective as Part of the October 1, 2003, ICD-9-CM Update

The National Center for Health Statistics (NCHS) has added three new diagnosis codes to annual update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), effective for services rendered on or after October 1, 2003. The new codes are:

079.82	SARS-associated coronavirus
480.3	Pneumonia due to SARS-associated coronavirus
V01.82	Exposure to SARS-associated coronavirus

The CMS Web site, *http://www.cms.hhs.gov/medlearn/icd9code.asp*, has been updated with the new ICD-9-CM diagnosis codes. If you wish to have an updated full diagnostic addendum and index when it is completed, you must download it from the NCHS Web site *at www.cdc.gov/nchs/icd9.htm*. The NCHS Web site will be updated shortly with the new codes.

Source: CMS Transmittal AB-03-129, CR 2842

***Third party Web sites**. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites, and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

CMS Posts Correct Coding Initiative Edits On Internet

The Centers for Medicare & Medicaid Services (CMS) has now made it easier for physicians and other providers to bill properly and be paid promptly for their services to Medicare beneficiaries. CMS has posted on its Web site the automated edits used to identify questionable claims and adjust payments to reflect what would have been paid if the claim had been filed correctly. The edits, known as the National Correct Coding Initiative (NCCI), identify pairs of services that normally should not be billed by the same physician for the same patient on the same day. The NCCI also promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies.

While the NCCI is one of the cornerstones of CMS' efforts to ensure that Medicare and beneficiaries do not pay twice for the same service or for duplicative services, CMS believes physicians should have easy access to the edits CMS uses to identify incorrect claims.

The NCCI includes two types of edits. One set – the comprehensive/component edits – identifies code pairs that should not be billed together because one service inherently includes the other. The other – the mutually exclusive edits – identifies code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day. For example, a mutually exclusive edit might identify two different types of testing that yield equivalent results.

Until today, the NCCI edits have been available to physicians and other providers on a paid subscription basis, but now they are available to anyone with a personal computer.

The NCCI edits will be posted as a spreadsheet that will allow users to sort by procedural code and by effective date. A "Find" feature will allow users to look for a specific code. The edit files are indexed by procedural code ranges for easy navigation. The new Web page also includes links to documents that explain the edits: the NCCI Policy Manual for Part B Medicare Carriers, Medicare Carriers Manual, and the NCCI Question and Answer page.

CMS developed the NCCI to promote national correct coding by physicians and other providers and to ensure appropriate payments for Medicare services. The coding policies developed are based on coding conventions defined in the American Medical Association's *CPT* (*Current Procedural Terminology*) manual, national and local policies and edits, coding guidelines developed by national medical specialty societies, analysis of standard medical and surgical practice, and review of current coding practice. The NCCI is updated quarterly.

The NCCI edits are posted at *http://cms.hhs.gov/physicians/cciedits/default.asp*.

HMO Claims Are Returned as Unprocessable

It is the responsibility of the beneficiary and his or her provider to ensure that claims are sent to the correct insurer. FCSO does not forward claims submitted to us incorrectly on behalf of beneficiaries who are members of a Health Maintenance Organization (HMO) to the HMO; such claims are returned as unprocessable. As a reminder, claims returned as unprocessable are not afforded appeal rights.

Claims for Services Furnished to a Beneficiary Who is a Member of an HMO for only a Portion of the Claim

Medicare carriers sometimes receive claims when the beneficiary is a member of an HMO that include services furnished when the beneficiary *was* a member, and services furnished when the beneficiary *was not* a member of an HMO. In such cases, the non-member portion of the claim is processed; the HMO portion is returned as unprocessable with instructions for the service provider to submit a claim to the beneficiary's HMO for those services.

Source: CMS Transmittal 1792, CR 2473; MCM 4267.1

Health Professional Shortage Areas

Physicians are eligible for a 10% bonus when they render service(s) in certain medically underserved areas. These areas, known as Health Professional Shortage Areas (HPSAs), may cover an entire county or a portion of a county or city, and are designated as either rural or urban HPSAs. HPSA designations are made by the Division of Shortage Designation (DSD) of the Public Health Service (PHS).

The incentive payments are based on 10% of the paid amount for both assigned and nonassigned claims for services performed by the physician. The incentive payment is not made on a claim-by-claim basis; rather, payments are issued quarterly.

Eligibility

A physician is eligible for the HPSA incentive payment *when services are furnished in an area designated as a HPSA*, regardless of where the physician's office is located. For example, a physician's office may be located in an area not designated as a HPSA; however, the physician may treat a patient in a nursing facility located in a HPSA. In this instance, the physician would be eligible for the HPSA incentive payment. Likewise, the physician's office may be in a HPSA; however, the physician may treat a patient in his/her home that is not located in a HPSA. In this case, the physician is *not* eligible for the HPSA incentive payment.

Only physicians are eligible for the HPSA incentive payments. The following degrees/credentials are considered physicians eligible for the incentive payments: M.D., D.O., D.C., D.P.M., D.D.S., and O.D.

Claims Filing Requirements

To report services furnished in a HPSA, one of the following procedure code modifiers should be reported with the service:

QB	Physician service rendered in a rural HPSA
QU	Physician service rendered in an urban HPSA

In addition, item 32 of Form CMS-1500 (or electronic equivalent) must be completed when either the QB or QU modifiers is billed. The physical location where the service was furnished must be indicated, if it is other than the patient's home.

Appeal of HPSA Incentive Payments

The incentive payments do not include remittance advice notices; only a list of the claims to which the incentive payment applies is provided with the payment. As a result, physicians have not been provided with an opportunity to challenge the amounts of their HPSA incentive payments on nonassigned claims or to challenge nonassigned claims where incentive has not been paid.

CMS has provided clarification of these issues:

- In cases where a physician is not satisfied with the amount of the incentive payment on either assigned or nonassigned claims, he or she may request a review of the incentive payment. The review request must be made within 60 days of the date when the incentive payment was issued.
- In cases where an incentive payment was not made on a claim (assigned or nonassigned), but the physician believes that one should have been made, he or she may request a reopening of that particular claim. The request must be within one year of the claim payment.

  Note: If the physician is unsure of the date a nonassigned claim was *processed*, the request for reopening may be made within one year of the date the claim was *submitted*, to ensure the request for the reopening is made within the one-year time limit.

Geographic HPSA Designations

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment), as of July 3, 2003.

Connecticut

- Fairfield/
  Southwest Bridgeport/
  Census tracts (C.T.) 0712.00, 0706.00, 0705.00, 0702.00, 7070.00, 0704.00, 0710.00, 0708.00, 0711.00, 0703.00, 0709.00
  Central/East Bridgeport/
  C.T. 0744.00, 0738.00, 0713.00, 0714.00, 0742.00, 0741.00, 0743.00, 0715.00, 0735.00, 0740.00, 0717.00, 0736.00, 0716.00, 0739.00
  Central Norwalk/
  C.T. 0440.00, 0441.00, 0444.00, 0445.00
- Hartford/
  North Central Hartford/
  C.T. 5044.00, 5014.00, 5022.00, 5020.00, 5009.00, 5037.00, 5017.00, 5012.00, 5034.00, 5031.00, 5033.00, 5035.00, 5040.00, 5005.00, 5039.00, 5042.00, 5041.00, 5018.00, 5016.00, 5008.00, 5036.00, 5038.00, 5032.00, 5011.00, 5021.00, 5021.00, 5013.00, 5015.00, 5010.00
  Charter Oak Terrace/Rice Heights/
  C.T. 5030.00, 5049.00, 5028.00, 5019.00, 5046.00, 5003.00, 5029.00, 5002.00, 5001.00, 5027.00, 5004.00, 5045.00, 5043.00
- New Haven/
  Fair Haven/
  C.T. 1421.00, 1423.00, 1424.00, 1426.01, 1426.02, 1425.00, 1422.00
- New London/
  Central Groton/
  C.T. 7028.00, 7027.00, 7023.00, 7022, 00, 7025.00

Florida

- Bradford
- Clay/
  Keystone Heights division
- Dixie
- Escambia /
  Atmore (AL/FL)/
  C.T. 0039.00, 0038.00, and 0040.00
- Gadsden
- Glades
- Hardee
- Hendry/
  Labelle/
  C.T. 9604.00, 9603.00
- Holmes
- Lafayette
- Madison
- Martin/
  Indiantown/
  Indiantown division
- Sumter
- Suwannee
- Wakulla
- Walton
- Washington

Invalid or Inappropriate Modifiers

Effective for claims processed on or after November 3, 2003, billing invalid or inappropriate modifiers will result in claims being **returned as unprocessable**. This applies to the following scenarios:

1. modifier invalid
2. discontinued modifier submitted after date of discontinuance
3. new modifier submitted before implementation date
4. incorrect or inappropriate procedure-to-modifier combination
5. modifier required but not submitted

The examples below are common errors that will cause claims to be returned as unprocessable:

- Modifier billed more than once for the same line item (e.g., *71020 26 26*; *80061* QW QW). This is an invalid procedure-to-modifier combination.
- Claims submitted with '00' in the modifier field; this is not a valid modifier. (**Note** to providers who bill electronically: if your billing software or vendor is 'zero-filling' the modifier fields when no modifier is to be indicated, this must be corrected.)
- Modifier Q1 is an old modifier that was once used generally by podiatrists; it was discontinued effective September 30, 1997, yet continues to be billed.
- Use of modifier 26 with procedure codes that are professional services by description, e.g., *CPT 93010 (Electrocardiogram, routine ECG with at least 12 leads;* ***interpretation and report only****)*, or use of modifier TC with codes that are technical-only, e.g., *93012 (Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time;* ***tracing only****)* [emphasis added].
- Spaces between modifier fields and/or in the modifier field, which causes the modifier to appear as a one-digit (and, therefore, invalid) modifier.

For more information regarding unprocessable claims, please refer to the Fourth Quarter 2002 *Medicare B Update!* (pages 6-11). As a reminder, claims returned as unprocessable must be corrected and resubmitted. Since such claims were not accepted, no appeal rights exist.

Jurisdictional Pricing Requirement for New Place of Service (POS) Codes

Information concerning new POS codes was published in the Fourth Quarter 2003 *Medicare B Update!* (pages 57-61). Since then, it has come to our attention that several of the new POS codes are subject to jurisdictional pricing rules. The new POS codes affected are:

13	Assisted Living Facility
14	Group Home
49	Independent Clinic
57	Non-residential Substance Abuse Treatment Facility

For these POS, providers *must* enter the name and complete address of the facility where the services were performed in Item 32 of Form CMS-1500 or electronic equivalent. A complete address includes the ZIP code. The ZIP code allows carriers to determine the correct pricing locality for claims payment purposes. Claims received without a name and complete address in Item 32 will be considered incomplete and will be returned as unprocessable. Claims returned as unprocessable are not afforded appeal rights; such claims must be corrected and resubmitted.

Requirements for Medicare Hearings—Reminder to Providers

To help reduce the number of hearing requests dismissed each month, and to handle your requests quicker, please remember that a request for a Medicare hearing (Part A or Part B) *must* meet a number of requirements before the request can be accepted:

- the service at issue must have been reviewed (appealed),
- the hearing request must be made within six months of the date of the review determination, and
- the amount in controversy must be at least $100.00.

Under the aggregation rules, claims may be combined to meet the amount in controversy requirement. When requesting a hearing officer hearing the provider ***must*** clearly state that he/she is aggregating claims to meet the amount in controversy requirement ***and*** the provider must specify in the appeal request the specific claims that are being aggregated. If the request for the hearing officer hearing does not specifically state that the claims are being aggregated, and/or does not list the specific claims being aggregated, each claim will be treated as an individual request for a hearing; those that do not meet the amount in controversy requirement will be dismissed.

"Split-Split" Care—Clarification of Date of Service Requirement

We published an article pertaining to billing for "split-split" care in the Fourth Quarter 2003 *Medicare B Update!* (pages 13-14). The CMS Form-1500 examples provided on page 14 incorrectly indicated a 2-digit year in the date(s) of service field (item 24A) – the year of service must be billed as a *4*-digit date (i.e., 2003 instead of 03). The examples also provided dates in month/day format in item 19; however, CMS Form-1500 requirements specify use of a 6- or 8-digit date. The article text and balance of the examples remain accurate. We apologize for any inconvenience this may have caused.

Timeframe Filing Provision on Reconsiderations and Appeals—Reminder to Providers

Providers and beneficiaries who disagree with Medicare's initial determination have the right to request a review. **A request for an appeal must be submitted in writing within 120 days from the date of the initial Medicare notice.**

Section 1869(a)(3)(C) of the Social Security Act eliminates the distinction between the 60-day time limit for requesting a Part A reconsideration and the 180-day time limit for requesting a Part B review by creating a 120-day time limit for filing requests for appeal of all Medicare initial determinations. On October 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented the uniform 120-day timeframe for requesting a reconsideration or appeal of and initial determination on a Medicare Part A or B claim.

Requests for an appeal of a Medicare Part B claim processed by the **Connecticut** Medicare carrier must be submitted to:

Attention: Appeals
First Coast Service Options, Inc.
Medicare Part B Claim Review
P. O. Box C 1016
Meriden CT 06450-1016

Requests for an appeal of a Medicare Part B claim processed by the **Florida** Medicare carrier must be submitted to:

First Coast Service Options, Inc.
Medicare Part B Claim Review
P. O. Box 2360
Jacksonville, FL 32231-0018

CMS recognizes that making the transition to a shorter timeframe for Part B appeal requests may prove difficult in situations where appellants need to obtain documentation from other sources in order to file an appeal.

In order to alleviate any hardship associated with the possible need to gather documentation faster than in the past, Medicare may grant an extension of up to 60 days in the 120-day filing deadline for appeals of Part B claims, provided that the appeal request includes a credible explanation from the beneficiary, physician, or supplier that the time was needed to gather the necessary supporting records. Without a credible explanation the extension will not be granted and these appeals will be considered untimely.

Timely Claim Filing Guidelines for All Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	*Last Filing Date*
October 1, 2001 – September 30, 2002	by December 31, 2003
October 1, 2002 – September 30, 2003	by December 31, 2004
October 1, 2003 – September 30, 2004	by January 3, 2006*****
October 1, 2004 – September 30, 2005	by January 2, 2007*****

*****If December 31 falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned as unprocessable, is not protected from the timely filing guidelines.

COVERAGE/REIMBURSEMENT

MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)/ HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

Medicare Physician Fee Schedule Payment Policy Indicators

We published an article in the Fourth Quarter 2003 *Medicare B Update!* (page 18) announcing CMS' new online Medicare physician fee schedule look-up, which is available on the CMS Web site at *http://cms.hhs.gov/physicians/mpfsapp/step0.asp*.

The information that follows provides definitions of the national policy indicators for each procedure code (and modifier, where applicable) on the Medicare physician fee schedule database (MPFSDB).

Procedure Code/Modifier (procmod)

The *CPT* or HCPCS procedure code and, where applicable, procedure code modifier.

Code Status (status)

Provides the fee schedule status of each code.

A Active code. These codes are separately paid under the physician fee schedule if covered. There will be relative value units (RVUs) and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D Deleted/discontinued codes. These codes are deleted effective with the beginning of the year and are always subject to a 90-day grace period.

E Excluded from physician fee schedule by regulation. These codes are for items and/or services that the Centers for Medicare & Medicaid Services (CMS) chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator was effective with the 2002 fee schedule as of January 1, 2002.

G Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90-day grace period.)

H Deleted modifier. For 2000 and later years, either the technical component (TC) or professional component (PC) shown for the code has been deleted and the deleted component is shown in the data base with the H status. (Code subject to a 90-day grace period.)

I Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code *not* subject to a 90-day grace period.)

L Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

N Non-covered service. These codes are carried on HCPCS as non-covered services.

P Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.

If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).

If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Social Security Act.

R Restricted coverage. Special coverage instructions apply.

T There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

X Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

Global Surgery (global)

Provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

MMM Maternity codes; usual global period does not apply.

XXX Global concept does not apply

YYY Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Preoperative, Intraoperative, and Postoperative Percentages

- Preoperative percentage (**pre op**) - modifier 56
  Provides the percentage for the preoperative portion of the global package.
- Intraoperative percentage (**intra op**) modifier 54
  Provides the percentage for the intraoperative portion of the global package including postoperative work in the hospital.
- Postoperative percentage (**post op**) - modifier 55
  Provides the percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.

The total of preoperative, intraoperative, and postoperative percentages will usually equal one. Any variance is slight and results from rounding.

Professional Component/Technical Component Indicator (PC/TC)

0 **Physician service codes**: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 **Diagnostic tests or radiology services**: This indicator identifies codes that describe diagnostic tests (e.g., pulmonary function tests), or therapeutic radiology procedures (e.g., radiation therapy). These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.

The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.

The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 **Professional component only codes**: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.

An example of a professional component only code is *93010, Electrocardiogram; interpretation and report*. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 **Technical component only codes**: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.

An example of a technical component code is *93005, Electrocardiogram, tracing only, without interpretation and report*. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes.

The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 **Global test only codes**: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 **Incident to codes**: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

6 **Laboratory physician interpretation codes**: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.

7 **Physical therapy service**: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.

8 **Physician interpretation codes**: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code *85060*. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for code *85060* furnished to hospital outpatients or non- hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 Concept of a professional/technical component does not apply.

Multiple Procedure (m/s) - Modifier 51

Indicates which payment adjustment rule for multiple procedures applies to the service.

0 No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 Standard payment adjustment rules in effect before January 1, 1996 or multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified on page 15.

Multiple endoscopy rules are applied to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).

If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

9 Concept does not apply.

Bilateral Surgery (b/s) - Modifier 50

Provides an indicator for services subject to a payment adjustment.

0 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).

The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

2 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).

The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 Concept does not apply.

Assistant at Surgery (a/s)

Provides an indicator for services where an assistant at surgery is never paid for per the Medicare Carriers Manual.

0 Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.

2 Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

9 Concept does not apply.

Co-Surgeons (co) - Modifier 62

Provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

0 Co-surgeons not permitted for this procedure.

1 Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.

2 Co-surgeons permitted; no documentation required if two specialty requirements are met.

9 Concept does not apply.

Team Surgeons (team) - Modifier 66

Provides an indicator for services for which team surgeons may be paid.

0 Team surgeons not permitted for this procedure.

1 Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.

2 Team surgeons permitted; pay by report.

9 Concept does not apply.

Physician Supervision of Diagnostic Procedures (supv dx)

Provides levels of physician supervision required for diagnostic tests payable under the physician fee schedule.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

01 Procedure must be performed under the general supervision of a physician.

02 Procedure must be performed under the direct supervision of a physician.

03 Procedure must be performed under the personal supervision of a physician.

04 Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

05 Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.

06 Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under state law.

21 Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

22 May be performed by a technician with on-line real-time contact with physician.

66 May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.

6A Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

77 Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

7A Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

09 Concept does not apply.

Facility Pricing

Codes that have reduced fees when performed in a facility setting are not identified in the tables that follow. However, these codes are annotated with an asterisk (*) in the *2003 Medicare Physician and Non-Physician Practitioner Fee Schedule* book. Facility fees are calculated at a national level with a reduced practice expense, because of reduced physician overhead associated with services provided in a facility.

Place of service (POS) codes to be used to identify facilities may be found in the Fourth Quarter 2003 *Medicare B Update!* (pages 57-61).

2003 Multiple Endoscopy Procedures (see page 12)

BASE	RELATED
29805	*29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826*
29830	*29834, 29835, 29836, 29837, 29838*
29840	*29843, 29844, 29845, 29846, 29847*
29860	*29861, 29862, 29863*
29870	*29871, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887*
31505	*31510, 31511, 31512, 31513*
31525	*31527, 31528, 31529, 31530, 31535, 31540, 31560, 31570*
31526	*31531, 31536, 31541, 31561, 31571*
31575	*31576, 31577, 31578, 31579*
31622	*31623, 31624, 31625, 31628, 31629, 31630, 31631, 31635, 31640, 31641, 31645*
43200	*43201, 43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226, 43227, 43228*
43235	*43231, 43232, 43236, 43239, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43258, 43259*
43260	*43240, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272*
44360	*44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373*
44376	*44377, 44378, 44379*
44388	*44389, 44390, 44391, 44392, 44393, 44394, 44397*
45300	*45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321, 45327*

45330	*45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45345*
45378	*45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387*
46600	*46604, 46606, 46608, 46610, 46611, 46612, 46614, 46615*
47552	*47553, 47554, 47555, 47556*
49320	*38570, 49321, 49322, 49323, 58550, 58551, 58660, 58661, 58662, 58670, 58671, 58672, 58673*
50551	*50555, 50557, 50559, 50561*
50570	*50572, 50574, 50575, 50576, 50578, 50580*
50951	*50953, 50955, 50957, 50959, 50961*
50970	*50974, 50976*
52000	*52007, 52010, 52204, 52214, 52224, 52250, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52282, 52283, 52285, 52290, 52300, 52301, 52305, 52310, 52315, 52317, 52318*
52005	*52320, 52325, 52327, 52330, 52332, 52334, 52341, 52342, 52343, 52344*
52010	*52347*
52351	*52345, 52346, 52352, 52353, 52354, 52355*
57452	*57454, 57455, 57456, 57460, 57461*
58555	*58558, 58559, 58560, 58561, 58562, 58563*

FLORIDA ONLY

2003 Carrier-Priced Codes for Florida—Correction

We provided allowances for certain carrier-priced codes (MPFSDB status=C) in the Fourth Quarter 2003 *Medicare B Update!* (pages 15-18). The fees for Florida were labeled incorrectly; the correct fees and labels are provided below.

This does not affect fees listed for Connecticut. We apologize for any inconvenience this has caused.

	Par			Nonpar			Limiting Charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0030	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0030 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0031	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0031 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0032	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0032 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0033	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0033 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0034	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0034 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0035	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0035 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0036	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0036 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0037	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0037 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0038	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0038 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0039	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0039 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45

	Par			Nonpar			Limiting Charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0040	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0040 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0041	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0041 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0042	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0042 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0043	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0043 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0044	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0044 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0045	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0045 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0046	138.05	145.14	150.70	131.15	137.88	143.16	150.82	158.57	164.64
G0046 TC	82.83	87.09	90.42	78.69	82.74	85.90	90.49	95.15	98.78
G0047	185.46	194.79	202.07	176.19	185.05	191.97	202.62	212.81	220.76
G0047 TC	111.27	116.87	121.24	105.71	111.03	115.18	121.56	127.68	132.45
G0125	2,099.10	2,397.25	2,412.98	1,994.14	2,277.39	2,292.33	2,293.27	2,619.00	2,636.18
G0125 TC	2,024.88	2,215.98	2,332.20	1,923.64	2,105.18	2,215.59	2,212.18	2,420.96	2,547.93
G0186	593.27	627.80	651.72	563.61	596.41	619.13	648.15	685.87	712.00
G0187	840.56	888.50	922.33	798.53	844.07	876.21	918.31	970.69	1,007.65
G0210	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0210 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0211	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0211 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0212	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0212 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0213	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0213 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0214	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0214 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0215	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0215 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0216	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0216 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0217	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0217 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0218	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0218 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0220	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0220 TC	2,024.88	2,215.99	2,332.50	1,923.64	2,105.19	2,215.88	2,212.18	2,420.97	2,548.26
G0221	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0221 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0222	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0222 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0223	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0223 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0224	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0224 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0225	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0225 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0226	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0226 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0227	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0227 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0228	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0228 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0229	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0229 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93

	Par			Nonpar			Limiting Charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0230	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0230 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0231	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0231 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0232	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0232 TC	2,024.42	2,215.99	2,332.20	1,923.20	2,105.19	2,215.59	2,211.68	2,420.97	2,547.93
G0233	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0233 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0234	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0234 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0253	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0253 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
G0254	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
G0254 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
R0070	97.02	97.02	97.02	92.17	92.17	92.17	105.99	105.99	105.99
R0075	97.02	97.02	97.02	92.17	92.17	92.17	105.99	105.99	105.99
21088	6,173.48	6,173.48	6,173.48	5,864.81	5,864.81	5,864.81	6,744.53	6,744.53	6,744.53
62367	58.72	62.24	65.32	55.78	59.13	62.05	64.15	68.00	71.36
62367 TC	35.23	37.35	39.19	33.47	35.48	37.23	38.49	40.80	42.82
62368	90.47	96.06	100.99	85.95	91.26	95.94	98.84	104.95	110.33
62368 TC	54.29	57.64	60.60	51.58	54.76	57.57	59.31	62.97	66.21
74300	45.91	48.60	50.84	43.61	46.17	48.30	50.16	53.10	55.54
74300 TC	27.55	29.16	30.51	26.17	27.70	28.98	30.10	31.86	33.33
74301	26.10	27.52	28.71	24.80	26.14	27.27	28.51	30.07	31.37
74301 TC	15.66	16.51	17.22	14.88	15.68	16.36	17.11	18.04	18.81
75952	639.19	698.08	752.27	607.23	663.18	714.66	698.32	762.65	821.85
75952 TC	38.51	415.85	451.37	36.58	395.06	428.80	42.07	454.32	493.12
75953	248.03	292.51	337.28	235.63	277.88	320.42	270.97	319.57	368.48
75953 TC	148.82	175.51	202.37	141.38	166.73	192.25	162.59	191.74	221.09
76012	189.45	208.37	226.05	179.98	197.95	214.75	206.97	227.64	246.96
76012 TC	113.67	125.02	135.63	107.99	118.77	128.85	124.18	136.58	148.18
76013	227.43	260.76	293.61	216.06	247.72	278.93	248.47	284.88	320.77
76013 TC	136.46	156.45	176.17	129.64	148.63	167.36	149.08	170.92	192.47
76350	14.50	15.98	16.95	13.77	15.18	16.10	15.84	17.46	18.52
78172	67.25	70.73	73.47	63.89	67.19	69.80	73.47	77.27	80.27
78172 TC	40.35	42.44	44.08	38.33	40.32	41.88	44.08	46.37	48.16
78282	47.71	50.43	52.69	45.32	47.91	50.06	52.12	55.09	57.56
78282 TC	28.63	30.26	31.61	27.20	28.75	30.03	31.28	33.06	34.53
78414	56.60	59.65	62.14	53.77	56.67	59.03	61.84	65.17	67.89
78414 TC	33.96	35.79	37.28	32.26	34.00	35.42	37.10	39.10	40.73
78459	2,101.42	2,296.18	2,415.14	1,996.35	2,181.37	2,294.38	2,295.80	2,508.58	2,638.54
78459 TC	2,024.88	2,215.99	2,332.20	1,923.64	2,105.19	2,215.59	2,212.18	2,420.97	2,547.93
79300	210.76	222.29	231.42	200.22	211.18	219.85	230.26	242.85	252.83
79300 TC	126.46	133.38	138.85	120.14	126.71	131.91	138.16	145.72	151.69
79420	189.35	199.23	207.15	179.88	189.27	196.79	206.86	217.66	226.31
79420 TC	113.61	119.54	124.29	107.93	113.56	118.08	124.12	130.60	135.79
86485	15.78	17.40	19.39	14.99	16.53	18.42	17.24	19.01	21.18
91132	65.26	69.16	72.36	62.00	65.70	68.74	71.30	75.56	79.05
91132 TC	39.15	41.50	43.49	37.19	39.42	41.32	42.77	45.34	47.51
91133	81.39	85.86	89.45	77.32	81.57	84.98	88.92	93.80	97.72
91133 TC	48.83	51.52	53.67	46.39	48.94	50.99	53.35	56.29	58.63
93318	280.81	294.27	304.45	266.77	279.56	289.23	306.78	321.49	332.61
93318 TC	168.49	176.56	182.67	160.07	167.73	173.54	184.08	192.89	199.57
93621	282.30	300.62	316.04	268.19	285.59	300.24	308.41	328.43	345.27
93621 TC	169.38	180.38	189.62	160.91	171.36	180.14	185.05	197.07	207.16
93622	469.01	521.31	570.90	445.56	495.24	542.35	512.39	569.53	623.71
93622 TC	281.41	312.79	342.54	267.34	297.15	325.41	307.44	341.72	374.22

	Par			Nonpar			Limiting Charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
93623	376.23	398.35	416.03	357.42	378.43	395.23	411.03	435.20	454.51
93623 TC	225.92	239.01	249.62	214.62	227.06	237.14	246.82	261.12	272.71
93662	396.20	432.09	465.04	376.39	410.49	441.79	432.85	472.06	508.06
93662 TC	237.72	259.25	279.03	225.83	246.29	265.08	259.71	283.23	304.84
94642	26.69	29.09	30.50	25.36	27.64	28.97	29.16	31.78	33.32
95824	88.92	99.71	104.70	84.47	94.72	99.47	97.15	108.93	114.38
95824 TC	53.35	59.82	62.82	50.68	56.83	59.68	58.28	65.35	68.63
95965	1,018.11	1,065.94	1,101.87	967.20	1,012.64	1,046.78	1,112.29	1,164.54	1,203.79
95965 TC	610.87	639.57	661.12	580.33	607.59	628.06	667.38	698.73	722.27
95966	518.80	547.25	570.02	492.86	519.89	541.52	566.79	597.87	622.75
95966 TC	311.28	328.35	342.00	295.72	311.93	324.90	340.07	358.72	373.63
95967	455.41	481.00	501.68	432.64	456.95	476.60	497.54	525.49	548.09
95967 TC	273.25	288.60	301.01	259.59	274.17	285.96	298.53	315.30	328.85
99082	1.93	1.93	1.93	1.83	1.83	1.83	2.11	2.11	2.11

AMBULANCE

Adjustment to the Rural Mileage Payment Rate for Ground Ambulance Services

The Ambulance Fee Schedule payment includes a rural adjustment to take into consideration the regional and operational variances in the cost of providing services in different areas of the country.

Effective January 1, 2004, the mileage rate for ground ambulance services originating in rural areas remains 150 percent of the urban mileage rate for the first 17 miles; the payment rate for ground ambulance miles 18 to 50, inclusive, will be equivalent to the urban mileage rate with no rural adjustment. The new payment rate for ground ambulance miles applies to all ground ambulance service claims with dates of service on or after January 1, 2004.

Source: CMS Transmittal AB-03-110, CR 2767

Payment Policy When More Than One Patient Is Onboard an Ambulance

The final regulation to establish an ambulance fee schedule contains a provision that clarifies payment policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance. This policy applies to both ground and air transports (for purposes of this article, the term "ground transport" includes transport by water ambulance). This policy is effective for services provided on or after April 1, 2002, processed on or after October 30, 2002.

- When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport (the "allowed charge" for a single beneficiary transport is the lower of the submitted charge and the fee schedule amount for the service—which, during the fee schedule transition period, is a blended amount). The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.
- If two patients are transported at the same time in one ambulance to the same destination, the adjusted payment allowance for each Medicare beneficiary would equal 75% of the single-patient allowed amount applicable to the level of service furnished a beneficiary, plus 50% of the total mileage payment allowance for the entire trip. If three or more patients are transported at the same time in one ambulance to the same destination, the adjusted payment for each Medicare beneficiary would equal 60% of the single-patient allowed amount applicable to the level of service furnished that beneficiary plus a proportional mileage allowed amount, (i.e., the total mileage allowed amount divided by the number of all the patients onboard). See "Processing Multiple Patient Transports," below.
- The fact that the level of medically necessary service among the patients may be different is not relevant to this payment policy. The percentage is applied to the allowed amount applicable to the level of service that is medically necessary for each beneficiary.
- If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency versus non-emergency ground transport.

  For an emergency ground transport, which includes basic life support - emergency (BLS-E), advanced life support 1 - emergency (ALS1-E), advanced life

support 2 (ALS2), and specialty care transport (SCT), the mileage payment is based on the number of miles to the nearest appropriate facility for each patient, divided by the number of patients on board when the vehicle arrives at the facility. This formula applies cumulatively for beneficiaries who are the second or third patient to be delivered. Absent evidence to the contrary, the carrier assumes the sequence of deliveries was predicated on the medical needs of each patient.

For a non-emergency ground transport, which includes BLS and ALS1, the mileage payment shall be based on the number of miles from the point of pick-up to the nearest appropriate facility for each beneficiary, divided by the number of beneficiaries on board at the point of pick-up. This formula applies cumulatively for beneficiaries for multiple points of pick-up. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pick-up to the nearest appropriate facility is not covered. Thus, for non-emergency transports, the extra mileage that may be incurred by having multi-destinations shall not be taken into account.

For air transports the policy is the same as for emergency ground transports.

- If a Medicare beneficiary is furnished medically necessary supplies, and the supplier bills supplies separately, then the allowed amount of the supplies is not subject to an apportionment for multiple patients. The allowed amount for supplies should be determined in the same manner as if the beneficiary was the only patient onboard the vehicle.

Claim Submission Requirements

Suppliers must identify claims for multiple transports with modifier **GM** (multiple patients on one ambulance trip). Documentation to specify particulars of a multiple transport must be submitted that includes at a minimum the total number of patients transported in the vehicle at the same time, and the health insurance claim number for each Medicare beneficiary. Submit the charge applicable to the appropriate service rendered to each beneficiary, and the total mileage for the trip. Suppliers should make every effort to submit all associated Medicare claims for that multiple transport at the same time. Associated Medicare claims for multiple transport must be submitted within a reasonable number of days of submitting the first claim.

Failure to comply with the documentation requirements and timely filing of associated claims may result in a delay of payment determination, additional development requests, and possible denials.

Processing Multiple Patient Transports

Carriers will process claims for covered multiple patient transports as follows:

When two patients are transported, for each beneficiary the carrier will allow 75% of the allowed amount for a single-person transport (excluding separately billable mileage). For mileage to a single destination, half of the total mileage will be allowed. For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for the first leg is the amount for the mileage divided by two. The allowed amount for the second leg is the full mileage. Thus, payment on behalf of a beneficiary whose transport is to the first nearest appropriate facility is based on half the mileage amount to that facility. Payment on behalf of the second beneficiary, whose transport was to the next nearest appropriate facility, is based on half of the mileage to the first facility plus all of the mileage from the first facility to the second facility. For mileage for non-emergency ground transports, only the mileage from the point of pickup to the nearest appropriate facility may be allowed. That amount is divided by the number of beneficiaries loaded on board at the point of pick-up. Mileage other than what would be incurred by transporting the beneficiary directly from the point of pick-up to the nearest appropriate facility is not covered.

When three or more patients are transported, for each beneficiary the carrier will allow 60% of the allowed amount for a single-person transport (excluding separately billable mileage). For mileage to a single destination, a pro rata share of the total mileage will be allowed. For mileage for emergency ground transports and all air transports to multiple destinations, the allowed amount for each leg of the transport is a pro rata share of the total mileage based on the number of patients on board upon arrival at each destination. For mileage for non-emergency ground transports, the allowed amount for each beneficiary is based on the mileage to the nearest appropriate facility divided by the number of beneficiaries loaded on board at the point of pick-up (including any intermediate points of pickup). Mileage other than what would be incurred by transporting each beneficiary directly from the point of pick-up to the nearest appropriate facility may not be taken into account.

Source: CMS Transmittal B-02-060, CR 1945

DRUGS AND BIOLOGICALS

Medicare Covered Drugs—Quarterly Pricing Update

The quarterly revisions to the single drug pricer (SDP) for most drugs and biologicals are provided below. These changes are effective for services rendered on or after January 1, 2003, processed on or after October 1, 2003.

***Note**: this is not a complete replacement file; only revisions are included. Please refer to previous publications for drugs not listed here.*

Code	Unit of Measure	Allowance	Code	Unit of Measure	Allowance	Code	Unit of Measure	Allowance
J0282	30 mg	15.94	J1742	1 mg	251.35	J9000	10 mg	9.69
J0300	Up to 125 mg	2.66	J1885	Per 15 mg	3.56	J9040	15 units	182.40
J0456	500 mg	25.55	J1940	Up to 20 mg	0.98	J9060	Per 10 mg	15.96
J0500	Up to 20 mg	17.06	J1950	3.75 mg	517.32	J9062	50 mg	79.80
J0592	0.1 mg	1.03	J2000	50 cc	3.99	J9065	Per 1 mg	51.30
J0600	Up to 1000 mg	44.10	J2010	Up to 300 mg	3.18	J9070	100 mg	5.73
J0620	Per 10 ml	6.42	J2020	200 mg	36.80	J9080	200 mg	10.89
J0640	50 mg	3.71	J2150	25% in 50 ml	3.27	J9090	500 mg	22.86
J0670	10 ml	2.15	J2210	Up to 0.2 mg	4.10	J9091	1 g	45.73
J0690	500 mg	2.25	J2250	Per 1 mg	1.28	J9092	2 g	91.45
J0725	Per 1,000 USP units	3.09	J2270	Up to 10 mg	0.77	J9093	100 mg	5.59
J0745	Per 30 mg	0.50	J2324	0.5 mg	151.62	J9094	200 mg	11.17
J0780	Up to 10 mg	4.18	J2370	Up to 1 ml	1.28	J9100	100 mg	3.19
J0850	Per vial	712.07	J2440	Up to 60 mg	3.56	J9110	500 mg	8.55
J1020	20 mg	2.68	J2510	Up to 600,000 units	9.60	J9140	200 mg	22.06
J1030	40 mg	4.13	J2515	Per 50 mg	1.32	J9150	10 mg	74.23
J1040	80 mg	8.27	J2545	Per 300 mg	50.77	J9160	300 mcg	1330.95
J1051	50 mg	5.04	J2590	Up to 10 units	1.72	J9180	50 mg	690.99
J1056	5 mg/25 mg	24.61	J2650	Up to 1 ml	0.31	J9181	10 mg	1.71
J1070	Up to 100 mg	4.95	J2680	Up to 25 mg	9.42	J9182	100 mg	17.10
J1080	1 cc, 200 mg	9.43	J2690	Up to 1 g	1.43	J9185	50 mg	356.07
J1120	Up to 500 mg	20.52	J2760	Up to 5 mg	31.92	J9190	500 mg	2.07
J1170	Up to 4 mg	1.55	J2765	Up to 10 mg	1.99	J9200	500 mg	136.80
J1190	Per 250 mg	233.97	J2770	500 mg	114.58	J9206	20 mg	145.74
J1245	Per 10 mg	5.70	J2788	50 mcg	34.77	J9214	1 million units	14.88
J1410	Per 25 mg	61.51	J2910	50 mg	17.31	J9216	3 million units	209.22
J1460	1 cc	12.17	J2920	Up to 40 mg	1.95	J9218	1 mg	70.28
J1470	2 cc	24.35	J2930	Up to 125 mg	3.24	J9266	Per single dose vial	1543.75
J1480	3 cc	36.56	J2941	1 mg	45.92	J9280	5 mg	63.84
J1490	4 cc	48.69	J2993	18.1 mg	1364.44	J9290	20 mg	207.48
J1500	5 cc	60.87	J2997	1 mg	36.70	J9291	40 mg	285.00
J1510	6 cc	72.88	J3100	50 mg	2690.88	J9310	100 mg	501.13
J1520	7 cc	85.12	J3120	Up to 100 mg	8.98	J9320	1 g	141.47
J1530	8 cc	97.38	J3130	Up to 200 mg	17.96	J9355	10 mg	58.13
J1540	9 cc	109.66	J3265	10 mg/ml	1.56	J9390	10 mg	89.36
J1550	10 cc	121.72	J3301	Per 10 mg	1.60	P9041	5%, 50 ml	14.54
J1580	Up to 80 mg	1.90	J3315	3.75 mg	398.62	P9048	5%, 250 ml	29.10
J1630	Up to 5 mg	6.83	J3320	Up to 2 g	28.27	Q0187	Per 1.2 mg	1681.50
J1631	Per 50 mg	9.12	J3360	Up to 5 mg	0.86	Q4076	40 mg	0.62
J1644	Per 1000 units	0.40	J3395	15 mg	1603.13	Q4077	1 mg	37.05
J1645	Per 2500 IU	15.69	J3475	Per 500 mg	0.27	90385	Per dose	34.77
J1650	10 mg	6.47	J7051	Up to 5 cc	0.76	90645	Per dose	25.38
J1655	1000 IU	3.83	J7317	20 to 25 mg	138.71	90704	Per dose	19.43
J1670	Up to 250 units	119.70	J7504	250 mg	278.70	90705	Per dose	15.03
J1720	Up to 100 mg	2.49	J7511	25 mg	357.58	90732	Per dose	18.62

Source: October 2003 SDP files

***Single Drug Pricer (SDP) Coverage**: The presence or absence of a particular drug on the SDP file does not represent a determination that the Medicare Program either covers or does not cover that drug. The amounts shown on the SDP file indicate the maximum Medicare payment allowance, if the Medicare contractor determines that the drug meets the program's requirements for coverage. Similarly, the absence of a particular drug from the SDP file means that if the Medicare contractor determines that the drug is covered by Medicare, the local contractor must then determine the program's payment allowance by applying the program's standard drug payment policy rules. Medicare contractors separately determine whether a particular drug meets the program's general requirements for coverage and, if so, whether payment may be made for the drug in the particular circumstance under which it was furnished. Examples of this latter determination include, but are not limited to, determinations as to whether a particular drug and route of administration are reasonable and necessary to treat the beneficiary's condition, whether a drug may be excluded from payment because it is usually self-administered, and whether a least costly alternative to the drug exists.*

DURABLE MEDICAL EQUIPMENT

New Requirements - Physician's Order and Certificates of Medical Necessity (CMNs)

Effective January 1, 2004, section 2100.4 of the Medicare Carriers Manual (MCM), "Repairs, Maintenance, Replacement, and Delivery," has been revised to reflect the current policy for Durable Medical Equipment (DME) replacements.

Under the circumstance specified below, payment may be made for repair, maintenance, and replacement of medically required DME, including equipment that had been in use before the user enrolled in Part B of the program. However, payment may not be made for repair, maintenance, or replacement of equipment in the frequent and substantial servicing or oxygen equipment payment categories. In addition, payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.

Repairs

To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment that a beneficiary owns are covered when necessary to make the equipment serviceable. However, payment may not be made for repair of previously denied equipment or equipment in the frequent and substantial servicing or oxygen equipment payment categories. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the excess.

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental, and inexpensive or routinely purchased payment categories which are being rented.

A new CMN and/or physician's order is not needed for repairs.

Maintenance

Routine periodic maintenance, such as testing, cleaning, regulating, and checking of the beneficiary's equipment is not covered. Such routine maintenance is generally expected to be done by the owner rather than by a retailer or some other person who charges the beneficiary. Normally, purchasers of DME are given operating manuals that describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered.

However, more extensive maintenance performed by authorized technicians (based on the manufacturers' recommendations) is covered as repairs for medically necessary equipment a beneficiary owns. This might include, for example, breaking down sealed components and performing tests that require specialized testing equipment not available to the beneficiary. Payment may not be made for maintenance of purchased items that require frequent and substantial servicing or oxygen equipment (MCM section 5102.2.G).

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for maintenance of rented equipment are generally not covered. Payment may not be made for maintenance of rented equipment other than the maintenance and servicing fee established for capped rental items in MCM section 5102.1.E.4.

A new CMN and/or physician's order is not needed for covered maintenance.

Replacement

Replacement refers to the provision of an identical or nearly identical item. Situations involving the provision of a different item because of a change in medical condition are not addressed in this section.

Equipment the beneficiary owns (or is a capped rental item) may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). A physician's order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

The reasonable useful lifetime of DME is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but in no case can it be less than five years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.

Charges for the replacement of oxygen equipment, items that require frequent and substantial servicing or inexpensive or routinely purchased items that are being rented are not covered.

Delivery

Payment for delivery of DME whether rented or purchased is generally included in the fee schedule allowance for the item.

Source: CMS Transmittal 1815, CR 2751

END-STAGE RENAL DISEASE (ESRD)

MCM Updates Pertaining to Dialysis Services—Correction to Effective Date

We published information pertaining to revisions to sections 15062.1 and 15350 of the Medicare Carriers Manual (MCM) in the Fourth Quarter 2003 *Medicare B Update!* (page 30). Since release of that publication, an additional revision to MCM section 15062.1, "Payment for Physician Services Furnished to Dialysis Inpatients," was issued. The effective date of the change to this section was published as January 1, 2003; however, the correct date is *October* 1, 2003.

We apologize for any inconvenience this may have caused

Source: CMS Transmittal 1810, CR 2622; MCM sections 15062.1 & 15350

IMMUNIZATIONS

2003 Allowances for Administration of Influenza Virus, Pneumococcal Pneumonia, and Hepatitis B Vaccines

The 2003 allowances for administration of immunizations effective for services rendered on or after March 1, 2003, are not included in the Medicare Physician Fee Schedule (MPFS). HCPCS codes are:

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

The allowance for these services is based on an MPFS code, *90471 (immunization administration [includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections]; one vaccine (single or combination vaccine/toxoid).* The 2003 allowances for participating providers for this service are:

Connecticut	***Florida***		
	Loc 01/02	Loc 03	Loc 04
$8.86	$7.43	$8.18	$8.67

Therefore, these are the allowances for codes G0008, G0009, and G0010.

New Diagnosis Code for Influenza Virus Vaccine Claims

A new diagnosis code has been issued for billing influenza virus vaccine claims.

All Medicare institutional providers, Part B physicians, nonphysician practitioners, and suppliers who administer the influenza virus vaccine must use the new diagnosis code ICD-9-CM, V04.81 for claims with dates of service **on and after October 1, 2003.**

CMS has extended a 90-day grace period to accept claims billed by Part B physicians, nonphysician practitioners, and suppliers submitted with the old influenza virus vaccine diagnosis code ICD-9-CM, V04.8. Effective January 1, 2004, **only** claims submitted with the new diagnosis code ICD-9-CM V04.81 will be accepted by Medicare.

Source: Medicare Learning Network @ CMS (*http://cms.hhs.gov/medlearn/*)

Payment Amount for the Influenza Virus Vaccine

The payment allowance for influenza virus vaccine codes **(***CPT 90658* and *CPT 90659*) has been revised, to **$9.95**. Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination must take assignment on the claim for the vaccine.

The whole virus vaccine (*CPT 90659*) has not been produced for the 2003 flu season; therefore, providers should not bill *90659* for the influenza virus vaccine, regardless of the inclusion of a payment rate in Change Request 2918. If claims are inadvertently submitted with *90659*, however, they shall be paid the same as *CPT 90658.*

This change is effective for services provided on or after September 1, 2003, for claims processed on or after October 1, 2003.

Source: CMS Pub. 100-20 Transmittal: 3 Date: September 12, 2003 Change Request 2918

Pneumococcal Pneumonia Vaccine (PPV) Payment Increase Effective October 1, 2003

Effective October 1, 2003, the Medicare Part B payment for PPV will be increased to the lower of the charge billed to Medicare or $18.62. Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer PPV must take assignment on the claim for the vaccine.

For additional information about immunizations, refer to the Immunizations Quick Reference Guide at *www.cms.hhs.gov/medlearn/refimmu.asp*.

Source: CMS Notification Dated August 20, 2003

LABORATORY/PATHOLOGY

Guidelines for Medicare Part B Laboratory Testing

This article explains the Centers for Medicare & Medicaid Services' (CMS) coverage policies for diagnostic and screening prostate specific antigen (PSA) laboratory tests under Medicare Part B. It also explains the importance of including the date of service on orders for laboratory testing.

Diagnostic PSA Laboratory Testing

- Under section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of negotiated rulemaking with interested parties in the laboratory community to promote uniformity, administrative simplicity, and program integrity regarding coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B. As a result of this negotiated rulemaking, a National Coverage Decision (NCD) was developed for the diagnostic PSA test, which is a tumor marker for adenocarcinoma of the prostate and may be useful in the differential diagnosis of men presenting with as yet undiagnosed disseminated metastatic disease. When used in conjunction with other prostate cancer tests, such as digital rectal examination, the PSA test may assist in the decision-making process for diagnosing prostate cancer. PSA also serves as a marker in following the progress of most prostate tumors once a diagnosis has been established, as an aid in the management of prostate cancer patients, and in detecting metastatic or persistent disease in patients following treatment. The test is of proven value in differentiating benign from malignant disease men with lower urinary tract signs and symptoms (i.e., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence) as well as patients with palpably abnormal prostate glands on physical exam, and in patients with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder.
- The NCD for diagnostic PSA tests does not apply to screening PSA tests.
- Use *CPT*/HCPCS code *84153* for diagnostic PSA testing.

Screening PSA Laboratory Testing

- Screening PSA testing measures the level of prostate specific antigen in the patient's blood for the early detection of the marker for adenocarcinoma of the prostate subject to coverage, frequency, and payment limitations as follows:
  -Covered at a frequency of once every 12 months for men who have attained age 50 if at least 11 months have passed following the month in which the last Medicare-covered screening PSA test was performed; and
  -Must be ordered by the patient's physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is authorized under state law to perform the examination, fully knowledgeable about patient's medical condition, and who would be responsible for using the results of any examination (test) performed in the overall management of the patient's specific medical problem which includes explaining the results of the test to the patient.
- Use HCPCS code G0103 for the screening PSA test.

Date of Service for Laboratory Testing

During the clinical diagnostic laboratory services negotiated rulemaking, CMS learned that there was considerable variability regarding the date of service on laboratory claims. In order to promote uniformity, the committee recommended a national policy related to the date of service on laboratory claims. CMS published a proposed rule for public comment on March 10, 2000 (65 FR 13082) and published the rule final on November 23, 2001 (66 FR 58788). The final rule states that:

- The date of service for laboratory tests that is reported on the claim is to be the date the tested specimen was collected; and
- The person obtaining the specimen must furnish the date of collection of the specimen to the entity billing Medicare.

Physicians or their staff who draw specimens for testing must report the date of collection of the specimen on orders for laboratory tests. Laboratories may refuse to perform tests on orders for laboratory tests that do not include the information they need in order to seek payment for services performed, i.e., the date of collection of the specimen.

Source: CMS Transmittal AB-03-132, CR 2841

Changes to the Laboratory National Coverage Determination Edit Software for January 1, 2004

National coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Science Corporation and incorporated in the shared systems so laboratory claims subject to one of 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. Listed below are changes included in the January 2004 release of the edit module for clinical diagnostic laboratory services.

1. In accordance with the decision memorandum published on the coverage Internet site on September 17, 2003 (see *http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=97*), the following diagnosis codes are being added to the list of ICD-9-CM Codes Covered by Medicare for the prothrombin time (PT) and fecal occult blood test (FOBT) NCDs:
   - 863.91, pancreas head with open wound into cavity;
   - 863.92, pancreas body with open wound into cavity;
   - 863.93, pancreas tail with open wound into cavity;
   - 863.94, pancreas multiple and unspecified sites with open wound into cavity;
   - 863.95, appendix with open wound into cavity; and,
   - 863.99, other gastrointestinal sites with open wound into cavity.
2. In accordance with the decision memorandum published on the coverage Internet site on September 23, 2003 (see *http://cms.hhs.gov/mcd/viewdecisionmem.asp?id=93*), the following diagnosis codes are being deleted from the list of ICD-9-CM Codes Covered by Medicare for prothrombin time (PT) and partial thromboplastin time (PTT) NCDs:
   - V72.81, pre-operative cardiovascular examination (from PTT);
   - V72.83, other specified pre-operative examination (from PTT); and,
   - V72.84, pre-operative examination, unspecified (from PT and PTT).
3. In Program Memorandum AB-03-104 (CR 2814), CMS announced the addition of diagnosis code 401.1, benign essential hypertension, to the list of covered diagnoses for lipid testing. However, the corresponding change to the narrative of the lipid NCD that authorizes this code was not announced. By inclusion in this notice, CMS is announcing a change to the narrative of the lipid NCD included in the July 17, 2003, decision memorandum posted on the Internet at *http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=94*. The third bullet listed in the lipid NCD indications section is amended to read: "Any form of atherosclerotic disease, or any disease leading to the formation of atherosclerotic disease."
4. In Program Memorandum AB-03-104, CMS announced a number of ICD-9-CM codes deleted by the update to ICD-9-CM codes that became effective October 1, 2003. A 90-day grace period for the provider and laboratory community to adapt to these changes is provided. Thus, while CMS announced the changes in CR 2814, the software was not altered to deny claims when these codes were used. However, the grace period expires with the January update of the software and the following ICD-9-CM codes will be denied: 282.4, 331.1, 348.3, 530.2, 600.0, 600.1, 600.2, 600.9, 767.1, 790.2, V04.8, V43.2, V53.9, V54.0, V65.1.

Source: CMS Pub. 100-20 Transmittal: 10 Date: October 24, 2003 Change Request 2940

Fecal Leukocyte Examination under a CLIA Certificate for Provider-Performed Microscopy

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require a facility to be appropriately certified for each test performed. A facility that has a CLIA certificate for provider-performed microscopy (PPM) procedures may only perform tests that are categorized as either PPM procedures or waived tests under CLIA.

The Healthcare Common Procedure Coding System (HCPCS) code G0026 (fecal leukocyte examination) was discontinued on December 31, 2002. For calendar year (CY) 2003, *CPT* code *89055 (Leukocyte count, fecal)* was suggested as a possible code to be used for the discontinued G0026. However, under CLIA, the fecal leukocyte examination permitted for a PPM procedure certificate does not include a fecal leukocyte count. For CY 2003, Medicare contractors were instructed to permit the use of existing HCPCS code Q0111 (Wet mounts, including preparations of vaginal, cervical or skin specimens) for fecal leukocyte examination claims submitted by facilities with a valid PPM procedure CLIA certificate with dates of services on or after January 1, 2003, in Transmittal AB-03-127 (Change Request 2843). This instruction was posted to our provider education Web site on September 5, 2003.

The wording of the *CPT* code *89055* has been revised for CY 2004 to read "*Leukocyte assessment, fecal, qualitative or semiquantitative.*" The revised text meets the CLIA definition of the PPM procedure for the fecal leukocyte examination.

Therefore, effective for services rendered on or after January 1, 2004, a facility that has a CLIA certificate for PPM procedures may bill *CPT* code *89055* for fecal leukocyte examination.

Source: CMS Pub. 100-04 Transmittal: 12 Date: October 24, 2003 Change Request 2924

Payment for Fecal Leukocyte Examination Under a CLIA Certificate for Provider-Performed Microscopy (PPM) Procedures During 2003

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) requires a facility to be appropriately certified for each test performed. A facility that has a CLIA certificate for PPM procedures may only perform tests that are categorized as either PPM procedures or waived tests under CLIA.

HCPCS code G0026 (fecal leukocyte examination) was discontinued effective for services rendered on or after January 1, 2003. *CPT* code *89055 (fecal leukocyte count)* was a possible replacement code to be used for the discontinued G0026; however, under CLIA the fecal leukocyte examination permitted for a PPM procedure certificate does not include a fecal leukocyte count. Therefore, Medicare will permit the use of HCPCS code Q0111 (Wet mounts, including preparations of vaginal, cervical or skin specimens) for fecal leukocyte examination claims submitted by facilities with a valid PPM procedure CLIA certificate with dates of services on or after January 1, 2003.

Source: CMS Transmittal AB-03-127, CR 2843

New CLIA Waived Tests

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), effective June 1, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must be billed with modifier QW to be recognized as a waived test.

***CPT* Code**	**Test Name**	**Manufacturer**	**Effective Date**	**Use**
80101QW	ADC CLIA Waived Marijuana (THC) Test	Advance Diagnostics Corporation (ADC)	4/29/03	Screening test for the presence/ detection of cannabinoids (THC) in urine
80101QW	ADC CLIA Waived Multiple Drug Test Card	Advance Diagnostics Corporation (ADC)	4/29/03	Screening test for the presence/ detection of cannabinoids (THC), cocaine metabolites, methamphetamine opiates and phencyclidine (PCP) in urine.
80101QW	ADC CLIA Waived Marijuana (THC) and Cocaine Test	Advance Diagnostics Corporation (ADC)	4/30/03	Screening test for the presence/ detection of cannabinoids (THC), cocaine metabolites in urine.
86308QW	Genzyme OSOM Mono Test	Wyntek Diagnostic, Inc.	3/6/03	Quantitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infections mononucleosis.
87077QW	GI Supply, Div. Chek-Med Systems HP One	Phamatech	3/24/03	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).

Source: CMS Pub. 100-20 Transmittal 5, CR 2791, PCM #0327503

Diagnosis Code for Screening Pap Smear and Pelvic Examination Services—Effective Date

We provided information regarding additional allowable diagnosis codes for Pap smear and pelvic examinations in the Fourth Quarter 2003 *Medicare B Update!* (page 33). We published this change as being based on the date services are provided; however, the additional diagnoses are effective for services *processed* on or after October 1, 2003. We apologize for any inconvenience this may have caused.

ICD-9-CM Codes and Definitions

Low Risk

V76.2 Cervix (routine cervical Papanicolaou smear)
V76.47 Special screening for malignant neoplasm, vagina
V76.49 Special screening for malignant neoplasm, other sites

High Risk

V15.89 Other

Source: CMS Transmittal AB-03-054, CR 2637

Use of Modifier GY to Identify Clinical Diagnostic Laboratory Services Not Covered by Medicare

In November 2002, Medicare implemented 23 national coverage determinations (NCDs) for clinical diagnostic laboratory services. These NCDs are specific down to the ICD-9-CM code level and included lists of ICD-9-CM codes that are covered and those that are not covered by Medicare. The ICD-9-CM codes that are not covered by Medicare are codes that are excluded from coverage based on technical denials, such as routine screening services, rather than denial due to lack of medical necessity. Laboratories are permitted to bill beneficiaries for services that are not covered by Medicare for reasons other than medical necessity without providing for an advance beneficiary notice (ABN).

Medicare clinical diagnostic laboratory services are processed using a standardized laboratory edit module. This edit module returns a message to the local contractor indicating whether the claim passed the NCDs coverage edits, is denied for diagnoses on the noncovered list, or is denied as not medically necessary. Healthcare Common Procedure Coding System (HCPCS) coding provides for modifier GY to be used to indicate an item or service that is statutorily excluded, or does not meet the definition of any Medicare benefit. At present, the laboratory edit module response is not affected by the use of this modifier.

By **January 1, 2004**, the clinical diagnostic laboratory service edit module will be changed to consider the presence of modifier GY in selecting the appropriate response for claims for clinical diagnostic laboratory services. Use of modifier GY will result in a not covered response from the edit module in all cases. Laboratories should append modifier GY to the procedure codes for any service where the appropriate diagnosis for that service is on the list of diagnoses that are not covered by Medicare.

Source: CMS Pub. 100-04 Transmittal: 11 Date: October 24, 2003 Change Request 2933

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Changes to Code List for Therapy Services

CMS Program Memorandum (PM) B-03-065 supplements PM AB-03-018, CR 2183 and directs carriers to update the code list for therapy services that will not apply to the financial limitations when billed by physicians and certain nonphysician practitioners when not done under a therapy plan of care. This PM supersedes the effective date and implementation dates of PM AB-03-057 (CR 2709) only with respect to the "+" indicators on the list of HCPCS codes.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital). These limits were in effect in 1999, but were removed in 2000-2002. Beginning September 1, 2003, the limitations on outpatient therapy services will be implemented again.

Applicable Outpatient Rehabilitation HCPCS Codes

The following is a complete list of the 55 "+" codes. It includes 36 newly designated codes in bold and 19 codes previously designated "+".

29065+ 29075+ 29085+ 29086+ 29105+ 29125+ 29126+ 29130+ 29131+ ***29200+ 29220+ 29240+ 29260+ 29280+*** *29345+ 29355+ 29365+ 29405+ 29425+ 29445+ 29505+ 29515+* ***29520+ 29530+ 29540+ 29550+*** *29580+* ***29590+ 64550+ 90901+ 90911+ 92610+ 92611+ 92612+ 92614+ 92616+ 95831+ 95832+ 95833+ 95834+ 95851+ 95852+ 96000+ 96001+ 96002+ 96003+ 96105+ 96110+ 96111+ 96115+*** *97601+* **G0279+ G0280+** ***0020T+ 0029T+***

\+ These codes will *not* apply to the financial limits when they are *not* done under a therapy plan of care and they are billed by providers of services who are represented by any specialty codes except 65 and 67 (PT in Private Practice, OT in Private Practice), also 73 and 74 (which were incorrectly noted in AB-03-018 and have since been reassigned to specialties that are not therapy services). Specialty codes 73 and 74 will be removed in a future instruction. Physicians and nonphysician practitioners should only use therapy modifiers (GP, GN, GO) with the above codes when the services are provided under a therapy plan of care.

As a reminder, a plan of care must be on file, when appropriate, for all outpatient therapy services. Providers should resubmit claims returned for lack of therapy modifiers (GP, GN, GO) on the above codes newly designated with "+" (bolded) for services provided during July and August 2003. In addition, therapy modifiers should not be used with claims with HCPCS codes noted with "+" unless that service is performed under a therapy plan of care.

Source: CMS Transmittal B-03-065, CR 2821

RADIOLOGY

Billing Mammography with CAD Codes

CMS has issued revised Medicare Carriers Manual instructions effective January 1, 2004, that change the billing requirements for computer aided detection devices (CAD) in conjunction with mammography services by deleting the two existing CAD codes and replacing them with two new codes. The revisions are as follows:

- **Section 4601.1, Screening Mammography Examinations**. Dates in the note (example) have been revised to reflect more recent dates.
- **Section 4601.2, Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim**, has been updated to include a language that carriers are no longer permitted to "plug" the ICD-9-CM code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims and denied for unassigned claims. It also reflects changes beginning January 1, 2004.
- **Section 4601.3, Adjudicating the Claim**, has been updated to reflect changes beginning January 1, 2004, the Common Working File (CWF) will not edit for place of service.
- **Section 4601.6, Diagnostic and Screening Mammograms Performed With New Technologies,** has been updated to add two new CAD codes, 76082 and 76083, to be billed in conjunction with screening or diagnostic film or digital mammography codes effective January 1, 2004. CAD code G0236 and CAD code 76085 should not be reported for claims with dates of service on or after January 1, 2004. Section has also been revised to include a statement that screening and diagnostic mammographies (film and digital) are subject to the FDA certification. CAD equipment does not require FDA certification. Section C has been deleted as it duplicates sections 4601.2H and 4601.2I.

Source: CMS Transmittal 1814, CR 2632

New Modifiers for Transportation of Portable X-Ray Equipment

Effective January 1, 2004, one of five new modifiers will be required on Medicare claims when reporting HCPCS code R0075 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen).

Only a single transportation payment for each trip the portable X-ray supplier makes to a particular location (e.g., nursing home) is allowed. When reporting a transportation service and more than one Medicare patient is X-rayed at the same location, payment for R0075 is prorated among all patients receiving the services.

R0075 must be billed in conjunction with the CPT radiology codes (70000 series) and only when the X-ray equipment used was actually transported to the location where the X-ray was taken. R0075 would not apply to the X-ray equipment stored in the location where the X-ray was done (e.g., a nursing home) for use as needed.

Below are the definitions for each modifier that must be reported with R0075. Only one of these five modifiers can be reported with R0075.

UN	Two patients served
UP	Three patients served
UQ	Four patients served
UR	Five patients served
US	Six patients or more served

Source: CMS Pub. 100-04 Transmittal: 14 Date: October 24, 2003 Change Request 2856

SURGERY

National Coverage Determination—Implantable Automatic Defibrillators

This provider education article discusses the background of the National Coverage Determination (NCD) to expand coverage of implantable automatic defibrillators for services rendered on or after October 1, 2003, coverage guidelines, billing instructions for providers who render services to managed care patients, and billing instructions for providers who render services to fee-for-service patients.

Background

The NCD will be effective on October 1, 2003, to expand coverage of implantable automatic defibrillators for Medicare managed care and fee-for-service patients. Providers will be reimbursed for services provided to managed care patients for implantable automatic defibrillators that fall under the expanded coverage indications effective October 1, 2003, according to the NCD on a fee-for-service basis until capitation rates are adjusted to account for this expanded coverage.

Coverage Guidelines

The following service is covered when rendered on or after July 1, 1991:

- Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause;

The following services are covered when rendered on or after July 1, 1999:

- Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause;
- Documented familial or inherited indications with a high risk of life-threatening VT, such as long QT syndrome or hypertropic cardiomyopathy;

As stated in the NCD, the following indications will be covered when rendered on or after October 1, 2003:

- Coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction = 0.35, and inducible, sustained VT or VF at EP study. (The MI must have occurred more than 4 weeks prior to defibrillator insertion. The EP test must be performed more than 4 weeks after the qualifying MI.);
- Documented prior MI and a measured left ventricular ejection fraction = 0.30 and a QRS duration of > 120 milliseconds. Patients must not have:
  a) New York Heart Association classification IV;
  b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
  c) Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within past 3 months;
  d) Had an enzyme-positive MI within past month;
  e) Clinical symptoms or findings that would make them a candidate for coronary revascularization; or
  f) Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.

As stated in the NCD, effective October 1, 2003, the following additional coverage guidelines apply:

- All patients considered for implantation of a defibrillator must not have irreversible brain damage, disease, or dysfunction that precludes the ability to give informed consent;
- MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram.
- Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography; and
- All other indications remain noncovered except in Category B IDE clinical trials (60 CFR 48417) or as a routine cost in clinical trials defined under CIM 30-1.

Note: Refer to Coverage Issues Manual, Section 35-85 (revisions effective October 1, 2003).

Billing Instructions for Providers Who Render Services to Managed Care Patients

The following instructions apply to providers who render expanded implantable automatic defibrillator services to managed care patients:

- Providers are encouraged not to submit claims for services rendered on or after October 1, 2003, because Medicare will not be able to process the claims until January 5, 2004. Providers should begin billing for these services on or after January 5, 2004.
- Physicians must use modifier KZ (new coverage not implemented by managed care) when billing for services rendered on and after October 1, 2003.
- Providers billing fiscal intermediaries on or after October 1, 2003, must use condition code 78 (payment for coverage not implemented by HMO).
- Providers who are paid under the Outpatient Prospective Payment System (OPPS) must bill all services related to this expanded coverage on one claim and for the same date of service, using condition code 78.
- Providers billing carriers and providers who are paid under the OPPS must split the bills if they overlap September 2003 and October 2003.
- Patients who receive these services must pay any applicable coinsurance amounts.
- For services rendered to managed care patients whose indications fall outside this expanded coverage, providers must not bill using condition code 78 or modifier KZ.

Billing Instructions for Providers Who Render Services to Fee-for-Service Patients

The following instructions apply to providers who render expanded implantable automatic defibrillator services to fee-for-service patients:

- Claims for these services cannot be billed using modifier KZ, condition code 78, or for services outside of this expanded coverage.

Procedure Codes

The new G codes listed at right are payable under OPPS effective October 1, 2003. These new G codes are **not** payable under the Medicare physician fee schedule and, therefore, should not be billed to Medicare carriers.

G0297, G0298, G0299, G0300,
ICD-9-CM Procedure Code 37.94 (for 11X TOBs)

The physician should bill for the appropriate service from the range of *CPT* codes below. These services should be billed to the appropriate Medicare carrier for payment.

33240, 33241, 33243, 33244, 33245, 33246, 33249

Source: CMS Transmittal AB-03-134, CR 2880
CMS PUB. 100-20 Transmittal 4, CR 2922

Processing and Payment of Incomplete Screening Colonoscopies

Background– Medicare covers colorectal cancer screening test/procedures for the early detection of colorectal cancer when coverage conditions are met. Among the screening procedures covered are screening colonoscopies (G0105–Colorectal cancer screening; colonoscopy on individual at high risk; and G0121–Colorectal screening; colonoscopy on individual not meeting criteria for high risk).

In some instances, a provider may begin a screening colonoscopy, but, because of extenuating circumstances, be unable to complete the procedure. At another time, the provider may attempt and complete the intended screening colonoscopy on the patient. This situation parallels those of diagnostic colonoscopies in which the provider is unable to complete the colonoscopy because of extenuating circumstances and must attempt a complete colonoscopy at a later time. If coverage conditions are met, Medicare pays for both the uncompleted colonoscopy and the completed colonoscopy whether the colonoscopy is screening in nature or diagnostic.

Because coverage of these services is subject to frequency limitations, we must be able to distinguish between those services that are subject to the frequency limitation from those that are not. It is not appropriate to count the incomplete colonoscopy toward the beneficiary's frequency limit for a screening colonoscopy because that would preclude the beneficiary's being able to obtain a covered completed colonoscopy. We are making changes to ensure that incomplete screening colonoscopies are not counted when calculating frequency limitations for this benefit.

Policy– When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (refer to Medicare Carriers Manual section 15100B), Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with modifier –53 to indicate that the procedure was interrupted. When submitting a claim for the facility fee associated with this procedure, Ambulatory Surgical Centers (ASCs) are to append the colonoscopy code with modifier –73 or –74, as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, will be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

The provider is expected to maintain adequate information in the patient's medical record in case it is needed by the contractor to document the incomplete procedure.

Source: CMS Transmittal AB-03-114, CR 2822

OTHER SERVICES AND PROCEDURES

Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities— Clarification

CMS has revised the national coverage decision for hyperbaric oxygen (HBO) therapy for the treatment of diabetic wounds of the lower extremities. Changes have been made to the ICD-9-CM codes in this policy effective for services furnished on or after April 1, 2003.

The following ICD-9-CM codes have been updated to the fifth level of specificity:

- 250.7 updated to 250.70
- 250.8 updated to 250.83
- 707.1 updated to 707.10, 707.12, 707.13, 707.14, 707.15 and 707.19
- ICD-9-CM 707 has been removed since this is the title of a category, not a valid ICD-9-CM code.

All other information and instructions in the local medical review policy (LMRP) 99183: Hyperbaric Oxygen Therapy (HBO Therapy) remain in effect. The LMRP reflecting these changes will be revised in the near future.

Source: CMS Transmittal AB-03-102, CR 2769

GENERAL INFORMATION

FRAUD, WASTE, AND ABUSE

Office of Inspector General Special Advisory Bulletin, April 2003—Contractual Joint Ventures

This Special Advisory Bulletin addresses certain complex contractual arrangements for the provision of items and services previously identified as suspect in our 1989 Special Fraud Alert on Joint Venture Arrangements.[1] While much of the discussion in the 1989 Special Fraud Alert focused on investor referrals to newly formed entities, we observed that:

> [t]he Office of Inspector General has become aware of a proliferation of arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays. Some examples of the items or services provided in these arrangements include clinical diagnostic laboratory services, durable medical equipment (DME), and other diagnostic services. Sometimes these deals are called "joint ventures." *A joint venture may take a variety of forms: it may be a contractual arrangement between two or more parties to cooperate in providing services,* or it may involve the creation of a new legal entity by the parties, such as a limited partnership or closely held corporation, to provide such services. [Emphasis added.]

Notwithstanding that caution, the Office of Inspector General (OIG) is concerned that contractual joint venture arrangements are proliferating.[2]

A. Questionable Contractual Arrangements

The federal anti-kickback statute, section 1128B(b) of the Social Security Act (the Act), prohibits knowingly and willfully soliciting, receiving, offering, or paying anything of value to induce referrals of items or services payable by a federal health care program. Kickbacks are harmful because they can (1) distort medical decision-making, (2) cause overutilization, (3) increase costs to the federal health care programs, and (4) result in unfair competition by freezing out competitors unwilling to pay kickbacks. Both parties to an impermissible kickback transaction may be liable. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to 5 years, or both. The OIG may also initiate administrative proceedings to exclude persons from the federal health care programs or to impose civil money penalties for kickback violations under sections 1128(b)(7) and 1128A(a)(7) of the Act.

This Special Advisory Bulletin focuses on questionable contractual arrangements where a health care provider in one line of business (hereafter referred to as the "Owner") expands into a related health care business by contracting with an existing provider of a related item or service (hereafter referred to as the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal health care program patients. The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals.

Some examples of potentially problematic contractual arrangements include the following:

- A hospital establishes a subsidiary to provide DME. The new subsidiary enters into a contract with an existing DME company to operate the new subsidiary and to provide the new subsidiary with DME inventory. The existing DME company already provides DME services comparable to those provided by the new hospital DME subsidiary and bills insurers and patients for them.
- A DME company sells nebulizers to federal health care beneficiaries. A mail order pharmacy suggests that the DME company form its own mail order pharmacy to provide nebulizer drugs. Through a management agreement, the mail order pharmacy runs the DME company's pharmacy, providing personnel, equipment, and space. The existing mail order pharmacy also sells all nebulizer drugs to the DME company's pharmacy for its inventory.
- A group of nephrologists establishes a wholly-owned company to provide home dialysis supplies to their dialysis patients. The new company contracts with an existing supplier of home dialysis supplies to operate the new company and provide all goods and services to the new company.

These problematic arrangements typically exhibit certain common elements. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business.[3] The new business line may be organized as a part of the existing entity or as a separate subsidiary. Typically, the new business primarily serves the Owner's existing patient base.

Second, the Owner neither operates the new business itself nor commits substantial financial, capital, or human resources to the venture. Instead, it contracts out

substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and health care personnel, billing support, and space. While the Manager/Supplier essentially operates the business, the billing of insurers and patients is done in the name of the Owner. In many cases, the contractual arrangements result in either practical or legal exclusivity for the Manager/Supplier through inclusion of non-competition provisions or restrictions on access. While the contract terms of these arrangements may appear to place the Owner at financial risk, the Owner's actual business risk is minimal because of the Owner's ability to influence substantial referrals to the new business.

Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement.

Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business.

Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. While in some arrangements certain payments are fixed (for example, the management fee), other payments, such as payments for goods and services supplied by the Manager/Supplier, will vary based on the number of goods and services provided. In other words, the aggregate payment to the Manager/Supplier from the whole arrangement will vary with referrals from the Owner. Likewise, the Owner's payments, that is, the difference between the net revenues from the new business and its expenses (including payments to the Manager/Supplier), also vary based on the Owner's referrals to the new business. Through these contractual payments, the parties are able to share the profits of the new line of business.

B. Safe Harbor Protection May Be Unavailable

Under the kickback statute, a number of statutory and regulatory "safe harbors" immunize certain arrangements that might otherwise violate the anti-kickback statute. (See 42 U.S.C. 1320a-7b(b)(3); 42 CFR 1001.952.) To qualify for safe harbor protection, an arrangement must fit squarely in one of these safe harbor provisions. Some parties attempt to carve otherwise problematic contracting arrangements into several different contracts for discrete items or services (e.g., a management contract, a vendor contract, and a staffing contract), and then qualify each separate contract for protection under a "safe harbor." Such efforts may be ineffectual and leave the parties subject to prosecution for the following reasons.

First, many of these questionable joint venture arrangements involve contracts pursuant to which the Manager/Suppliers agree to sell items and services to the Owners at a discounted price. However, where a discount is given as part of an overarching business arrangement, it cannot qualify for protection under the discount safe harbor. Simply put, the discount safe harbor does not protect – and has never protected – prices offered by a seller to a buyer in connection with a common enterprise. To be protected under the discount safe harbor, a price reduction must be based on an *arms length transaction*. (See 42 CFR 1001.952(h) under which "the term *discount* means a reduction in the amount a buyer . . . is charged for an item or service based on an arms-length transaction."). As we expressly stated in the preamble to the 1991 safe harbor regulations, the provision of items or services to a joint venture by a participant in the venture is not an "arms length" transaction:

> Another problem exists where an entity, which is both a provider and supplier of items or services and joint venture partner with referring physicians, makes discounts to the joint venture as a way to share its profits with the physician partners. Very often this entity furnishes items or services to the joint venture, and also acts as the joint venture's general partner or provides management services to the joint venture. . . . *These arrangements are not arms length transactions where the joint venture shops around for the best price on a good or service. Rather it has entered into a collusive arrangement with a particular provider or supplier of items or services that seeks to share its profits with referring physician partners. [We did] . . . not intend to protect these types of transactions which are sometimes made to appear as 'discounts'*. . . . [Emphasis added] (See 56 FR 35977; July 29, 1991).

In short, a discount is not based on arms length transaction if it is provided by a seller to a purchaser in connection with a common venture, regardless of whether the venture is memorialized in separate contracts. Second, even if the various contracts could fit in one or more safe harbors, they would only protect the remuneration flowing from the Owner to the Manager/Supplier for actual services rendered. In the contractual arrangements that are the subject of this Bulletin, however, the illegal remuneration is often the difference between the money paid by the Owner to the Manager/Supplier and the reimbursement received from the federal health care programs. By agreeing effectively to provide services it could otherwise provide in its own right for less than the available reimbursement, the Manager/Supplier is providing the Owner with the opportunity to generate a fee and a profit. The opportunity to generate a fee is itself remuneration that may implicate the anti-kickback statute.

C. Indicia of a Suspect Contractual Joint Venture

To help identify the suspect contractual joint ventures that are the focus of this Special Advisory Bulletin, we describe below some characteristics, which, taken separately or together, potentially indicate a prohibited arrangement. This list is illustrative, not exhaustive.

New Line of Business. The Owner typically seeks to expand into a health care service that can be provided to the Owner's existing patients. As illustrated in Part A, examples include, but are not limited to, hospitals

expanding into DME services, DME companies expanding into the nebulizer pharmacy business, or nephrologists expanding into the home dialysis supply business.[4]

Captive Referral Base. The newly-created business predominantly or exclusively serves the Owner's existing patient base (or patients under the control or influence of the Owner). The Owner typically does not intend to expand the business to serve new customers (i.e., customers not already served in its main business) and, therefore, makes no or few *bona fide* efforts to do so.

Little or No *Bona Fide* Business Risk. The Owner's primary contribution to the venture is referrals; it makes little or no financial or other investment in the business, delegating the entire operation to the Manager/Supplier, while retaining profits generated from its captive referral base. Residual business risks, such as nonpayment for services, are relatively ascertainable based on historical activity.

Status of the Manager/Supplier. The Manager/Supplier is a would-be competitor of the Owner's new line of business and would normally compete for the captive referrals. It has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

Scope of Services Provided by the Manager/Supplier. The Manager/Supplier provides all, or many, of the following key services:

- day-to-day management;
- billing services;
- equipment;
- personnel and related services;
- office space;
- training;
- health care items, supplies, and services.[5]

In general, the greater the scope of services provided by the Manager/Supplier, the greater the likelihood that the arrangement is a contractual joint venture.

Remuneration. The practical effect of the arrangement, viewed in its entirety, is to provide the Owner the opportunity to bill insurers and patients for business otherwise provided by the Manager/Supplier. The remuneration from the venture to the Owner (i.e., the profits of the venture) takes into account the value and volume of business the Owner generates.

Exclusivity. The parties may agree to a non-compete clause, barring the Owner from providing items or services to any patients other than those coming from Owner and/or barring the Manager/Supplier from providing services in its own right to the Owner's patients.

As noted above, these factors are illustrative, not exhaustive. The presence or absence of any one of these factors is not determinative of whether a particular arrangement is suspect. As indicated, this Special Advisory Bulletin is not intended to describe the entire universe of suspect contractual joint ventures. This Bulletin focuses on arrangements where substantially all of the operations of a new line of business are contracted out to a would-be competitor. Arrangements involving the delegation of fewer than substantially all services, or delegation to a party not otherwise in a position to bill for the identical services, may also raise concerns under the anti-kickback statute, depending on the circumstances.

[1] The 1989 Special Fraud Alert was reprinted in the Federal Register in 1994. See 59 FR 65372 (December 19, 1994). The Special Fraud Alert is also available on our web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.*

[2] The kinds of contractual arrangements addressed in this Special Advisory Bulletin are sometimes referred to as "joint ventures" or "contractual joint ventures" or may be referenced by other terminology. For purposes of the analysis set forth in this Bulletin, a "joint venture" is any common enterprise with mutual economic benefit. The application of this Bulletin is not limited to "joint ventures" that meet technical qualifications under applicable state or common law.

[3] The Owner's referrals may be direct or indirect and may include not only ordering or purchasing goods or services, but also "arranging for" or "recommending" goods and services. See section 1128B(b) of the Act. For example, a hospital may generate business for a DME company, notwithstanding that orders for specific DME items must be signed by a physician who may or may not be a hospital employee.

[4] These examples are illustrative only. This list is not intended to suggest that other analogous ventures are not equally suspect.

[5] The Manager/Supplier may also provide marketing services, although in many instances no such services are required since the Owner generates substantially all of the venture's business from its existing patient base.

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse, and waste in the department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations, and inspections.

The Fraud and Abuse Control Program, established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), authorized the OIG to provide guidance to the health care industry to prevent fraud and abuse and to promote the highest level of ethical and lawful conduct. To further these goals, the OIG issues Special Advisory Bulletins about industry practices or arrangements that potentially implicate the fraud and abuse authorities subject to enforcement by the OIG.

Source: OIG Special Advisory Bulletin April 2003

New England Benefit Integrity Support Center Selected as New Program Safeguards Contractor for Connecticut

On August 1, 2003, CMS expanded the New England Benefit Integrity Support Center (NE-BISC) to include Medicare benefits integrity functions formerly performed by TriCenturion, LLC. Benefit integrity workload for Part B in Connecticut is now included in the scope of work for EDS' NE-BISC. This project is part of the CMS Medicare Integrity Program to engage new program safeguards contractors to address Medicare fraud, waste, and abuse. EDS will begin this work effective October 1, 2003.

The NE-BISC does not replace the Medicare program administration work that is performed by First Coast Service Options, Inc. (FCSO). FCSO will continue their current responsibilities including processing and paying claims, performing customer service, reviewing medical necessity, and auditing facilities for Medicare expenses and reimbursement.

The NE-BISC will incorporate this work into the EDS team focused on detecting and deterring fraud in the Medicare Part A and Part B programs in Connecticut. The NE-BISC will perform extensive and unique Medicare regional data analysis to identify aberrant Medicare activities in this region. The NE-BISC will develop cases for referral to law enforcement and provide ongoing support of those cases as needed. The NE-BISC will also process complaints alleging fraud. Additional responsibilities shall include coordination of benefit integrity activities in the region, and dissemination of relevant benefits integrity information to the related affiliated contractors (e.g., FCSO), providers, and beneficiaries.

Expected outcomes include:

- Identification of situations of potential fraud, waste, and abuse in the Medicare Program for case development and referral to law enforcement.
- Timely and accurate resolution of complaints alleging fraud.
- Identification of Medicare program weaknesses and vulnerabilities, and communication of recommendations for corrective actions including overpayment recovery and provider education.

Questions may be directed to Eileen M. Guinney, UMBI (Utilization Management Benefit Integrity), at:

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Teams and Locations

NE-BISC Program Administration
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5400 Legacy Dr.
Plano, TX 75024

Complaints, Investigations & Data Analysis
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Investigations & Data Analysis

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FINANCIAL SERVICES

Overpayment Interest Rate

Medicare assesses interest on overpaid amounts that are not refunded timely. Interest will be assessed if the overpaid amount is not refunded within 30 days from the date of the overpayment demand letter. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds rate.

Effective August 11, 2003, the interest rate applied to Medicare overpayments is **12.125 percent**, based on the revised PCR. The following table lists previous interest rates.

April 28, 2003 – August 10, 2003	11.625%
February 11, 2003 – April 27, 2003	10.75%
November 19, 2002 – February 10, 2003	11.25%
August 8, 2002 – November 18, 2002	12.625%
May 8, 2002 – August 7, 2002	11.75%
February 1, 2002 – May 7, 2002	12.625%
October 31, 2001 – January 31, 2002	13.25%
August 7, 2001 – October 30, 2001	13.25%
April 26, 2001 – August 6, 2001	13.75%
February 7, 2001 – April 25, 2001	14.125%

Source: Transmittal AB-03-122; CR 2432

HOME HEALTH CONSOLIDATED BILLING

Correction to Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Program Memorandum AB-03-096, the third quarterly home health (HH) consolidated billing (CB) update for calendar year 2003, was published on July 3, 2003. Among other changes, it removed code A4421 (Ostomy Supply misc) from the list of supply codes subject to HH CB. Removing code A4421 was an error. This instruction is to notify providers that code A4421 *will not* be deleted from HH CB enforcement:

Providers and suppliers interested in an updated complete list of codes subject to HH CB should refer to the HH CB master code list available at *http://cms.hhs.gov/providers/hhapps/*.

Source: CMS Transmittal AB-03-136 Date: August 29, 2003 Change Request 2892

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

CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list submitted to Medicare contractors will not be paid separately on dates when a beneficiary for whom such 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 the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing. Medicare contractors include fiscal intermediaries (FIs), carriers, and durable medical equipment regional carriers (DMERCs).

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the 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 the services subject to HH consolidated billing are being redefined.

This notification provides the annual HH consolidated billing update for calendar year 2004. Quarterly updates may follow in the course of calendar year 2004 if necessary. The specific changes are described in the attached code list.

The HH consolidated billing master code list is available at *http://www.cms.hhs.gov/providers/hhapps/#billing*.

New & Deleted Codes for HH CB

Code	Action	Replacement Code or Code Being Replaced
Non-Routine Supplies		
K0581	Delete	Replacement Code: A4416
K0582	Delete	Replacement Code: A4417
K0583	Delete	Replacement Code: A4418
K0584	Delete	Replacement Code: A4419
K0585	Delete	Replacement Code: A4420
K0586	Delete	Replacement Code: A4423
K0587	Delete	Replacement Code: A4424
K0588	Delete	Replacement Code: A4425
K0589	Delete	Replacement Code: A4426
K0590	Delete	Replacement Code: A4427
K0591	Delete	Replacement Code: A4428
K0592	Delete	Replacement Code: A4429
K0593	Delete	Replacement Code: A4430
K0594	Delete	Replacement Code: A4431
K0595	Delete	Replacement Code: A4432
K0596	Delete	Replacement Code: A4433
K0597	Delete	Replacement Code: A4434
A4416	Add	Replaces Code: K0581
A4417	Add	Replaces Code: K0582
A4418	Add	Replaces Code: K0583
A4419	Add	Replaces Code: K0584
A4420	Add	Replaces Code: K0585
A4423	Add	Replaces Code: K0586
A4424	Add	Replaces Code: K0587
A4425	Add	Replaces Code: K0588
A4426	Add	Replaces Code: K0589
A4427	Add	Replaces Code: K0590
A4428	Add	Replaces Code: K0591
A4429	Add	Replaces Code: K0592
A4430	Add	Replaces Code: K0593
A4431	Add	Replaces Code: K0594
A4432	Add	Replaces Code: K0595
A4433	Add	Replaces Code: K0596
A4434	Add	Replaces Code: K0597
A4319	Delete	Replacement codes: A4216 & A4217
A4323	Delete	Replacement codes: A4216 & A4217
A4216	Add	Replaces A4319 & A4323
A4217	Add	Replaces A4319 & A4323
A4712	Delete	
A4622	Delete	Replacement codes: A7520, A7521, & A7522

Code	Action	Replacement Code or Code Being Replaced
Non-Routine Supplies		
A7520	Add	Replaces code: A4622
A7521	Add	Replaces code: A4622
A7522	Add	Replaces code: A4622
A7523	Add	Tracheostomy
A7524	Add	From or related to discontinued code, A4622 and/or A4623: Tracheostomy
A4623	Add	
A7525	Add	Replaces code: A4623
A7526	Add	Replaces code: A4623
K0621	Delete	Replacement code: A6407
A6407	Add	Replaces: K0621
A4248	Add	
A4366	Add	
A6025	Add	
A6441	Add	
A6442	Add	
A6443	Add	
Non-Routine Supplies		
A6444	Add	
A6445	Add	
A6446	Add	
A6447	Add	
A6448	Add	
A6449	Add	
A6450	Add	
A6451	Add	
A6452	Add	
A6453	Add	
A6454	Add	
A6455	Add	
A6456	Add	
Therapies		
97755	Add	

Source: CMS Pub. 100-04 Transmittal: 8 Date: October 17, 2003 Change Request 2931

MANAGED CARE (MEDICARE+CHOICE)

Billing Instructions for Claims for Ventricular Assist Devices for Beneficiaries in a Medicare+Choice Plan

CMS recently expanded coverage for ventricular assist devices (VADs). Until Medicare capitation rates to Medicare+Choice (M+C) organizations are adjusted to account for this expanded VADs coverage, Medicare will pay providers on a fee-for-service basis for VADs that fall under the new indication for destination therapy (see National Coverage Determination [NCD] manual section 20.9). This notification provides billing instructions for claims for VADs for beneficiaries in a M+C Plan.

The fee-for-service claim processing system automatically excludes claims for services provided for risk M+C beneficiaries except in certain circumstances for which editing has been created (e.g. NETT claims, clinical trial claims).

Physicians/practitioners are instructed to use modifier KZ (new coverage not implemented by managed care) and hospitals to use condition code 78 (new coverage not implemented by HMO) when billing for services for VADs for beneficiaries in an M+C plan when conditions fall under the new indications for destination therapy, which are effective October 1, 2003.

Claims for M+C organizations' beneficiaries with existing covered indications (NCD manual section 20.9) should *not* be billed with the condition code or modifier; such indications are currently included in the M+C plan's capitated rates.

Source: CMS Pub. 100-04 Transmittal: 10 Date: October 17, 2003 Change Request 2958

MEDICARE SECONDARY PAYER (MSP)

Clarification of Policy for the Medicare Secondary Payer Working Aged Provision

Section 10.2 of the Medicare Secondary Payer (MSP) manual (Publication 100-05) has been revised to clarify what individuals are not subject to the limitation on payment. The last bullet (below) has been added as a result of this revision.

The Medicare secondary provision for working aged does not apply to:

- Individuals enrolled in Part B only.
- Individuals enrolled in Part A on the basis of a monthly premium. Anyone who is under age 65. (Medicare is secondary to large group health plans [GHP] that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.).
- Individuals covered by a health plan other than a GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer.
- Employees of employers of fewer than 20 employees who are covered by a single employer plan, or members of multi-employer plans that have been approved by CMS for the "multi-employer exemption," whom the plan identified as employees of employers with fewer than 20 employees.
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status.
- Individuals enrolled in single employer GHPs of employers of fewer than 20 employees; or members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected (see section 10.4) to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.
- Domestic partners who are given "spousal" coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus, a domestic partner cannot be recognized as a spouse.

Source: CMS Pub. 100-05 Transmittal: 2 Date: October 17, 2003 Change Request 2252

PROVIDER ENROLLMENT

What's New from Enrollment

To ensure that only qualified providers and suppliers enroll in the Medicare Program, validation of information obtained from providers is now directly linked to the Social Security Administration (SSA) and the Internal Revenue Service (IRS). Prior to processing an initial enrollment or making changes to existing enrollees, Medicare Enrollment must validate specific information obtained from applicants with these two agencies. We will be using existing information contained in a provider's file to accomplish this. If we do not have the required information on file, or the information we have on file does not concur with the information from the referenced agencies, CMS has instructed that we obtain the information via the applicable Form CMS-855, pursuant to section 1124(a)(1) and 1124A(a)(3) of the Social Security Act.

[42 U.S.C. section 1320a-3a]

1124A(a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT No payment may be made under part B of title XVIII for items or services furnished by any disclosing Part B provider unless such provider has provided the Secretary with full and complete information—

1124A(a)(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest;

1124A(a)(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).

Please ensure that you promptly supply Medicare Enrollment with any requested information on initial enrollments or changes regarding your practice in order to prevent possible disruption of claims payment.

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

Guidelines for Skilled Nursing Facility (SNF) Consolidated Billing

This provider education article discusses the background of the SNF consolidated billing regulation; services, supplies, and facilities included and excluded from SNF consolidated billing; professional and technical components of diagnostic tests; and ambulance services. In addition, the article includes information resources for SNF consolidated billing.

Background

SNF consolidated billing, which was effective for cost reporting periods beginning on or after July 1, 1998, states that SNFs must submit Medicare claims to the fiscal intermediary (FI) for all Part A and Part B services that its residents receive during the course of a covered Part A stay, except for a limited number of specifically excluded services. These services must be furnished either directly or under arrangement with outside providers. Section 4432(b) of the Balanced Budget Act of 1997 (BBA, PL 105-33), mandated the exclusion of entire categories of services from SNF consolidated billing. These services are separately billable to the Part B Medicare carrier and include the services of physicians and certain other types of medical practitioners.

Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F), effective on April 1, 2000, enacted a second more targeted set of exclusions for high cost, low probability services within a number of broader service categories (e.g., chemotherapy services) that otherwise remained subject to consolidated billing.

Effective January 1, 2002, Section 313 of the Benefits Improvement and Protection Act restricted SNF consolidated billing to the majority of services provided to patients in a Medicare Part A covered stay and only to physical, occupational, and speech-language therapy services provided to patients in a noncovered stay.

For claims with dates of service on or after April 1, 2001, for those services and supplies that are not specifically excluded by law and furnished to a SNF resident covered under the Part A benefit, physicians must forward the technical portions of any services to the SNF to be billed by the SNF to the FI. The SNF cannot receive additional payment for these technical services and is to pay the physician for the technical portion of the service. Physical, occupational, and speech-language therapy services provided to patients in a non-covered stay must also be forwarded to the SNF to be billed by the SNF to the FI for payment. It is the responsibility of the rendering physician or nonphysician practitioner to develop a business relationship with the SNF in order to receive payment from the SNF for services they render that are included in consolidated billing.

Services and Supplies Included in SNF Consolidated Billing

The SNF consolidated billing requirement confers on SNFs the billing responsibility for the entire package of services that residents receive including:

- All services and supplies received during the course of a Part A covered stay (including physical, occupational, and speech-language therapy services), with the exception of statutory exclusions; and
- For SNF residents in noncovered stays (e.g., Part A benefits exhausted or no prior qualifying hospital stay), physical, occupational, and speech-language therapy services.

Services and Supplies Excluded from SNF Consolidated Billing

A. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier:
   - The professional component of physician services (see Section 1861(r) of the Social Security Act for the definition of a physician for Medicare purposes) except physical, occupational, and speech-language therapy services;
   - Physician assistant services, when a physician assistant is working under a physician's supervision;
   - Nurse practitioner services, when a nurse practitioner is working in collaboration with a physician;
   - Clinical nurse specialists, when a clinical nurse specialist is working in collaboration with a physician;
   - Certified mid-wife services;
   - Qualified psychologist services; and
   - Certified registered nurse anesthetist services.

Note: Physical, occupational, and speech-language therapy services included in SNF consolidated billing are subject to SNF consolidated billing regardless of who provides them, even if the services that type of practitioner normally provides are excluded from SNF consolidated billing.

A. The following are excluded from SNF consolidated billing and the institutional or technical component must be billed separately to the Medicare FI:
   - The following services furnished on an outpatient basis by a hospital or critical access hospital (CAH):
     - Cardiac catheterization services;
     - Computerized axial tomography scans;
     - Magnetic resonance imaging;
     - Ambulatory surgery involving the use of an operating room;
     - Radiation therapy;
     - Emergency services;
     - Angiography;

- Lymphatic and venous procedures; and
- Ambulance services furnished in connection with any of the above outpatient hospital services.

- Maintenance dialysis received in a renal dialysis facility by an end stage renal disease patient;
- Certain dialysis-related services including covered ambulance transportation to obtain dialysis services;
- Erythropoietin for certain dialysis patients when given along with dialysis; and
- Hospice care related to a patient's terminal condition;

C. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier or FI, as appropriate:

- Ambulance trips that transport a patient to the SNF for initial admission or from the SNF following a final discharge (see below for additional ambulance services information);
- Services to risk based HMO enrollees; and
- The following services for residents in a Part A covered stay (only certain services in these categories are excluded):
  - Certain chemotherapy drugs;
  - Certain chemotherapy administrative services;
  - Certain radioisotope services; and
  - Certain customized prosthetic devices.

Facilities Included in SNF Consolidated Billing

- Medicare participating SNFs, including Medicare-certified distinct part SNFs and swing beds in all hospitals except CAHs.

Facilities Excluded from SNF Consolidated Billing

- Nursing homes that have no Medicare certification (e.g., do not participate at all in either the Medicare or Medicaid program);
- Nursing homes that exclusively participate only in the Medicaid program as a nursing facility;
- The nonparticipating portion of a nursing home that also contains a Medicare-certified distinct part SNF; and
- Swing beds in CAHs.

Professional and Technical Components of Diagnostic Tests

The professional component, or the physician's interpretation of a diagnostic test, is considered a physician service and is separately billable to the Medicare carrier. The technical component, or the diagnostic test itself, is considered a diagnostic test and is subject to consolidated billing. As an example, for diagnostic radiology services, the exclusion of physician services from consolidated billing applies only to the professional component of the diagnostic radiology service. The technical component of the diagnostic radiology service is considered a diagnostic test that must be billed to the Medicare FI by the SNF and is included in the SNF consolidated billing payment for covered Part A stays. Because the technical component is already included within Part A's comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would look to the SNF, rather than Part B, for payment.

Ambulance Services

Except for specific exclusions, SNF consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a Part A stay. In most cases, ambulance trips are excluded from SNF consolidated billing when the covered Part A stay has ended, at which time the ambulance company must bill the Medicare carrier or FI directly for payment. The specific circumstances under which a patient may receive ambulance services that are covered by Medicare but excluded from SNF consolidated billing are:

- A medically necessary ambulance trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services;
- A medically necessary ambulance trip after a formal discharge or other departure from the SNF, unless the patient is readmitted or returns to that or another SNF before midnight of the same day;
- An ambulance trip to receive dialysis or dialysis-related services;
- An ambulance trip for an inpatient admission to a Medicare participating hospital or CAH; and
- After discharge from a SNF, a medically necessary ambulance trip to the patient's home where he/she will receive services from a Medicare participating home health agency under a plan of care.

Note: A patient's transfer from one SNF to another before midnight of the same day is not excluded from SNF consolidated billing. The first SNF is responsible for the ambulance services.

SNF Consolidated Billing Information Resources

- Consolidated Billing Web Site
  www.cms.hhs.gov/medlearn/snfcode.asp
  - General SNF consolidated billing information.
  - HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
  - Therapy codes that must be consolidated in a noncovered stay.
  - All code lists are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.
- Program Memoranda
  www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
  - Transmittal AB-03-094 dated 7/3/2002
  - Transmittal AB-02-175 dated 12/13/2002
  - Transmittal A-02-118 dated 11/8/2002
    1) Updated codes for exclusions
    2) SNF Help File
       a) HCPCS codes included in the SNF Part A payment
       b) Codes that may be paid and on what basis to a SNF by the FI under Part B
  - Transmittal AB-02-038 dated 3/27/2002
- The SNF Help File will be available on a new CMS Web site in the near future.
- Medicare Carriers Manual Part 3, Section 4210

Source: CMS Joint Signature Memorandum dated August 29, 2003

2004 Annual Update for Skilled Nursing Facility Consolidated Billing

The coding files for skilled nursing facility consolidated billing will be updated effective January 1, 2004. These updates will appear on the CMS Web site at *www.cms.hhs.gov/medlearn/snfcodes.asp* on or about December 1, 2003. In order to correctly bill services, physicians, nonphysician practitioners, and suppliers should carefully review the revised codes files.

Source: CMS Transmittal B-03-068, CR 2858

GENERAL INFORMATION

2004 Holiday Schedule

First Coast Service Options, Inc will observe the following holiday closings in 2004:

January 1, (Thursday)	New Year's Day
January 19, (Monday)	Martin Luther King Jr. Day
April 9, (Friday)	Good Friday
May 31, (Monday)	Memorial Day
July 5, (Monday)	Independence Day
September 6, (Monday)	Labor Day
November 25, (Thursday)	Thanksgiving Holiday
November 26, (Friday)	Thanksgiving Holiday
December 23, (Thursday)	Christmas Holiday
December 24, (Friday)	Christmas Holiday

Interactive Voice Response Unit Operating Guide

To better serve you, First Coast Service Options' interactive voice response unit (IVR) operating guides have been developed to improve your navigation through the IVR. These operating guides will help to increase your knowledge of the technology and services we offer our beneficiaries and providers. By utilizing the IVR, you can also obtain claims status, eligibility, and the most up to date Medicare information.

Connecticut 1-866-419-9455

HELPFUL TIPS
Use Power Keys

Repeat Information, press **1**
Repeat Menu, Press **7**
Return to Main Menu, press **8**
To end call, press **9**
To speak to an associate, press **0**

To receive any information, you must enter your Provider number, Beneficiary name, Medicare number and date of birth.

*To enter the alphabetical portion of your provider number, indicate you are entering an alphabetical character by pressing the * key. Then, press the key containing the letter you wish to enter. To complete, press the number 1,2 or 3 depending on the position of the number on that key.*

For Example: To enter A, press *****, **2**, **1**
To enter B, press *****, **2**, **2**

If the Medicare number begins with a letter, please enter the number that corresponds to the letter(s) below:

- For the letter **A**, press **1**
- For the letter **MA**, press **2**
- For the letter **WA**, press **3**
- For the letter **WCA**, press **4**
- For the letter **CD**, press **5**
- For all other letters, press **7**

If the Medicare number ends with a letter, please enter the number that corresponds to the letter below:

- For the letter **A**, press **1**
- For the letter **B**, press **2**
- For the letter **C**, press **3**
- For the letter **D**, press **4**
- For the letter **T**, press **5**
- For the letter **M**, press **6**
- For all other letters, press **7**

To enter the Beneficiary's date of birth:

- Enter 2-digit month
- Enter 2-digit year

To enter date of claim:

- Enter 2-digit month
- Enter 2-digit day
- Enter 2-digit year

END HELPFUL TIPS

****

PRICING LEGISLATION
- To hear 2003 legislation, press **1**
- Otherwise, press **2**

MAIN MENU
- For information about current Medicare changes and issues, press **1**
- To receive claim status, correspondence Status and Medicare Remittance notices, press **2**
- For eligibility, HMO, deductible and physical and occupational limitation information, press **3**
- For pending and payment floor claims or to receive month – year dollar amounts Currently on file, press **4**
- To receive check information, press **5**

CHECK HISTORY BY CHECK NUMBER
- From the main menu, press **5**, then press **3**

CHECK HISTORY BY ISSUE DATE
- From the main menu, press **5**, then press **2**

CLAIM STATUS
- From the main menu, press **2**, then press **1**
- If the beneficiary's number begins with a letter, press **1**
- If the beneficiary's Medicare number is nine digits and is followed by a number, press **2**
- If the beneficiary's Medicare number is followed by two or more letters, press **0**

CORRESPONDENCE STATUS
- From the main menu, press **2**, then press **2**
- Receive info on another claim, press **2**
- To receive info on a different control number, press **3**
- To receive info on a different provider number, press **6**

ELIGIBILITY, HMO, DEDUCTIBLE, AND PHYSICAL AND OCCUPATIONAL LIMITATION INFORMATION
- From the main menu, press **3**
- For Eligibility, HMO and deductibles, press **1**
- For Physical and Occupational limitations, press **2**
- For information on a different Medicare number, press **2**

LAST THREE CHECKS
- From the main menu, press **5**, then press **1**
- For check history by issue date, press **2**
- For check history by check number, press **3**

MEDICARE CHANGES AND ISSUES
- From the main menu, press **1**
- For current pricing information, press **1**
- For PSC hours of operation, press **2**
- For Connecticut Medicare Part B Web site, press **3**
- For information you need when calling Medicare, press **4**
- To learn about the IVR features, press **5**

MEDICARE REMITTANCE
- From the main menu, press **2**, then press **3**

MONTH OR YEAR TO DATE DOLLAR AMOUNT
- From the main menu, press **4**, then press **2**
- To receive information on a different provider number, press **1**

PENDING CLAIMS
- From the main menu, press **4**, then press **1**
- To receive information on different provider number, press **1**

Florida 1-877-847-4992

HELPFUL TIPS
Use Power Keys

Repeat Information, press **1**
Repeat Menu, Press **7**
Return to Main Menu, press **8**
To end call, press **9**
To speak to an associate, press **0**

To receive any of the information, you must enter your Provider number, Medicare number and date of birth.

*To enter the alphabetical portion of your provider number, you must indicate you are entering an alphabetical character, by pressing the * key. Second, press the key containing the letter you wish to enter. Third, press the number 1,2 or 3 depending on the position of the number on that key.*
For Example: To enter A, press *****, **2**, **1**
To enter B, press *****, **2**, **2**

If the Medicare number begins with a letter, please enter the number that corresponds to the letter(s) below:
- For the letter **A**, press **1**
- For the letter **MA**, press **2**
- For the letter **WA**, press **3**
- For the letter **WCA**, press **4**
- For the letter **CD**, press **5**
- For all other letters, press **7**

If the Medicare number ends with a letter, please enter the number that corresponds to the letter below:
- For the letter **A**, press **1**
- For the letter **B**, press **2**
- For the letter **C**, press **3**
- For the letter **D**, press **4**
- For the letter **T**, press **5**
- For the letter **M**, press **6**
- For all other letters, press **7**

To enter the Beneficiary's date of birth:
- Enter 2-digit month
- Enter 2-digit year

To enter date of claim:
- Enter 2-digit month
- Enter 2-digit day
- Enter 2-digit year

(END HELPFUL TIPS)

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PRICING LEGISLATION
- To hear current legislation, press **1**
- Otherwise, press **2**

MAIN MENU
- For information about legislation and other provider issues, press **1**
- To receive claim status, correspondence status and Medicare Remittance notices, press **2**
- For eligibility, HMO, deductible, and physical and occupational limitation information, press **3**
- For pending and payment floor claims or to receive month – year dollar amounts currently on file, press **4**
- To receive check information, press **5**
- For pricing information on reason codes, press **6**

CHECK HISTORY BY CHECK NUMBER
- From the main menu, press **5**, then press **3**

CHECK HISTORY BY ISSUE DATE
- From the main menu, press **5**, then press **2**

CLAIM STATUS
- From the main menu, press **2**, then press **1**
- If the beneficiary's number begins with a letter, press **2**
- For all other Medicare numbers, press **1**

CORRESPONDENCE STATUS
- From the main menu, press **2**, then press **2**
- Receive info on another claim, press **2**
- To receive info on a different control number, press **3**
- To receive info on a different provider number, press **6**

ELIGIBILITY, HMO, DEDUCTIBLE, AND PHYSICAL AND OCCUPATIONAL LIMITATION INFORMATION
- From the main menu, press **3**
- For Eligibility, HMO and deductibles, press **1**
- For Physical and Occupational limitations, press **2**
- For information on a different Medicare number, press **2**

LAST THREE CHECKS
- From the main menu, press **5**, then press **1**
- For check history by issue date, press **2**
- For check history by check number, press **3**

MEDICARE REMITTANCE
- From the main menu, press **2**
- For status of claim, press **1**
- For status of correspondence, press **2**

MONTH OR YEAR TO DATE DOLLAR AMOUNT
- From the main menu, press **4**, then press **2**
- To receive information on a different provider number, press **1**

NEW LEGISLATION AND PROVIDER ISSUES
- From the main menu, press **1**
- For what provider customer service is about, press **1**
- For PSC hours of operation, press **2**
- For Florida Medicare Part B Web site, press **3**
- For information you need when calling Medicare, press **4**
- To learn about the IVR features, press **5**

PENDING CLAIMS
- From the main menu, press **4**, then press **1**
- To receive information on different provider number, press **1**

PRICING
- From the main menu, press **6**
- Ambulance providers, press **1**
- All others, press **2**

Our Customer Service hours of operation are Monday through Friday 8:00am - 4:30pm. The hours of operation to receive patient eligibility and claim status information through the Interactive Voice Response Unit are Monday through Friday 6:00am – 6:00pm. The hours of operation to receive general Medicare Information and current issues are available 24 hours a day.

The New Online CMS Manual System Announcement

Beginning October 1, 2003, CMS will transition from a paper-based manual system to a Web-based system. The process includes the streamlining, updating, and consolidating of CMS' various program instructions into an electronic Web-based manual system for all users. The new system is called the online CMS Manual System and is located at *http://www.cms.hhs.gov/manuals*.

The new online CMS Manual System will be organized by functional area, (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity). The functional orientation of the new manual will eliminate significant redundancy within the manuals and will streamline the updating process, thus making CMS program instructions available in a more timely and accessible fashion.

Specifically, the CMS Manual System will include the following functional areas:

Pub. 100-01—Medicare General Information, Eligibility, and Entitlement
Pub. 100-02—Medicare Benefit Policy
Pub. 100-03—Medicare National Coverage Determinations
Pub. 100-04—Medicare Claims Processing
Pub. 100-05—Medicare Secondary Payer
Pub. 100-06—Medicare Financial Management
Pub. 100-07—Medicare State Operations
Pub. 100-08—Medicare Program Integrity
Pub. 100-09—Medicare Contractor Beneficiary and Provider Communications
Pub. 100-10—Medicare Quality Improvement Organization
Pub. 100-11—Reserved
Pub. 100-12—State Medicaid
Pub. 100-13—Medicaid State Children's Health Insurance Program
Pub. 100-14—Medicare End Stage Renal Disease Network Organization
Pub. 100-15—Medicare State Buy-In
Pub. 100-16—Medicare Managed Care
Pub. 100-17—Medicare Business Partners Systems Security
Pub. 100-18—Medicare Business Partners Security Oversight
Pub. 100-19—Demonstrations
Pub. 100-20—One-Time Notification

The table below identifies what current paper-based manuals were used to construct the new Internet-only manuals. It is just a cursory overview. A detailed crosswalk is being developed to guide you from a specific section of the old manual to where the information now appears in the new manuals. In addition, the Internet-only manual will have a crosswalk to show how the information in each section was derived.

Paper-Based Manuals	**Internet-Only Manuals**
Pub. 06—Medicare Coverage Issues Pub. 09—Medicare Outpatient Physical Therapy Pub. 10—Medicare Hospital Pub. 11—Medicare Home Health Agency Pub. 12—Medicare Skilled Nursing Facility Pub. 13—Medicare Intermediary Manual, Parts 1, 2, 3, and 4 Pub. 14—Medicare Carriers Manual, Parts 1, 2, 3, and 4 Pub. 21—Medicare Hospice Pub. 27—Medicare Rural Health Clinic and Federally Qualified Health Center Pub. 29—Medicare Renal Dialysis Facility **Program Memoranda** Pub. 60A—Intermediaries Pub. 60B—Carriers Pub. 60AB—Intermediaries/Carriers **Note**: Information derived from Pub. 06 to Pub. 60AB was used to develop Pub. 100-01 to Pub. 100-09 for the Internet-only manual.	Pub. 100-01— Medicare General Information, Eligibility, and Entitlement Pub. 100-02— Medicare Benefit Policy Pub. 100-03— Medicare National Coverage Determinations Pub. 100-04— Medicare Claims Processing Pub. 100-05— Medicare Secondary Payer Pub. 100-06— Medicare Financial Management Pub. 100-08— Medicare Program Integrity Pub. 100-09— Medicare Contractor Beneficiary and Provider Communications

Paper-Based Manuals	**Internet-Only Manuals**
Pub. 19—Medicare Peer Review Organization	Pub. 100-10— Medicare Quality Improvement Organization
Pub. 07—Medicare State Operations	Pub. 100-07— Medicare State Operations
Pub. 45—State Medicaid	Pub. 100-12— State Medicaid Pub. 100-13— Medicaid State Children's Health Insurance Program
Pub. 81—Medicare End Stage Renal Disease Network Organizations	Pub. 100-14— Medicare End Stage Renal Disease Network Organizations
Pub. 24—Medicare State Buy-In	Pub. 100-15— Medicare State Buy-In
Pub. 75—Health Maintenance Organization/ Competitive Medical Plan Pub. 76—Health Maintenance Organization/ Competitive Medical Plan (PM) Pub. 77—Manual for Federally Qualified Health Maintenance Organizations	Pub. 100-16— Medicare Managed Care
Pub. 13—Medicare Intermediaries Manual, Part 2 Pub. 14—Medicare Carriers Manual, Part 2	Pub. 100-17— Business Partners Systems Security
Pub. 13—Medicare Intermediaries Manual, Part 2 Pub. 14—Medicare Carriers Manual, Part 2	Pub. 100-18— Business Partners Security Oversight
Demonstrations (PMs)	Pub 100-19— Demonstrations
Program instructions that impact multiple manuals or have no manual impact.	Pub 100-20— One-Time Notification

Source: CMS Pub. 100-20, Transmittal: 2, September 12, 2003, Change Request 2886

HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This material provides a basic overview of the consumer privacy protection rules adopted by the United States Department of Health and Human Services in conformance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This material does not interpret these rules or attempt to apply the rules to your particular circumstances. The information provided is (1) for your information only, (2) subject to change without notice, and (3) provided "as is" without warranty of any kind, expressed or implied. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS RESPONSIBILITY FOR ANY CONSEQUENCES OR LIABILITY ATTRIBUTABLE TO OR RELATED TO ANY USE, NON-USE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THIS MATERIAL. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS ANY LIABILITY FOR ANY DIRECT, SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL LOSSES OR DAMAGES RELATED TO THE ACCURACY OR COMPLETENESS OF THIS MATERIAL. The information provided is no substitute for your own review and analysis of the relevant law.

Contingency Plan for Health Insurance Portability and Accountability Act Transaction and Code Sets

The following article has been provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of a contingency plan for HIPAA transaction and code sets as of October 16, 2003.

After a careful analysis of Medicare provider, submitter, and other trading partner HIPAA readiness, Medicare will continue to accept and send standard and non-standard versions and/or formats for any electronic transaction for a limited time period beyond October 16, 2003.

This is a temporary measure to maintain provider cash flow and minimize operational disruption while trading partners who are not compliant on October 16, 2003, work with Medicare to achieve full compliance.

This contingency plan is only for a limited time. Providers who must continue to bill and receive non-compliant formats, should test and move into production on the HIPAA required formats as soon as possible, or risk possible cash flow problems.

Source: CMS Notification Dated September 23, 2003

Medicare Electronic Data Interchange (EDI) Enrollments

As a condition for beginning to transmit claims electronically to Medicare, a new EDI enrollment form is required from each interested provider. Once on file, ~~and~~ a new form is not required for that provider as he/she participates in the Medicare program.

Specifically, a new EDI enrollment form is not required in any of the following situations:

(1) submission of transaction in a HIPAA format,
(2) as a condition of continued use of EDI,
(3) changing from one format (National Standard Format) to another (ANSI), or
(4) changing billing services/clearinghouses.

If you are a provider who does not currently submit claims electronically and who would like to begin, enrollment forms are available and can be downloaded from our provider education Web sites at *www.connecticutmedicare.com* for Connecticut Part B providers of service, or *www.floridamedicare.com* for Florida Part A or B providers. If you have questions related to the forms, or to getting started submitting claims electronically, please call Medicare EDI Marketing/Operations 1-203-639-3160, option 4 (Connecticut providers), or at 1-904-791-8767, option 1 (Florida providers).

Source: CMS Joint Signature Memorandum dated July 29, 2003

HIPAA Privacy Medical Records

Protecting the Privacy of Patients' Health Information

Notice of Privacy Practices: Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and rights under the new privacy regulations. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be asked to sign, initial or otherwise acknowledge they received this notice.

Limits on use of Personal Medical Information: To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. Personal health information may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose.

Stronger State Laws: The new federal privacy standards do not affect state laws that provide additional privacy protections for patients.

Guidance and technical assistance materials: HHS has provided an extensive, searchable collection of frequency asked questions that address major aspects of the rule. These materials are available at: *http://www.hhs.gov/ocr/hipaa/assist.html*

(HHS 4/14/2003 Fact Sheet)

Uses and Disclosures for Treatment, Payment, and Health Care Operations

(45 CFR 164.506)

"Treatment" generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

"Payment" encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Common payment examples under the Privacy Rule include, but are not limited to:

- Determining eligibility or coverage under a plan and adjudicating claims;
- Risk adjustments
- Billing and collection activities
- Reviewing health care services for medical necessity, coverage, justification of charges, and the like;
- Utilization review activities; and
- Disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).

"Health care operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, which are limited to the activities listed in the definition of "health care operations" at 45 CFR 164.501, include:

- Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, and case management and care coordination;
- Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals; accreditation, certification, licensing, or credentialing activities;
- Underwriting and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and coding, securing, or placing a contract for reinsurance of risk relating to health care claims;
- Conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity; and
- Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

Examples:

- A health care provider may disclose protected health information about an individual as part of a claim for payment to a health plan.
- A primary care provider may send a copy of an individual's medical record to a specialist who needs the information to treat the individual
- A hospital may send a patient's health care instructions to a nursing home to which the patient is transferred.

Uses and Disclosures of Psychotherapy Notes: Except when psychotherapy notes are used by the originator to carry out treatment, or by the covered entity for certain other limited health care operations, uses and disclosures of psychotherapy notes for treatment, payment, and health care operations require the individual's authorization. See 45 CFR 164.508(a)(2).

Minimum Necessary: A covered entity must develop policies and procedures that reasonably limit its disclosures of, and requests for, protected health information for payment and health care operations to the minimum necessary. A covered entity also is required to develop role-based access policies and procedures that limit which members of its workforce may have access to protected health information for treatment, payment, and health care operations, based on those who need access to the information to do their jobs. However, covered entities are not required to apply the minimum necessary standard to disclosures to or requests by a health care provider for treatment purposes. See the fact sheet and frequently asked questions on this web site about the minimum necessary standard for more information.

Consent: A covered entity may voluntarily choose, but is not required, to obtain the individual's consent for it to use and disclose information about him or her for treatment, payment, and health care operations.

Notice: Any use or disclosure of protected health information for treatment, payment, or health care operations must be consistent with the covered entity's notice of privacy practices.

Questions and Answers (HHS 2003)

May a health care provider disclose parts of a medical record that were created by another provider?
Yes, the Privacy Rule permits a provider who is a covered entity to disclose a complete medical record including portions that were created by another provider, assuming that the disclosure is for a purpose permitted by the Privacy Rule, such as treatment.

Does the HIPAA Privacy Rule strictly prohibit the use, disclosure, or request of an entire medical record?
No. The Privacy Rule does not prohibit the sue, disclosure, or request of an entire medical record, and a covered entity may use, disclose, or request an entire medical record without a case-by-case justification, if the covered entity has documented in its policies and procedures that the entire medical record is the amount reasonably necessary for certain identified purposes.

***Does the HIPAA Privacy Rule require my doctor to send my medical records to the government*?**
No. The Rule does not require a physician or any other covered entity to send medical information to the government for a government data base or similar operation. This Rule does not require or allow any new government access to medical information, with one exception: the Rule does give the Department of Health and Human Services Office for Civil Rights (OCR) the authority to investigate complaints that Privacy Rule protections or rights have been violated, and otherwise to ensure that covered entities comply with the Rule.

If patients require copies of their medical records, are they required to pay for the copies?
The Privacy Rule permits the covered entity to impose reasonable, cost-based fees. The fee may include only the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed. If the patient has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary or explanation. The fee may not include costs associated with searching for and retrieving the requested information. See 45 CFR 164.524.

Can a physician's office FAX patient medical information to another physician's office?
The HIPAA Privacy Rule permits physicians to disclose protected health information to another health care provider for treatment purposes. Covered entities must have in place reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information that is disclosed using a fax machine. Examples of measures that could be reasonable and appropriate in such a situation include the sender confirming that the fax number to be used is in fact the correct one for the other physician's office, and placing the fax machine in a secure location to prevent unauthorized access to the information.

References:

United States Department of Health & Human Services. Office for Civil Rights – HIPAA. Medical Privacy – National Standards to Protect the Privacy of Personal Health Information. OCR Summary of the HIPAA Privacy Rule. April 11, 2003. Available at: *http://www.hhs.gov/ocr/hipaa/privacy.html*

United States Department of Health & Human Services. Protecting the Privacy of Patients' Health Information. Monday, April 14, 2003. Fact Sheet. Available at: *http://www.hhs.gov/news/facts/privacy.htm*

CONNECTICUT 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 comprehensive data analysis initiatives. These 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), carriers no longer include full-text local medical review policies (LMRPs) to providers 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.connecticutmedicare.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, *wwwconnecticutmedicare.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:

Attention: Medical Policy
First Coast Service Options, Inc.
P.O. Box 9000
Meriden, CT 06450-9000

Phone: 1-866-419-9455

Medical Review - Table of Contents

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.

COMPREHENSIVE DATA ANALYSIS

Widespread Probe Review Results—Codes *36245*, *75724*, and *93508*

Procedure codes *36245, 75724,* and *93508* were chosen for comprehensive data analysis for fiscal year 2003, based on a study performed by the New York PRO in conjunction with the CMS PRO Staff, to examine the medical necessity of diagnostic procedures performed at the same time as primary cardiac catheterizations. The study focused on a review of Medicare beneficiaries who undergo renal arteriogram during inpatient admission for cardiac catheterization. The findings of the New York study indicated providers were inappropriately performing and or billing medically unnecessary services. This review was performed following a recommendation from the Office of the Carrier Medical Director to ensure that the services performed in Connecticut were performed and or billed appropriately for medically necessary services.

Summary of the Findings

CPT code *36245 (Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family)*

- 73 services (out of a total of 103) were billed with covered indications and allowed as billed.
- 29 services were denied due to the lack of documented signs or symptoms or clinical indications or diagnostic studies to substantiate that the service was medically necessary.
- 1 service was denied due to the lack documentation submitted for review.
- The review of procedure code *36245* consisted of 13 providers; including 12 cardiologists, 10 diagnostic radiologists, 1 interventional radiologist; and 61 beneficiaries.
- 10 of the services were performed by cardiologists, 6 of the services were performed by interventional radiologists, and 87 of the services were performed by diagnostic radiologists.

CPT code *75724 (Angiography, renal, bilateral, selective [including flush], radiological supervision and interpretation)*

- 14 services (out of a 15) were billed with covered indications and allowed as billed.
- 1 service was denied due to the lack of documented signs or symptoms or clinical indications or diagnostic studies to substantiate that the service was medically necessary.
- The review of procedure code *75724* included 4 providers, 3 cardiologists, 1 diagnostic radiologist; and 13 beneficiaries.
- 3 of the services were performed by a diagnostic radiologist and 11 of the services were performed by cardiologists.
- The documentation for 2 of the beneficiaries representing 3 services stated that renal arteriograms and cardiac catheterizations were performed on the same day, by cardiologists.
- The documentation for 4 beneficiaries representing 6 services clearly demonstrated the medical necessity of the renal studies. 3 of these services were performed by cardiologists, and 3 services were performed by a diagnostic radiologist.

CPT code *93508 (Catheter placement in coronary artery[s], arterial coronary conduit[s], and/or venous coronary bypass graft[s] for coronary angiography without concomitant left heart catheterization)*

- 59 services (out of a total of 60) were billed with covered indications and allowed as billed.
- 1 service was denied because it was a duplicate bill.
- The review of procedure code *93508* included 13 providers and 60 beneficiaries. Cardiologists performed all of the services.
- None of the documentation submitted stated that renal arteriograms and cardiac catheterization procedures were performed on the same day.

Based on the wide spread probe findings, a local medical review policy will be developed to include cardiac catheterization services, renal angiography, and selective catheter placement services. Educational letters will be written to the providers that failed to sufficiently document the medical necessity and reasonability of the services, failed to submit documentation of the billed services, and billed for one service twice on the same day. Overpayments will be collected from providers included in the wide spread probe in which the medical records failed to demonstrate that the services were a covered service or the documentation did not sufficiently support the services being performed (e.g., insufficient or no documentation submitted), and for the service that was billed twice.

Widespread Probe Review Results—Codes *92225* and *92226*

Procedure codes *92225 (Ophthalmoscopy, extended, with retinal drawing [e.g. for retinal detachment, melanoma], with interpretation and report; initial)* and *92226 (Ophthalmoscopy, extended, with retinal drawing [e.g. for retinal detachment, melanoma], with interpretation and report, subsequent)* were chosen for comprehensive data analysis for fiscal year 2003, based on data from May through October 2002. The data revealed a carrier-to-nation ratio of allowed dollars of 2.08 with a maximum potential savings of $357,014 for procedure code *92225*, and a carrier-to-nation ratio of allowed dollars of 2.31 with a maximum potential savings of $875,982 for procedure code *92226*. Based on the conclusions of the findings, the performance of these services were considered a widespread problem; therefore, recommendation to perform a widespread probe and subsequent enhancement/revision of the current local medical review policy (LMRP) for *CPT* codes *92225* and *92226*. A widespread probe of 100 claims from 20 providers from May 1, 2002 to October 31, 2002 was conducted. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, and to determine the medical conditions for which the services were being performed. The American Medical Association's *Physicians' Current Procedural Terminology* (*CPT 2001*) was used in reviewing the services.

Summary of the Findings

- Of the 100 claims reviewed, 100% of the services billed were for either procedure code *92225* or *92226*.
- Indications documented for procedure code *92225* included: vitreous degeneration, non-exudative macular degeneration, exudative macular degeneration, diabetic retinopathy, and vitreous membranes. Indications documented for procedure code *92226* included: non-exudative macular degeneration, exudative macular degeneration, diabetic retinopathy, vitreous degeneration, and proliferative diabetic retinopathy.
- All 100 services reviewed were allowed as billed.

An article will be published in a future issue of the *Medicare B Update!* upon completion of a revision of the current LMRP for *92225* and *92226*. Changes will include: revision of the LMRP description, expansion of indications and limitations, clarification of documentation requirements, and addition of ICD-9-CM codes that support medical necessity for this service.

Widespread Probe Review Results—Code *92235*

Procedure code *92235 (Fluorescein angiography [includes multiframe imaging] with interpretation and report)* was chosen for comprehensive data analysis for fiscal year 2003, based on data from May through October 2002. The data revealed a carrier-to-nation ratio of allowed dollars of 1.71, with a maximum potential savings of $579,019. Based on the conclusions of the findings, performance of these services was considered a widespread problem; therefore, recommendation was made to perform a widespread probe and subsequent enhancement/revision of the current local medical review policy (LMRP) for *CPT* code *92235*. A widespread probe of 100 claims from 20 providers from May 1, 2002 to October 31, 2002 was conducted. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, and to determine the medical conditions for which the services were being performed. The American Medical Association's *Physicians' Current Procedural Terminology* (*CPT 2001*) was used in reviewing the services.

Summary of the Findings

- Of the 100 claims reviewed, 100% of the services billed were for code *92235*.
- Indications documented for *92235* included: exudative macular degeneration, non-exudative macular degeneration, retinal edema, diabetic retinopathy, and cystoid macular degeneration.
- 99 services were allowed as billed.
- 1 service was denied, as the documentation submitted indicated that this service was not rendered as billed.

An article will be published in a future issue of the *Medicare B Update!* upon completion of a revision of the current LMRP. Revisions will include clarification/expansion of the LMRP description, and addition of ICD-9-CM codes that support medical necessity for this service.

Widespread Probe Review Results—Code 92250

Procedure code *92250 (Fundus photography with interpretation and report)* was chosen for comprehensive data analysis for fiscal year 2003, based on data from May through October 2002. The data revealed a carrier-to-nation ratio of allowed dollars of 2.20 with a maximum potential savings of $550,473. Based on the conclusions of the findings, 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 100 claims from 20 providers from May 1, 2002 to October 31, 2002 was conducted. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, and to determine the medical conditions for which the services were being performed. The American Medical Association's *Physicians' Current Procedural Terminology* (*CPT 2001*) was used in reviewing the services.

Summary of the Findings

- Of the 100 claims reviewed, 100% of the services billed were for *92250*.
- Indications noted for *92250* included: exudative macular degeneration, primary open-angle glaucoma, open-angle glaucoma with borderline findings, non-exudative macular degeneration, and diabetic retinopathy.
- 96 services were allowed as billed.
- 4 services were denied, as the procedure billed was not sufficiently documented (no interpretation and report).

An article will be published in a future issue of the *Medicare B Update!* upon completion of an LMRP, which will identify a procedure to diagnosis relationship, and clarify coding guidelines and documentation requirements.

LOCAL MEDICAL REVIEW POLICY (NEW)

ERASV: Endoluminal Radiofrequency Ablation of the Saphenous Vein

A local medical review policy (LMRP) has been developed for endoluminal radiofrequency ablation of the saphenous vein to define the indications and limitations for this service.

This procedure is a minimally invasive alternative to vein ligation and stripping. It has received FDA approval for treatment of varicose veins. The technique involves delivery of radiofrequency energy through a catheter inserted into the affected vein. The energy from the radiofrequency damages the intimal wall of the vessel resulting in fibrosis and obliteration of a long segment of the vein thus eliminating reflux. The procedure is performed by inserting a specially designed catheter through a small incision in the distal medial thigh to within 1-2 cm of the sapheno-femoral junction. High radiofrequency energy is delivered to the vein wall, causing it to heat. As the vein warms, it collapses and seals shut. The procedure is generally done in an outpatient setting under local anesthesia. When billing this service, the unlisted *CPT* code *37799* should be used, and a comment should be placed in item 19 of Form CMS-1500 (or in the appropriate comment field for electronic submitters), indicating that this code corresponds to radiofrequency ablation of the saphenous vein.

This LMRP is available on our provider education Web site, *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

NCSVCS: The List of Medicare Noncovered Services

The purpose of this new local medical review policy (LMRP) is to create a working list of medical services and procedures that are never covered by Medicare.

A service or procedure on the national noncoverage list may be noncovered for a variety of reasons. It may be noncovered based on a specific exclusion contained in the Medicare law; it may be viewed as not proven safe and effective and, therefore, not medically reasonable and necessary; or it may be a procedure that is always considered cosmetic in nature. The precise basis for a national decision to noncover a procedure may be found in references cited in the LMRP.

A service or procedure on the local noncoverage list is always denied on the basis that we do not believe it is medically reasonable and necessary. The list of LMRP exclusions contains procedures that are experimental, not yet proven safe and effective, or not yet approved by the FDA, but are not included on the national noncoverage list.

It is our policy that new services, procedures, drugs, or technology must be evaluated and approved nationally or by our LMRP process before they may be considered Medicare-covered services.

The full-text LMRP is effective for claims processed on or after January 5, 2004, and may be found on our provider education Web site, *www.connecticutmedicare.com*.

D0120: Dental Services

Dental care includes items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Although payment may be made for certain services by a dentist, items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered (Medicare Carriers Manual, Part 3, CMS-Pub. 14-3).

As a result of data analysis, a widespread probe for the period October 1, 2001, through March 31, 2002, was completed for medical services performed by specialty 19 (Dentist/Oral Surgery). Based on the review findings, a local medical review policy (LMRP) has been developed to define the indications and limitations of coverage, coding and documentation requirements; as well as, restricted coverage and special coverage instructions for dental services (D0120-D9999).

This LMRP is effective for claims processed on or after January 5, 2004. The full-text LMRP is available on our provider education Web site at *www.connecticutmedicare.com*.

G0179: Physician Certification and Re-certification of Home Health Services

Physician's services involved in physician certification (and re-certification) of Medicare-covered home health services may be separately coded and reimbursed. These services include creation and review of a plan of care, and verification that the home health agency initially complies with the physician's plan of care. The physician's work in reviewing data collected in the home health agency's patient assessment would be included in these services.

Using statistical medical data obtained for dates of service from July 1 2002, to December 31, 2002, the use of codes G0179 and G0180 was found to have an aberrancy ratio of 5.93 and 2.17, respectively, per 1000 enrollees. Analysis of the data revealed that the majority of services were performed by internal medicine and family practice physicians in the office and home settings.

Due to these findings, local medical review policy (LMRP) is being developed to define the indications and limitations of coverage and clarify the appropriate use of physician certification and recertification of home health services (codes G0179 and G0180).

The following *CPT*/HCPCS codes are included in the LMRP:

G0179	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period
G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period

This new LMRP is effective for claims processed on or after January 5, 2004, and is available on our provider education Web site at *www.connecticutmedicare.com*.

J2792: Rho (D) Immune Globulin Intravenous

Statistical medical data obtained for code J2792 (Injection, Rho [D] immune globulin, intravenous, human, solvent detergent, 100 iu) was found to have an aberrancy ratio of 2.83 per 1,000 enrollees. Local medical review policy (LMRP) has been developed to define the indications and limitations for this service.

Rho (D) immune globulin intravenous (Rho (D) IGIV) is a gamma globulin (IgG) which contains antibodies to Rho (D). Rho (D) IGIV currently has two medical applications. Connecticut Medicare will consider Rho (D) Immune Globulin Intravenous medically necessary for the suppression of Rh isoimmunization. Coverage is additionally provided for the treatment of immune thrombocytopenic purpura (ITP) for non-splenectomized Rho (D) positive individuals in clinical situations requiring an increase in platelet count to prevent excessive hemorrhaging.

The full-text of this new LMRP is effective for claims processed on or after January 5, 2004, and is available on our provider education Web site at *www.connecticutmedicare.com*.

J2820: Sargramostim (GM-CSF, Leukine®)

Granulocyte macrophage colony stimulating factor (GM-CSF) is an antineutropenic growth factor, which supports survival, clonal expansion, and differentiation of hematopoietic progenitor cell. GM-CSF is also capable of activating mature granulocytes and macrophages. This drug is not a cancer chemotherapy agent. GM-CSF is considered reasonable and necessary for the treatment of FDA-approved indications when it is not self/caregiver administered.

Statistical medical data identified HCPCS code J2820 (Injection, sargramostim (GM-CSF), 50 mcg) with an aberrancy ratio of 1.66. Therefore, local medical review policy (LMRP) has been developed to define the indications and limitations for this service.

This new LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

31525: Laryngoscopy

A new local medical review policy (LMRP) has been developed to define the indications and limitations for diagnostic laryngoscopy services. This procedure provides direct visualization of the larynx and secondary structures. The fiberoptic technique utilizes specialized endoscopic techniques.

The *CPT* codes included in this policy are:

31525 *Laryngoscopy, direct, with or without tracheoscopy; diagnostic, except newborn*
31575 *Laryngoscopy, flexible fiberoptic; diagnostic*

The full-text of this new LMRP available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

64561: Sacral Neuromodulation

Sacral neuromodulation is a new treatment modality used in the management of patients who suffer from refractory urinary urge incontinence, significant urgency/frequency, and urinary retention in patients without mechanical obstruction. The aim of therapy is to modulate the micturation reflex by electrically stimulating the sacral nerves that influence the bladder and pelvic floor muscles.

This therapy involves the surgical implantation of a system for long-term use. The system consists of a lead, a neurostimulator, and an extension that connects the two. Under general anesthesia, the lead is placed through an open incision over the selected foramen. The proximal end of the lead is tunneled around to the neurostimulator implanted into the lower abdomen or upper buttock. An extension connects the neurostimulator to the lead. Noninvasive programming of the neurostimulator parameters and modes occurs post-operatively.

Based on CMS Transmittal AB-01-143, Change Request 1881, effective January 1, 2002, sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome, and urinary retention. Local medical review policy (LMRP) has been developed to further define the indications and limitations of coverage and/or medical necessity, to allow access to care, and to outline proper utilization of this procedure. The following *CPT*/HCPCS codes are included in the LMRP:

64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)*
64581 *Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)*
64585 *Revision or removal of peripheral neurostimulator electrodes*
64590 *Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling*
64595 *Revision or removal of peripheral neurostimulator pulse generator or receiver*
95970 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming*
95971 *simple brain, spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming*
95972 *complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour*
95973 *complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure) (Use 95973 in conjunction with code 95972)*
A4290 Sacral nerve stimulation test lead, each
E0745 Neuromuscular stimulator, electronic shock unit
E0752 Implantable neurostimulator electrode, each
E0754 Patient programmer (external) for use with implantable programmable neurostimulator pulse generator
E0756 Implantable neurostimulator pulse generator
E1399 Durable medical equipment, miscellaneous

The following ICD-9-CM codes are included in the "ICD-9 Codes that Support Medical Necessity:"

595.1 Chronic interstitial cystitis
788.20-788.29 Retention of urine
788.31 Urge incontinence
788.41 Urinary frequency

The full-text of this new LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

74150: Computed Tomography of the Abdomen

A computed tomography (CT) image is a display of the anatomy of a thin slice of the body developed from multiple X-ray absorption measurements made around the periphery of the body. Unlike conventional tomography, where the image of a thin section is created by blurring out the information from unwanted regions, the CT image is constructed mathematically using data arising only from the section of interest. Generating such an image is confined to cross-sections of the anatomy that are oriented essentially perpendicular to the axial dimensions of the body. Reconstruction of the final image can be accomplished in any plane. A CT of the abdomen extends from the dome of the diaphragm to the pelvic brim or pubic symphysis depending upon whether one groups the pelvis with the abdomen or treats it separately.

Statistical medical data obtained for dates of service from July 2002 through December 2002 found *CPT* code *74150* to have an aberrancy ratio of 1.91 per 1000 enrollees. Based on these findings, local medical review policy (LMRP) has been developed to provide indications and limitations for this service. The *CPT* codes included in this policy are:

74150 *Computed tomography, abdomen; without contrast material*
74160 *with contrast material(s)*
74170 *without contrast material, followed by contrast material(s) and further sections*

The full-text of this LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

83880: B-Type Natriuretic Peptide (BNP)

Congestive heart failure (CHF) is characterized by a progressive activation of the neurohormonal systems that control vasoconstriction and sodium retention; the activation of these systems plays a role in its pathogenesis and progression. As the heart fails, B-Type Natriuretic Peptide (BNP), a cardiac neurohormone is secreted from the cardiac ventricles in response to ventricular volume expansion and pressure overload. Used in conjunction with other clinical information, rapid measurement of BNP is useful in establishing or excluding the diagnosis and assessment of severity of CHF in patients with acute dyspnea so that appropriate and timely treatment can be initiated. BNP levels are also useful for risk stratification among patients with acute coronary syndrome (myocardial infarction with or without T-wave elevation and unstable angina).

Local medical review policy (LMRP) has been developed for *CPT* code *83880 (Natriuretic peptide)* to allow providers access to this new technology, and to provide indications and limitations for this procedure. For the purposes of this policy, the total and N terminal assays are both acceptable.

The full-text of this LMRP is available on the provider education Web site *www.connecticutmedicare.com*, and will be effective for claims processed on or after January 5, 2004.

84154: Free Prostate Specific Antigen

Prostate-specific antigen (PSA) is a serum glycoprotein tumor marker used in the early detection of prostate cancer. PSA exists in multiple forms in serum and is predominantly complexed to protease inhibitors; however, one form of PSA, free PSA, is not bound to these proteins. The measurement of PSA forms in serum helps discriminate between prostate cancer and benign prostatic disease. For unknown reasons, the percentage of free PSA (fPSA) is lower in serum samples from patients with prostate cancer than in serum samples from patients with a normal prostate or benign disease.

Statistical medical data obtained for dates of service from January 1, 2002, to June 30, 2002, use of *CPT* code *84154 (Prostate specific antigen; free)* was found to have an aberrancy ratio of 16.38 per 1000 enrollees. Analysis of the data revealed that the services were performed by clinical laboratories. Some of the diagnoses submitted were determined to be inappropriate for the services billed (e.g., impotence, hyperlipidemia, hypertension, urinary obstruction).

Due to these findings, local medical review policy (LMRP) has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of fPSA (procedure code *84154*).

Connecticut Medicare will consider *84154* medically reasonable and necessary in the following circumstances:

- To evaluate the patient whose total PSA level is between 4.0-10.0 ng/mL and has a palpable benign prostate gland; **and**
- To eliminate the need for unnecessary biopsies.

The following ICD-9-CM code is included in the "ICD-9 Codes that Support Medical Necessity" for *CPT* code *84154*:

790.93 Elevated prostate specific antigen, (PSA)

The full-text LMRP is available on our provider education Web site, *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

88180: Flow Cytometry and Morphometric Analysis

Flow cytometric analysis of DNA provides a useful method of quantifying the changes in nuclear DNA that accompany neoplastic transformation. This technique may be used as an adjuvant diagnostic tool in cases where the subjective staging of a tumor is particularly difficult.

Morphometric analysis utilizes a quantitative image analysis system (light or fluorescent microscopy with quantitative morphometry and computerized data reduction) to assess a sample after the diagnosis of malignancy has already been established by histopathology. This assessment can assist in estimating prognosis and planning treatment for patients from whom tumors have been sampled or excised.

Local medical review policy (LMRP) has been developed to address flow cytometry and morphometric analysis services in one policy. Therefore, existing policies *88180* Immunophenotypic Analysis of Tissues by Flow Cytometry and *88182* Cell Cycle or DNA Analysis by Flow Cytometry will be deleted. The new policy defines the indications and limitations of coverage, establishes a procedure to diagnosis application, and clarifies the appropriate use of flow cytometry and morphometric analysis of tumor.

The full-text of this LMRP is available on the provider education Web site *www.connecticutmedicare.com*, and will be effective for claims processed on or after January 5, 2004.

88271: Urinary Fluorescent In Situ Hybridization (FISH) Test for Recurrent Bladder Cancer

The urinary FISH test for recurrent bladder cancer is an FDA-approved multiprobe fluorescent in situ hybridization DNA technology designed to detect aneuploidy for chromosomes 3, 7, 17, and loss of the 9p21 locus via FISH in voided urine specimens from patients with transitional cell carcinoma of the bladder (urothelial carcinoma). In situ hybridization is a technique that allows visualization of specific nucleic acid sequences within a cellular preparation. Specifically, DNA FISH involves the precise annealing of a single stranded fluorescently labeled DNA probe to complementary target sequences. Hybridization of the probe with the cellular DNA site is visible by direct detection using fluorescence microscopy. Results from the urinary FISH test are intended for use as a noninvasive method for monitoring tumor recurrence in conjunction with cystoscopy in patients previously diagnosed with bladder cancer.

Local medical review policy (LMRP) has been developed to allow providers access to this new technology, and to provide indications and limitations for this procedure.

CPT/HCPCS Codes

88271	*Molecular cytogenetics; DNA probe, each (eg, FISH)*
88274	*Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells*
88291	*Cytogenetics and molecular cytogenetics, interpretation and report*

ICD-9-CM codes that support medical necessity for this service include:

188.0-188.9	Malignant neoplasm of bladder
189.0-189.9	Malignant neoplasm of kidney and other and unspecified urinary organs
198.1	Secondary malignant neoplasm of other urinary organs
233.7	Carcinoma in situ of bladder
236.7	Neoplasm of uncertain behavior of bladder
239.4	Neoplasms of unspecified nature, bladder
V10.50	Personal history of malignant neoplasm, urinary organ, unspecified
V10.51	Personal history of malignant neoplasm, bladder
V10.52	Personal history of malignant neoplasm, kidney

The full-text of this LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for claims processed on or after January 5, 2004.

0025T: Ocular Corneal Pachymetry

Ocular corneal pachymetry is the ultrasonic measurement of corneal thickness. Measurement of corneal thickness in individuals presenting with increased intraocular pressure assists in determining if there is a risk of glaucoma or if the individual's increased eye pressure is the result of abnormal corneal thickness.

A recent study has demonstrated the benefit of assessing corneal thickness in individuals with increased intraocular pressure. Several physicians requested evaluation of this technology for separate reimbursement consideration. Development of a local medical review policy (LMRP) for *CPT* code *0025T (Determination of corneal thickness [eg, pachymetry] with interpretation and report, bilateral)* resulted from the evaluation.

CPT 0025T is considered medically necessary for specific diseases of the cornea. The full text of this new LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for services processed on or after January 5, 2004.

LOCAL MEDICAL REVIEW POLICY (REVISED)

2004 ICD-9-CM Coding Changes

The 2004 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2003. Updated diagnosis codes *must* be used for all services billed on or after January 1, 2004. A 90-day grace period is provided during which Connecticut Medicare will accept both old and new ICD-9-CM codes, for claims received October 1 through December 31, 2003. 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, 2004 *must* be billed with the updated 2004 ICD-9-CM codes.

Connecticut Medicare has reviewed all local medical review policies (LMRPs) for procedure codes with specific diagnosis criteria that are affected by the 2004 ICD-9-CM update. The table on the following pages lists the LMRPs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2004 ICD-9-CM update:

2004 ICD-9-CM Part B LMRP Changes

LMRP Title	2004 Changes
53850: Prostate Treatments	Change 600.0 to 600.00-600.01 (Hypertrophy [benign] of prostate) for procedure codes *53850*, *53852*, and *53853*
55700: Ultrasound Guided Prostate Needle Biopsy	Change 600.0-600.9 to 600.00-600.91 (Hyperplasia of prostate) for procedure code *55700*
71010: Radiologic Examination of the Chest	Add 011.90-011.96, 018.90-018.96, 033.9, 084.0-084.8, 093.9, 115.93-115.95, 142.9, 143.9, 144.9, 145.9, 147.9, 148.9, 150.9, 151.9, 162.9, 163.9, 164.9, 174.9, 180.9, 183.9, 185, 189.0, 189.9, 191.0-191.9, 196.9, 231.9, 236.90, 236.99, 239.1, 239.3, 254.9, 396.9, 398.90, 401.0-401.9, 402.00-402.91, 403.00-403.91, 404.91, 404.93, 405.01-405.19, 410.90-410.92, 414.8, 414.9, 417.9, 422.90, 423.9, 424.90, 427.69, 427.9, 428.9, 429.0, 429.9, 447.2, 480.9, 482.84, 482.9, 493.02, 493.12, 493.22, 493.90-493.92, 505, 506.9, 518.6, 518.83, 518.84, 519.9, 530.12, 745.8, 745.9, 746.9, 786.9, 770.9, 785.0, 785.50, 786.00-786.09, 786.50, 807.00, 807.10, 810.10, 848.40, 862.29, 862.31, 862.32, 934.9, 942.00, 942.10, 942.20, 942.30,

	942.40, 942.50, 983.9, 993.9, 996.00, 996.60, 997.00, V10.00, V10.20, V10.40, V10.48, V10.50, V10.53, V45.00, and V58.81-V58.89 for procedure codes *71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034,* and *71035* to be consistent with Florida's policy. **(Not related to 2004 ICD-9-CM Update)** Change 959.1 to 959.11 (Other injury of chest wall) and 959.19 (Other injury of other sites of trunk) for procedure codes *71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034,* and *71035* Change V43.2-V43.3 to V43.21-V43.3 (Organ or tissue replaced by other means, heart and heart valve) for procedure codes *71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034,* and *71035*
78460: Myocardial Perfusion Imaging	Add 414.07 (Coronary atherosclerosis of bypass graft [artery] [vein] of transplanted heart) for procedure codes *78460, 78461, 78464, 78465, 78478,* and *78480*
83735: Serum Magnesium	Change 255.1 to 255.10-255.14 (Hyperaldosteronism) for procedure code *83735* Change 458.0-458.2 to 458.0 (Orthostatic hypotension), 458.1 (Chronic hypotension), and 458.21-458.29 (Iatrogenic hypotension) for procedure code *83735* Change 638.1-638.9 to 638.0-638.9 (Failed attempted abortion) for procedure code *83735* **(Not related to 2004 ICD-9-CM Update)** Change 643.10-643.93 to 643.00-643.93 (Excessive vomiting in pregnancy) for procedure code *83735* **(Not related to 2004 ICD-9-CM Update)** Change 763.8 to 763.81-763.89 (Other specified complications of labor and delivery affecting fetus or newborn) for procedure code *83735* **(Not related to 2004 ICD-9-CM Update)**
90801: Psychiatric Diagnostic Interview Examination	Add 780.93 (Memory loss) for procedure code *90801*
92980: Interventional Cardiology in the Treatment of Ischemic Heart Disease	Add 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure codes *92980, 92981, 92982, 92984, 92995,* and *92996* **(Not related to 2004 ICD-9-CM Update)** Add 414.07 (Coronary atherosclerosis of bypass graft [artery] [vein] of transplanted heart) for procedure codes *92980, 92981, 92982, 92984, 92995,* and *92996*
93000: Electrocardiography	Change 959.1 to 959.11-959.19 (Injury, trunk) for procedure codes *93000, 93005,* and *93010* Change 995.0-995.89 to 995.0-995.94 (Certain adverse effects not elsewhere classified) for procedure codes *93000, 93005,* and *93010* **(Not related to 2004 ICD-9-CM Update)**
J0150: Adenosine (Adenocard®, Adenoscan®)	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure code J0150 Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure code J0151

Policy Revision Initiative

Several local medical review policies (LMRP) have been revised. In the process of updating these policies, the diagnosis to procedure code edits were reviewed and changes were identified that occurred due to the MCS conversion. The system was updated under the direction of the Connecticut Carrier Medical Director (CMD) and medical staff to reflect diagnoses that were included in the edits prior to MCS conversion. System updates were done prior to policy revisions due to provider inquiries and a high volume of post-payment reviews.

The following LMRPs have been revised by the addition of ICD 9-CM diagnosis criteria:

Policy #	Policy Title
65855	Laser Trabeculoplasty
71010	Radiological Examination of the Chest
99-2 V1.0 FINAL	Biofeedback Therapy for Fecal Incontinence
94004A V1.2	Coverage for Services for Trimming, Reduction of Non-dystrophic and Dystrophic Toenails, Reduction of Corns and Calluses of the Feet
76700 formerly *98043* V1.0 FINAL	Abdominal Ultrasound
92567	Tympanometry
44388	Colonoscopy

The full-text of these local medical review policies may be viewed on our provider education Web site at *www.connecticutmedicare.com* when they become available.

EPO: Epoetin Alfa (formerly 99-4 V1.1 Final: Labeled and Off-Labeled uses of Erythropoietin)

Erythropoietin is a glycoprotein that stimulates red blood cell production. It is produced in the kidneys and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow. The local medical review policy (LMRP) for labeled and off-labeled uses of erythropoietin was last updated January 1, 2003.

This policy has been revised to define the indications and limitations of coverage and/or medical necessity; and to clarify the appropriate use of epoetin alfa. The following major revisions have been incorporated:

- Laboratory requirements for initiation of epoetin alfa therapy have been revised.
- The following "Indications and Limitations of Coverage and/or Medical Necessity" have been added to the policy:
  - Anemia associated with malignancy
  - Reduction of allogeneic blood transfusions in surgery patients
  - Anemia associated with the management of hepatitis C
- The "Coding Guidelines" section of the LMRP has been revised with updated dual diagnosis requirements.
- The policy number and title have been changed to EPO: Epoetin Alfa.

The following HCPCS codes are included in the LMRP:

Q0136	Injection, epoetin alpha, (for non ESRD use), per 1,000 units
Q9920	Injection of EPO, per 1000 units, at patient HCT of 20 or less
Q9921	Injection of EPO, per 1000 units, at patient HCT of 21
Q9922	Injection of EPO, per 1000 units, at patient HCT of 22
Q9923	Injection of EPO, per 1000 units, at patient HCT of 23
Q9924	Injection of EPO, per 1000 units, at patient HCT of 24
Q9925	Injection of EPO, per 1000 units, at patient HCT of 25
Q9926	Injection of EPO, per 1000 units, at patient HCT of 26
Q9927	Injection of EPO, per 1000 units, at patient HCT of 27
Q9928	Injection of EPO, per 1000 units, at patient HCT of 28
Q9929	Injection of EPO, per 1000 units, at patient HCT of 29
Q9930	Injection of EPO, per 1000 units, at patient HCT of 30
Q9931	Injection of EPO, per 1000 units, at patient HCT of 31
Q9932	Injection of EPO, per 1000 units, at patient HCT of 32
Q9933	Injection of EPO, per 1000 units, at patient HCT of 33
Q9934	Injection of EPO, per 1000 units, at patient HCT of 34
Q9935	Injection of EPO, per 1000 units, at patient HCT of 35
Q9936	Injection of EPO, per 1000 units, at patient HCT of 36
Q9937	Injection of EPO, per 1000 units, at patient HCT of 37
Q9938	Injection of EPO, per 1000 units, at patient HCT of 38
Q9939	Injection of EPO, per 1000 units, at patient HCT of 39
Q9940	Injection of EPO, per 1000 units, at patient HCT of 40 or above

The revised LMRP is effective for claims processed on or after January 5, 2004, and is available on our provider education Web site at *www.connecticutmedicare.com*.

G0030: Positron Emission Tomography (PET) Scan

The local medical review policy (LMRP) for positron emission tomography (PET) scan was last updated January 1, 2003. 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 (radiopharmaceuticals) such as 2-(F-18) fluoro-D-glucose (FDG), that are administered intravenously to the patient.

CMS Transmittal AB-03-092, Change Request 2687, provides expanded coverage for noninvasive imaging of the perfusion of the heart using FDA-approved Ammonia N-13 as a tracer. Ammonia N-13 and Rubidium are the only two tracers covered for PET scans for the perfusion of the heart. Additional instructions are provided for carriers billing Rubidium in CMS transmittal AB-03-119, Change Request 2853.

The LMRP for PET has been revised to reflect these changes. Coverage has also been expanded to include restaging of recurrent residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.

The full text of the revised LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for services rendered on or after October 1, 2003.

J2430: Pamidronate (Aredia®, APD)

The local medical review policy (LMRP) for pamidronate was last updated on June 30, 2003. Based on comments received from providers, it was determined the changes made effective June 30, 2003, further restricted the LMRP. Therefore, the dual diagnosis requirements contained in the "ICD-9 Codes that Support Medical Necessity" and "Coding Guidelines" sections of the LMRP have been removed.

HCPCS code J2430 (Pamidronate disodium, per 30 mg) may be billed with the following ICD-9-CM codes:

174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
198.5	Secondary malignant neoplasm of bone and bone marrow
203.00-203.01	Multiple myeloma
275.42	Hypercalcemia (associated with malignancy)
731.0	Osteitis deformans without mention of bone tumor (Paget's disease of bone)
V10.3	Personal history of malignant neoplasm; breast

The revised LMRP is effective for claims processed on or after September 30, 2003, and is available on our provider education Web site at *www.connecticutmedicare.com*.

J9999: Antineoplastic Drugs

The local medical review policy (LMRP) for antineoplastic drugs was last updated September 29, 2003. The following revisions have since been made:

Indications and Limitations of Coverage and/or Medical Necessity

The indication for off-label use of chemotherapeutic agents has been revised.

The following off-label indications have been added to the respective agent:

- Carboplatin – Hormone Refractory Prostate Cancer
- Docetaxel – Soft tissue sarcomas
- Gemcitabine – Soft tissue sarcomas
- Topotecan Hydrochloride – Cervical carcinoma

ICD-9 Codes that Support Medical Necessity

The ICD-9-CM list for HCPCS code J9015 (Aldesleukin) has been corrected to include 205.10-205.11 (Chronic myeloid leukemia), effective for claims processed on or after September 29, 2003.

The ICD-9-CM list for HCPCS code J9355 (Trastuzumab) has been corrected to include 198.89 (Secondary malignant neoplasm of other specified sites), effective for claims processed on or after September 29, 2003.

The following ICD-9-CM codes have been added to the respective agent:

- J9045 (Carboplatin) – 185 (Malignant neoplasm of prostate), effective for claims processed on or after October 20, 2003.
- J9170 (Docetaxel) – 171.0-171.9 (Malignant neoplasm of connective and other soft tissue [soft tissue sarcomas]), effective for claims processed on or after October 20, 2003.
- J9185 (Fludarabine) – 273.3 (Macroglobulinemia [Waldenstrom's macroglobulinemia]), effective for claims processed on or after September 22, 2003.
- J9201 (Gemcitabine) – 171.0-171.9 (Malignant neoplasm of connective and other soft tissue [soft tissue sarcomas]), effective for claims processed on or after October 20, 2003.
- J9350 (Topotecan Hydrochloride) – 180.0-180.9 (Malignant neoplasm of cervix uteri), effective for claims processed on or after October 20, 2003.

The full-text of the revised LMRP is available on our provider education Web site at *www.connecticutmedicare.com*.

70544: Magnetic Resonance Angiography (MRA)

CMS Transmittal 1795, Change Request 2673, expands coverage for MRA to include MRA of the pelvis. Therefore, the local medical review policy (LMRP) for MRA has been revised to define the indications and limitations of coverage and to add the following ICD-9-CM codes to the "ICD-9 Codes that Support Medical Necessity" section of the policy for *CPT* code ***72198 (Magnetic resonance angiography, pelvis, with or without contrast material[s])***:

189.0-189.9	Malignant neoplasm of kidney and other and unspecified urinary organs
198.0	Secondary malignant neoplasm of kidney
223.0	Benign neoplasm of kidney, except pelvis
223.1	Benign neoplasm of renal pelvis
233.9	Carcinoma in situ of other and unspecified urinary organs
236.90-236.99	Neoplasm of uncertain behavior of other and unspecified urinary organs
403.00-403.91	Hypertensive renal disease
404.00-404.93	Hypertensive heart and renal disease
405.01	Secondary hypertension, malignant, renovascular
405.11	Secondary hypertension, benign, renovascular
405.91	Secondary hypertension, unspecified, renovascular
440.1	Atherosclerosis of renal artery
447.3	Hyperplasia of renal artery
580.0-580.9	Acute glomerulonephritis
581.0-581.9	Nephrotic syndrome
582.0-582.9	Chronic glomerulonephritis
583.0-583.9	Nephritis and nephropathy, not specified as acute or chronic
588.0-588.9	Disorders resulting from impaired renal function
593.81	Vascular disorders of kidney
593.9	Unspecified disorder of kidney and ureter

The full-text of the revised LMRP is available on our provider education Web site at *www.connecticutmedicare.com*. These changes are effective for services processed on or after January 5, 2004.

78460: Myocardial Perfusion Imaging

Information concerning the local medical review policy (LMRP) for myocardial perfusion imaging was published in the Fourth Quarter 2002 *Medicare B Update!* Based on a provider request, the policy has since been revised to add ICD-9-CM codes 410.00 - 419.02, 786.05, 786.50, and 786.51 to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The full-text of this LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for claims processed on or after October 20, 2003.

88141: Pap Smears Laboratory Testing

CMS Transmittal AB-03-054, Change Request 2637, expands coverage for screening Pap smears. Therefore, the local medical review policy (LMRP) for Pap smears laboratory testing has been revised to define the indications and limitations of coverage, and to add ICD-9-CM codes V76.47 and V76.49 to the "ICD-9 Codes that Support Medical Necessity" section of the policy. These changes are effective for services processed on or after October 1, 2003.

In addition, after policy reconsideration, coverage was expanded for diagnostic Pap smears to add ICD-9-CM codes to the "ICD-9 Codes that Support Medical Necessity" section of the policy, effective for services processed on or after October 20, 2003.

The full-text of this LMRP may be found on the provider education Web site *www.connecticutmedicare.com*.

90901: Biofeedback

CPT Code *90911 (Biofeedback training by any modality)* was found to be aberrant based on data for services from January 1, 2002, through June 30, 2002. The local medical review policy (LMRP) has been revised to define the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of procedure code *90911*. In addition, this revised LMRP replaces the following policies:

- 99-2 V1.0 FINAL Biofeedback Therapy for Fecal Incontinence
- *90911*: Biofeedback Therapy for Urinary Incontinence

The full-text of this LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for services performed on or after January 5, 2004.

92136: Optical Coherence Biometry

The latest revision to the local medical review policy (LMRP) for optical coherence biometry was effective March 1, 2003. CMS Program Memorandum AB-03-119, Change Request 2853, dated August 8, 2003, was issued to communicate a change in the final update to the 2003 Medicare Physician Fee Schedule Database that indicates procedure code 92136-26 as a bilateral procedure. Therefore, the "Coding Guidelines" section of the policy has been revised accordingly.

The full-text of this local medical review policy is available on our provider education Web site *www.connecticutmedicare.com*, and is effective for services rendered on or after March 1, 2003.

98940: Chiropractic Services (formerly 98037 V1.0 FINAL Manual Spinal Manipulation Services by Chiropractic Physicians)

The latest revision for local medical review policy (LMRP) for manual spinal manipulation services was January 1, 2003. This LMRP has been updated to reflect: revision of policy number, title and LMRP description, clarification of indications and limitations, reasons for denials, coding guidelines, documentation requirements, revision of utilization guidelines and other comments, and addition of ICD-9-CM codes that support medical necessity.

The full-text of this LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for services processed on or after October 20, 2003.

99183: Hyperbaric Oxygen Therapy (HBO Therapy)

The latest revision to the local medical review policy (LMRP) for HBO therapy was effective April 1, 2003. Program Memorandum (PM) AB-03-102, Change Request 2769, dated July 25, 2003, was issued to correct PM AB-02-183, Change Request 2388, as the original PM did not include some pertinent information regarding diagnosis codes. Revisions include: addition of ICD-9-CM Code 707.15 (Ulcer of other part of foot) to the "ICD-9 Codes That Support Medical Necessity" section of the policy for this therapy and deletion of ICD-9-CM code 707.0 (Decubitus ulcer) from this section of the policy.

The full-text of the revised LMRP is available on our provider education Web site at *www.connecticutmedicare.com*, and is effective for services rendered on or after April 1, 2003.

LOCAL MEDICAL REVIEW POLICY (RETIRED)

95 LMRP010-V1.0-*97010*: Physical Medicine for Chronic Pain

The local medical review policy (LMRP) for physical medicine therapy for chronic pain is retired, effective for services processed on or after September 28, 2003. It has been determined that a policy for physical medicine specifically addressing chronic pain is no longer relevant. The coverage information for physical medicine can be found in the LMRP for physical medicine and rehabilitation. The full text of the LMRP for physical medicine and rehabilitation may be found on our provider education Web site at *www.connecticutmedicare.com*.

CORRECTIONS

Comprehensive Data Analysis for Eye Exams—Correction

An article published in the Third Quarter 2003 *Medicare B Update!* (page 67) made reference to two local medical review policies (LMRP), one for gonioscopy and one for visual field examination. The LMRP for visual field examination has not yet been finalized; therefore, this reference is inaccurate. Connecticut Medicare apologizes for any confusion this may have caused.

55700: Biopsy of Prostate Using Image Guidance—Correction

We published information concerning revisions to the local medical review policy (LMRP) for biopsy of the prostate using image guidance in the Fourth Quarter 2003 Medicare B Update! *(page 69). Regrettably, we included information specific to Florida in the article for the Connecticut LMRP revision. The correct information for Connecticut is as follows:*

The digital rectal exam (DRE) and prostate specific antigen (PSA) blood test are two ways to detect changes in the prostate gland. However, these procedures cannot determine if the changes are due to prostate cancer or to a non-cancerous condition. A prostate biopsy must be performed to make a definitive diagnosis of prostate cancer. The LMRP for biopsy of the prostate using image guidance has been revised to expand the indications and limitations of coverage, to add ICD-9-CM codes that support medical necessity, and clarify the appropriate use of *CPT* codes *55700* and *76942*.

This revision is effective for services processed on or after September 29, 2003. The full-text LMRP will be available on the provider education Web site *www.connecticutmedicare.com* on or after that date.

73218: Magnetic Resonance Imaging of Upper Extremity—Correction

The new local medical review policy (LMRP) pertaining to magnetic resonance imaging of upper extremity that was effective September 29, 2003, included an invalid ICD-9-CM diagnosis code. We have corrected the LMRP to reflect ICD-9-CM code V67.00 (Follow-up examinations; following surgery) instead of V67.0.

This correction is effective for services processed on or after September 29, 2003. The full-text LMRP is available on our provider education Web site at *www.connecticutmedicare.com*.

CONNECTICUT EDUCATIONAL RESOURCES

"Connect with Medicare" Teleconference

Presented by First Coast Service Options, Inc., your Connecticut Medicare Part B Carrier

Hot Topics on Evaluation and Management Visit Codes that impact claim processing
Important information you should know!

Friday, November 14, 2003

1:00 p.m. PowerPoint Presentation

- Commonly Used Terms
- Selection of Appropriate Level of Care
- Office Visit Codes
- Routine Exams with Evaluation and Management (E/M) Visits
- Consultations
- Referrals vs. Consultations
- Medical Review Case Study
- MCS processing guidelines
- Hot Topics!

2:00 - 2:30 p.m. Open Forum (limit one question per caller)

No Pre-Registration Required—Open to First 100 callers!

Participants may begin to dial in (1-800-860-2442) 10 minutes prior to scheduled conference time.
The pass code is "EM Hot Topics."

For more information, call our Education and Outreach Department at 1-203-634-5430

If you cannot attend this teleconference, see flyer on our Web site for E/M Hot Topics Seminar

Enhance your Medicare Billing Knowledge!
Visit our Web site at *www.connecticutmedicare.com*

Free Medicare Part B Evaluation and Management Claim Filing–Hot Topics Seminar

Presented by First Coast Service Options, Inc., your Connecticut Medicare Part B Carrier

Hot Topics on Evaluation and Management Visit Codes that impact claim processing

Can you answer yes to the following questions?

1. Do you ever receive unprocessable claims?
2. Do you ever receive claim denials?
3. Do you know the difference between a procedure and a diagnostic test?
4. Do you know when to use a modifier 25 or modifier 24?
5. Do you know how to bill a routine visit that includes a covered visit?

If you answered yes to even one question, your practice cannot afford to miss this seminar. Your reimbursement depends on it!

You can choose between morning, or afternoon session (the content is the same). Select the time most convenient for your office. All sessions are free. No registration required. Come early, seating is limited to first 75 attendees.

Date:	Location	2 sessions daily
Tuesday November 18, 2003	Courtyard by Marriott 63 Grand Street Waterbury, CT 06702 203-596-1000	9:00-11:00 a.m. or 1:00- 3:00 p.m.
Friday November 21, 2003	Quality Inn and Conference Center 51 Hartford Turnpike, Rte. 83 Vernon, CT 06066 860-646-5700	9:00-11:00 a.m. or 1:00-3:00 p.m.

For more information, call our Education and Outreach Department at 1-203-634-5430

FLORIDA 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 comprehensive data analysis initiatives. These 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), carriers no longer include full-text local medical review policies (LMRPs) to providers 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

1-904-791-8465

Medical Review - Table of Contents

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.

Hand Carried Device for Neuromuscular Junction Testing

Medical equipment described as "hand held device" for neuromuscular junction testing does not meet Medicare requirements for *CPT* code *95937 (Neuromuscular junction testing [repetitive stimulation, paired stimuli], each nerve, any one method).* The equipment used to perform neuromuscular junction testing must provide the full extent, quality, completeness, and documentation required for use of that code. A "hand held device" used for neuromuscular junction testing is included in any other service performed.

COMPREHENSIVE DATA ANALYSIS

Widespread Probe Review Results—Code *36245* Arterial, Pelvic, or Lower Extremity Arterial Catheter Placement

Procedure code *36245 (Selective catheter placement, arterial, pelvic or lower extremity artery branch within a vascular family)* was chosen for comprehensive data analysis for fiscal year 2003 based on July through December 2001 data revealing a carrier to nation ratio of allowed dollars of 1.68 with a maximum potential savings of $608,336. 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 (LMRP) was made. A widespread probe of 50 claims from 10 providers for the period January 1, 2002, to June 30, 2002, was performed 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.

Summary of the Findings

- Of the 50 claims reviewed, 100% of the services billed were for selective catheter placement, arterial, pelvic or lower extremity artery branch within a vascular family.
- Indications noted for the catheter placement included: abnormal ultrasound doppler of the kidney arteries, renal artery stenosis with prior stent placement and uncontrolled hypertension.
- 23 services were allowed as billed.
- 34 services were denied because medical necessity could not be established from the submitted documentation.

Based on these widespread probe findings, LMRP will be developed to define the indications and the limitations of coverage and/or medical necessity, to identify a procedure to diagnosis relationship, to clarify guidelines, and the documentation requirements. Overpayments will be collected from providers when medical records do not sufficiently support the medical necessity for the procedure to be performed (e.g., abnormal non-invasive test), and education will be provided via the widespread probe education letter to the provider suggesting that functional tests should be performed before arteriography so angioplasty of suitable lesions may be performed at the time of the arteriography.

Widespread Probe Review Results—Code *75724* Renal Angiography

Procedure code *75724 (Angiography, renal, bilateral, selective [including flush aortogram], radiological supervision and interpretation)* was chosen for comprehensive data analysis for fiscal year 2003 based on July through December 2001 data revealing a carrier to nation ratio of allowed dollars of 3.36 with a maximum potential savings of $396,980. 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 (LMRP) was made. A widespread probe of 50 claims from 10 providers for the period January 1, 2002, to June 30, 2002, was performed 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.

Summary of the Findings

- Of the 50 claims reviewed, 100% of the services billed were for selective catheter placement, arterial, pelvic or lower extremity artery branch within a vascular family.
- Indications noted for the catheter placement included: abnormal ultrasound Doppler of the kidney arteries, renal artery stenosis with prior stent placement and uncontrolled hypertension.
- 30 services were allowed as billed.

- 16 services were denied because medical necessity could not be established from the submitted documentation.
- 5 services were denied for no submitted documentation for the services billed.

Based on these widespread probe findings, LMRP will be developed to define the indications and the limitations of coverage and/or medical necessity, to identify a procedure to diagnosis relationship, to clarify guidelines, and the documentation requirements. Overpayments will be collected from providers when medical records do not sufficiently support the medical necessity for the procedure to be performed (e.g., abnormal non-invasive test), and education will be provided via the widespread probe education letter to the provider suggesting that functional tests should be performed before arteriography so angioplasty of suitable lesions may be performed at the time of the arteriography.

Widespread Probe Review Results—Codes *78465*, *78478*, and *78480* Myocardial Perfusion Imaging

Procedure code *78465* was identified as aberrant as a result of ongoing follow-up from a 1998 comprehensive data analysis study. Procedure codes *78465 (Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress [exercise and/or pharmacologic] and redistribution and/or rest njection, with or without quantification), 78478 (Myocardial perfusion study with wall motion, qualitative or quantitative study),* and *78480 (Myocardial perfusion study with ejection fraction).* were identified as aberrant based on the January through June 2001 data revealing a carrier to nation ratio of allowed dollars of 2.39, 2.27, and 2.14 with a maximum potential savings of $35,396. 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 was made. A widespread probe of 100 claims, from 20 providers consisting of 100 ICN's and 261 services for the period September 2001 through February 2002 was performed to determine if the services billed to Medicare were documented as having been performed, to determine the medical conditions for which the service was being performed, and to determine if the local medical review policy (LMRP) for myocardial perfusion imaging should require a revision.

Summary of the Findings

- 92 of the services were allowed as billed and 8 services were denied based on lack of documented medical necessity.
- The top diagnoses billed for allowed services were for the following ICD-9-CM codes: 414.00 (Coronary atherosclerosis of unspecified type of vessel, native or graft), 413.9 (Other and unspecified angina pectoris), and 414.00 (Coronary atherosclerosis of native artery).
- The diagnoses billed for claims denied were for the following ICD-9-CM codes: 413.9 (Other and unspecified angina pectoris), 411.1 (Intermediate coronary syndrome), and 414.9 (Chronic ischemic heart disease, unspecified).
- The documentation for the services denied indicated the services were performed for routine screening, no prior cardiac history, normal baseline EKG, or no other present cardiac symptoms.

Based on these findings, the LMRP for myocardial perfusion imaging will be revised to incorporate the latest ACC/AHA guidelines and clarify indications and limitations for coverage.

Widespread Probe Review Results—Code *80076* Hepatic Panel Function

Procedure code *80076 (Hepatic panel function)* was identified as aberrant for July through December 2001 data as defined in, and accordance with the Statistical Medical Data Analysis (SMDA) Comprehensive Data Analysis (CDA) Standard Operating Procedure No. 1.01. The aberrant data revealed a carrier to nation ratio of allowed dollars of 1.85 with a maximum potential savings of $836,411. 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 to determine if hepatic panels (*80076*) are being billed/performed on beneficiaries with the diagnosis of hyperlipidemia/hypercholesterolemia that are not being managed with medication and to identify the appropriateness of performing a hepatic panel for other conditions. A widespread probe of 100 randomly selected claims from 20 providers, consisting of 100 services for the period July 2001 through December 2001 was performed to determine if services rendered were medically reasonable and necessary.

Summary of the Findings

- 82 of the services were allowed as billed and 18 services were denied.
- 17 denials were based on the failure of documentation submitted to support the medical necessity of the services performed.
- 1 denial was based on failure to submit requested documentation for review.

- The top diagnoses billed for allowed services were for ICD-9-CM codes 272.0 (Pure hypercholesterolemia), 272.2 (Mixed hyperlipidemia), and 272.4 (Other and unspecified hyperlipidemia)
- The top diagnoses billed for claims denied were for ICD-9-CM codes 272.4 (Other and unspecified hyperlipidemia) and 780.79 (Other malaise and fatigue). The documentation for the services denied did not support that the beneficiary exhibited any signs and symptoms that warranted this service.
- 64 of the 82 paid services documented the administration of heptatoxic medications. Clinical studies prompted manufacturers of the medications to recommend hepatic panels as a standard of care when prescribing these pharmaceuticals to patients. The remaining 18 paid services documented a history of recurrent metastatic cancer, elevated liver enzymes, or other signs of hepatic dysfunction.
- Documentation reviewed did not present an identifiable pattern of frequency. 64% of the claims reviewed revealed that services were rendered at intervals of 6 months or less. 36% of the claims reviewed revealed that services were rendered at intervals of every six months or more. 1% of the total claims reviewed reflected that services were rendered at intervals of 12 months or greater.

Efforts to educate providers will be initiated via articles in the *Medicare B Update!* A local medical review policy (LMRP) will be developed and implemented in the near future.

Widespread Probe Review Results—Code *93508* Catheter Placement in Coronary Artery

Procedure code *93508 (Catheter placement in coronary artery[s], arterial coronary conduit[s], and/or venous coronary bypass graft[s] for coronary angiography without concomitant left heart catheterization)* was chosen for comprehensive data analysis for fiscal year 2003 based on July through December 2001 data revealing a carrier to nation ratio of allowed dollars of 1.02 with a maximum potential savings of $5,059. 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 50 claims from 10 providers for the period January 1, 2002, to June 30, 2002, was performed 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.

Summary of the Findings

- Of the 50 claims reviewed, 100% of the services billed were for catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization.
- Indications noted for the catheter placement included: unstable angina, chest pain, previous beneficiaries with stent placement or bypass surgery now presenting with chest pain and exertional dyspnea.

Based on the widespread probe findings, it was determined that all services were appropriately coded for procedure performed. No additional action is required.

Widespread Probe Review Results—Pulmonary Codes *94240*, *94260*, *94720*, and *94725*

Procedure codes *94240*, *94260*, *94720*, and *94725* were chosen for comprehensive data analysis for fiscal year 2003 based on January through June 2001 data revealing a carrier to nation ratio of allowed dollars varying from 1.83 (*94720*) to 6.12 (*94725*) with a maximum potential savings of $2,734,265. Based on the conclusions of the findings, the performance of the services was considered a widespread problem; therefore, a recommendation to perform a widespread probe and possibly develop local medical review policy (LMRP) was made. A widespread probe of 101 claims from 21 providers for the period January 1, 2001, to June 30, 2001, was performed, 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.

The following pulmonary codes were reviewed:

94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94260 Thoracic gas volume
94720 Carbon monoxide diffusing capacity (eg, single breath, steady state)
94725 Membrane diffusion capacity

Summary of the Findings

Of the 101 services reviewed, 99 were allowed as billed and 2 were denied because no documentation was received to support that the services were performed. All submitted documentation supported some type of pulmonary symptom and/or disease. Approximately 15% of the submitted documentation did not include office or progress notes and the services were reviewed by the

submitted ICD-9-CM codes, the "reason for test" and/or the PFT results.

An LMRP will be developed to define all pulmonary services, including indications and limitations, components of each test with the expected interpretive results, and the conditions that one would expect services to be repeated. In addition, the current LMRPs related to pulmonary services (*94240*, *94620*, and *94010*, which includes *94360*) will be retired and these codes will be included in a comprehensive pulmonary policy.

Widespread Probe Review Results—Pulmonary Codes *94240*, *94260*, *94360*, *94370*, *94620*, *94720*, and *94750*

Procedure codes *94240, 94260, 94360, 94370, 94620, 94720,* and *94750* were chosen for comprehensive data analysis for fiscal year 2003 based on January through June 2001 data revealing a carrier to nation ratio of allowed dollars varying from 1.83 (*94720*) to 10.15 (*94750*) with a maximum potential savings of $2,734,265. Based on the conclusions of the findings, the performance of the services was considered a widespread problem; therefore, a recommendation to perform a widespread probe and possibly develop local medical review policy (LMRP) was made. A widespread probe of 100 claims from 16 providers for the period January 1, 2001, to June 30, 2001, was performed, 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.

The following pulmonary codes were reviewed:

94240 *Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method*
94260 *Thoracic gas volume*
94360 *Determination of resistance to airflow, oscillatory or plethysmographic methods*
94370 *Determination of airway closing volume, single breath tests*
94620 *Pulmonary stress test; simple (eg, prolonged exercise test for bronchospasm with pre- and post-spirometry)*
94720 *Carbon monoxide diffusing capacity (eg, single breath, steady state)*
94750 *Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)*

Summary of the Findings

Of the 100 services reviewed, 99 were allowed as billed and 1 was denied because no documentation was received to support that the services were performed. All submitted documentation supported some type of pulmonary symptom and/or disease. Approximately 10% of the submitted documentation did not include office or progress notes and the services were reviewed by the submitted ICD-9-CM codes, the "reason for test" and/or the PFT results.

A local medical review policy will be developed to define all pulmonary services, including indications and limitations, components of each test with the expected interpretive results, and the conditions that one would expect services to be repeated. In addition, the current policies related to pulmonary services (*94240, 94620,* and *94010*, which includes *94360*) will be retired and these codes will be included in a comprehensive pulmonary policy.

Widespread Probe Review Results—Home Visit Evaluation and Management Services Codes *99341-99345*

Procedure codes *99341-99345* (home E/M services) were chosen for comprehensive data analysis for fiscal year 2003 based on January through June 2001 data revealing a carrier to nation ratio of allowed dollars varying from 1.63 (*99341*) to 3.48 (*99344*), with a maximum potential savings of $587,250. Based on the conclusions of the findings, performance of this service was considered a widespread problem; therefore, a recommendation was made to perform a widespread probe and possibly develop local medical review policy (LMRP). A widespread probe of 99 claims from 10 providers for the period from January 1, 2001, to June 30, 2001, was performed, 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.

Summary of the Findings

- Of the 99 services reviewed, 48 were allowed as billed, 42 were recoded to reflect the level of care documented, and 9 were denied. Of the denied services, 8 were denied because there were no records submitted for review, and 1 was denied as not sufficiently documented.
- Approximately 56% of the beneficiaries were homebound.
- Approximately 22% of the beneficiaries were not documented to be homebound.
- Approximately 12% of the beneficiaries were residents of a facility. Of these beneficiaries, 7 resided in an assisted living facility (ALF) and were receiving assistance with medication administration; and, 4 resided in a skilled nursing facility (SNF).

Based on these widespread probe findings, LMRP will be developed to include home E/M services (*CPT* codes *99341-99345*) to indicate the appropriate place of service, define "homebound" and develop indications and limitations of coverage. An educational article will be written to indicate that home E/M services must be provided in a private residence. Overpayments will be collected from providers included in the widespread probe in which the medical records failed to demonstrate the level of E/M service billed, the provider failed to submit medical records, or the documentation did not sufficiently support the E/M service was performed.

Widespread Probe Review Results—Home Visit Evaluation and Management Services Codes *99347-99350*

Procedure codes *99347-99350* (home E/M services) were chosen for comprehensive data analysis for fiscal year 2003 based on the January through June 2001 data revealing a carrier to nation ratio of allowed dollars varying from 1.47 (*99347*) to 1.92 (*99349*) with a maximum potential savings of $2,610,568. Based on the conclusions of the findings, the performance of this service was considered a widespread problem; therefore, a recommendation was made to perform a widespread probe and possibly develop local medical review policy (LMRP). A widespread probe of 100 claims from 10 providers for the period January 1, 2001, to June 30, 2001, was performed, 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.

Summary of the Findings

- Of the 100 services reviewed, 74 were allowed as billed, 16 were recoded to reflect the level of care documented, and 10 were denied. Of the denied services, 7 were denied because there were no records submitted for review, 2 were denied because the procedure billed was not supported by documentation, and 1 was denied because there was no separately identifiable E/M service performed.
- Approximately 61% of the beneficiaries were homebound.
- Approximately 18% of the beneficiaries were not documented to be homebound.
- Approximately 11% of the beneficiaries were residents of a facility.
- Documentation was not received for approximately 11% of the beneficiaries; therefore, place of residence is undetermined.
- It was determined the documentation submitted for approximately 8% of the allowed services (7 services) did not support medical necessity for the E/M service billed.

Based on these widespread probe findings, LMRP will be developed to include home E/M services (*CPT* codes *99347-99350*) to indicate the appropriate place of service, define "homebound" and develop indications and limitations of coverage. An educational article will be written to indicate that home E/M services must be provided in a private residence. Overpayments will be collected from providers included in the widespread probe in which the medical records failed to demonstrate the level of E/M service billed, the provider failed to submit medical records, or the documentation did not sufficiently support the E/M service was performed.

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LOCAL MEDICAL REVIEW POLICY (NEW)

ERASV: Endoluminal Radiofrequency Ablation of the Saphenous Vein

A local medical review policy (LMRP) has been developed for endoluminal radiofrequency ablation of the saphenous vein to define the indications and limitations for this service.

This procedure is a minimally invasive alternative to vein ligation and stripping. It has received FDA approval for treatment of varicose veins. The technique involves delivery of radiofrequency energy through a catheter inserted into the affected vein. The energy from the radiofrequency damages the intimal wall of the vessel resulting in fibrosis and obliteration of a long segment of the vein thus eliminating reflux. The procedure is performed by inserting a specially designed catheter through a small incision in the distal medial thigh to within 1-2 cm of the sapheno-femoral junction. High radiofrequency energy is delivered to the vein wall, causing it to heat. As the vein warms, it collapses and seals shut. The procedure is generally done in an outpatient setting under local anesthesia. When billing this service, the unlisted *CPT* code *37799* should be used, and a comment should be placed in item 19 of Form CMS-1500 (or in the appropriate comment field for electronic submitters), indicating that this code corresponds to radiofrequency ablation of the saphenous vein.

This LMRP is available on our provider education Web site, *www.floridamedicare.com*, and is effective for claims processed on or after January 5, 2004.

OOS: Outpatient Observation Services

A new local medical review policy (LMRP) has been developed to communicate to physicians and allied staff the Medicare provisions for outpatient observation services. This policy contains information that applies to outpatient observation services and billing guidelines, which are applicable to services billed by the hospital to the Medicare Part A fiscal intermediary (FI). It serves as a resource for physicians in clarifying Medicare's definition of outpatient observation services.

Implementation of the outpatient prospective payment system (OPPS) in August 2000 brought changes to the traditional Medicare payment methodology of hospital outpatient services. CMS continues to refine OPPS with periodic clarifications and updates. Despite the change in outpatient payment methodology from a generally cost-based reimbursement to a prospective payment system, for the services billed by the hospital to the FI, the Medicare *definition* of observation services has not changed.

Outpatient observation services are defined as: the use of a bed and periodic monitoring by nursing or other ancillary staff that are reasonable and necessary to evaluate the patient's condition for possible need of inpatient admission. These services are only considered reimbursable when performed under a specific order of a physician (or under the order of another person who is authorized by state statute and the hospital's bylaws to admit patients or order outpatient testing). The order must be based on the physician's expectation of the care that the patient will require.

Outpatient observation services are not to be used as a substitute for medically necessary inpatient admissions. Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, or patient's families, or while awaiting placement to another facility.

In general, a patient is considered an inpatient if he/she has been formally admitted to a hospital with the physician expectation that he/she will need hospital care for 24 hours or longer, or needs services only available in an inpatient environment. Admission to the intensive care level of service does not fit the criteria for observation. This level of care and observation is not reimbursable to a hospital as outpatient observation services.

Outpatient observation services must be patient specific. Outpatient observation services, generally, do not exceed 24 hours. Some patients may require a second day of observation; only in rare and exceptional cases do observation services span more than 48 hours.

The full-text of this LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after January 5, 2004.

19318: Reduction Mammaplasty

Local medical review policy (LMRP) has been developed for reduction mammaplasty. This policy was developed to define indications and limitations for this service.

CPT code *19318 (Reduction mammaplasty)* is the surgical removal of a substantial portion of the breast, including the skin and underlying glandular tissue. Breasts are pair organs and breast hypertrophy generally affects both sides. Although bilateral surgery is usually performed, unilateral surgery may be reasonable and necessary.

The full-text of this LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for services for claims processed on and after January 5, 2004.

31525: Laryngoscopy

Statistical medical data obtained for dates of service from November 2002 through April 2003 found *CPT* code *31575* to have an aberrancy ratio of 1.84 per 1000 enrollees. Therefore, a new local medical review policy (LMRP) has been developed to define the indications and limitations for diagnostic laryngoscopy services. This procedure provides direct visualization of the larynx and secondary structures. The fiberoptic technique utilizes specialized endoscopic techniques.

The *CPT* codes included in this policy are:

31525	*Laryngoscopy, direct, with or without tracheoscopy; diagnostic, except newborn*
31575	*Laryngoscopy, flexible fiberoptic; diagnostic*

The full-text of this new LMRP available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after January 5, 2004.

43842: Surgical Management of Morbid Obesity

Local medical review policy (LMRP) has been developed to define the indications and limitations for surgical management of morbid obesity (*CPT* code *43842*).

Gastrointestinal surgery for obesity, also called bariatric surgery, promotes weight loss by closing off parts of the stomach to make it smaller. Procedures that only reduce stomach size are considered "restrictive" surgeries because they restrict the amount of food the stomach can hold. Procedures that combine stomach restriction with a partial bypass of the small intestine are known as "malabsorptive" surgeries. Malabsorptive surgeries create a direct connection from the stomach to the lower segment of the small intestine, bypassing the portions of the digestive tract that absorb calories and nutrients.

Florida Medicare will consider surgical management for the treatment of morbid obesity reasonable and necessary when all of the following conditions are met:

- The patient meets the definition of morbid obesity which is defined as a body mass index (BMI) of 40kg/m^2 or greater and comorbid conditions exist. Documentation of the level of severity of the comorbid existing condition must be included in the patient's medical record; AND
- There is documented evidence of repeated failure of multiple attempts (usually 3) to lose weight on a supervised non-surgical management weight loss program (e.g., diet, exercises, or drugs). It would be expected that a weight loss program would consist of a consecutive 6 month period; AND
- Psychological evaluation and counseling associated with the lifestyle changes associated with the surgery have been performed prior to the surgery; AND
- Treatable metabolic causes for obesity (e.g., adrenal of thyroid disorders) have been ruled out or have been clinically treated if present.

***CPT*/HCPCS codes covered by this policy:**

43842 *Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty*
43843 *Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty*
43846 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100cm) Roux-en-Y gastroenterostomy*
43847 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption*
43848 *Revision of gastric restrictive procedure for morbid obesity (separate procedure)*
43999 *Unlisted procedure, stomach*

The full-text of this new LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for services processed on or after January 5, 2004.

83880: B-Type Natriuretic Peptide (BNP)

Congestive heart failure (CHF) is characterized by a progressive activation of the neurohormonal systems that control vasoconstriction and sodium retention; the activation of these systems plays a role in its pathogenesis and progression. As the heart fails, B-type natriuretic peptide (BNP), a cardiac neurohormone is secreted from the cardiac ventricles in response to ventricular volume expansion and pressure overload. Used in conjunction with other clinical information, rapid measurement of BNP is useful in establishing or excluding the diagnosis and assessment of severity of CHF in patients with acute dyspnea so that appropriate and timely treatment can be initiated. BNP levels are also useful for risk stratification among patients with acute coronary syndrome (myocardial infarction with or without T-wave elevation and unstable angina).

Local medical review policy (LMRP) has been developed for *CPT* code *83880 (Natriuretic peptide)* to allow providers access to this new technology, and to provide indications and limitations for this procedure. For the purposes of this policy, the total and N terminal assays are both acceptable.

The full-text of this LMRP is available on the provider education Web site *www.floridamedicare.com*, and will be effective for services rendered on or after January 5, 2004.

88141: Pap Smears

CMS Transmittal AB-03-054, Change Request 2637, expands coverage for screening Pap smears. Therefore, the local medical review policy (LMRP) for Pap smears laboratory testing has been revised to define the indications and limitations of coverage, and to add ICD-9-CM codes V76.47 and V76.49 to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The full-text of this LMRP may be found on the provider education Web site *wwwfloridamedicare.com*. These changes are effective for services processed on or after October 1, 2003.

88271: Urinary Fluorescent In Situ Hybridization (FISH) Test for Recurrent Bladder Cancer

The urinary FISH test for recurrent bladder cancer is an FDA-approved multiprobe fluorescent in situ hybridization (FISH) DNA technology designed to detect aneuploidy for chromosomes 3, 7, 17, and loss of the 9p21 locus via FISH in voided urine specimens from patients with transitional cell carcinoma of the bladder (urothelial carcinoma). In situ hybridization is a technique that allows the visualization of specific nucleic acid sequences within a cellular preparation. Specifically, DNA FISH involves the precise annealing of a single stranded fluorescently labeled DNA probe to complementary target sequences. The hybridization of the probe with the cellular DNA site is visible by direct detection using fluorescence microscopy. Results from this urinary FISH test are intended for use as a noninvasive method for monitoring tumor recurrence in conjunction with cystoscopy in patients previously diagnosed with bladder cancer.

Local medical review policy (LMRP) has been developed to allow providers access to this new technology, and to provide indications and limitations for this procedure.

CPT/HCPCS Codes

88271	*Molecular cytogenetics; DNA probe, each (eg, FISH)*
88274	*Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells*
88291	*Cytogenetics and molecular cytogenetics, interpretation and report*

ICD-9-CM codes that support medical necessity for this service include:

188.0-188.9	Malignant neoplasm of bladder
189.0-189.9	Malignant neoplasm of kidney and other and unspecified urinary organs
198.1	Secondary malignant neoplasm of other urinary organs
233.7	Carcinoma in situ of bladder
236.7	Neoplasm of uncertain behavior of bladder
239.4	Neoplasms of unspecified nature, bladder
V10.50	Personal history of malignant neoplasm, urinary organ, unspecified
V10.51	Personal history of malignant neoplasm, bladder
V10.52	Personal history of malignant neoplasm, kidney

The full-text of this LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after January 5, 2004.

0025T: Ocular Corneal Pachymetry

Ocular corneal pachymetry is the ultrasonic measurement of corneal thickness. Measurement of corneal thickness in individuals presenting with increased intraocular pressure assists in determining if there is a risk of glaucoma or if the individual's increased eye pressure is the result of abnormal corneal thickness.

A recent study has demonstrated the benefit of assessing corneal thickness in individuals with increased intraocular pressure. Several physicians requested evaluation of this technology for separate reimbursement consideration. Development of a local medical review policy (LMRP) for *CPT* code *0025T (Determination of corneal thickness [eg, pachymetry] with interpretation and report, bilateral)* resulted from the evaluation.

CPT 0025T is considered medically necessary for specific diseases of the cornea. The full text of this new LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for services processed on or after January 5, 2004.

LOCAL MEDICAL REVIEW POLICY (REVISED)

2004 ICD-9-CM Coding Changes

The 2004 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2003. Updated diagnosis codes *must* be used for all services billed on or after January 1, 2004. 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, 2003. 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, 2004 *must* be billed with the updated 2004 ICD-9-CM codes.

Florida Medicare has reviewed all local medical review policies (LMRPs) for procedure codes with specific diagnosis criteria that are affected by the 2004 ICD-9-CM update. The table on the following pages lists the LMRPs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2004 ICD-9-CM update:

2004 ICD-9-CM Part B LMRP Changes

LMRP Title	2004 Changes
33999: Pacemaker Lead Extraction, Unusually Difficult	Change 959.1 to 959.11 (Other injury of chest wall) for procedure code *33999*
36511: Therapeutic Apheresis (Plasma and/or Cell Change)	Change 358.0 to 358.00 (Myasthenia gravis without (acute) exacerbation) for procedure codes *36511*, *36512*, *36513*, and *36514* Add 358.01 (Myasthenia gravis with (acute) exacerbation) for procedure codes *36511*, *36512*, *36513*, and *36514*
43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy	Add V58.64 (Long-term (current) use of non-steroidal anti-inflammatories [NSAID]) for procedure codes *43235*, *43236*, *43239*, *43241*, *43243-43251*, *43255*, and *43258*
52282: Urethral Stents	Change 600.0-600.9 to 600.00-600.91 (Hyperplasia of prostate) for procedure code *52282*
53850: Prostate Treatments	Change 600.0 to 600.00-600.01 (Hypertrophy (benign) of prostate) for procedure codes *53850*, *53852*, and *53853*
55700: Biopsy of Prostate Using Image Guidance	Change 600.0-600.9 to 600.00-600.91 (Hyperplasia of prostate) for procedure code *55700*
70450: Computed Tomography Scans	Change 767.1 to 767.11 (Epicranial subaponeurotic hemorrhage [massive]) and 767.19 (Other injuries to scalp) for procedure codes *70450*, *70460*, and *70470* Add 781.94 (Facial weakness) for procedure codes *70450*, *70460*, and *70470*
70551: Magnetic Resonance Imaging of the Brain	Change 358.0-358.1 to 358.00-358.1 (Myasthenia gravis and myasthenic syndromes in diseases classified elsewhere) for procedure codes *70551*, *70552*, and *70553* Add 781.94 (Facial weakness) for procedure codes *70551*, *70552*, and *70553*
71010: Chest X-Ray	Change 959.1 to 959.11 (Other injury of chest wall) and 959.19 (Other injury of other sites of trunk) for procedure codes *71010*, *71015*, *71020*, *71021*, *71022*, *71023*, *71030*, *71034*, and *71035* Change V43.2-V43.3 to V43.21-V43.3 (Organ or tissue replaced by other means, heart and heart valve) for procedure codes *71010*, *71015*, *71020*, *71021*, *71022*, *71023*, *71030*, *71034*, and *71035*
72192: Computed Tomography of the Pelvis	Change 752.8 to 752.81 (Scrotal transposition) and 752.89 (Other specified anomalies of genital organs) for procedure codes *72192*, *72193*, and *72194* Change 820.00-820.99 to 820.00-820.9 (Fracture of neck of femur) for procedure codes *72192*, *72193*, and *72194* (**Not related to 2004 ICD-9-CM Update**) Change 959.1 to 959.12 (Other injury of abdomen), 959.13 (Fracture of corpus cavernosum penis), and 959.14 (Other injury of external genitals) for procedure codes *72192*, *72193*, and *72194* Add 995.91 (Systemic inflammatory response syndrome due to infectious process without organ dysfunction) and 995.92 (Systemic inflammatory response syndrome due to infectious process with organ dysfunction) for procedure codes *72192*, *72193*, and *72194*

76512: B-Scan	Change descriptor for 282.60 (Sickle-cell disease, unspecified), 282.61 (Hb-SS disease without crisis), 282.62 (Hb-SS disease with crisis), 282.63 (Sickle-cell/Hb-C disease without crisis), and 282.69 (Other sickle-cell disease with crisis) for procedure codes *76512* and *76513* Add 282.64 (Sickle-cell/Hb-C disease with crisis) and 282.68 (Other sickle-cell disease without crisis) for procedure codes *76512* and *76513*
78460: Myocardial Perfusion Imaging	Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes *78460, 78461, 78464, 78465, 78478,* and *78480*
78472: Cardiac Blood Pool Imaging	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes *78472, 78473, 78481, 78483, 78494,* and *78496*
82108: Aluminum	Change 348.3 to 348.30-348.39 (Encephalopathy, not elsewhere classified) for procedure code *82108* Change 973 to 973.0 (Poisoning by antacids and antigastric secretion drugs) for procedure code *82108* (**Not related to 2004 ICD-9-CM Update**)
82310: Total Calcium	Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code *82310* Add 780.01 (Coma) for procedure code *82310* (**Not related to 2004 ICD-9-CM Update**)
82435: Chloride	Change 255.1 to 255.10-255.14 (Hyperaldosteronism) for procedure code *82435*
82784: Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, Each	Change 600.0-600.9 to 600.00-600.91 (Hyperplasia of prostate) for procedure code *82784*
83735: Magnesium	Change 255.1 to 255.10-255.14 (Hyperaldosteronism) for procedure code *83735* Change 643.10-643.83 to 643.00-643.83 (Excessive vomiting in pregnancy) for procedure code *83735* (**Not related to 2004 ICD-9-CM Update**) Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code *83735* Change 941.00-949.5 to 940.0-949.5 (Burns) for procedure code *83735* (**Not related to 2004 ICD-9-CM Update**)
84100: Serum Phosphorus	Change 348.3 to 348.30-348.39 (Encephalopathy, not elsewhere classified) for procedure code *84100* Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code *84100* Change E944.0-E944.5 to E944.0-E944.7 (Drugs, medicinal and biological substances causing adverse effects in therapeutic use, water, mineral, and uric acid metabolism drugs) for procedure code *84100* (**Not related to 2004 ICD-9-CM Update**)
90801: Psychiatric Diagnostic Interview Examination	Add 780.93 (Memory loss) for procedure code *90801*
92015: Ophthalmological Diagnostic Services	Change 250.50-250.51 to 250.50-250.53 (Diabetes with ophthalmic manifestations) for procedure code *92250* (**Not related to 2004 ICD-9-CM Update**) Change 282.60 to 282.60-282.69 (Sickle-cell disease) for procedure code *92250* Change 342.0-342.92 to 342.00-342.92 (Hemiplegia and hemiparesis) for procedure code *92250* (**Not related to 2004 ICD-9-CM Update**) Add 379.39 (Aphakia and other disorders of lens) for procedure code *92250* (**Not related to 2004 ICD-9-CM Update**) Change 998.5 to 998.51-998.59 (Postoperative infection) for procedure code *92285* (**Not related to 2004 ICD-9-CM Update**)
92081: Visual Field Examination	Change descriptor for 282.60-282.69 (Sickle-cell disease) for procedure codes *92081, 92082,* and *92083* Change 743.52-743.58 to 743.51-743.59 (Congenital anomalies of posterior segment) for procedure codes *92081, 92082,* and *92083* (**Not related to 2004 ICD-9-CM Update**)
92973: Interventional Cardiology	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure codes *92973, 92980, 92981, 92982, 92984, 92995,* and *92996* Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes *92973, 92980, 92981, 92982, 92984, 92995,* and *92996*
93000: Electrocardiography	Change 959.1 to 959.11-959.19 (Injury, trunk) for procedure codes *93000, 93005,* and *93010* Change 995.0-995.89 to 995.0-995.94 (Certain adverse effects not elsewhere classified) for procedure codes *93000, 93005,* and *93010* (**Not related to 2004 ICD-9-CM Update**)
93224: Electrocardiographic Monitoring for 24 Hours (Holter Monitoring)	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure codes *93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236,* and *93237* Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes *93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236,* and *93237*

93303: Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes *93307* and *93308* Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes *93320*, *93321*, and *93325*
93312: Transesophageal Echocardiogram	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes *93312*, *93313*, *93314*, *93315*, *93316*, *93317*, and *93318*
93350: Stress Echocardiography	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure code *93350* Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure code *93350*
94760: Non-invasive Ear or Pulse Oximetry for Oxygen Saturation	Add 493.81 (Exercise induced bronchospasm) and 493.82 (Cough variant asthma) for procedure codes *94760* and *94761* Add 493.81 (Exercise induced bronchospasm) and 493.82 (Cough variant asthma) for procedure code *94762*
94799: Pulmonary Rehabilitation Services	Change descriptor for 493.00 (Extrinsic asthma, unspecified), 493.10 (Intrinsic asthma, unspecified), and 493.20 (Chronic obstructive asthma, unspecified) for procedure code *94799* Add 493.81-493.82 (Other forms of asthma) for procedure code *94799*
95816: Electroencephalography (EEG)	Change 331.1 to 331.11 (Pick's disease) for procedure code *95819* Add 331.19 (Other frontotemporal dementia) and 331.82 (Dementia with Lewy bodies) for procedure code *95819* Change 348.3 to 348.30 (Encephalopathy, unspecified) for procedure code *95819* Add 348.31 (Metabolic encephalopathy) and 348.39 (Other encephalopathy) for procedure code *95819* Add 781.94 (Facial weakness) for procedure code *95819* Add 331.82 (Dementia with Lewy bodies) for procedure codes *95950*, *95951*, *95953*, and *95956* Change 348.3 to 348.30 (Encephalopathy, unspecified) for procedure codes *95950*, *95951*, *95953*, and *95956* Add 348.31 (Metabolic encephalopathy) and 348.39 (Other encephalopathy) for procedure codes *95950*, *95951*, *95953*, and *95956* Add 781.94 (Facial weakness) for procedure code *95950*, *95951*, *95953*, and *95956*
95857: Tensilon Test	Change 358.0 to 358.00-358.01 (Myasthenia gravis) for procedure codes *95857* and *95858*
95937: Neuromuscular Junction Testing	Change 358.0 to 358.00-358.01 (Myasthenia gravis) for procedure code *95937* Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code *95937*
A4644: Low Osmolar Contrast Media (LOCM)	Change 282.4 to 282.41-282.49 (Thalassemias) for procedure codes A4644, A4645, and A4646 Change descriptor for 282.60 (Sickle-cell disease, unspecified), 282.61 (Hb-SS disease without crisis), 282.62 (Hb-SS disease with crisis), 282.63 (Sickle-cell/Hb-C disease without crisis), and 282.69 (Other sickle-cell disease with crisis) for procedure codes A4644, A4645, and A4646 Add 282.64 (Sickle-cell/Hb-C disease with crisis) and 282.68 (Other sickle-cell disease without crisis) for procedure codes A4644, A4645, and A4646 Change descriptor for 493.00 (Extrinsic asthma, unspecified), 493.02 (Extrinsic asthma, with (acute) exacerbation), 493.10 (Intrinsic asthma, unspecified), 493.12 (Intrinsic asthma, with (acute) exacerbation), 493.20 (Chronic obstructive asthma, unspecified), 493.22 (Chronic obstructive asthma, with (acute) exacerbation), 493.90 (Asthma, unspecified), and 493.92 (Asthma, with (acute) exacerbation) for procedure codes A4644, A4645, and A4646 Add 785.52 (Septic shock) for procedure codes A4644, A4645, and A4646
G0030: Positron Emission Tomography (PET) Scans	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure codes G0030-G0047 Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes G0030-G0047
J0150: Adenosine (Adenocard®, Adenoscan®)	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure code J0150 Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure code J0151

EPO: Epoetin Alfa (formerly Q0136: Non-ESRD Epoetin [Procrit] and Q9920: Chronic Renal Failure Erythropoietin [Epogen])

The local medical review policy (LMRP) for non-ESRD (end-stage renal disease) epoetin was last updated October 1, 2000. Erythropoietin is a glycoprotein that stimulates red blood cell production. It is produced in the kidneys and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

This policy has been revised to define the indications and limitations of coverage and/or medical necessity; and to clarify the appropriate use of epoetin alfa. The following major revisions have been incorporated:

- Laboratory requirements for initiation of epoetin alfa therapy have been revised.
- The following "Indications and Limitations of Coverage and/or Medical Necessity" have been added to the policy:
  - Anemia associated with malignancy
  - Anemia associated with the management of hepatitis C
- The "Coding Guidelines" section of the LMRP has been revised with updated dual diagnosis requirements.
- The LMRPs for non-ESRD epoetin and chronic renal failure erythropoietin have been combined. The new policy number and name is EPO: Epoetin Alfa.

The following HCPCS codes are included in the LMRP:

Q0136	Injection, epoetin alpha, (for non ESRD use), per 1,000 units
Q9920	Injection of EPO, per 1000 units, at patient HCT of 20 or less
Q9921	Injection of EPO, per 1000 units, at patient HCT of 21
Q9922	Injection of EPO, per 1000 units, at patient HCT of 22
Q9923	Injection of EPO, per 1000 units, at patient HCT of 23
Q9924	Injection of EPO, per 1000 units, at patient HCT of 24
Q9925	Injection of EPO, per 1000 units, at patient HCT of 25
Q9926	Injection of EPO, per 1000 units, at patient HCT of 26
Q9927	Injection of EPO, per 1000 units, at patient HCT of 27
Q9928	Injection of EPO, per 1000 units, at patient HCT of 28
Q9929	Injection of EPO, per 1000 units, at patient HCT of 29
Q9930	Injection of EPO, per 1000 units, at patient HCT of 30
Q9931	Injection of EPO, per 1000 units, at patient HCT of 31
Q9932	Injection of EPO, per 1000 units, at patient HCT of 32
Q9933	Injection of EPO, per 1000 units, at patient HCT of 33
Q9934	Injection of EPO, per 1000 units, at patient HCT of 34
Q9935	Injection of EPO, per 1000 units, at patient HCT of 35
Q9936	Injection of EPO, per 1000 units, at patient HCT of 36
Q9937	Injection of EPO, per 1000 units, at patient HCT of 37
Q9938	Injection of EPO, per 1000 units, at patient HCT of 38
Q9939	Injection of EPO, per 1000 units, at patient HCT of 39
Q9940	Injection of EPO, per 1000 units, at patient HCT of 40 or above

The revised LMRP is effective for claims processed on or after January 5, 2004, and is available on our provider education Web site at *www.floridatmedicare.com.*

NCSVCS: The List of Medicare Noncovered Services

The local medical review policy (LMRP) for The List of Medicare Noncovered Services was last updated on September 29, 2003.

Instructions were received from the Centers for Medicare & Medicaid Services (CMS) to designate HCPCS code J1910 (injection, kutapressin, up to 2 ml) as noncovered by Medicare. Kutapressin has not been approved by the Food and Drug Administration (FDA). Therefore, J1910 was added to the "National Noncoverage Decisions" section of the LMRP, effective for claims processed on or after September 30, 2003.

The full-text LMRP is available on our provider education Web site at *www.floridamedicare.com.*

VISCO: Viscosupplementation Therapy for Knee

The LMRP for viscosupplementation therapy for knee was last updated on January 1, 2003.

Based on comments received from the provider community, revisions have been made to the "Indications and Limitations of Coverage and/or Medical Necessity," "ICD-9 Codes that Support Medical Necessity," "Reasons for Denials" and "Documentation Requirements" sections of the LMRP.

The following indications and limitations of coverage and/or medical necessity apply to viscosupplementation therapy for knee:

- The patient must have painful osteoarthritis of the knee, and
- The patient must have an intolerance to non-steroidal anti-inflammatory drugs (NSAIDs) with a condition such as peptic ulcer disease, or

- Mild analgesics such as acetaminophen have not been effective in pain reduction, and/or the patient has failed other conservative treatment, and
- Joint effusion, if any, must be removed prior to injection, and
- The patient should not be markedly obese, and
- The joint(s) injected must be the knee(s), and
- The patient has not had a previous reaction to an earlier administration of one of these medications.

The following ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of the LMRP.

715.16 Osteoarthrosis, localized, primary, lower leg
715.26 Osteoarthrosis, localized, secondary, lower leg
715.36 Osteoarthrosis, localized, not specified whether primary or secondary, lower leg

In addition, the LMRP has been revised to indicate ICD-9-CM codes 715.16, 715.26, 715.36 and 715.96 (Osteoarthrosis, unspecified whether generalized or localized, lower leg) are applicable to HCPCS codes J7317 and J7320. Claims will no longer be denied when the patient has severe osteoarthritis and/or large joint effusions (joint effusion must be removed prior to injection).

Finally, the documentation requirements have been revised to state the physician should indicate in the patient's medical documentation the inability to take or respond to NSAIDs.

This LMRP revision is effective for claims processed on or after September 8, 2003.

G0030: Positron Emission Tomography (PET) Scan

The local medical review policy (LMRP) for positron emission tomography (PET) scan was last updated on October 1, 2003.

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 (radiopharmaceuticals) such as 2-(F-18) fluoro-D-glucose (FDG), that are administered intravenously to the patient.

CMS Transmittal AB-03-092, Change Request 2687, provides expanded coverage for noninvasive imaging of the perfusion of the heart using FDA-approved ammonia N-13 as a tracer. Ammonia N-13 and rubidium are the only two tracers covered for PET scans for the perfusion of the heart. Additional instructions are provided for carriers billing rubidium in CMS transmittal AB-03-119, Change Request 2853.

The LMRP for PET has been revised to reflect these changes. Coverage has also been expanded to include restaging of recurrent residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.

The full text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for services rendered on or after October 1, 2003.

J0207: Amifostine (Ethyol®)

The local medical review policy (LMRP) for amifostine (Ethyol®) was last updated on June 18, 2001.

A request was received from a provider to add ICD-9-CM code **238.7** (Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues [Myelodysplastic syndrome]) to the "ICD-9 Codes that Support Medical Necessity" section of the LMRP. After reviewing the information provided, it was determined this request was appropriate.

Therefore, the "ICD-9 Codes that Support Medical Necessity" section of the LMRP has been updated to include ICD-9-CM code 238.7 for HCPCS code J0207. In addition, the following indication has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LMRP: Myelodysplastic syndrome (treatment) – for salvage treatment, as part of a combination regimen (e.g., erythropoietin, topotecan, etoposide, cytarabine), for the treatment of myelodysplastic syndromes (MDS).

The full-text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after October 20, 2003.

J0640: Leucovorin (Wellcovorin®)

The local medical review policy (LMRP) for leucovorin was implemented June 30, 2003. The policy has since been revised to correct an invalid ICD-9 CM code. Code 181.0 is invalid; the correct ICD-9-CM code is 181 (Malignant neoplasm of placenta (choriocarcinoma). The "ICD-9 Codes That Support Medical Necessity" section of the policy has been changed to reflect this correction.

The full-text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after September 23, 2003.

J2355: Oprelvekin (Neumega®)

The local medical review policy (LMRP) for oprelvekin (Neumega®) was implemented on December 20, 1999.

Since then, a request was received from a provider to add ICD-9-CM code 273.3 (Macroglobulinemia) to the "ICD-9 Codes that Support Medical Necessity" section of the LMRP. After reviewing the information provided, it was determined this request was appropriate.

Therefore, the "ICD-9 Codes that Support Medical Necessity" section of the LMRP has been updated to include ICD-9-CM code 273.3 for HCPCS code J2355. The billing of oprelvekin requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9-CM codes 140.0-202.98 or 273.3 and 287.4 (thrombocytopenia due to drugs) to report the approved indication for J2355.

The full-text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after August 25, 2003.

J9999: Antineoplastic Drugs

The local medical review policy (LMRP) for antineoplastic drugs was last updated January 1, 2003. The following revisions have since been made:

Indications and Limitations of Coverage and/or Medical Necessity

The indication for off-label use of chemotherapeutic agents has been revised.

The following off-label indications have been added to the respective agent:

- Carboplatin – Hormone refractory prostate cancer
- Docetaxel – Soft tissue sarcomas
- Gemcitabine – Soft tissue sarcomas
- Topotecan Hydrochloride – Cervical carcinoma

ICD-9 Codes that Support Medical Necessity

The ICD-9-CM range for HCPCS codes J9181-J9182 (Etoposide) has been corrected from 186.0-186 to 186.0-186.9 (Malignant neoplasm of testis), effective for claims processed on or after September 29, 2003.

The following ICD-9-CM codes have been added to the respective agent:

- J9045 (Carboplatin) – 185 (Malignant neoplasm of prostate), effective for claims processed on or after October 20, 2003.
- J9170 (Docetaxel) – 171.0-171.9 (Malignant neoplasm of connective and other soft tissue [soft tissue sarcomas]), effective for claims processed on or after October 20, 2003.
- J9185 (Fludarabine) – 273.3 (Macroglobulinemia [Waldenstrom's macroglobulinemia]), effective for claims processed on or after September 23, 2003.
- J9201 (Gemcitabine) – 171.0-171.9 (Malignant neoplasm of connective and other soft tissue [soft tissue sarcomas]), effective for claims processed on or after October 20, 2003.
- J9350 (Topotecan Hydrochloride) – 180.0-180.9 (Malignant neoplasm of cervix uteri), effective for claims processed on or after October 20, 2003.

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

33215: Implantation of Automatic Defibrillators

The local medical review policy (LMRP) for implantation of automatic defibrillators was last revised on January 1, 2003. Since that time, ICD-9-CM codes **996.01** (Mechanical complication of cardiac device, implant, and graft due to cardiac pacemaker [electrode]) and **V53.31** (Fitting and adjustment of other device, cardiac pacemaker) have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

This change is effective for services processed on or after August 11, 2003.

Additional changes have been made to this LMRP, based on CMS Transmittal 173, Change Request 2880, dated August 22, 2003. This transmittal specifies expanded coverage to include: Coronary artery disease with a documented prior myocardial infarction (MI), a measured left ventricular ejection fraction = 0.35, and inducible, sustained ventricular tachyarrhythmia or ventricular fibrillation at electrophysiology study; or documented prior MI and a measured left ventricular ejection fraction = 0.30 and a QRS duration of > 120 milliseconds.

In addition, the policy has been revised to include ICD-9-CM code **412** (Old myocardial infarction) to the "ICD-9 Codes that Support Medical Necessity" section. Language has also been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

All other indications for defibrillators not otherwise specified in section 35-85 of the Medicare Coverage Issues Manual remain noncovered except when furnished in accordance with Food and Drug Administration approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials (as stated in the *Federal Register* at 60 FR 48417).

This change is effective for services rendered on or after October 1, 2003.

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

43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy

The local medical review policy (LMRP) for diagnostic and therapeutic esophagogastroduodenoscopy was last updated on January 1, 2003.

Since then, a request was received from a provider to add ICD-9-CM code V12.79 (Personal history of other diseases of digestive system) to the "ICD-9 Codes that Support Medical Necessity" section of the LMRP. After reviewing the information provided, it was determined this request was appropriate.

Therefore, the LMRP has been updated to include ICD-9-CM code V12.79 for *CPT* codes *43235*, *43236*, *43239*, *43241*, *43243-43251*, *43255*, and *43258*.

The full-text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after September 22, 2003.

58340: Infertility

The latest revision to the local medical review policy (LMRP) for infertility was effective January 1, 2003. Program Memorandum AB-03-119, Change Request 2853, dated August 8, 2003, was issued by CMS to communicate a change in the final update to the 2003 Medicare physician fee schedule database that indicates reinstatement of HCPCS code G0027 (Semen analysis; presence and/or motility of sperm excluding Huhner test) to this policy. Therefore, HCPCS code G0027 has been added to the "*CPT*/HCPCS Codes" section of the policy; the 'Documentation Requirements' section of the policy has been revised accordingly.

The full-text of the revised LMRP is available on the provider education Web site at *www.floridamedicare.com*, and is effective for services rendered on or after March 1, 2003.

64561: Sacral Neuromodulation

The latest revision for the local medical review policy (LMRP) for sacral neuromodulation was effective January 1, 2002. It has since been determined that ICD-9-CM code **595.1** (Chronic interstitial cystitis) should be added to the policy as a covered indication for this therapy. Therefore, diagnosis code 595.1 has been added to the "ICD-9 Codes That Support Medical Necessity" section of the policy for this service.

The full-text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for claims processed on or after September 22, 2003.

70544: Magnetic Resonance Angiography (MRA)

CMS Transmittal 1795, Change Request 2673, expands coverage for MRA to include MRA of the pelvis. Therefore, the local medical review policy (LMRP) for MRA has been revised to define the indications and limitations of coverage and to add the following ICD-9-CM codes to the "ICD-9 Codes that Support Medical Necessity" section of the policy for *CPT* code ***72198 (Magnetic resonance angiography, pelvis, with or without contrast material[s])***:

189.0-189.9	Malignant neoplasm of kidney and other and unspecified urinary organs
198.0	Secondary malignant neoplasm of kidney
223.0	Benign neoplasm of kidney, except pelvis
223.1	Benign neoplasm of renal pelvis
233.9	Carcinoma in situ of other and unspecified urinary organs
236.90-236.99	Neoplasm of uncertain behavior of other and unspecified urinary organs
403.00-403.91	Hypertensive renal disease
404.00-404.93	Hypertensive heart and renal disease
405.01	Secondary hypertension, malignant, renovascular
405.11	Secondary hypertension, benign, renovascular
405.91	Secondary hypertension, unspecified, renovascular
440.1	Atherosclerosis of renal artery
447.3	Hyperplasia of renal artery
580.0-580.9	Acute glomerulonephritis
581.0-581.9	Nephrotic syndrome
582.0-582.9	Chronic glomerulonephritis
583.0-583.9	Nephritis and nephropathy, not specified as acute or chronic
588.0-588.9	Disorders resulting from impaired renal function
593.81	Vascular disorders of kidney
593.9	Unspecified disorder of kidney and ureter

The full-text of the revised LMRP is available on our provider education Web site at *www.floridamedicare.com*. These changes are effective for services processed on or after January 5, 2004.

90901: Biofeedback

CPT code *90911 (Biofeedback training by any modality)* was found to be aberrant based on data for services from January 1, 2002, through June 30, 2002. The local medical review policy (LMRP) has been revised to define the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of procedure code *90911*.

The full-text of this LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for services processed on or after January 5, 2004.

92136: Optical Coherence Biometry

The latest revision to the local medical review policy (LMRP) for optical coherence biometry was effective March 1, 2003. CMS Program Memorandum AB-03-119, Change Request 2853, dated August 8, 2003, was issued to communicate a change in the final update to the 2003 Medicare physician fee schedule database that indicates procedure code 92136-26 as a bilateral procedure. Therefore, the 'Coding Guidelines' section of the policy has been revised accordingly.

The full-text of this local medical review policy is available on our provider education Web site *www.floridamedicare.com*, and is effective for services rendered on or after March 1, 2003.

97001: Physical Medicine and Rehabilitation (formerly *97010*: Physical Medicine and Rehabilitation)

The local medical review policy (LMRP) for Physical Medicine and Rehabilitation was last updated on April 1, 2003. Since that time, the policy number has been changed to *97001*.

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

98940: Chiropractic Services

The latest revision for local medical review policy (LMRP) for chiropractic services was effective January 1, 2002. Upon updating this policy, it has been determined that additional ICD-9-CM codes should be added to this policy as covered indications for this service. Therefore, additional codes have been added to the "ICD-9 Codes That Support Medical Necessity" section of the policy. In addition, revisions have been made to the "Indications and Limitations of Coverage and/or Medical Necessity," "Reasons for Denials," "Coding Guidelines," and "Documentation Requirements" sections of the policy.

The full-text of this LMRP is available on our provider education Web site at *www.floridamedicare.com*, and is effective for services processed on or after October 20, 2003.

99183: Hyperbaric Oxygen Therapy (HBO Therapy)

The latest revision to the local medical review policy (LMRP) for HBO therapy was effective April 1, 2003. Program Memorandum (PM) AB-03-102, Change Request 2769, dated July 25, 2003, was issued to correct PM AB-02-183, Change Request 2388, as the original PM did not include some pertinent information regarding diagnosis codes. Revisions include: addition of ICD-9-CM Code 707.15 (Ulcer of other part of foot) to the "ICD-9 Codes That Support Medical Necessity" section of the policy for this therapy and deletion of ICD-9-CM code 707.0 (Decubitus ulcer) from this section of the policy.

These revisions are effective for services rendered on or after April 1, 2003. The full-text of this LMRP is available on our provider education Web site at *www.floridamedicare.com*.

LOCAL MEDICAL REVIEW POLICY (RETIRED)

90657: Influenza Virus Vaccine

The local medical review policy (LMRP) for influenza virus vaccine is retired, effective for services rendered on or after October 28, 2003. It has been determined that the policy is no longer relevant based on *CPT* coding and national coverage determination. The full text of the LMRP for influenza virus vaccine may be found on our provider education Web site at *www.floridamedicare.com*.

CORRECTIONS

90853: Group Psychotherapy

The local medical review policy (LMRP) for group psychotherapy was published in the Second Quarter 2003 *Medicare B Update!* (page 56) with an incorrect effective date. The correct effective date is for claims processed on or after **February 18, 2003**. We apologize for any inconvenience this may have caused.

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

93880, *93882*: Duplex Scans, Extracranial—Correction

The article pertaining to duplex scans, extracranial, published in the Fourth Quarter 2003 Medicare B Update! *(page 81) included two inappropriate ICD-9-CM diagnosis codes. The corrected article is as follows:*

If you are performing an extracranial duplex scan (*CPT* code *93880* or *93882*) to monitor a patient following a surgical procedure or a patient on a high-risk medication, one of the following ICD-9-CM diagnoses codes should be used when billing Medicare:

V67.00 Follow-up examination following surgery, unspecified
V67.09 Follow-up examination following other surgery

This information is outlined in local medical review policy (LMRP) **93875: Noninvasive Extracranial Arterial Studies**. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

FLORIDA EDUCATIONAL RESOURCES

Medicare Education and Training Presents:

MEDICARE AT THE MOVIES

Have you ever wanted to share popcorn with a Medicare Representative?
*Join us for a **free** one-day educational extravaganza – attend one "movie" or all!*

November 13, 2003

To be viewed at
Doubletree
701 NW 53rd Street
Boca Raton, Florida

Shows and times are:

Driving Miss Daisy to the ASC

8:30 a.m. – 10:30 a.m.

Rating: MS (Medicare Specialty Population)

ASC Specialty Workshop: Are you an Ambulatory Surgical Center who wants to have a sound understanding of the global surgery policy? Do you want to know if ASCs can bill for prosthetics and orthotics? Are you unsure about what modifiers are valid for ASC billing? Don't miss this opportunity to participate in a workshop designed specifically for ASCs.

A Few Good Cases

12:30 p.m. – 2:30 p.m.

Rating: MG (Medicare General Population)

Understanding the Appeals Process: Do you want to gain a better understanding of what happens when you request a review? Do you want to know what constitutes a medical necessity denial and how to avoid them? Does your documentation substantiate the services for which you billed as well as clearly convey the patient's condition? Don't miss this opportunity to learn how to avoid the top mistakes providers make when submitting reviews.

Modifier Matrix

3:00 p.m. – 5:00 p.m.

Rating: MN (Medicare Novice)

Modifiers Made Easy: Are you having problems matching modifiers to procedure codes? Do you want to know how to avoid billing invalid/inappropriate modifiers? Do you understand how modifiers affect your reimbursement? Then you don't want to miss this workshop.

Special Feature: HIPAA Lunch and Learn

Intermission: 11:00 a.m. – 12:00 noon

Chat with a FCSO HIPAA representative while you sit and eat your lunch. Learn about the CMS contingency plan, testing, and the way enforcement will work, as well as latest updates.

December 5, 2003

To be viewed at
First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, Florida

Shows and times are:

You've Got Mail!

8:30 a.m. – 10:30 a.m.

Rating: MS (Medicare Specialty Population)

Navigating FCSO's Web site: Do you frequently look for medical policies on FCSO's Web site? Do you want to learn how to find the latest HIPAA information? Then don't miss this opportunity to understand FCSO's Web site structure, content, and functions. Participants will also gain a basic understanding of Internet and browser functions.

A Few Good Cases

12:30 p.m. – 2:30 p.m.

Rating: MG (Medicare General Population)

Understanding the Appeals Process: Do you want to gain a better understanding of what happens when you request a review? Do you want to know what constitutes a medical necessity denial and how to avoid them? Does your documentation substantiate the services for which you billed as well as clearly convey the patient's condition? Don't miss this opportunity to learn how to avoid the top mistakes providers make when submitting reviews.

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Want to know more? Visit our Web site at *www.floridamedicare.com* or call us at 1-904-791-8103.

MEDICARE EDUCATION & TRAINING EVENT REGISTRATION FORM

Please complete all portions of this form.

One form per person, per registration, please.

1. Who are you? **Mr. ___Mrs.__Ms.___MD ___DO___**

Name _____

Title/Position _____

Company/Organization _____

Address _____

City _____ **State** _____ **ZIP Code** _____

Phone Number ( ) _____ **Fax Number ( )** _____

Email Address _____

2. Which event do you want to attend?

Event Name _____

Event Date _____

City _____ **State** _____

3. To register:

Mail your completed form to:
First Coast Service Options, Inc.,
P.O. Box 45157
Jacksonville, FL 32232-5157

or

Fax your completed form to 1-904-791-6035

Important!

Seating Is Limited. Please submit your registration form as soon as possible. Seating for most events is limited.

Bring Your Confirmation. Be sure to bring your event confirmation notice with you to the event. It will be treated as proof of registration when you sign in at the event and receive your materials.

Substitutions. If you cannot attend an event, you may send *only one* person to substitute in your place for the duration of the event.

Questions? Call our registration hotline at 1-904-791-8103.

ORDER FORM — 2004 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.

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
❒	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *www.connecticutmedicare.com* and *www.floridamedicare.com*. Hardcopy distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to continue to receive the *Update!* in hardcopy format. Qualifying providers will be eligible to receive one hardcopy of each issue, if a valid reason can be shown why the electronic publication available on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published during calendar year 2004 (back issues for subscription requests received after January 2004 will be sent upon receipt of order).	700395	$70.00
❒	**2004 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered March 1, 2004, through December 31, 2004, is available free of charge online at *www.connecticutmedicare.com* and *www.floridamedicare.com*. Providers who do not have Internet access may purchase a hardcopy. The Fee Schedule contains calendar year 2004 payment rates for all localities. These items do not include the payment rates for injectable drugs, 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.	700400	$5.00 (CT) $10.00 (FL)

Please write legibly

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

Index to Connecticut and Florida *Medicare B Update!* - Fiscal Year 2003

The following is a comprehensive index covering all articles published the *FCSO Medicare B Update!* during fiscal year 2003 (including special electronic-only issues).

Separate Connecticut and Florida issues of the *Update!* were published for the First Quarter 2003. Beginning in January 2003, the *Update!* is consolidated into one issue for both states. In this index, content published for both Connecticut and Florida are listed first, followed by content published only for Connecticut, then content published only for Florida.

> **Note**: Electronic issues denoted with an asterisk (*) are *not* produced in hard copy format, and are available only on FCSO's provider education Web sites, *www.connecticutmedicare.com* and *www.floridamedicare.com*.

Connecticut and Florida

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CONNECTICUT MEDICARE PART B MAIL DIRECTORY

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Reviews and Medicare EDI, please submit all correspondence with the appropriate attention line to:

Attention: (insert dept name)
First Coast Service Options, Inc.
Medicare Part B
P.O. Box 9000
Meriden, CT 06454-9000

Attention: Correspondence

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

Attention: Financial Services

Use this attention line to return duplicate payments or overpayment refunds.

Attention: Fraud and Abuse

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

Attention: Freedom of Information (FOIA)

This department handles requests for information available under the Freedom of Information Act.

Attention: Medical Review

Questions regarding Local Medical Review Policies and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

Attention: MSP

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

Attention: Pricing/ Provider Maintenance

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

Attention: Resolutions

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

Attention: Hearings

If you believe that your review determination was incorrect and want it reviewed by a Hearing Officer, send your inquiry to the attention of the Hearing Department. A request for a hearing must be made within six months of the date of the Review Department determination and at least $100.00 must remain in controversy from this decision.

MAILING ADDRESS EXCEPTIONS

We have established special P.O. boxes to use when mailing your review requests, or to contact Medicare EDI:

Attention: Review

Please mail only your requests for reviews to this P.O. Box. *DO NOT* send new claims, general correspondence, hearings, or other documents to this location; doing so will cause a delay in the processing of that item. This P.O. Box is only for appeals.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for review must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include review requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should not be sent as a review. These resubmitted claims should be sent in as new claims.

Post Office Box for Reviews:

Attention: Appeals
First Coast Service Options, Inc.
P.O. Box C-1016
Meriden, CT 06450-1016

Attention: EDI

The Electronic Data Interchange department handles questions and provides information on electronic claims submission (EMC).

Post Office Box for EDI:

Attention: CT Medicare EDI
First Coast Service Options, Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services

First Coast Service Options, Inc.
Medicare Part B
1-866-419-9455 ***(toll-free)***

Beneficiary Services

First Coast Service Options, Inc.
Medicare Part B
1-800-982-6819 ***(toll-free)***
1-866-359-3614 *(hearing impaired)*

Electronic Data Interchange (EDI)

Enrollment
1-203-639-3160, option 1

PC-ACE® PRO-32
1-203-639-3160, option 2

Marketing and Reject Report Issues
1-203-639-3160, option 4

Format, Testing, and Remittance Issues
1-203-639-3160, option 5

Electronic Funds Transfer Information
1-203-639-3219

Hospital Services

Empire Medicare Services
Medicare Part A
1-800-442-8430

Durable Medical Equipment

HealthNow NY
DMERC Medicare Part B
1-800-842-2052

Railroad Retirees

Palmetto GBA
Medicare Part B
1-800-833-4455

Quality of Care

Peer Review Organization
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

American Association of Retired Persons (AARP)
1-800-523-5800

To Report Lost or Stolen Medicare Cards
1-800-772-1213

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

Department of Social Services/ConnMap
1-800-842-1508

ConnPace/ Assistance with Prescription Drugs
1-800-423-5026

WEB SITES

PROVIDER

Connecticut
www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARY

Connecticut
www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
www.medicare.gov

FLORIDA MEDICARE PART B MAIL DIRECTORY

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
First Coast Service Options, Inc.
P. O. Box 45087
Jacksonville, FL 32232-5087

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-333-7586
Hearing Impaired:
1-800-754-7820

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:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

For Seminar Registration Only (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-803-735-1034

MEDICARE PART A

Toll-Free:
1-877-602-8816

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
P.O. BOX 9000 MERIDEN, CT 06454-9000

*** ATTENTION BILLING MANAGER ***