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

A Letter to All Providers From CMS About HIPAA

The following is a letter to providers from Thomas A. Scully, CMS Administrator

Testing and Other Help Available Before the October 16, 2003 Compliance Date for Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Standards

Dear Medicare Provider,

Will you be ready to bill Medicare effective October 16?

Should you be concerned about getting your Medicare claims paid starting October 16? If you are not ready to use the HIPAA standard transaction and code sets by October 16, you may not get paid!

HIPAA is more than a privacy law; it touches many aspects of health care, including the bills you submit to all health insurers, not just Medicare. Effective October 16, 2003, all electronic transactions covered by HIPAA must comply with these standards for format and content. For example, the electronic claim that a physician or hospital sends to a health plan must be compliant and health plans are only allowed to process compliant transactions. Any non-compliant claims submitted after the October deadline will be returned to you, unpaid.

You may have thought that you can still submit paper bills to Medicare, but in many cases, this is not true. The Administrative Simplification Compliance Act (ASCA) includes a provision that requires electronic submissions to Medicare effective October 16, 2003, with a few exceptions [1].

CMS and its contractors are eager to help you through this transition. Testing with your carrier or fiscal intermediary is required to assure that you and your business partners can send and receive HIPAA compliant transactions. Medicare contractors are ready to test with you now! To schedule testing, contact your Medicare carrier or fiscal intermediary. For more information, please review the helpful HIPAA resources, shown below.

Although we have all been working hard to achieve HIPAA compliance and the benefits it will bring, there is still much to be done. Time is growing short; please be sure to test and start sending and receiving HIPAA compliant transactions as early as possible to avoid any last-minute problems.

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

[1] One of the major exceptions is for claims submitted by "a small provider of services or supplier." The term "small provider of services or supplier" is defined to mean: a provider of services with fewer than 25 full-time equivalent employees; or a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. There will be other limited exceptions.

(For more information about "small provider" and "waivers" go to www.cms.hhs.gov/hipaa/hipaa2.*)*

More information concerning HIPAA is available inside, beginning on page 41.

Features

Connecticut and Florida
A Physician's Focus 3
About the *Update!* 5
Claims 7
Coverage/Reimbursement 15
HIPAA and EMC 41
General Information 50
Index 92

Connecticut Only
Claims 14
General Information 61
Medical Review 66
Educational Resources 76

Florida Only
Coverage/Reimbursement 39
Medical Review 78
Educational Resources 89

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.

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 ________

TABLE OF CONTENTS

A Letter to All Providers From CMS About HIPAA 1

A Physician's Focus
FCSO Office of the Medical Director announces the appointment of a new Medical Director 3

About the *Update!*
About the Connecticut and Florida *Medicare B Update!* 4
Advance Beneficiary Notices (ABNs) 5

Claims
Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)—Effective October 1, 2003 7
Establishing New Requirements for ICD-9-CM Coding on Claims Submitted to Medicare Carriers—Increased Role for Physicians/Practitioners 7
ICD-9-CM Coding Requirements for Claims Submitted to Medicare Carriers 8
Appeal Requests Should be Submitted with Appropriate Supporting Documentation 9
Correct Coding Initiative—Update 9
Services Requiring a Mammography Certification Number and a CLIA Certification Number Must Be Submitted on Separate Claims 10
Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines 10
Billing for Postoperative Management for Cataract Surgery—"Split-Split" Care 13

Claims – Connecticut Only
Filing Tips for Paper Claim Submissions 14

Coverage/Reimbursement
Medicare Physician Fee Schedule (MPFS)/Healthcare Common Procedure Coding System (HCPCS)
Addition of Temporary Codes Q4052 and Q4053 15
Cancellation of the Automatic July 2003 Mass Adjustments – 2003 Medicare Physician Fee Schedule 15
2003 Carrier–Priced Codes 15
Online Medicare Physician Fee Schedule Look-up 18
Ambulance
Payment for Drugs Administered During Ambulance Transport of a Beneficiary in a Part A Covered Skilled Nursing Facility (SNF) Stay 19
Third Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule 19
Ambulatory Surgical Center (ASC)
Services Provided in an Ambulatory Surgical Center (ASC) Not on the ASC Approved Procedures List—Clarification 23
The List of Procedures Approved in an Ambulatory Surgical Center 23
Diagnostic Tests
Ambulatory Blood Pressure Monitoring—Revision to National Coverage Determination (NCD) 28
Drugs and Biologicals
Medicare Covered Drugs—Quarterly Pricing Update 29
Durable Medical Equipment
October Quarterly Update for 2003 DMEPOS Fee Schedule 30
End-stage Renal Disease (ESRD)
MCM Updates Pertaining to Dialysis Services 30
Evaluation & Management Services
Physician Certification and Re-certification for Home Health Services 31
Laboratory/Pathology
July 2003 Update to the Laboratory National Coverage Determination Edit Software 32
October 2003 Update to the Laboratory National Coverage Determination Edit Software 32
New CLIA Waived Tests 33
Diagnosis Code for Screening Pap Smear and Pelvic Examination Services 33
Physical Therapy/Occupational Therapy
Delay in Implementation of the Financial Limitation for Outpatient Rehabilitation Services to September 1, 2003 34
Implementation of the Financial Limitation for Outpatient Rehabilitation Services—Clarification on Requirement to Submit Modifier GN, GO, or GP 34
Financial Limitation of Claims for Outpatient Rehabilitation Services 34
Radiology
Additional Coverage for Magnetic Resonance Angiography 37
Expanded Coverage for PET Scans 37
Expanded Coverage of Positron Emission Tomography Scans 38
Payment Review for Portable X-Ray Transportation Services 39
Surgery
17304: Mohs Micrographic Surgery—Multiple Surgery Guidelines Revised 40
Other Services and Procedures
Coverage of Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities—Clarification 40

Coverage/Reimbursement – Florida Only
Positron Emission Tomography (PET) Scan Code G0125, G0125-TC—Important Information 39

HIPAA - The Health Insurance Portability and Accountability Act
Are Small Providers Covered Entities under HIPAA? 41
Guidance on Compliance with HIPAA Transactions and Code Sets after the October 16, 2003, Implementation Deadline 42
Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") Business Associate Provisions 43
HIPAA-AS Transactions and Code Sets: Testing and Updates 44
Important Information for Providers about HIPAA 44
General HIPAA Information 44
Helpful HIPAA Resources 45
HIPAA Resources *Updated 06/16/03* 46
CMS Southern Consortium's FREE HIPAA Presentations 47
Free CMS HIPAA Training 47
HIPAA Information Series for Providers 48
Electronic Media Claims
PC-ACE Pro32® May Be The Solution 49
Ensuring Your PC-ACE Pro32® Software Is HIPAA Compliant for Medicare Part B 49

General Information
CMS Quarterly Provider Update 50
National Participating Physician Directory 50
Remittance Advice Remark and Reason Code Update . 50
Update of the Place of Service (POS) Code Set 57
Accounting/Financial Services
Notice of Interest Rate for Medicare Overpayments and Underpayments 61
Home Health Consolidated Billing
Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement 62
Medicare Secondary Payer (MSP)
Multiple Primary Payers on Part B Claims 63
Provider Enrollment
Provider Enrollment Information for the Railroad Medicare Carrier 63
Skilled Nursing Facility (SNF) Consolidated Billing (CB)
Quarterly Update for Skilled Nursing Facility (SNF) Consolidated Billing 64
The Patient Friendly Advisory
New Medicare Limits on Therapy Services 64

General Information – Connecticut Only
News from the Accounting Department 61

Connecticut Medical Review
Medical Review Table of Contents 66
Advance Notice Statement 66
Comprehensive Data Analysis 69
Local Medical Review Policy (New) 69
Local Medical Review Policy (Revised) 71
Local Medical Review Policy (Retired) 75

Connecticut Educational Resources
Claim Submission Tips 76

Florida Medical Review
Medical Review Table of Contents 78
Advance Notice Statement 78
Comprehensive Data Analysis 81
Local Medical Review Policy (New) 83
Local Medical Review Policy (Revised) 85
Local Medical Review Policy (Retired) 88

Florida Educational Resources
Medicare Education and Outreach Will Hold August Medifest in Tampa 89
MEDIFEST Class Schedule 89
Medifest Registration Form 90

Order Form – 2003 Part B Materials 91
Index to Connecticut and Florida *Medicare B Update!* for Fiscal Year 2003 92
Important Addresses, Phone Numbers, and Web Sites
– Connecticut 98
– Florida 99

Medicare B Update!

Vol. 1, No. 3
Fourth Quarter 2003

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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:

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32232-5270

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A PHYSICIAN'S FOCUS

FCSO *Office of the Medical Director* announces the appointment of a new Medical Director

The First Coast Service Options, Inc. (FCSO) Contractor Medical Directors provide medical leadership for the company. As Medicare Part A fiscal intermediary and Part B carrier in Florida and Medicare Part B carrier in Connecticut, FCSO processes over 82 million claims for health care services and issues nearly $13 billion in Medicare benefits for the Centers for Medicare & Medicaid Services (CMS). FCSO houses its medical directors in the *Office of the Medical Director* (OMD), with locations in Jacksonville, Florida (1-904-791-6195) and Meriden, Connecticut (1-203-634-5407). The OMD's priority areas include medical policy development (Carrier Advisory Committee process and local medical review policy), medical review and progressive corrective action (data analysis and education), quality improvement initiatives both internal and external to the organization, medical issues leadership, and professional/organizational relationships. A contractor medical director's success depends on good relationships with the physician and allied provider community at the individual, professional level and at the society, organization level. Recently, with the retirement of Dr. Sidney R. Sewell, FCSO and Medicare lost a respected and successful Chief Medical Officer.

With this background, I am pleased to announce the appointment of a new contractor medical director, John M. Montgomery, MD, MPH. John started with FCSO on July 9 at our Jacksonville office. He has responsibilities in Florida Medicare A and B, while Dr. Frank Delli Carpini will continue his focus on Connecticut Medicare B from our Meriden office. I will focus on Medicare A and B from Jacksonville.

John received his BA and MD degrees from Brown University, and Master of Public Health from Yale University. He has extensive experience in health care administration, planning, education, and research including public health practice as chief epidemiologist for the City of Jacksonville. He completed a family practice residency at the Naval Hospital, Jacksonville and is board certified in Family Practice. He has also enjoyed a private practice with emphasis on family and emergency medicine. He has most recently served as the Director of Health Services/Medical Epidemiologist for the Duval County Health Department and interim Director of the Volusia County Health Department in Florida.

I, along with Dr. Delli Carpini in Connecticut, am excited about the opportunity to work closely with Dr. Montgomery in the Medicare Program, a vital part of the American health care system.

James J. Corcoran, MD, MPH

FCSO Chief Medical Officer
James.Corcoran@fcso.com

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 2003 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2003	Mid-November 2002	January 1, 2003
Second Quarter 2003	Mid-February 2003	April 1, 2003
Third Quarter 2003	Mid-May 2003	July 1, 2003
Fourth Quarter 2003	**Mid-August 2003**	**October 1, 2003**

Important notifications that require communication in between these dates will be posted to the 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.

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Reader Survey—*Medicare B Update!*

The purpose of this survey is to determine our customers' satisfaction. Once the survey is complete, we will publish the results and will begin to implement any necessary revisions. Thank you for taking the time to complete this survey!

Please complete the questions below and return your reply to us by September 30, 2003.

Please Indicate Your Location: ❑ **Connecticut** ❑ **Florida**

Overall Satisfaction

On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

5 4 3 2 1

Accuracy

"When I read the *Medicare B Update!* I feel comfortable that the information presented is accurate."

5 4 3 2 1

"When I read the *Medicare B Update!* I am confident that the information is up-to-date."

5 4 3 2 1

Clarity

"Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare B Update!* clear."

5 4 3 2 1

"Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare B Update!* easy to read."

5 4 3 2 1

Value

"The *Medicare B Update!* assists me in performing my job."

5 4 3 2 1

Layout/Format

"The *Medicare B Update!* is arranged in a manner that makes it easy to find the information I need."

5 4 3 2 1

Comments/Feedback –

What else could we do to improve the publication for you?

____

____

____

Please fax your survey to 1-904-791-6292, or you may mail it to:

Reader Survey
Medicare Communication and Education – Publications
P.O. Box 45270
Jacksonville, FL 32232-52700

CLAIMS

Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)—Effective October 1, 2003

The ICD-9-CM Addendum containing the new and revised codes effective for dates of service on or after October 1, 2003, is now available on the CMS Web site at *http://www.cms.hhs.gov/medlearn/icd9code.aspin*. We also encourage providers to visit the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm*. NCHS posted the ICD-9-CM Addendum to their Web site on June 18, 2003.

You may begin using the new and revised codes for services rendered on after October 1, 2003. We will accept both old and new codes for services provided through December 31, 2003. You *must* use the new and revised codes for services on or after January 1, 2004.

Source: CMS Transmittal AB-03-091, CR 2763

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Establishing New Requirements for ICD-9-CM Coding on Claims Submitted to Medicare Carriers—Increased Role for Physicians/Practitioners

Effective for dates of service **on or after October 1, 2003,** ICD-9-CM diagnosis codes must be included on all Medicare electronic and paper claims billed to Part B carriers, with the exception of ambulance claims. Providers and suppliers rely on physicians to provide a diagnosis code or narrative diagnostic statement on orders/referrals. This guidance serves as a reminder that physicians/practitioners must provide a diagnosis on all orders and referrals.

Background

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a final rule published in the **Federal Register** on August 17, 2000, established new standards, requirements, and implementation specifications for health plans, health care clearing houses, and health care providers who transmit any health information in an electronic form. The applicable electronic format for transmitting Medicare claims information is the ASC X12N 837. The implementation specifications define the new requirements for these formats. The ASC X12N 837 Professional Implementation Guide (version 4010A.1) requires a diagnosis on "all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims)."

Program Memorandum B-03-045 (CR 2725) clarified that based upon the implementation specifications for HIPAA, an ICD-9-CM code is not required for all ambulance supplier claims but is required for all other professional claims, e.g., physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, and ambulatory surgery centers. Although the HIPAA requirements apply only to electronic claims, in order to maintain consistency in claims processing, CMS has mandated that these ICD-9-CM requirements will be applied to paper claims as well as electronic claims.

New Policy

Effective for dates of service **on or after October 1, 2003,** all paper and electronic claims submitted to carriers must contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59). Carriers will return as unprocessable paper and electronic claims that do not contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59).

Carriers will no longer place invalid or valid diagnosis codes on any claim prior to sending the claim to the Common Working File and their coordination-of-benefits trading partners. Therefore, the diagnosis code must be entered on the claim by the submitter.

Immunization Claims

For claims submitted by mass immunizers and any other entities billing for flu and pneumonia vaccinations, Medicare carriers will no longer be able to enter missing diagnosis codes on claims. The diagnosis code must be entered on the claim by the submitter.

Mammography Screening Claims

For claims submitted for screening mammography services, Medicare carriers will no longer be able to enter missing diagnosis codes on claims. The diagnosis code must be entered on the claim by the submitter. Carriers will return claims for mammography services with no ICD-9-CM code as unprocessable.

HIPAA Requirements Affect Physicians/Practitioners When a Diagnostic Test Is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that "if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the services to provide diagnostic or other medical informa-

tion to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner." A laboratory or other provider must report on a claim for Medicare payment the diagnostic code(s) furnished by the ordering/referring physician/practitioner. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering/referring physician/practitioner's narrative diagnostic statement or seek diagnostic information from the ordering/referring physician/practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician/practitioner-supplied diagnostic information supporting such code.

When providers/suppliers (except ambulance suppliers) submit a claim to a Medicare Part B carrier, they must assign an ICD-9-CM code to the service as follows:

1. **Coding When Diagnosis is Known**
   Assign an ICD-9-CM code that provides the highest degree of accuracy and completeness. In the past, there has been some confusion about the meaning of "highest degree of specificity" and in "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5 digits. If a 3-digit code has a 4-digit code that further describes it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has a 5-digit code that further describes it, then the 4-digit code is not acceptable for claim submission.
2. **Coding When Diagnosis is Unknown**
   Diagnoses documented as "probable," "suspected," "questionable," "rule-out," or "working diagnosis" should not be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit such as signs, symptoms, abnormal test results, exposure to communicable disease, or other reason for the visit. (See American Hospital Association *Coding Clinic for ICD-9-CM*, Fourth Quarter 1995, page 45.)

Information for Laboratories

Include the ICD-9-CM diagnosis code, as furnished by the physician/practitioner.

If a diagnosis or narrative diagnosis is not submitted by the physician/practitioner, laboratories must request this information from the physician/practitioner who ordered the service.

Information for Ambulance Suppliers

Since emergency medical technicians and paramedics do not have the necessary training to make a diagnosis, diagnosis is not available at the time of transport. It is the condition of the patient at the time of transport, rather than the patient's diagnosis, that determines whether transport and services are payable under the Medicare ambulance benefit.

Carriers may request the trip sheet that documents the condition of the patient, including patient's chief complaints, at the time patient was loaded onto the ambulance in order to determine whether ambulance transport and services were medically necessary.

Timely and Accurate Claims Processing

With the exception of ambulance suppliers, physicians/practitioners submitting claims to Medicare Part B carriers must include a valid ICD-9-CM code in order to have their claims processed and paid as quickly as possible. Therefore, physicians/practitioners must ensure that all necessary information is included on orders/referrals. Failure to do so will result in processing delays and nonpayment of covered services.

Source: CMS Transmittal B-03-046, CR 2784

ICD-9-CM Coding Requirements for Claims Submitted to Medicare Carriers

CMS recently issued Program Memorandum (PM) B-03-045, Change Request (CR) 2725, which implements a new policy to require an ICD-9-CM diagnosis code on all paper and electronic claims billed to carriers with the exception of ambulance claims (specialty 59).

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a final rule published in the Federal Register on August 17, 2000, established new standards, requirements, and implementation specifications for health plans, health care clearing houses, and health care providers who transmit any health information in an electronic form. The applicable electronic format for transmitting Medicare claims information is the ASC X12N 837. The implementation specifications define the new requirements for these formats. The ASC X12N 837 Professional Implementation Guide (version 4010A.1) requires a diagnosis(es) on "all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims)."

PM B-03-045 clarifies that based upon the implementation specifications for HIPAA, an ICD-9-CM code is not required for all ambulance supplier claims, but is required for all other professional claims (e.g., physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, and ASCs). Although the HIPAA requirements do not apply to paper claims, the ICD-9-CM requirement will be implemented for paper claims, as well as all electronic claims regardless of the version of the electronic claim format.

Emergency medical technicians (EMTs) and paramedics use a trip sheet to document the condition of the beneficiary, including the patient's chief complaints, at the time the beneficiary is loaded onto the ambulance. This documentation may later be requested by the intermediary/carrier during medical review of the claim for use in determining whether the ambulance transport and services provided were medically necessary.

However, EMTs and paramedics do not have the training necessary to make a diagnosis. Thus, no diagnosis is available at the time of transport. Moreover, it is the condition of the beneficiary at the time of transport, rather than the beneficiary's diagnosis, that determines whether the transport and services provided are payable under the Medicare ambulance benefit.

Policy

A diagnosis code must be included on all Medicare claims (electronic and paper) submitted to Part B carriers, except those claims submitted by ambulance suppliers. Professional suppliers of service include: physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, and ASCs.

The claim should contain the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes that further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes that further describe it, then the 4-digit code is not acceptable for claim submission.

Editing for the Presence of a Diagnosis Code

Effective for dates of service on or after October 1, 2003, all paper and electronic claims submitted to carriers must contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59). Carriers will return as unprocessable paper and electronic claims that do not contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59).

PM B-03-028, CR 2672, implemented requirements for submittal of a diagnosis for electronic claims processed by durable medical equipment regional carriers. PM B-03-045 expands the requirements for submittal of the diagnosis required in PM B-03-028 to include paper claims.

Physicians Reporting Diagnosis Codes when a Diagnostic Test Is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that "if the Secretary (or fiscal agent of the Secretary [of DHHS]) requires the entity furnishing the services to provide diagnostic or other medical information to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner." A laboratory or other provider must report on a claim for Medicare payment the diagnostic code(s) furnished by the ordering physician. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering physician's narrative diagnostic statement or seek diagnostic information from the ordering physician/practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician-supplied diagnostic information supporting such code.

Source: CMS Transmittal B-03-045, CR 2725

Appeal Requests Should be Submitted with Appropriate Supporting Documentation

In an effort to manage incoming appeal requests in fiscal year 2003, the Centers for Medicare & Medicaid Services (CMS) has provided guidance to Medicare contractors relative to processing appeals.

In general, contractors use a first-in, first-out method to process appeals and manage workload; however, during times of limited resources it may become necessary to prioritize the processing of appeals to more efficiently manage the workload. Therefore, when contractors are experiencing an increase in appeal receipts resulting in a backlog situation, incoming appeal requests submitted **without** necessary supporting documentation will be given secondary priority to appeal requests submitted **with** appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed.

Source: CMS Transmittal AB-03-052, CR 2330

Correct Coding Initiative—Update

Version 9.3 of the Correct Coding Initiative (CCI) will be implemented October 1, 2003. Version 9.3 will include all previous versions and updates from January 1, 1996, to the present, and will be organized in two tables: Comprehensive/Component Edits and Mutually Exclusive Code (MEC) Edits.

The U.S. Department of Commerce, National Technical Information Service (NTIS) has developed a national correct coding policy manual to assist physicians in correctly coding services for reimbursement. Medicare carriers are prohibited from publishing specific correct coding edits. Information related to CCI may be obtained by ordering a national correct coding policy manual from NTIS.

- Single issues of the national correct coding policy manual may be requested by calling 1-703-605-6000.
- Subscriptions to the national correct coding policy may be requested by calling 1-703-605-6060 or 1-800-363-2068.

- To receive information from NTIS by mail, call 1-800-553-6847.
- Ordering and product information is also available online at *http://www.ntis.gov/products/families/cci/index.asp*

Concerns about correct coding edit pairs must be submitted in writing to:

The National Correct Coding Initiative
AdminaStar Federal
P. O Box 50469
Indianapolis, IN 46250-0469
Fax: 1-317-841-4600

Providers can find additional information at CMS' Frequently Asked Questions online: *http://cms.hhs.gov/medlearn/ncci.asp*.

As a reminder, First Coast Service Options, Inc. (FCSO) is not liable for information provided and/or published by AdminaStar Federal and/or NTIS.

Source: CMS Transmittal B-03-047, CR 2756

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.*

Services Requiring a Mammography Certification Number and a CLIA Certification Number Must Be Submitted on Separate Claims

The Mammography Quality Standards Act (MQSA) requires that all mammography centers billing Medicare be certified by the Food and Drug Administration (FDA). The facility's FDA certification number must be provided in Item **32** of Form CMS-1500 (or electronic equivalent) when billing for diagnostic or screening mammograms, whether film or digital (***all*** **components – global, professional, or technical**).

On claims for laboratory services, the provider's appropriate CLIA (Clinical Laboratory Improvements Act) certification number is submitted in Item 23. However, when a claim is submitted with both mammography and CLIA certification numbers, the Multi-Carrier System (MCS) mapping process overlays the mammography number with the CLIA number, resulting in the mammography service(s) being returned as unprocessable (return unprocessable claim, or RUC).

To avoid RUC denials, providers must submit separate claims. Mammography services must be submitted with the FDA certification number on one claim, while another claim must be submitted for laboratory services that require a CLIA number. This applies to paper claims as well as those submitted electronically. Providers/entities who use Form CMS-1500 pre-printed with a CLIA certification number must ensure they do not use such forms when submitting claims for mammography services.

Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

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

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

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

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

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

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they

feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

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

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

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

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

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

Frequency of Vaccinations

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

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

Billing for Additional Services

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

Nonparticipating Physicians and Suppliers

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

Separate Claims for Vaccines and Their Administration

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

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

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

CPT/HCPCS Codes

The following *CPT* codes are used for billing influenza virus, pneumococcal pneumonia, and hepatitis B vaccines:

90657	*Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use*
90658	*Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use*
90659	*Influenza virus vaccine, whole virus, for intramuscular or jet injection use*
90732	*Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use*
90748	*Hepatitis B and hemophilus influenza B vaccine (HEPB-HIB), for intramuscular use*

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

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

Billing Requirements

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

Diagnosis Codes

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

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

Reimbursement Guidelines

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

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

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

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

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

Simplified Roster Bills

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

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

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

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

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

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

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

CMS-1500 Item	Influenza Virus Vaccine Claims	PPV Claims
Item 1	Check "Medicare"	Check "Medicare"
Item 2	See attached roster	See attached roster
Item 11	None	None
Item 17	N/A	N/A effective 7/1/2000
Item 17a	N/A	N/A effective 7/1/2000
Item 20	No	No
Item 21	V04.8	V03.82
Item 24B	60-Mass Immunization Center	60-Mass Immunization Center
Item 24D (line 1) (line 2)	 90657, 90658 or 90659 G0008	 90732 G0009
Item 24E (lines 1 AND 2)	 1	 1
Item 24F	Enter the charge for each listed service.	Enter the charge for each listed service.
Item 27	X in YES item	X in YES item
Item 29	0.00	0.00
Item 31	Entity's representative must sign	Entity's representative must sign
Item 32	N/A	N/A
Item 33	Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number	Enter the entity's billing name, address, ZIP code, and telephone number, and enter the carrier-assigned Provider Identification Number

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

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

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Billing for Postoperative Management for Cataract Surgery—"Split-Split" Care

When an ophthalmologist performs the surgical procedure and part of the out-of-hospital follow-up care, then turns over the remainder of the follow-up care to an optometrist or another ophthalmologist, this is called split-split care. There are specific claim submission requirements for billing split-split care, to ensure both providers are appropriately reimbursed.

When billing for split-split care, the ophthalmologist who performed the surgery and part of the follow-up care should bill separate lines for the surgery and his/her

portion of the follow-up care. The line for the surgery should be appended with modifier 54 (surgical care only); the line for the follow-up care should be appended with modifier 55 (postoperative management only). The date of service should be the date of surgery. In addition, he/she must indicate in item 19 of Form CMS-1500 (or in the appropriate narrative record of its electronic equivalent) the specific eye treated, when the patient was referred for follow-up care for co-management (the date care was relinquished), and the total number of days the beneficiary was in his/her care.

The ophthalmologist or optometrist who provided the follow-up care, for his/her portion of the post-operative care must use the *date of the surgery* for the date of service and append the line with modifier 55. He/she must indicate in item 19: the specific eye treated, when care of the beneficiary was assumed and relinquished, and the number of days the patient was followed during that portion of follow-up care.

The examples that follow assume *CPT 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [eg, irrigation and aspiration or phacoemulsification])* was performed on March 1, 2003; the surgeon provided follow-up care through March 17 and referred the patient to another physician for the remainder of the 90-day follow-up period.

Example 1

A claim for the ophthalmologist performing the surgery and a portion of the follow-up care should look like this:

19. RESERVED FOR LOCAL USE
LT EYE- ASSUMED CARE 03-01; RELINQUISHED CARE 03-17; TOTAL DAYS 17

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 366 50 3.
2. 4.

24.	A Date(s) of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS	Modifier		E Diagnosis Code
1	03	01	03				22		66984	54	LT	1
2	03	01	03				22		66984	55	LT	1

Example 2

A claim for the ophthalmologist or optometrist providing the remainder of the follow-up care should look like this:

19. RESERVED FOR LOCAL USE
LT EYE- ASSUMED CARE 03-18; RELINQUISHED CARE 05-29; TOTAL DAYS 73

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 366 50 3.
2. 4.

24.	A Date(s) of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS	Modifier		E Diagnosis Code
1	03	01	03				22		66984	55	LT	1
2												

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CONNECTICUT ONLY

Filing Tips for Paper Claim Submissions

To process paper claims more efficiently, Connecticut Medicare recently began using optical character recognition (OCR) scanning for entering paper claims versus manually keying the data. It is important for providers who submit claims on paper to be sure that all entered information is aligned within the field parameters, typed, or machine printed in Courier font, 12-point size, and dark print. This will enable the OCR automated scanning system to accurately read and interpret the character entries.

The OCR Scanning and Operations department offers the following tips for submitting paper claims:

- Paper claims must be submitted on an approved red and white Form CMS-1500 (original only; copies are not acceptable).
- Print must be regular font – not italic, bold, or script.
- Do not fold or staple claims and/or attachments. OCR scanner operators have to remove staples from claims and documentation, which increases processing time.
- Do not use labels, flags, or highlighters.
- Attachments must not be irregular sized pages, but full 8½ by 11.
- When making copies of documentation, ensure the documentation is clean and legible. Ensure copier lid is down. Leaving the lid up causes “blackout” on pages where the documentation is smaller than the paper size. When blackout is on a claim or attachment, the scanner sees this as half of a claim. The system cannot read a half-page claim; this causes the scanner to stop. The operator then has to restart the scanner, increasing processing time. Closing the copier lid produces a “clean” copy the scanner can read.
- Handwriting on the claims must be avoided.

Source: OCR Scanning and Operations

Coverage/Reimbursement

Medicare Physician Fee Schedule (MPFS)/ Healthcare Common Procedure Coding System (HCPCS)

Addition of Temporary Codes Q4052 and Q4053

CMS has established two new "Q" codes for billing for octreotide and pegfilgrastim, effective for services rendered on or after July 1, 2003. The code descriptions are as follows:

Q4052 Injection, octreotide, depot form for intramuscular injection, 1 mg
Q4053 Injection, pegfilgrastim, 1 mg

Note: HCPCS code J2352 (Injection, octreotide acetate, 1 mg) may no longer be used to report the depot form of octreotide.

Source: CMS Transmittal B-03-048, CR 2798

Cancellation of the Automatic July 2003 Mass Adjustments – 2003 Medicare Physician Fee Schedule

Over the past several months, the Centers for Medicare & Medicaid Services (CMS) had been educating the physician community about the automatic mass adjustments that were going to occur beginning in July 2003. The Medicare Physician Fee Schedule (MPFS) did not become effective until March 1, 2003 (delayed from January 1, 2003). These adjustments were going to be necessary as a result of a limitation in the Medicare payment system, which delayed the implementation of the MPFS, and which resulted in the incorrect payment of a substantial number of claims.

This news had been announced at several of the Physician Open Door Forums, and via carriers' Web sites, and bulletins. Because January 2003 and February 2003 physician services submitted between March 1 and June 30, 2003 may have resulted in an incorrect payment, CMS had previously directed Medicare carriers to automatically adjust these claims, beginning in July 2003, and to recover any applicable overpayments.

The Good News….

We now want to inform you that CMS has determined that it will **NOT** require Medicare carriers to go forward with the automatic July mass adjustments and resulting collection of overpayments. If an overpayment exists, you will not be receiving any "Demand" letters related to an incorrect payment based on the delay of the 2003 MPFS. This also means that Medicare beneficiaries will not be receiving copies of those "Demand" letters that would have potentially caused unnecessary confusion to them. You should be aware, however, that if you bring to the attention of the Medicare carrier that an incorrect payment for January or February 2003 was received, the carrier will still process such an adjustment.

Issues or questions should be addressed to your local carrier (i.e., FCSO) on a case-by-case basis.

Source: CMS Joint Signature Memorandum dated June 26, 2003

2003 Carrier–Priced Codes

Reimbursement for most procedures paid on the basis of the Medicare Physician Fee Schedule Database (MPFSDB) is calculated by CMS and provided to carriers annually. These are listed on the MPFSDB with a code status of "A" (Active code). Reimbursement for other procedures, known as "C" status or carrier-priced codes, is calculated by each carrier. Per CMS, status "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."

In many instances, however, enough historical data has been collected to allow FCSO to develop a consistent allowance for some C status codes. These codes and allowances, effective for services rendered on or after March 1, 2003, are listed separately for Connecticut and Florida, beginning on the next page.

CONNECTICUT ONLY

Code/Mod	Par	Nonpar	Limiting Charge
G0210	2,676.58	2,542.75	2,924.16
G0210 TC	2,591.71	2,462.12	2,831.44
G0211	2,677.03	2,543.18	2,924.66
G0211 TC	2,592.15	2,462.54	2,831.92
G0212	2,676.58	2,542.75	2,924.16
G0212 TC	2,591.71	2,462.12	2,831.44
G0213	2,676.58	2,542.75	2,924.16
G0213 TC	2,591.71	2,462.12	2,831.44
G0214	2,676.58	2,542.75	2,924.16
G0214 TC	2,591.71	2,462.12	2,831.44
G0215	2,676.58	2,542.75	2,924.16
G0215 TC	2,591.71	2,462.12	2,831.44
G0216	2,676.58	2,542.75	2,924.16
G0216 TC	2,591.71	2,462.12	2,831.44
G0217	2,676.58	2,542.75	2,924.16
G0217 TC	2,591.71	2,462.12	2,831.44
G0218	2,676.58	2,542.75	2,924.16
G0218 TC	2,591.71	2,462.12	2,831.44
G0220	2,676.58	2,542.75	2,924.16
G0220 TC	2,591.71	2,462.12	2,831.44
G0221	2,676.58	2,542.75	2,924.16
G0221 TC	2,591.71	2,462.12	2,831.44
G0222	2,676.58	2,542.75	2,924.16
G0222 TC	2,591.71	2,462.12	2,831.44
G0223	2,676.58	2,542.75	2,924.16
G0223 TC	2,591.71	2,462.12	2,831.44
G0224	2,676.58	2,542.75	2,924.16
G0224 TC	2,591.71	2,462.12	2,831.44
G0225	2,676.58	2,542.75	2,924.16
G0225 TC	2,591.71	2,462.12	2,831.44
G0226	2,676.58	2,542.75	2,924.16
G0226 TC	2,591.71	2,462.12	2,831.44
G0227	2,676.58	2,542.75	2,924.16
G0227 TC	2,591.71	2,462.12	2,831.44
G0228	2,676.58	2,542.75	2,924.16
G0228 TC	2,591.71	2,462.12	2,831.44
G0229	2,676.58	2,542.75	2,924.16
G0229 TC	2,591.71	2,462.12	2,831.44
G0230	2,676.58	2,542.75	2,924.16
G0230 TC	2,591.71	2,462.12	2,831.44
R0070	156.12	148.31	170.56
R0075	156.12	148.31	170.56

FLORIDA ONLY

	Loc 01/02			Loc 03			Loc 04		
Code/Mod	Par	Nonpar	LChg	Par	Nonpar	LChg	Par	Nonpar	LChg
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
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

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CONTINUED

Code/Mod	Loc 01/02 Par	Loc 01/02 Nonpar	Loc 01/02 LChg	Loc 03 Par	Loc 03 Nonpar	Loc 03 LChg	Loc 04 Par	Loc 04 Nonpar	Loc 04 LChg
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
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

Code/Mod	Loc 01/02 Par	Loc 01/02 Nonpar	Loc 01/02 LChg	Loc 03 Par	Loc 03 Nonpar	Loc 03 LChg	Loc 04 Par	Loc 04 Nonpar	Loc 04 LChg
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
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

Online Medicare Physician Fee Schedule Look-up

The Centers for Medicare & Medicaid Services (CMS) has a Web site application that allows the user to look up physician service information regarding fee schedule amounts and geographic practice cost indices for every carrier and locality. It also allows you to look up payment policy information for every physician service *CPT*/HCPCS code. This application may be found at: *http://cms.hhs.gov/physicians/mpfsapp/step0.asp.*

This application is designed to provide information on services covered by the Medicare Physician Fee Schedule (MPFS). It provides more than 10,000 physician services, the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

The Medicare physician fee schedule pricing amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and

malpractice). CMS applies GPCIs in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

This site is designed to take you through the selection steps prior to the display of the information. The site allows you to:

- Search pricing amounts, various payment policy indicators, RVUs, and GPCIs by a single procedure code, a range, and a list of procedure codes.
- Search for the nation, a specific carrier, or a specific carrier locality. Each page has associated Help/Hint available to complete your selections.

For your convenience, we have added a link to this application to the "Fee Schedules" section of our provider education Web sites, *www.connecticutmedicare.com* and *www.floridmedicare.com.*

Source: CMS Web site, *http://cms.hhs.gov*

AMBULANCE

Payment for Drugs Administered During Ambulance Transport of a Beneficiary in a Part A Covered Skilled Nursing Facility (SNF) Stay

The information that follows is provided at the request of the Centers for Medicare & Medicaid Services (CMS). It should be noted that this ***does not*** *affect carriers who, prior to implementation of the Ambulance Fee Schedule, processed claims for ambulance services using method 2 (supplies not separately payable). Both Connecticut and Florida Medicare were method 2 carriers; therefore,* ***this notice is informational only*** *for our suppliers who may operate ambulance companies in other carriers' jurisdictions.*

Ambulance suppliers' claims for certain drugs with dates of service on or after April 1, 2002, may have been denied in error for beneficiaries in a Part A covered SNF stay (except when billed with the "NN" modifier). This applies in carrier jurisdictions that allowed separate payment for these items prior to the implementation of the ambulance fee schedule.

Affected suppliers should resubmit claims for HCPCS codes J7030, J7040, J7042, J7050, J7051, J7130, or J7050 that were processed incorrectly.

Source: CMS Transmittal B-03-039, CR 2707

Third Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule

This is a reminder of current Medicare policy regarding the Ambulance Fee Schedule, which was implemented on April 1, 2002. It is not intended to replace previously issued instructions and does not encompass all issues that have been addressed to date.

This is the third set of instructions to provide additional guidance on issues related to the implementation of the Ambulance Fee Schedule.

During the implementation of the Ambulance Fee Schedule, issues concerning the interpretation of Medicare policy have arisen which require clarification. This instruction provides additional guidance on these issues, and supplements previously issued instructions regarding the implementation of the Ambulance Fee Schedule.

The following clarifications reflect Medicare policy regarding the implementation of the Ambulance Fee Schedule.

Ambulance Fee Schedule Appeals

The ambulance final rule published on February 27, 2002, established a fee schedule for the payment of ambulance services under the Medicare Program, thereby implementing section 1834(l) of the Social Security Act. The Ambulance Fee Schedule is effective for claims with dates of service on or after April 1, 2002.

The final rule established a 5-year transition period, during which time payment will be based on a blended amount, based in part on the Ambulance Fee Schedule and in part on reasonable cost or reasonable charge, as applicable. In accordance with section 1834(l)(5) of the Social Security Act (the Act) and 42 CFR section 414.625, ambulance providers/suppliers may not appeal the fee schedule amounts.

Inherent Reasonable Adjustments

The final rule implementing inherent reasonable (IR) adjustments to Medicare payment allowances was published in the *Federal Register* on December 13, 2002 (67 FR 76684). The criteria for applying IR, specified in the final rule, includes a threshold of 15 percent that must be met before IR adjustments may be made. That is, if a payment allowance is determined to be either deficient or excessive by an amount that is less than 15 percent, then no IR adjustment may be made. Prospective payment systems, including the Ambulance Fee Schedule, are exempt from IR. Therefore, IR applies

only to the reasonable charge portion of the blended payment for ambulance services during the transition period.

CMS has not yet developed contractor processes for applying IR. Until these processes are in place, contractors may not make any IR adjustments. Therefore, carriers that receive requests for IR adjustments to the reasonable charge portion of the blended payment for ambulance services may not make any such adjustments until CMS issues further guidance on how to implement IR. Carriers that receive requests for IR adjustments to the Ambulance Fee Schedule portion of the blended payment must deny any such requests.

Supplier Requests to Change Billing Methods During the Transition Period

Suppliers were instructed to elect a single billing method by March 31, 2002. In the absence of any election, carriers were required to convert suppliers using multiple billing methods to billing method 2. During the transition period, April 1, 2002 through December 31, 2005, a supplier may not change its billing method. Carriers must deny any such requests from a supplier. Effective with the full implementation of the Ambulance Fee Schedule beginning January 1, 2006, all ambulance suppliers will be converted to billing method 2.

***Note**: Connecticut Medicare and Florida Medicare utilized billing method 2 exclusively prior to April 2002.*

Advance Beneficiary Notice (ABN) Requirements

I. ABN Requirements for Non-Emergency Transports

The ABN (form CMS-R-131) is a written notice a physician or provider/supplier gives to a Medicare beneficiary before items or services are furnished when the physician or provider/supplier believes that Medicare probably or certainly will not pay for some or all of the items or services based on certain Medicare statutory exclusions. See PM AB-02-168 and AB-02-114 for more information concerning ABN and beneficiary limitation of liability issues.

An ABN is rarely used for ambulance services, and may only be issued for non-emergency transports. An ABN may not be used when a beneficiary is under great duress. A beneficiary is considered to be under great duress when his or her medical condition requires emergency care. Intermediaries and carriers will use the following guidelines to determine when it is appropriate for an ambulance provider/supplier to issue an ABN for ambulance services.

An ABN may be needed and may be used for *non-emergency* transports in the following situations:

a. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.
b. A level of care downgrade (e.g., from ALS-2 to ALS-1, or from ALS to Basic Life Support [BLS]), when the transport at the lower level of care is a covered transport.

An ABN is not needed, and should not be used, in the following situations:

a. Any denial where the patient could be transported safely by other means (these are denials under section 1861(s)(7) of the Act).
b. Any denial that is based on not meeting an origin or destination requirement (these denials are based on 42 CFR 410.40 and generally also constitute section 1861(s)(7) denials).
c. A denial for mileage that is beyond the nearest appropriate facility (for the same reason as "b" above).
d. A denial where the PCS or accepted alternative (e.g., certified mail) is not obtained (for the same reason as "b" above).
e. A convenience discharge (e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family [for the same reason as "b" above]).

The Notice of Exclusions from Medicare Benefits (NEMB, Form CMS-20007) is an optional form that CMS developed to assist suppliers and providers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. When an ABN is not appropriate to use because medical necessity is not the basis for the expected denial, an NEMB may be used. Ambulance providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for excluded services, for which the ABN is not appropriate.

The NEMB Form CMS-20007 is available in English and Spanish online and can be accessed at the CMS Beneficiary Notices Initiative Web page at *http://www.cms.hhs.gov/medicare/bni/*.

In the case of the denials listed above for which an ABN is not appropriate, on the NEMB, check Box #1 and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example: "ambulance transports that do not meet an origin or destination requirement," or "ambulance transports where the patient could be transported safely by other means," or "personal convenience transports."

The following table summarizes situations when an ABN is applicable regarding ambulance services:

Situation	Statutory Provision	ABN Applicable	Limitation On Liability Applicable	Responsible for Payment
Other means of transportation not contraindicated	1861(s)(7) - Benefit Category	NO. An NEMB may be used.	NO	BENEFICIARY
Air to Ground Downcoding	1862(a)(1)(A) Reasonable & Necessary	YES **	YES	SUPPLIER/PROVIDER or BENEFICIARY if ABN is signed
ALS to BLS Downcoding	1862(a)(1)(A) Reasonable & Necessary	YES**	YES	SUPPLIER/PROVIDER or BENEFICIARY if ABN is signed
Mileage Partial Denial	1861(s)(7) - Benefit Category	NO. An NEMB may be used.	NO	BENEFICIARY

**Indicates that an ABN is applicable. However, if it is an emergency transport, ABNs cannot be used, since beneficiaries are considered under great duress in such situations. (See PM-AB-02-168, section I2.B.2.)

II. ABN Requirements for International Flights

Absent the rare circumstance of coverage of an ambulance service under section 1814(f) of the Act, services outside the United States furnished to a Medicare beneficiary are statutorily excluded from Medicare coverage under section 1862(a)(4) of the Act. Thus, when the point of pickup is outside the United States, including a point of pickup outside of the U.S. territories, then the transport from the point of pickup to the nearest U.S. point of entry is statutorily excluded. The use of an ABN is not indicated but the beneficiary should be informed that Medicare will not pay for the international portion of the flight. An NEMB may be used, in which case, on the NEMB, check Box #2 and the sixth box in the left column ("Health care received outside of the USA") and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example: "ambulance transports outside of the USA." If the beneficiary (or his/her representative) desires a formal Medicare determination on a claim for a transport originating outside the U.S., then the transporting entity must file a claim to Medicare.

Following the international portion of a flight, if the beneficiary is then transported from the nearest point of entry by ambulance, including the same aircraft used to transport the beneficiary on the international flight, then standard Medicare rules apply. If the beneficiary is transported from the nearest point of entry to the nearest appropriate facility, then, assuming all other Medicare rules are met, the transport would be covered and payable. If the transporting entity has a reasonable basis to believe that the domestic portion of a non-emergency flight would not be covered because it is not reasonable and necessary under Medicare rules, then use of an ABN is indicated for non-emergency ambulance transports.

Physician Certification Statement (PCS) Requirements

I. PCS Requirements for Emergency Transports

The regulations governing PCS requirements are specified at 42 CFR section 410.40(d). As stated in previously issued instructions, a PCS is not required if the transport is an emergency transport. This instruction applies to providers submitting ambulance claims to intermediaries as well as suppliers submitting ambulance claims to carriers. In accordance with PM AB-02-130, an emergency response is defined as a BLS or ALS-1 level of service provided in immediate response to a 911 call or the equivalent. The patient's diagnosis, and whether the transport is documented as an "emergency" due to the patient's condition, is not relevant to this determination. See item h. for more information concerning the Medicare definition of "emergency."

II. PCS Requirements for Repetitive Ambulance Services

The regulations governing PCS requirements for repetitive, scheduled, non-emergency ambulance services are specified at 42 CFR section 410.40(d)(2). A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary. However, the requirement for submitting the PCS form for repetitive, scheduled, non-emergency ambulance services is based on the quantitative standard (three or more times during a ten-day period or at least once per week for at least three weeks). Similarly, regularly scheduled ambulance services for follow-up visits, whether routine or unexpected, are not "repetitive" for purposes of this requirement unless one of the quantitative standards is met. PCS requirements for other types of ambulance transports are specified in PM AB-03-007.

III. Computer Generated PCS Forms and Electronic Signatures

Providers/suppliers may use computer-generated PCS forms and computerized physician signatures to meet the PCS requirements of 42 CFR section 410.40(d).

IV.Proof of Mailing When a PCS Cannot be Obtained

When a PCS cannot be obtained in accordance with section 410.40(d)(3)(iv), a provider/supplier may send a letter via U.S. Postal Service (USPS) certified mail with a return receipt proof of mailing or other similar commercial service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS. Providers/suppliers may also use the USPS Certificate of Mailing, Form 3817 as an acceptable alternative to certified mail.

Billing for Air Mileage

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing.

Unsuccessful ALS Interventions

An ALS intervention is a procedure that is, in accordance with state and local laws, beyond the scope of practice of an emergency medical technician-basic (EMT-Basic). An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

Establishing an ALS Transport Based on an ALS Assessment

When a BLS ambulance is dispatched and an ALS assessment is performed, the transport may be billed as ALS only for emergency transports. Medicare pays the BLS-level rate for non-emergency transports regardless of whether an ALS assessment is performed.

For Medicare Program purposes, an emergency level of ambulance services depends upon how the ambulance was dispatched and how it responded. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived. Medicare defines "emergency response" as a BLS or ALS-1 level of service that has been provided in immediate response to a 911 call or the equivalent". An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. An emergency is determined based on the information available to the dispatcher at the time of the call, based on standard dispatch protocols. Medicare also specifies that an ALS assessment is relevant only with respect to payment for an ALS emergency transport. That is, the ALS assessment may be relevant to determine whether an emergency transport is payable at the BLS or ALS level. However, an ALS assessment has no bearing on whether the transport qualifies for emergency-level payment. Furthermore, identifying a service as an emergency response has no bearing on its status under SSA 1861(s)(7) (i.e., whether transportation by other means is feasible).

Mandated ALS Response

During the transition period, Medicare allows the ALS-level payment for emergency and non-emergency transports when an ALS vehicle is used but no ALS service is furnished in areas where an ALS-only response is mandated. As stated in previously issued instructions, two temporary Healthcare Common Procedure Coding System (HCPCS) codes have been established to allow billing for these services during the transition period. HCPCS code Q3019 applies when an ALS vehicle is used for an emergency transport, but no ALS-level service is furnished. HCPCS code Q3020 applies when an ALS vehicle is used for a non-emergency transport, but no ALS level service is furnished. The fee schedule portion of the blended payment is based on the emergency or non-emergency BLS level, as applicable, and the reasonable charge portion of the blended payment is the ALS emergency/non-emergency rate. (See PM AB-02-036.)

The use of an ALS vehicle to furnish only BLS-level services would most often occur in local jurisdictions that mandate all ambulances to be ALS. However, a contract with a government agency to furnish general ambulance services in one or more specific political jurisdictions may also qualify as a "mandated ALS response" if the terms of the contract require an ALS-only response for all requests for service. For example, in a locality where there is no ordinance requiring an "ALS only" EMS response, but there is a contract with a supplier for 911 services that requires an ALS response to all requests for services, the contractual requirement to provide such services may qualify as a "mandated ALS response." The intermediary or carrier must determine whether, in the totality of the circumstances, any particular contractual requirement is tantamount to a "mandated ALS response." However, a contractual requirement for ALS-only service in a contract either with a private entity, or with a government agency for less than general, jurisdiction-wide ambulance services, would not qualify as a "mandated ALS response." Note that the ALS vehicle must meet the crew requirements specified in 42 CFR section 410.41.

The policy of paying according to the medically necessary services actually furnished continues under the Ambulance Fee Schedule. That is, payment is based on the level of service provided, not on the vehicle used. Even if a local government requires an ALS response for all calls, Medicare pays only for the level of service provided and then only when the service is medically necessary. The use of Q3019 and Q3020 described in this instruction, and in PM AB-02-036, is effective only during the transition period.

Physician Services Provided During an Ambulance Transport

Under the Ambulance Fee Schedule, payment for all ambulance-related items and services (including ambulance services that happen to be furnished by a physician) is included in the base payment for the ambulance transport. Therefore, under the Ambulance Fee Schedule, there is no separate payment for these services. However, if, during an ambulance transport, a physician furnishes a service(s) that is covered as a physician's service, and not covered under the Medicare ambulance benefit, then the physician may bill and be paid separately from the Ambulance Fee Schedule payment for such a service.

Billing the Beneficiary for Noncovered Services

When a provider/supplier issues an ABN because the service is not reasonable and necessary, it may only collect upfront the coinsurance amount and deductible from the beneficiary. If a transport is clearly statutorily excluded for another reason (e.g., it originates outside the United States), or if there is no benefit category for the service, the provider/supplier may charge the individual its full fee and collect the fee at a time of its choosing. In this situation, the provider/supplier may wish to advise the beneficiary, in advance of furnishing the service, that such transportation is not covered under Medicare. (An NEMB may be used, since an ABN is not appropriate.)

Source: CMS Transmittal AB-03-106, CR 2770

AMBULATORY SURGICAL CENTER

Services Provided in an Ambulatory Surgical Center (ASC) Not on the ASC Approved Procedures List—Clarification

We have received a number of inquiries about the place of service that should be used on the Medicare claim when a service that is not on the ASC approved procedures list is furnished in an ASC. In these circumstances, physicians should indicate ASC as the place of service on Form CMS-1500 (or electronic equivalent).

Other questions have arisen as to whether a beneficiary can be billed for the ASC facility fee when Medicare does not pay a facility fee because a procedure not on the ASC list is performed in a certified ASC. In this situation, because the ASC is effectively serving as a physician's office, Medicare pays the physician the higher nonfacility rate. Therefore, payment for the physician's service includes payment for all practice expenses incurred in furnishing the service. The ASC benefit is not implicated since the services do not meet the provisions of section 1833(i) of the Social Security Act. The services are covered as physicians' services and paid under the Medicare Physician Fee Schedule. Payment to the physician reflects payment for the whole service; the beneficiary cannot be charged in excess of the limiting charge for the physician fee schedule service.

Source: *The Federal Register*, November 1, 2001 (66 FR 55264)

The List of Procedures Approved in an Ambulatory Surgical Center

The following is an inclusive list of surgical procedures that may be reimbursed when billed by an ASC, effective for services rendered on or after July 1, 2003. An ASC's charge for a procedure *other than* one on this list is not a benefit of Medicare, although the physician's fee may be covered.

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
10121	2	11626	2	12046	2	14061	3	15574	3	15826	3	15940	3	19160	3
10180	2	11644	2	12047	2	14300	4	15576	3	15828	3	15941	3	19162	7
11010	2	11646	2	12054	2	14350	3	15600	3	15829	5	15944	3	19180	4
11011	2	11770	3	12055	2	15000	2	15610	3	15831	3	15945	4	19182	4
11012	2	11771	3	12056	2	15050	2	15620	4	15832	3	15946	4	19290	1
11042	2	11772	3	12057	2	15100	2	15630	3	15833	3	15950	3	19291	1
11043	2	11960	2	13100	2	15101	3	15650	5	15834	3	15951	4	19316	4
11044	2	11970	3	13101	3	15120	2	15732	3	15835	3	15952	3	19318	4
11404	1	11971	1	13120	2	15121	3	15734	3	15840	4	15953	4	19324	4
11406	2	12005	2	13121	3	15200	3	15736	3	15841	4	15956	3	19325	9
11424	2	12006	2	13131	2	15201	2	15738	3	15845	4	15958	4	19328	1
11426	2	12007	2	13132	3	15220	2	15740	2	15876	3	16015	2	19330	1
11444	1	12016	2	13150	3	15221	2	15750	2	15877	3	19020	2	19340	2
11446	2	12017	2	13151	3	15240	3	15760	2	15878	3	19100	1	19342	3
11450	2	12018	2	13152	3	15241	3	15770	3	15879	3	19101	2	19350	4
11451	2	12020	1	13160	2	15260	2	15775	3	15920	3	19102	2	19355	4
11462	2	12021	1	14000	2	15261	2	15776	3	15922	4	19103	2	19357	5
11463	2	12034	2	14001	3	15350	2	15820	3	15931	3	19110	2	19366	5
11470	2	12035	2	14020	3	15351	2	15821	3	15933	3	19112	3	19370	4
11471	2	12036	2	14021	3	15400	2	15822	3	15934	3	19120	3	19371	4
11604	2	12037	2	14040	2	15401	2	15823	5	15935	4	19125	3	19380	5
11606	2	12044	2	14041	3	15570	3	15824	3	15936	4	19126	3	20005	2
11624	2	12045	2	14060	3	15572	3	15825	3	15937	4	19140	4	20200	2

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
20205	3	21275	7	23031	3	23545	1	24341	3	25031	2	25390	3	26025	1
20206	1	21280	5	23035	3	23550	3	24342	3	25035	2	25391	4	26030	2
20220	1	21282	5	23040	3	23552	4	24345	2	25040	5	25392	3	26034	2
20225	2	21295	1	23044	4	23570	1	24350	3	25066	2	25393	4	26040	4
20240	2	21296	1	23066	2	23575	1	24351	3	25075	2	25400	3	26045	3
20245	3	21300	2	23075	2	23585	3	24352	3	25076	3	25405	4	26055	2
20250	3	21310	2	23076	2	23600	1	24354	3	25077	3	25415	3	26060	2
20251	3	21315	2	23077	3	23605	2	24356	3	25085	3	25420	4	26070	2
20525	3	21320	2	23100	2	23615	4	24360	5	25100	2	25425	3	26075	4
20650	3	21325	4	23101	7	23616	4	24361	5	25101	3	25426	4	26080	4
20670	1	21330	5	23105	4	23620	1	24362	5	25105	4	25440	4	26100	2
20680	3	21335	7	23106	4	23625	2	24363	7	25107	3	25441	5	26105	1
20690	2	21336	4	23107	4	23630	5	24365	5	25110	3	25442	5	26110	1
20692	3	21337	2	23120	5	23650	1	24366	5	25111	3	25443	5	26115	2
20693	3	21338	4	23125	5	23655	1	24400	4	25112	4	25444	5	26116	2
20694	1	21339	5	23130	5	23660	3	24410	4	25115	4	25445	5	26117	3
20900	3	21340	4	23140	4	23665	2	24420	3	25116	4	25446	7	26121	4
20902	4	21345	7	23145	5	23670	3	24430	3	25118	2	25447	5	26123	4
20910	3	21355	3	23146	5	23675	2	24435	4	25119	3	25449	5	26125	4
20912	3	21400	2	23150	4	23680	3	24470	3	25120	3	25450	3	26130	3
20920	4	21401	3	23155	5	23700	1	24495	2	25125	3	25455	3	26135	4
20922	3	21421	4	23156	5	23800	4	24498	3	25126	3	25490	3	26140	2
20924	4	21440	3	23170	2	23802	7	24500	1	25130	3	25491	3	26145	3
20926	4	21445	4	23172	2	23921	3	24505	1	25135	3	25492	3	26160	3
20975	2	21450	3	23174	2	23930	1	24515	4	25136	3	25505	1	26170	3
21010	2	21451	4	23180	4	23931	2	24516	4	25145	2	25515	3	26180	3
21015	3	21452	2	23182	4	23935	2	24530	1	25150	2	25520	1	26185	4
21025	2	21453	3	23184	4	24000	4	24535	1	25151	2	25525	4	26200	2
21026	2	21454	5	23190	4	24006	4	24538	2	25210	3	25526	5	26205	3
21029	2	21461	4	23195	5	24066	2	24545	4	25215	4	25535	1	26210	2
21034	3	21462	5	23330	1	24075	2	24546	5	25230	4	25545	3	26215	3
21040	2	21465	4	23331	1	24076	2	24560	1	25240	4	25565	2	26230	7
21044	2	21480	1	23395	5	24077	3	24565	2	25248	2	25574	3	26235	3
21046	2	21485	2	23397	7	24100	1	24566	2	25250	1	25575	3	26236	3
21047	2	21490	3	23400	7	24101	4	24575	3	25251	1	25605	3	26250	3
21050	3	21493	3	23405	2	24102	4	24576	1	25260	4	25611	3	26255	3
21060	2	21494	4	23406	2	24105	3	24577	1	25263	2	25620	5	26260	3
21070	3	21497	2	23410	5	24110	2	24579	3	25265	3	25624	2	26261	3
21100	2	21501	2	23412	7	24115	3	24582	2	25270	4	25628	3	26262	2
21121	7	21502	2	23415	5	24116	3	24586	4	25272	3	25635	1	26320	2
21122	7	21555	2	23420	7	24120	3	24587	5	25274	4	25645	3	26350	1
21123	7	21556	2	23430	4	24125	3	24600	1	25275	4	25660	1	26352	4
21127	9	21600	2	23440	4	24126	3	24605	2	25280	4	25670	3	26356	4
21181	7	21610	2	23450	5	24130	3	24615	3	25290	3	25671	1	26357	4
21206	5	21700	2	23455	7	24134	2	24620	2	25295	3	25675	1	26358	4
21208	7	21720	3	23460	5	24136	2	24635	3	25300	3	25676	2	26370	4
21209	5	21725	3	23462	7	24138	2	24655	1	25301	3	25680	2	26372	4
21210	7	21800	1	23465	5	24140	3	24665	4	25310	3	25685	3	26373	3
21215	7	21805	2	23466	7	24145	3	24666	4	25312	4	25690	1	26390	4
21230	7	21820	1	23480	4	24147	2	24670	1	25315	3	25695	2	26392	3
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21244	7	22310	1	23505	1	24301	4	24925	3	25337	5	25825	5	26418	4
21245	7	22315	2	23515	3	24305	4	25000	3	25350	3	25830	5	26420	4
21246	7	22505	2	23520	1	24310	3	25020	3	25355	3	25907	3	26426	3
21248	7	22900	4	23525	1	24320	3	25023	3	25360	3	25922	3	26428	3
21249	7	23000	2	23530	3	24330	3	25024	3	25365	3	25929	3	26432	3
21267	7	23020	2	23532	4	24331	3	25025	3	25370	3	26011	1	26433	3
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26442	3	26645	1	27194	2	27427	3	27656	2	27846	3	28193	4	28505	3
26445	3	26650	2	27202	2	27428	4	27658	1	27848	3	28200	3	28525	3
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26450	3	26675	2	27238	1	27430	4	27664	2	27870	4	28208	3	28545	1
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26460	3	26685	3	27250	1	27437	4	27675	2	27884	3	28222	1	28555	2
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26476	1	26706	2	27265	1	27442	5	27681	2	27893	3	28234	2	28585	3
26477	1	26715	4	27266	2	27443	5	27685	3	27894	3	28238	3	28605	1
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29856	4	30801	1	31571	2	36532	1	40761	3	42420	7	43244	2	45000	1
29860	4	30802	1	31576	2	36533	3	40801	2	42425	7	43245	2	45005	2
29861	4	30903	1	31577	2	36534	2	40814	2	42440	3	43246	2	45020	2
29862	9	30905	1	31578	2	36535	1	40816	2	42450	2	43247	2	45100	1
29863	4	30906	1	31580	5	36640	1	40818	1	42500	3	43248	2	45108	2
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29876	4	31030	3	31590	5	36820	3	40843	3	42510	4	43256	3	45305	1
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29881	4	31070	2	31613	2	36831	9	41006	1	42725	2	43261	2	45315	1
29882	3	31075	4	31614	2	36832	4	41007	1	42802	1	43262	2	45317	1
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30520	4	31531	3	36261	2	40527	2	42320	1	43234	1	44386	1	46220	1
30540	5	31535	2	36262	1	40530	2	42325	2	43235	1	44388	1	46250	3
30545	5	31536	3	36488	1	40650	3	42340	2	43236	2	44389	1	46255	3
30560	2	31540	3	36489	1	40652	3	42405	2	43239	2	44390	1	46257	3
30580	4	31541	4	36490	1	40654	3	42408	3	43240	2	44391	1	46258	3
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46275	3	49560	4	52005	2	53080	3	54308	3	55400	1	58546	9	62350	2
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46761	3	49651	7	52277	2	53405	2	54385	3	56441	1	58672	5	64410	1
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46924	1	50393	1	52285	2	53430	2	54406	3	56700	1	58900	3	64421	1
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49421	1	51020	4	52450	3	54105	1	54830	3	57400	2	62225	1	64623	1
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49525	4	51726	1	52648	9	54163	2	55120	2	57820	3	62287	9	64716	3
49540	2	51772	1	52700	2	54164	2	55150	1	58120	2	62294	3	64718	2
49550	5	51785	1	53000	1	54205	4	55175	1	58145	5	62310	1	64719	2

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
64721	2	64862	3	65275	4	66250	2	67108	7	67901	5	68700	2	69641	7
64722	1	64864	3	65280	4	66500	1	67112	7	67902	5	68720	4	69642	7
64726	1	64865	4	65285	4	66505	1	67115	2	67903	4	68745	4	69643	7
64727	1	64870	4	65290	3	66600	3	67120	2	67904	4	68750	4	69644	7
64732	2	64872	2	65400	1	66605	3	67121	2	67906	5	68770	4	69645	7
64734	2	64874	3	65410	2	66625	3	67141	2	67908	4	68810	1	69646	7
64736	2	64876	3	65420	2	66630	3	67218	5	67909	4	68811	2	69650	7
64738	2	64885	2	65426	5	66635	3	67227	1	67911	3	68815	2	69660	5
64740	2	64886	2	65710	7	66680	3	67250	3	67914	3	69110	1	69661	5
64742	2	64890	2	65730	7	66682	2	67255	3	67916	4	69120	2	69662	5
64744	2	64891	2	65750	7	66700	2	67311	3	67917	4	69140	2	69666	4
64746	2	64892	2	65755	7	66710	2	67312	4	67921	3	69145	2	69667	4
64771	2	64893	2	65770	7	66720	2	67314	4	67923	4	69150	3	69670	3
64772	2	64895	3	65772	4	66740	2	67316	4	67924	4	69205	1	69676	3
64774	2	64896	3	65775	4	66821	2	67318	4	67935	2	69300	3	69700	3
64776	3	64897	3	65800	1	66825	4	67320	4	67950	2	69310	3	69711	1
64778	2	64898	3	65805	1	66830	4	67331	4	67961	3	69320	7	69714	9
64782	3	64901	2	65810	3	66840	4	67332	4	67966	3	69421	3	69715	9
64783	2	64902	2	65815	2	66850	7	67334	4	67971	3	69436	3	69717	9
64784	3	64905	2	65850	4	66852	4	67335	4	67973	3	69440	3	69718	9
64786	3	64907	1	65865	1	66920	4	67340	4	67974	3	69450	1	69720	5
64787	2	65091	3	65870	4	66930	5	67350	1	67975	3	69501	7	69725	5
64788	3	65093	3	65875	4	66940	5	67400	3	68115	2	69502	7	69740	5
64790	3	65101	3	65880	4	66982	8	67405	4	68130	2	69505	7	69745	5
64792	3	65103	3	65900	5	66983	8	67412	5	68320	4	69511	7	69801	5
64795	2	65105	4	65920	7	66984	8	67413	5	68325	4	69530	7	69802	7
64802	2	65110	5	65930	5	66985	6	67415	1	68326	4	69550	5	69805	7
64821	4	65112	7	66020	1	66986	6	67420	5	68328	4	69552	7	69806	7
64831	4	65114	7	66030	1	67005	4	67430	5	68330	4	69601	7	69820	5
64832	1	65130	3	66130	7	67010	4	67440	5	68335	4	69602	7	69840	5
64834	2	65135	2	66150	4	67015	1	67450	5	68340	4	69603	7	69905	7
64835	3	65140	3	66155	4	67025	1	67550	4	68360	2	69604	7	69910	7
64836	3	65150	2	66160	2	67027	4	67560	2	68362	2	69605	7	69915	7
64837	1	65155	3	66165	4	67030	1	67715	1	68500	3	69620	2	69930	7
64840	2	65175	1	66170	4	67031	2	67808	2	68505	3	69631	5	G0105	2
64856	2	65235	2	66172	4	67036	4	67830	2	68510	1	69632	5	G0121	2
64857	2	65260	3	66180	5	67038	5	67835	2	68520	3	69633	5	G0260	1
64858	2	65265	4	66185	2	67039	7	67880	3	68525	1	69635	7		
64859	1	65270	2	66220	3	67040	7	67882	3	68540	3	69636	7		
64861	3	65272	2	66225	4	67107	5	67900	4	68550	3	69637	7		

DIAGNOSTIC TESTS

Ambulatory Blood Pressure Monitoring—Revision to National Coverage Determination (NCD)

Effective July 1, 2003, section 50-42 of the Medicare Coverage Issues Manual (CIM) is revised to specify that a physician is required to perform the interpretation of the data obtained through ambulatory blood pressure monitoring, but that there are no requirements regarding the setting in which the interpretation is performed. Everything else in this NCD remains unchanged.

Source: CMS Transmittal 168, CR 2625 (CIM section 50-42)

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 July 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	PAR	NON-PAR
90376	78.11	74.20
90675	136.16	129.35
90703	14.37	13.65
J0280	1.05	1.00
J0282	6.16	5.85
J0540	23.40	22.23
J0560	9.89	9.40
J0570	19.78	18.79
J0580	39.56	37.58
J0585	4.95	4.70
J0610	1.02	0.97
J0620	6.20	5.89
J0630	NC	NC
J0637	32.95	29.90
J0702	4.98	4.73
J0704	1.07	1.02
J0706	3.44	3.27
J0720	7.22	6.86
J0725	3.33	3.16
J0744	13.69	13.01
J0800	92.94	88.29
J0895	15.63	14.85
J0945	0.95	0.90
J1000	1.90	1.81
J1040	8.61	8.18
J1094	0.71	0.67
J1110	40.28	38.27
J1170	1.49	1.42
J1240	0.38	0.36
J1270	5.50	5.23
J1380	0.52	0.49
J1390	1.05	1.00
J1435	0.57	0.54
J1450	95.92	91.12
J1455	13.07	12.42
J1480	34.24	32.53
J1510	68.27	64.86
J1520	79.72	75.73
J1540	102.70	97.57
J1563	78.38	74.46
J1580	1.77	1.68
J1630	7.13	6.77
J1631	24.94	23.69
J1644	0.38	0.36
J1645	11.33	10.76
J1655	3.82	3.63
J1790	2.81	2.67
J1835	36.85	35.01
J1840	3.29	3.13
J1910	15.52	14.74
J1956	20.81	19.77
J1980	8.56	8.13
J2000	1.18	1.12
J2150	3.03	2.88
J2180	4.72	4.48
J2250	1.15	1.09
J2271	11.07	10.52
J2300	1.51	1.43
J2320	3.84	3.65
J2321	7.67	7.29
J2322	15.74	14.95
J2355	267.90	254.51
J2430	265.87	252.58
J2440	3.50	3.33
J2460	1.02	0.97
J2515	0.59	0.56
J2515	0.59	0.56
J2540	0.29	0.28
J2540	0.29	0.28
J2550	2.85	2.71
J2550	2.85	2.71
J2597	3.45	3.28
J2650	0.45	0.43
J2710	0.67	0.64
J2765	2.07	1.97
J2790	100.32	95.30
J2800	14.77	14.03
J2940	NC	NC
J3010	0.93	0.88
J3030	NC	NC
J3150	1.71	1.62
J3240	617.50	586.63
J3245	471.39	447.82
J3260	4.46	4.24
J3280	5.65	5.37
J3360	0.97	0.92
J3364	10.23	9.72
J3370	7.03	6.68
J3410	1.21	1.15
J3420	0.13	0.12
J3430	2.42	2.30
J3475	0.29	0.28
J7051	1.33	1.26
J7060	9.04	8.59
J7070	10.97	10.42
J9001	393.48	373.81
J9010	584.54	555.31
J9015	734.46	697.74
J9031	160.13	152.12
J9045	148.75	141.31
J9050	136.17	129.36
J9062	210.90	200.36
J9150	78.34	74.42
J9170	357.91	340.01
J9190	2.27	2.16
J9211	419.94	398.94
J9250	0.39	0.37
J9260	4.75	4.51
J9265	164.08	155.88
J9280	127.40	121.03
J9290	323.20	307.04
J9293	359.35	341.38
J9300	2183.81	2074.62
J9350	798.65	758.72
J9375	67.96	64.56
J9390	109.00	103.55
Q0183	15.40	15.40
Q0187	1675.80	1675.80
Q4052	88.69	84.26
Q4053	467.09	443.74

NC = Noncovered

Source: July 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

October Quarterly Update for 2003 DMEPOS Fee Schedule

The durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedules are updated quarterly to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The updates that follow are effective for items furnished on or after October 1, 2003.

The fee schedule amounts implemented for code L0462 on July 1, 2003, were based on incorrect pricing information. The base fee schedule amounts for this code will be revised by the durable medical equipment regional carriers (DMERCs).

Gradient compression stockings falling under codes L8110 or L8120 may be covered under the surgical dressing benefit when the beneficiary has an open venous stasis ulcer that has been treated by a physician or other health care professional requiring medically necessary debridement, and when the gradient stocking can be proven to deliver compression greater than 30 mm Hg. and less than 50 mm Hg:

New HCPCS codes K0622, K0623, K0624, K0625, and K0626 are added.

Claims for items billed under the above codes furnished by outpatient hospital departments or skilled nursing facilities are processed by intermediaries. All other claims for items billed under these codes are processed by the DMERCs. No fee schedules for items/ HCPCS codes submitted to local carriers are affected by this update. Contact your DMERC for more information.

Source: CMS Transmittal AB-03-100, CR 2802

End-stage Renal Disease (ESRD)

MCM Updates Pertaining to Dialysis Services

CMS has issued the following revisions to the Medicare Carriers Manual (MCM), effective October 1, 2003:

Section 15062.1, Payment for Physician Services Furnished to Dialysis Inpatients, is revised to clarify a *CPT* Editorial change in the description for *CPT* codes *90935* and *90937*. The change in the code descriptor allows for these codes to be used for outpatient acute dialysis services (that is, patients who are expected to regain their renal function) as well as for inpatient ESRD and acute dialysis services.

> …Beginning January 1, 2003, claims for physicians' services for outpatient acute hemodialysis services will be processed using codes 90935 and 90937 according to the rules in section 15350B. Prior to this date, these codes were used for acute dialysis services only when it was furnished on an inpatient basis. All carriers must use these codes for these services.

Section 15350, Dialysis Services (Codes *90935-90999*), adds a new subsection allowing payment for *CPT* codes *90935* or *90937* for dialysis services furnished to acute dialysis patients requiring hemodialysis on an outpatient or inpatient basis.

> …*CPT* codes *90935* and *90937* are used to report inpatient ESRD hemodialysis and outpatient hemodialysis performed on non-ESRD patients (e.g., patients in acute renal failure requiring a brief period of dialysis prior to recovery). *CPT* codes *90945* and *90947* are used to report all non-hemodialysis procedures. All four of these codes include payment for any evaluation and management services related to the patients renal disease that are provided on the same date as the dialysis service. Therefore, payment for all evaluation and management services is bundled into the payment for *90935*, *90937*, *90945*, and *90947*, except for the following evaluation and management services which may be reported on the same date as a dialysis service with the use of the –25 modifier and they are significant and separately identifiable and met any medical necessity requirements:
>
> | | |
> |---|---|
> | *99201-99205* | Office or Other Outpatient Visit for a New Patient |
> | *99211-99215* | Office or Other Outpatient Visit for an Established Patient |
> | *99221-99223* | Initial Hospital Care for a New or Established Patient |
> | *99238-99239* | Hospital Discharge Day Management Services |
> | *99241-99245* | Office or Other Outpatient Consultations, New or Established Patient |
> | *99251-99255* | Initial Inpatient Consultations, New or Established Patient |
> | *99291-99292* | Critical Care Services |

In the absence of one of these codes being reported with the –25 modifier and meeting the other requirements listed above, Medicare will pay only the dialysis service and deny the evaluation and management service. Furthermore, payment is not allowed for more than one dialysis service per day.

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

EVALUATION & MANAGEMENT SERVICES

Physician Certification and Re-certification for Home Health Services

In 2001, CMS established HCPCS codes G0179 and G0180 for billing services involved in physician certification/re-certification and development of plan of care for Medicare-covered home health services. Because we have noted some apparent confusion regarding billing for these services, we are reprinting the descriptors for these codes.

Note: code G0179 should be billed only *once* for each re-certification period, after a patient has received services for at least 60 days.

G0179 Physician re-certification services for Medicare covered services provided by a participating home health agency (patient not present), including review of subsequent reports of patient status, review of patient's responses to the oasis assessment instrument, contact with the home health agency to ascertain the follow-up implementation plan of care and documentation in the patient's office records, per certification period

(G0179 is to be used for re-certification after a patient has received services for at least 60 days (or one certification period)

G0180 Physician certification services for Medicare covered services provided by a participating home health agency (patient not present), including review of subsequent reports and patient status, review of patient's responses to the oasis assessment instrument, contact with the home health agency to ascertain the initial implementation plan and care, and documentation in the patient's office record, per certification period

(G0180 is to be used when the patient has not received Medicare covered home health services for at least 60 days)

Billing Guidelines—Correction

Billing guidelines published in the Third Quarter 2001 *Medicare B Update!* instructed providers to enter the date of service on Form CMS-1500 with the date the physician signed the home health agency's or hospice's certification form. The date of service should reflect the date the physician ordered the Medicare-covered home plan of care, not the date he/she signed the certification plan of care.

Example: The home health/hospice called the provider on February 1, 2003; the provider subsequently ordered the necessary service(s) over the phone. On February 14, 2003, the physician signed the certification plan of care form. The date of service on the claim should be listed as February 1, 2003.

We apologize for any inconvenience this may have caused.

LABORATORY/PATHOLOGY

July 2003 Update to the Laboratory National Coverage Determination Edit Software

Changes to the national uniform edit software that was developed for processing clinical diagnostic laboratory services subject to one of the 23 national coverage determinations (NCDs) were implemented in the July 2003 release. The following changes to the edit module are effective for services furnished on or after July 1, 2003.

1. The following procedure codes, which were added to the *Current Procedure Terminology (CPT)* beginning in January 1, 2003, will be added to the blood count NCD:

85004 Blood count automated differential white blood cell (WBC) count
85032 Manual cell count (erythrocyte, leukocyte, or platelet) each
85049 Platelet, automated

CMS has determined these are essentially the same codes originally included in the blood count NCD as negotiated by the rulemaking committee.

2. Under the blood glucose testing NCD, ICD-9-CM code range 730.07-730.27 was erroneous described as osteomyelitis of the tarsal bones. This range is corrected by the following ICD- 9-CM diagnosis codes, which reflect more accurately the intent of the committee to include osteomyelitis of the ankle and foot:

730.07 Acute osteomyelitis of ankle and foot
730.17 Chronic osteomyelitis of ankle and foot
730.27 Unspecified osteomyelitis of ankle and foot

3. In the NCD coding manual issued for the January and April software releases, ICD-9-CM diagnosis code 136.2 was inadvertently repeated in the list of covered diagnoses for HIV testing. The descriptions of the

codes and the software implementing the NCD edits remained accurate. Thus, CMS is changing the NCD coding manual only to show the correct ICD-9-CM diagnosis code 136.3 for pneumocystosis.

Source: CMS Transmittal AB-03-084, CR 2737

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October 2003 Changes to the Laboratory National Coverage Determination Edit Software

Changes to the national uniform edit software that was developed for processing clinical diagnostic laboratory services subject to one of the 23 (NCDs) will be implemented in the October 2003 release. The laboratory edit module for the NCDs will be updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCD developed through the NCD process.

The following changes are made to the edit module effective for services furnished on or after October 1, 2003.

1. In accordance with the decision memorandum published on the coverage Internet site on July 17, 2003, (see *http://cms.hhs.gov/ncdr/memo.asp?id=94*), diagnosis code 401.1, benign essential hypertension, is added to the list of ICD-9-CM codes covered by Medicare for lipid testing. Hypertension may be viewed as a cause of atherosclerosis that requires tighter management when accompanied by dyslipidemia.
2. ICD-9-CM codes are updated annually. New ICD-9-CM codes can render some of the presently covered codes inappropriate. Most commonly, codes are expanded so that additional digits are necessary. For example, a code that presently is displayed as 4 digits may be expanded to require 5 digits. The coding changes below are considered ministerial in that existing codes within the NCD are being replaced with the more current code structure or adding new codes that are within an existing covered range. The following specific changes to the NCDs and edit module are being made; however, because a 90-day grace period for new ICD-9-CM codes is provided, the codes will not actually be removed from the edit module until the January 2004 release.
   - In the serum iron studies NCD list of covered diagnoses, code is being removed 282.4 and replaced with 282.41, 282.42, and 282.49. Code V43.2 is being removed and replaced with V43.21 and V43.22. New ICD-9-CM diagnosis codes 282.64, 282.68, and 289.52 are being added.
   - In the urine culture bacterial NCD list of covered diagnoses, code 600.0 is being removed and replaced with 600.00 and 600.01; code 600.1 is being removed and replaced with 600.10 and 600.11; code 600.2 and is being removed and replaced with 600.20 and 600.21; and code 600.9 is being removed and replaced with 600.90 and 600.91. New codes 780.93, 780.94, 785.52, and 788.63 are also being added.
   - In the human immunodeficiency virus testing (diagnosis) NCD list of covered diagnoses, ICD-9-CM diagnosis code 348.3 is being removed and replaced with 348.30 and 348.39; code 530.2 is being removed and replaced with 530.20, 530.21, and 530.85. New code 331.19 is being added.
   - In the blood counts NCD list of ICD-9-CM codes that do not support medical necessity, code 600.0 is being removed and replaced with 600.00 and 600.01; code 600.1 is being removed and replaced with 600.10 and 600.11; code 600.2 is being removed and replaced with 600.20 and 600.21; and code 600.9 is being removed and replaced with 600.90 and 600.91. Code V04.8 is being removed and replaced with V04.81, V04.82, and V04.89; code V53.9 is being removed and replaced with V53.90, V53.91, and V53.99; code V54.0 is being removed and replaced with V54.01, V54.02, and V54.09. In addition, new codes 799.81, V25.03, V45.85, and V65.46 are being added.
   - In the partial thromboplastin time NCD list of covered diagnoses, code 767.1 is being removed and replaced with 767.11.
   - In the prothrombin time NCD list of covered diagnoses, code 767.1 is being removed and replaced with 767.11. Code V43.2 is being removed and replaced with V43.21 and V43.22. New code 414.07 is being added.
   - In the collagen cross-links NCD list of covered diagnoses, new code V58.65 is being added.
   - In the blood glucose NCD list of covered diagnoses, code 790.2 is being removed and replaced with 790.21, 790.22, and 790.29; code 348.3 and removing with 348.31. New codes 414.07, V58.63, V58.64, and V58.65 are being added.
   - In the glycated hemoglobin NCD list of covered diagnoses, code 790.2 is being removed and replaced with 790.21, 790.22, and 790.29.
   - In the thyroid testing NCD list of covered diagnoses, code 331.1 is being removed and replaced with 331.11 and 331.19. New codes 728.87, 780.93, and 780.94 are being added.
   - In the lipid testing NCD list of covered diagnoses, codes 414.07, V58.63, and V58.64 are being added.
   - In the prostate specific antigen NCD list of covered procedures, new code 788.63 is being added.
   - In the gamma glutamyl transferase NCD list of covered diagnoses, we are adding new codes 282.64, 282.68, 289.52, V58.63, and V58.64.
   - In the fecal occult blood NCD list of covered diagnoses, code 530.2 is being removed and replaced with new codes 530.20, 530.21, and 530.85. New codes V58.63, V58.64, and V58.65 are being added.
   - In the list of ICD-9-CM codes denied that are applicable to all 23 NCDs, code V65.1 is being removed and replaced with V65.11 and V65.19.

Source: CMS Transmittal AB-03-104, CR 2814

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 March 21, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

CPT Code	Test Name	Manufacturer	Effective Date	Use
81003QW	Hypoguard Diascreen® Urine Chemistry Analyzer	Hypoguard USA, Inc.	12/6/02	Screening of urine to monitor/ diagnose various diseases/ conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections.
82273QW	Aerscher Hemaprompt FG	Aerscher Diagnostics	2/11/03	Rapid screening test to detect the presence of gastric occult blood.
83036QW	Bio-Rad Micromat II Hemoglobin A1c Prescription Home Use Test	Bio-Rad Laboratories	12/17/02	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
86701QW	OraSure Technologies OraQuick Rapid HIV-1 Antibody Test	OraSure Technologies, Inc.	1/31/03	Qualitative immunoassay to detect antibodies to human immunodeficiency virus type 1 (HIV-1) in fingerstick whole blood specimens.
87880QW	Immunostics Immuno/Strep A Detector	ACON Laboratories, Inc.	2/13/03	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever.
87880QW	Stanbio QuStick Strep A	Stambio Laboratory	3/5/03	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever.

There is a national coverage determination (NCD) for glycated hemoglobin and for immunoassays performed by multiple step methods for HIV-1. These NCDs will be applied to claims for *CPT* code 83036QW and 86701QW.

Source: CMS Transmittal AB-03-056, CR 2685

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Diagnosis Code for Screening Pap Smear and Pelvic Examination Services

Effective January 1, 1998, section 1861(nn) of the Social Security Act (42 USC 1395x(nn)) provided coverage for a screening Pap smear for women under certain conditions. See the Medicare Carriers Manual (MCM) section 4603.1A and the Medicare Intermediary Manual (MIM) section 3628.1 for the applicable conditions for coverage and allowable frequencies. Effective for services rendered on or after October 1, 2003, CMS is adding the diagnosis codes for low risk patients to the Common Working File (CWF) edits for Pap smear and Pelvic examinations. The two new additional diagnosis codes for low risk are V76.47 and V76.49. V76.49 has been added for providers to use for women without a cervix.

The following are the diagnosis codes that will be recognized for low risk or high risk patients for Pap smear and pelvic examinations:

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

There are no changes to the *CPT*/HCPCS codes used to bill screening Pap smears.

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

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Delay in Implementation of the Financial Limitation for Outpatient Rehabilitation Services to September 1, 2003

The financial limitation for outpatient rehabilitation services (CMS Program Memorandum AB-03-057) **scheduled for implementation on July 1, 2003 has been delayed until September 1, 2003**.

Effective for services received on or after September 1, 2003, Medicare coverage for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) will be limited. For the period September 1, 2003 through December 31, 2003, the limits are $1,590 for PT and SLP combined, and $1,590 for OT alone. These limits do not apply to therapy provided in a hospital outpatient department, unless the beneficiary is a resident of and occupies a Medicare-certified bed in a skilled nursing facility.

Source: CMS Transmittal AB-03-097, CR 2837

Implementation of the Financial Limitation for Outpatient Rehabilitation Services—Clarification on Requirement to Submit Modifier GN, GO, or GP

Implementation of the financial limitations on therapy services (outpatient therapy caps) has been delayed until September 1, 2003 (Program Memorandum AB-03-097). **The effective date of all other information previously communicated, including the requirement to submit modifier GN, GO, or GP, remains July 1, 2003.** Implementation of the outpatient therapy caps is the ***only*** part delayed to September 1, 2003.

Failure to include one of these modifiers will result in claims being returned as unprocessable. An unprocessable claim is not afforded appeal rights; it must be corrected and resubmitted as a new claim.

Source: CMS Transmittals AB-03-097 (CR 2837), AB-03-057 (CR 2709), AB-03-085 (CR 2792), and AB-03-072 (CR 2603)

Financial Limitation of Claims for Outpatient Rehabilitation Services

This article, published at a request from the Centers for Medicare & Medicaid Services (CMS), addresses the implementation of the financial limitation for outpatient rehabilitation services including physical therapy (PT), speech language pathology (SLP), and occupational therapy (OT) claims submitted with dates of service ***on and after July 1, 2003 (note: see additional information concerning a delay in implementation until September 1, 2003).*** *This article contains additional important information related to "Beneficiary Notification" not published in previous notifications.*

Financial limits on outpatient physical therapy services provided in private practice settings began in 1972, and included occupation therapy services provided in private practice settings in 1987. The Balanced Budget Act of 1997 expanded the caps to include all PT, SLP, and OT services in every outpatient setting except outpatient hospital. These caps were effective in 1999, but were not fully implemented due to Y2K issues. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 suspended the caps for the years 2000, 2001, and 2002. The moratorium expired on December 31, 2002.

Description

The caps apply to outpatient rehabilitation (PT, SLP, and OT) services provided by any provider/supplier except outpatient therapy services provided by:

1) a hospital to an outpatient or to an inpatient who has exhausted Part A benefits
2) another entity under an arrangement with a hospital to provide the same services to the same beneficiaries.

Note*: Only services billed by the hospital as type of bill (TOB) 12x or 13x are exempt from limitations on therapy services.*

For skilled nursing facilities (SNFs), this limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (TOB 22x) who are in a Medicare-certified section of the facility – i.e., one that is either certified by Medicare alone or is dually certified (by Medicare as a SNF and by Medicaid as a nursing facility [NF]). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, SNF residents who are in a non-Medicare certified section of the facility – i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program – use TOB 23x (see CR 2674). For SNF residents in non-Medicare certified portions of the facility and SNF non-residents who go to the SNF for outpatient treatment (TOB 23x) medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded.

Limitations do not apply to SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Similarly, limitations do not apply to any therapy services billed under PPS home health or inpatient hospitals, including critical access hospitals.

The limits apply to outpatient rehabilitation therapy services provided by:

- Physicians
- Nurse practitioners
- Clinical nurse specialists
- Physician's assistants
- Physical therapists
- Occupational therapists
- Speech-language pathologists.

Settings affected by the caps consist of all settings paid using the Medicare physician fee schedule except the outpatient hospital setting including:

- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy providers, e.g., outpatient rehabilitation facilities/rehabilitation agencies
- Part B services in skilled nursing facilities (see above details for SNF settings)
- Home health agencies providing therapies to patients who are not homebound
- Physician offices
- Nonphysician practitioner offices
- Physical and occupational therapist private practices.

The 2003 limits per beneficiary per year are:

- $1590 for PT and SLP combined; and
- $1590 for OT.

In 2003, the caps will be implemented beginning with claims submitted for dates of service on and after July 1, 2003. Due to systems limitations, the caps could not be implemented between January 1, 2003 and June 30, 2003. The full $1590 limit is available for beneficiary use between July 1, 2003 and December 31, 2003. In 2004 and subsequent years, the caps will apply to the entire year.

Billing Instructions

Therapy services, no matter who performs them, must meet the standards and conditions that apply to therapy services. For example, there must be an appropriate plan of care and documentation that supports medical necessity whenever therapy services are billed to Medicare.

Deductibles and co-insurance are subtracted from the allowed amount. For example, if the deductible for the year has been met and services are received that total $1590 (the limit of the allowed amount), Medicare pays 80 percent of the allowed amount ($1272) and the beneficiary pays $318 in co-insurance.

Providers/suppliers must continue to add a modifier (GP, GN, GO) to claims, which identify the type of service (PT, SLP, OT) that represents the therapy plan of care. A therapy plan of care is required whenever therapy services, represented by therapy codes noted below, are billed to Medicare.

Therapy service claims without modifiers on applicable *CPT*/HCPCS or revenue codes will be returned.

Note: *For the first time, these limits will be tracked for all provider/supplier types, including physicians' and nonphysician practitioners' (NPP) claims. Claim payment depends on the use of the modifier. Therefore everyone, including physicians and NPPs who provide these services, should make certain that the appropriate modifier (GN, GO or GP) is included on each code for therapy services. Modifiers should reflect the plan of care under which the service is provided, rather than the specialty of the person who provides the service.*

Certain *CPT*/HCPCS codes may be used under more than one type of plan of care (PT, OT, SLP), in which case the physician or NPP should chose the appropriate modifier for their plan. Failure to include one of these code modifiers for these services will result in the claim/service being returned as unprocessable.

Applicable Outpatient Rehabilitation *CPT*/ HCPCS Codes

The following codes apply to each financial limitation except as noted below. These codes supersede the codes listed in section 3653 of the Medicare Intermediary Manual, Part 3: (**Note:** listing of the following codes does not imply that services are covered.)

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	92506
92507	92508	92526	92597
92601**	92602**	92603**	92604**
92607	92608	92609	92610
92611	92612	92614	92616
95831	95832	95833	95834
95851	95852	96000	96001
96002	96003	96105	96110
96111	96115	97001	97002
97003	97004	97012	97016
97018	97020	97022	97024
97026	97028	97032	97033
97034	97035	97036	97039
97110	97112	97113	97116
97124	97139	97140	97150
97504	97520	97530	97532
97533	97535	97537	97542
97601*	97703	97750	97799
V5362	V5363	V5364	G0279
G0280	G0281	G0283	0020T
0029T			

Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with modifier 59 to denote a separate anatomic site.

* These codes for casts and splints will not apply to the financial limitations when billed by physicians and nonphysician practitioners, as appropriate. When these codes are billed by Part A providers (TOB 22x, 23x, 34x, 74x, and 75x), or other Part B providers/ suppliers, physical therapists or occupational therapists in private practice, specialty codes "65" and "67," they must be billed with a GO or GP modifier. Specialty codes 73 and 74 were not included because they are no longer applicable.

** If an audiology procedure code is performed by an audiologist, the modifiers GN, GO, and GP should not be reported, as these procedures are not subject to the financial limitation. When these codes are billed under a speech language pathology plan of care, they should be accompanied with a GN modifier and applied to the financial limitation.

Beneficiary Notification

Providers/suppliers will be denied payment for services that exceed the limitations. Therefore, it is recommended that they make every effort to learn if prior therapy was performed before a patient is accepted for treatment. Since CMS can only report claims that have been submitted, providers/suppliers should track expenditures in their own facility or office and inform beneficiaries when they may become liable for payment. Providers and suppliers are encouraged to inform beneficiaries that they will be responsible for 100 percent of therapy costs after the limit has been met unless additional services are furnished directly or under arrangement by a hospital. It is recommended that they notify beneficiaries about this responsibility at the first therapy encounter, thereby allowing beneficiaries to make informed decisions regarding their continued care and financial responsibility.

CMS developed the Notice of Exclusion from Medicare Benefits (NEMB) (Form No. CMS-20007 and Formulario No. CMS-20007) to assist in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. Use of the NEMB form is optional.

Providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for services over the cap. (Do not use the Advance Beneficiary Notice form.) **The NEMB form can be found at:** *http://www.cms.hhs.gov/medlearn/refabn.asp*. (Page down twice for both English and Spanish versions.)

On the NEMB, check Box #1 and write a reason for the limitations as follows: "Medicare will not pay for physical therapy and speech-language pathology over $1590 (including dates of service from July 1, 2003 through December 31, 2003)." Substitute "occupational therapy services" in place of PT and SLP for patients under an OT plan of care.

Beginning on July 1, 2003, CMS will include a generic message on each Medicare summary notice (MSN) containing therapy services which states that Medicare provides up to $1590 a year for PT and SLP services combined and up to $1590 for OT services and that additional medically necessary services over these limits are covered only in a hospital outpatient department. CMS will track the total dollar amount of allowed costs for therapy services reported for payment. Beneficiaries will receive a message on the MSN indicating when the caps have been exceeded and payment is denied.

Beginning October 1, 2003, CMS plans to include an MSN message that informs beneficiaries of the amount of allowed cost that has accrued during this calendar year toward the cap. Providers (facilities) with access to HIQA may obtain the accrued amounts for beneficiaries from this database.

When HIPAA goes into effect, (planned for October 2003) the accrued therapy amounts will be available on the ELGA and ELGB screens. Beneficiaries and providers without access to this information may contact the call center at their intermediary or carrier to obtain these amounts.

Appeals

Beneficiaries may appeal claims denied due to exceeding therapy caps. The beneficiary is to be advised of his or her appeal rights set forth in 42 CFR Part 405, subpart G. Physicians, therapists, and other suppliers who accept assignment may also appeal denials. Physicians, therapists, and other suppliers who do not accept assignment, and institutional providers do not have the right to appeal.

For additional information about the financial limitation for outpatient rehabilitation services, refer to CR 2709 which can be accessed at *http://www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp*. A PowerPoint presentation that CMS developed to assist providers in understanding these financial limits is available at *http://www.cms.hhs.gov/medlearn/therapy*.

Source: CMS Transmittal AB-03-073, CR 2603

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RADIOLOGY

Additional Coverage for Magnetic Resonance Angiography

Coverage of magnetic resonance angiography (MRA) of the head and neck, and MRA of the peripheral vessels of the lower extremities is limited as described in section 50-14 of the Medicare Coverage Issues Manual. This instruction has been revised as of July 1, 2003, based on a determination that coverage is reasonable and necessary in additional circumstances. Under that instruction, MRA is generally covered only to the extent that it is used as a substitute for contrast angiography, except to the extent that there are documented circumstances consistent with that instruction that demonstrate the medical necessity of both tests. There is no coverage of MRA outside of the indications and circumstances described in that instruction.

Coding Requirements

Providers must use the following procedure codes when submitting claims for MRA of the chest, abdomen, head, neck, or peripheral vessels of lower extremities (include modifier 26 to denote the professional component or modifier TC to denote the technical component):

70544 Magnetic resonance angiography, head; without contrast material(s)
70545 with contrast material(s)
70546 without contrast material(s), followed by contrast material(s) and further sequences
70547 Magnetic resonance angiography, neck; without contrast material(s)
70548 with contrast material(s)
70549 without contrast material(s), followed by contrast material(s) and further sequences
71555 Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72198 Magnetic resonance angiography, pelvis, with or without contrast material(s)
73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)
74185 Magnetic resonance angiography, abdomen, with or without contrast material(s)

Source: CMS Transmittal 1795, CR 2673

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Expanded Coverage for PET Scans

On April 16, 2003, The Centers for Medicare & Medicaid Services (CMS) announced its intent to expand coverage of positron emission tomography (PET) for Medicare beneficiaries with thyroid cancer and heart disease. This expanded coverage enhances physicians' current evaluative options, and are examples of CMS' commitment to making new medical technologies available to its beneficiaries when evidence is adequate to conclude that the technology is reasonable and necessary for diagnosis or treatment of an illness.

Thyroid Cancer

Thyroid cancer constitutes less than one percent (1%) of all human malignant tumors. In a small number of these patients, the usually accurate Iodine-131 whole body scan is not helpful in identifying recurrent disease following initial treatment. In these patients, CMS determined that the evidence is adequate to conclude that PET is reasonable and necessary, with certain limitations, for management of patients with recurrent thyroid cancer.

Cardiac Diseases

Cardiovascular disease is a broad term encompassing conditions such as hypertension, coronary artery disease, and congestive heart failure. These conditions cause significant morbidity and mortality in the Medicare population. CMS determined that the evidence is adequate to conclude that cardiac imaging with PET, using the radiopharmacological ammonia N-13, is reasonable and necessary, with certain limitations, for the diagnosis and management of patients with known or suspected coronary artery disease.

PET Coverage Not Expanded

Alzheimer's Disease

Alzheimer's disease (AD) is an age-related and irreversible brain disorder that occurs gradually and results in memory loss, behavior and personality changes, and a decline in thinking abilities. AD is the most common cause of dementia representing approximately two-thirds of cases.

PET has been **proposed** as a diagnostic tool in the management of patients with AD. CMS's review of the evidence concluded that PET did not improve patient outcomes in this group of beneficiaries and, therefore, CMS will continue its present noncoverage policy. The clinical benefit of using PET for patients with AD has not been demonstrated.[1]

To provide the best of emerging medical technology for Medicare beneficiaries, CMS will design a demonstration to evaluate the appropriate role of PET for

patients with suspected dementia. CMS will work with Health and Human Services' National Institutes of Health to convene a multi-disciplinary expert meeting with geriatricians, neurologists, radiologists, PET experts, and patient advocates to fully explore the value of PET for AD.

Soft Tissue Sarcoma

CMS has decided against expanding coverage of PET for soft tissue sarcoma, a rare type of cancer for which current imaging techniques have good diagnostic capabilities. CMS determined that the evidence was not adequate to conclude that PET for soft tissue sarcoma was reasonable and necessary and, therefore, CMS will continue its present noncoverage policy.

Other Coverage

Medicare covers PET, with certain limitations, for the diagnosis, staging, and restaging of various cancers, including lung, esophageal, colorectal, lymphoma, head and neck, and breast along with myocardial viability and pre-surgery evaluation of refractory seizures.

Source: CMS Joint Signature Memorandum dated June 16, 2003

[1] Medicare covers clinical evaluation of cognitive impairment, as recommended by the American Academy of Neurology. At present, the available scientific evidence indicates that clinical evaluation remains the most appropriate approach for diagnosis and management of Alzheimer's disease.

Expanded Coverage of Positron Emission Tomography Scans

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as 2-(F-18) fluoro-D-glucose (FDG), that are administered intravenously to the patient.

Medicare has expanded coverage for PET scans for fluoro-D-glucose (FDG) PET for thyroid cancer and perfusion of the heart using ammonia N-13. This expanded coverage is effective for claims with dates of service **on or after October 1, 2003.**

Thyroid Cancer

For services provided **on or after October 1, 2003,** Medicare covers the use of FDG PET for thyroid cancer only for restaging of recurrent or 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.

Limitations: All other uses of FDG PET in the diagnosis and treatment of thyroid cancer remain noncovered.

HCPCS Code

A new HCPCS code has been assigned to thyroid cancer management for services provided **on or after October 1, 2003**:

G0296 PET imaging, full and partial ring PET scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.

Perfusion of the Heart Using Ammonia N-13

Effective for service provided **on or after October 1, 2003,** PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical ammonia N-13 are covered, provided the following requirements are met.

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or
- The PET scan, whether at rest alone, or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. For the purposes of this requirement, an inconclusive test is a test, whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.

HCPCS Code

A new temporary HCPCS code has been assigned to identified ammonia N-13 tracer for services provided **on or after October 1, 2003**:

Q4078 Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, per dose.

Effective for service provided **on or after October 1, 2003,** only two tracers are covered for PET scans for the perfusion of the heart, for HCPCS code range G0030-G0047:

- Code Q3000, which identifies the tracer rubidium 82; and
- New code Q4078, which identifies the tracer ammonia N-13.

Claim Processing Requirements

Claims for PET scan services must be billed on Form CMS-1500, or electronic equivalent with the appropriate HCPCS and diagnosis codes. **The electronic equivalent formats other than the HIPAA format are effective through October 16, 2003. After October 16, 2003 the X12N 837 version 4010A1 is the only acceptable format.** The 837 versions 4010 and 4010A1 can be downloaded at *www.wpc-edi.com*. Reimbursement for the new HCPCS codes is based on the Medicare physician fee schedule methodology. The appropriate fees will be listed in the October 2003 release of the Medicare physician fee schedule database.

Source: CMS Transmittal AB-03-092, CR 2687

Payment Review for Portable X-Ray Transportation Services

In response to a number of inquiries from carriers and providers, CMS has developed the following clarifying instructions in order to implement CMS policy for the carrier pricing of HCPCS code R0070 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, per patient). These instructions are being published as part of CMS' clarifications.

As a carrier priced service, carriers must initially determine a payment rate for portable X-ray transportation services that is associated with the cost of providing the service. In order to determine an appropriate cost, the carrier should, at a minimum, cost out the vehicle, vehicle modifications, gasoline, and the staff time involved in only the transportation for a portable X-ray service. A review of the pricing of this service should be done every five years.

Direct costs related to the vehicle carrying the X-ray machine are fully allocable to determining the payment rate. This includes the cost of the vehicle using a recognized depreciation method, the salary and fringe benefits associated with the staff who drive the vehicle, the communication equipment used between the vehicle and the home office, the salary and fringe benefits of the staff who determine the vehicles route (this could be proportional of office staff), repairs and maintenance of the vehicle(s), insurance for the vehicle(s), operating expenses for the vehicle(s), and any other reasonable costs associated with this service as determined by the carrier. The carrier will have discretion for allocating indirect costs (those costs that cannot be directly attributed to portable X-ray transportation) between the transportation service and the technical component of the X-ray tests.

Suppliers may send carriers unsolicited cost information. The carrier may use this cost data as a comparison to its carrier priced determination. The data supplied should reflect a year's worth (either calendar or corporate fiscal) of information. Each provider who submits such data is to be informed that the data is subject to verification and will be used to supplement other information that is used to determine Medicare's payment rate.

Carriers are required to update the rate on an annual basis using independently determined measures of the cost of providing the service. A number of readily available measures (e.g., ambulance inflation factor, the Medicare economic index) that are used by the Medicare program to adjust payment rates for other types of services may be appropriate to use to update the rate for years that the carrier does not recalibrate the payment. Each carrier has the flexibility to identify the index it will use to update the rate. In addition, the carrier can consider locally identified factors that are measured independently of CMS as an adjunct to the annual adjustment.

FLORIDA ONLY

Positron Emission Tomography (PET) Scan Code G0125, G0125-TC—Important Information

Effective with the implementation of the 2003 Medicare Physician Fee Schedule Database (MPFSDB) in March 2003, the procedure status for the global and technical component of procedure code G0125 (PET imaging regional or whole body; single pulmonary nodule) was changed from A to C, which denotes that pricing is determined by the local carrier. The status code for the professional component (G0125-26) was not changed and remains A status.

Status Codes Defined

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.

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.

Pricing Has Been Established

We have established the following allowances for G0125 and G0125-TC, effective for claims processed on or after May 23, 2003:

Code/Mod	Loc 01/02	Loc 03	Loc 04
G0125	$2099.10	$2397.25	$2412.98
G0125-TC	$2024.88	$2215.98	$2332.20

What Providers Should Do

Claims processed March 10, 2003, through May 22, 2003, for services rendered March 1, 2003, and after, were developed for additional information. If you received one of these development letters, **it is not necessary to return it** to us. We have "turned off" the additional development requests. If you have already received denials for these services because we did not receive the additional information requested, **you do not have to appeal this decision**; we will automatically reprocess denied claims for these services.

For services rendered March 1, 2003, and after, processed March 10, 2003, through May 22, 2003, we developed to providers for additional information. If you received one of these development letters, **it is not necessary to return it** to us. We have "turned off" the additional development requests and processed the claim(s). If you received denials for these services because we did not receive the additional information requested, **you do not have to appeal this decision**; we will automatically reprocess denied claims for these services.

We apologize for any inconvenience this may have caused.

SURGERY

17304: Mohs Micrographic Surgery—Multiple Surgery Guidelines Revised

Several providers have expressed concerns regarding the application of multiple surgery guidelines to procedure code *17304 (Chemosurgery [Mohs micrographic technique], including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain [eg, hematoxylin and eosin, toluidine blue]; first stage, fresh tissue technique, up to 5 specimens.)* When the Centers for Medicare & Medicaid Services (CMS) implemented the 2003 Medicare Physician Fee Schedule Database (MPSFDB) in March, the multiple surgery tag was changed to subject this code to multiple surgery guidelines. CMS has reversed this decision; therefore, this code will no longer be subject to the multiple surgery rule. **This change is effective for services processed on or after July 7, 2003, retroactive for dates of service January 1, 2003 and after**.

You should continue to submit your claims as usual. We will perform automatic adjustments on claims that were underpaid as a result of multiple surgery reductions, beginning in July.

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OTHER SERVICES AND PROCEDURES

Coverage of Hyperbaric Oxygen 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 on 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 to 250.70
- 250.8 to 250.83
- 707.1 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 will be revised to reflect these changes in the near future.

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

HIPAA - The Health Insurance Portability and Accountability Act

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Are Small Providers Covered Entities under HIPAA?

As a health care provider, you have probably heard about HIPAA – the Health Insurance Portability and Accountability Act of 1996. HIPAA mandates new standards and procedures that promote standardization and efficiency in the health care industry. Today's health care industry relies more and more on advances in technology to help administer health care. Doctors, hospitals, clearinghouses, and health care vendors, such as billing services and software companies, use computers to conduct many of their health care transactions.

Congress passed HIPAA in response to the health care industry's increasing reliance on electronic transmission of health care data. The law will help streamline the administration of health care by requiring basic standards for conducting several transactions in electronic form, including processing claims and payments. It also governs disclosure of electronic patient protected health information and provides the minimum safeguards required to ensure the security of electronic health care information.

This document responds to many questions CMS has received from small providers – especially those small providers who currently do not conduct any of their health care transactions electronically. If you are a provider that conducts office operations manually, there are two important questions you should ask in order to determine if HIPAA applies to you:

Does your office conduct *all* of the following transactions on paper, by phone, or by fax (from a dedicated fax machine, as opposed to faxing from a computer)?

- Submitting claims or managed care encounter information
- Checking claim status inquiry and response
- Checking eligibility and receiving a response
- Checking referral certifications and authorizations
- Enrolling and disenrolling in a health plan
- Receiving health care payments and remittance advice
- Providing coordination of benefits

If your office does not conduct any of these standard transactions electronically and you do not have someone else conduct them electronically on your behalf – such as a clearinghouse or billing service – you are not a covered entity and HIPAA does not apply to you.

If you conduct any of these transactions electronically, you are a covered entity and you must comply with all HIPAA requirements, regardless of the size of your practice.

Do you bill Medicare and are you a small provider with fewer than 10 full-time equivalent employees?

Effective October 16, 2003, Medicare may not pay claims submitted on paper, with certain exceptions. One of the major exceptions is for claims submitted by "a small provider of services or supplier." **The term "small provider of services or supplier" is defined to mean:**

- a provider of services* with fewer than 25 full-time equivalent employees, and
- a physician, practitioner, facility, or supplier** (other than provider of services) with fewer than 10 full-time equivalent employees.

** The term "provider of services" is defined for Medicare by section 1861(u) of the Social Security Act to include seven specific types of institutional or special purpose providers. This term generally describes hospitals, nursing facilities, and other institutional providers that are paid through Medicare fiscal intermediaries (**Medicare Part A**).*

*** The terms found in the phrase "physician, practitioner, facility, or supplier" are used to describe entities that furnish Medicare services described in section 1861(s) of the Act, and are generally paid through Medicare carriers (**Medicare Part B**).*

If you do not meet the small provider exception, you are required to submit your Medicare claims electronically, effective October 16, 2003. Once you begin submitting your claims electronically to Medicare, your

answer to the first question above would be "no," and you would become a covered entity under HIPAA.

If you have additional questions about HIPAA, please visit the CMS Web site at *www.cms.hhs.gov/hipaa/hipaa2*. You will find a wealth of informative material developed specifically for the provider community. You may also call the CMS hotline at 1-866-282-0659 or email *askhipaa@cms.hhs.gov*.

Source: CMS Web site (*www.cms.hhs.gov/hipaa/hipaa2*)

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.*

Guidance on Compliance with HIPAA Transactions and Code Sets after the October 16, 2003, Implementation Deadline

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which included a series of "administrative simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003.

The law is clear: October 16, 2003, is the deadline for covered entities to comply with HIPAA's electronic transaction and code sets provisions. After that date, covered entities, including health plans, may not conduct noncompliant transactions. With the October deadline just ahead, HHS has received a number of inquiries expressing concern over the health care industry's state of readiness. In response, the Department believes it is particularly important to outline its approach to enforcement of HIPAA's electronic transactions and code sets provisions. The Department will continue to provide technical assistance and issue guidance on the transactions and code sets provisions and compliance therewith.

Enforcement Approach

The Secretary has made the Centers for Medicare & Medicaid Services (CMS) responsible for enforcing the electronic transactions and code sets provisions of the law.

CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA's electronic transactions and code sets provisions. When CMS receives a complaint about a covered entity, it will notify the entity in writing that a complaint has been filed. Following notification from CMS, the entity will have the opportunity to 1) demonstrate compliance, 2) document its good faith efforts to comply with the standards, and/or 3) submit a corrective action plan.

Demonstrating Compliance - Covered entities will be given an opportunity to demonstrate to CMS that they submitted compliant transactions.

Good Faith Policy - CMS's approach will utilize the flexibility granted in section 1176(b) of the Social Security Act to consider good faith efforts to comply when assessing individual complaints. Under section 1176(b), HHS may not impose a civil money penalty where the failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured with a 30-day period. HHS has the authority under the statute to extend the period within which a covered entity may cure the noncompliance "based on the nature and extent of the failure to comply."

CMS recognizes that transactions often require the participation of two covered entities and that noncompliance by one covered entity may put the second covered entity in a difficult position. Therefore, during the period immediately following the compliance date, CMS intends to look at both covered entities' good faith efforts to come into compliance with the standards in determining, on a case-by-case basis, whether reasonable cause for the noncompliance exists and, if so, the extent to which the time for curing the noncompliance should be extended.

CMS will not impose penalties on covered entities that deploy contingencies (in order to ensure the smooth flow of payments) if they have made reasonable and diligent efforts to become compliant and, in the case of health plans, to facilitate the compliance of their trading partners. Specifically, as long as a health plan can demonstrate to CMS its active outreach/testing efforts, it can continue processing payments to providers. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress.

Indications of good faith might include, for example, such factors as:

- Increased external testing with trading partners.
- Lack of availability of, or refusal by, the trading partner(s) prior to October 16, 2003 to test the transaction(s) with the covered entity whose compliance is at issue.
- In the case of a health plan, concerted efforts in advance of the October 16, 2003 and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider community.

While there are many examples of complaints that CMS may receive, the following is one example that illustrates how CMS expects the process to work.

> Example: A complaint is filed against an otherwise-compliant health plan that accepts and processes both compliant and noncompliant transactions while working to help its providers achieve compliance.

In this situation, CMS would 1) notify the plan of the complaint, 2) based on the plan's response to the notification, evaluate the plan's efforts to help its noncompliant providers come into compliance, and 3) if it determined that the plan had demonstrated good faith

and reasonable cause for its noncompliance, not impose a penalty for the period of time CMS determines is appropriate, based on the nature and extent of the failure to comply.

For example, CMS would examine whether the health plan undertook a course of outreach actions to its trading partners on awareness and testing, with particular focus on the actions that occurred prior to October 16. Similarly, health care providers should be able to demonstrate that they took actions to become compliant prior to October 16. If CMS determines that reasonable and diligent efforts have been made, the cure period for noncompliance would be extended at the discretion of the government. Furthermore, CMS will continue to monitor the covered entity to ensure that their sustained efforts bring progress towards compliance. If continued progress is not made, CMS will step up their enforcement efforts towards that covered entity.

Organizations that have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should be prepared to document them in the event of a complaint being filed. This flexibility will permit health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the transition to the standards, as well as on the availability and quality of patient care.

Corrective Action Plan (CAP) – After October 16, 2003, in addition to possible fines and penalties imposed, CMS will expect noncompliant covered entities to submit plans to achieve compliance in a manner and time acceptable to the Secretary. More detailed information on CAPs will be forthcoming.

Working Toward Compliance

In the few remaining months before the October 16 deadline, HHS encourages health plans and providers to intensify their efforts toward achieving transaction and code set compliance. In addition, HHS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Although transaction and code set compliance is a huge undertaking, the result will be greatly enhanced electronic communication throughout the health care community. Successful implementation will require the attention and cooperation of all health plans and clearinghouses, and of all providers that conduct electronic transactions. There is considerable industry support for transaction and code sets, and we all look forward to realizing the many advantages of its successful implementation.

Source: CMS Web site posting, July 24, 2003

Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") Business Associate Provisions

Medicare fee-for-service (FFS) contractors that perform health care activities involving the use of protected health information on behalf of the Medicare FFS health plan (i.e., claims processing functions) are business associates of the Medicare FFS health plan (the covered entity). By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity (45 CFR section 164.103).

Medicare contractors that perform health care activities involving the use of protected health information on behalf of the Medicare FFS health plan are not business associates of providers, physicians, suppliers, or other health plans. Likewise, providers, physicians, suppliers, or other health plans are not business associates of the Medicare contractor, unless the provider, physician, supplier, or other health plan is doing work on behalf of the Medicare contractor.

Questions have been raised about whether there is a business associate relationship between Medicare contractors and the trading partners that receive crossover claims data from them. Currently, Medicare FFS contractors execute trading partner agreements (TPAs) with a host of payers, including Medigap insurers, Medicare supplemental/employee retiree health plans, multiple employer welfare trusts, as well as state Medicaid Agencies, for the purpose of exchanging adjudicated Medicare claims for secondary liability determination by those partners. This exchange of data is commonly referred to as the "claims crossover process." For coordination of benefits (COB) purposes, Medicare contractors and trading partners are not business associates since neither entity is doing work on the other's behalf; therefore, the Medicare FFS contractors should not sign business associate agreements with supplemental insurers (trading partners). Further, the Standard TPA for eligibility file-based COB, which CMS will soon be issuing, is not a business associate agreement.

Business associate provisions developed by CMS in accordance with Privacy Rule sample language, including instructions for ensuring compliance, will be added to Medicare FFS contractors' existing contracts shortly, in accordance with 45 CFR section 164.504(e)(2)(ii)(D). Medicare FFS contractors will incorporate this language into their subcontracts, either on the next contract modification cycle or by April 14, 2004, whichever is the earlier date.

Source: CMS Transmittal AB-03-078, CR 2712

HIPAA-AS Transactions and Code Sets: Testing and Updates

The Health Insurance Portability and Accountability Act–Administrative Simplification (HIPAA-AS) requires each electronic submitter to submit all of their electronic claims, claim status inquiries, and eligibility inquiries in compliance with the X12N version 4010A1 requirements, by October 16, 2003. If you have successfully tested the 837-claim version 4010 with Medicare, you do **not** need to be retested on 4010A1.

Providers who use clearinghouses, billing services, or vendor software are urged to follow up with these associates to ensure they are testing with payers well in advance of the deadline. Our provider education Web sites (*www.connecticutmedicare.com* and *www.floridamedicare.com*.) have a list of electronic billing vendors who have passed testing with First Coast Service Options, Inc. (FCSO).

To schedule testing of the 4010A1 Inbound 837 Claim with Medicare, call:

1 (904) 791-0153 for Connecticut
1 (904) 791-6794 for Florida

HIPAA noncompliant (but previously approved version) submissions **will not be rejected prior to October 16, 2003,** regardless of whether the provider applied for an extension under the Administrative Simplification Compliance Act prior to October 16, 2002. Medicare will **not** charge for processing paper claims.

There is a host of Internet sites available to learn more about HIPAA-AS and to obtain up-to-date information. Please visit our provider education Web site for more information and links to other sites.

Important Information for Providers about HIPAA

The October 16, 2003, deadline for compliance with the HIPAA electronic transactions and code set standards is approaching quickly. Many providers are only now starting to think about what they need to do to become HIPAA compliant. Some consultants are suggesting that providers consider switching from electronic transmission to paper claims in order to avoid being a HIPAA covered entity. This advice is extremely shortsighted and not a good solution, especially for Medicare providers. Consider the following:

Requirement to Go to Electronic Claims

Effective October 16, 2003, Medicare will not accept paper claims. There will be exceptions for small providers and other *limited* situations. Regulations are expected soon.

Negative Fiscal Impact of Paper Claims

Processing paper claims takes longer than electronic claims. Faster payment can be made for electronic claims submitted to Medicare. Clean electronic claims can be paid 14 days after they are received, while clean paper claims cannot be paid before 28 days after receipt. In addition, processing paper claims has increased administrative, postage, and handling costs, for both Medicare *and* providers.

Changes to Business Processes

Switching from electronic transmission to paper claims would have numerous repercussions on the business processes of your office. Remember that HIPAA transactions include more than just claims submission. Providers often conduct eligibility queries, claim status queries, and referral transmission electronically. All of these would have to be done on paper to avoid being a HIPAA covered entity, ultimately leaving less time for patient care and more time devoted to administration. However, you could decide to do some paper transactions and some electronic transactions, but remember that the electronic transactions must be HIPAA compliant.

General HIPAA Information

What is HIPAA?

Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. Four main areas comprise administrative simplification:

1. Electronic Transactions and code sets
2. Unique Identifiers
3. Privacy
4. Security

What are the HIPAA transactions?

Electronic Transaction Standards have been developed for the following exchanges of information that providers conduct:

1. Health care claims or electronic encounter information
2. Health care payment and remittance advice
3. Health care claims status
4. Eligibility inquiry
5. Referral certification and authorization
6. Claims attachment (standards forthcoming)
7. First report of injury (standards forthcoming)

What is "electronic?"

The term "electronic" is used to describe moving health care data via the Internet, and extranet, leased lines, dial-up lines such as for "direct data entry" or DDE, private networks, points of service, and health care data that is physically moved from one location to another using magnetic tape, disk, or CD media. For example, if a provider transmits information electronically by transmitting claims, conducting claim status queries or referrals, they would be considered a covered entity under HIPAA.

A benefit to consider

HIPAA efficiencies include using the same format for all payers rather than separate formats for each payer, as is often done today.

HIPAA Deadlines

April 14, 2003 Privacy – all covered entities except small health plans.
April 16, 2003 Electronic Health Care Transactions and Code Sets – all covered entities must have started internal software and systems testing.
October 16, 2003 Electronic Health Care Transactions and Code Sets – all covered entities that filed for an extension and small health plans.
April 14, 2004 Privacy – small health plans.
April 21, 2005 Security – all covered entities except small health plans.
April 21, 2006 Security – small health plans.

Where to go for help:

CMS Web site: *http://www.cms.hhs.gov/hipaa/hipaa2*.
HIPAA hotline: 1-866-282-0659
AskHIPAA mailbox, send and email to *askhipaa@cms.hhs.gov/ocr/hipaa*.
For more information on privacy, visit *http://www.cms.hhs.gov/ocr/hipaa*.
For privacy questions, call 1-866-627-7748

Helpful HIPAA Resources

The following information was provided with the open letter to providers from CMS Director Scully that appears on the front cover of this issue.

www.cms.hhs.gov/medlearn

Register to be a Host Site for Satellite Broadcasts

www.cms.hhs.gov/hipaa/hipaa2

General HIPAA Information
Educational Materials
Frequently Asked Questions
HIPAA Administrative Simplification Information Series for Providers
Links to Additional HIPAA Web Pages

www.eventstreams.com/cms/tm_001

View HIPAA Educational Web cast
Topics:
HIPAA Basics
Provider Steps for Getting Paid Under HIPAA

askHIPAA@cms.hhs.gov

Request Answers to Your HIPAA Administrative Simplification Questions

1-866-282-0659

HIPAA Hotline Staff Will Answer Your HIPAA Administrative Simplification Questions or Direct You to the Appropriate Resources

Local Carriers and Fiscal Intermediaries

HIPAA Scheduling and Testing

Connecticut Part B	1-904-791-0153
Florida Part A	1-904-791-6865
Florida Part B	1-904-791-6794

HIPAA Resources *Updated 06/16/03*

CMS

Products / Resources

- **Web site – *http://www.cms.hhs.gov/hipaa/hipaa2/*** – Answers to Frequently Asked Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.
- **HIPAA Information Series for Providers – *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/*** This series of ten short papers gets straight to the point describing HIPAA, what it means to providers, and what is needed to prepare for the electronic transactions and code sets requirements for October 16, 2003. All ten papers are available on the Web site and most papers are now available in Spanish.
- **FREE CMS HIPAA Training Web cast – *http://www.eventstreams.com/cms/tm_001/*** – CMS' Southern Consortium has developed a series of HIPAA presentations. They are available for the public to view for free.
- **Conference for Employers** – Are you an employer in need of information on HIPAA? CMS Dallas and Atlanta offices are co–sponsoring this national conference with the Workgroup for Electronic Data Interchange (WEDI) and the Society for Human Resource Management (SHRM). For more information visit: ***http://www.wedi.org/public/articles/dis_viewArticle.cfm?ID=198.***
- **Video and CD–ROM** – Coming Soon! CMS' HIPAA 101 Video and CD–ROM are packed with tips for preparing your office for HIPAA. Stay tuned to our Web site for information.
- **FREE Listserves** – Both listserves are operated by the U.S. Department of Health & Human Services

  Regulations – *http://www.cms.hhs.gov/hipaa/hipaa2/regulations/lsnotify.asp* – Sign up to receive notification when proposed or final rules on HIPAA have been published in the Federal Register (The Federal Register is the place where the government, upon passing a law, tells the public how the law will be implemented).

  New!* Outreach – *http://list.nih.gov/archives/hipaa-outreach-l.html – Sign up here to receive free notices on HIPAA announcements, new tools and educational material, and related information.
- **Small Provider Checklist Tool** – Use this tool to help you determine first steps you should be taking to prepare for HIPAA: ***http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLst.pdf***. Also available in Spanish at ***http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLstEsp.pdf***.
- **White Papers**:

  Am I a Covered Entity Provider? ***http://www.wedi.org/snip/public/articles/coveredEntitiy.pdf***

  How HIPAA is Reshaping the Way We Do Business. ***http://www.wedi.org/snip/public/articles/centMedicarencaid.pdf***
- **Medicare Free / Low Cost Billing Software – *http://cms.hhs.gov/providers/edi/*** – If you bill Medicare, there is software available to you free or for a small charge. This software is designed only for Medicare claims. Check the above link for the appropriate contact in your state for more information.
- **CMS Medicaid HIPAA Web Address – *http://www.cms.hhs.gov/medicaid/hipaa/adminsim/***. Also, see ***http://www.cms.hhs.gov/medicaid/hipaa/adminsim/0203laconf/*** for presentations from the 2003 National Medicaid HIPAA and MMIS Conference held in New Orleans February 9–13.

Contact info for CMS

- **CMS E–Mail Box – *askhipaa@cms.hhs.gov***. Send HIPAA administrative simplification questions here.
- **CMS HIPAA Hotline – 1-866-282-0659** –This hotline has been established to help answer your HIPAA administrative simplification questions.

Other Resources

- **HHS' Office for Civil Rights (Privacy)– *http://www.hhs.gov/ocr/hipaa/*** – The U.S. Department of Health & Human Services' Office for Civil Rights oversees the privacy requirements.

  New! Interim final rule: Civil Money Penalties – *http://www.hhs.gov/ocr/moneypenalties.html*

  Model "Business Associate Agreement" at: ***http://www.hhs.gov/ocr/hipaa/contractprov.html***

  "Guidance Explaining Significant Aspects of the Privacy Rule" at: ***http://www.hhs.gov/ocr/hipaa/privacy.html***.

  Top 15 Privacy Concerns at: ***http://www.regreform.hhs.gov/HIPAAQUIZ_0204171/sld001.htm***

  Contact information

  OCRPrivacy@hhs.gov or

  Call **1–866–627–7748**
- **WEDI SNIP Web site – *http://www.wedi.org/snip/*** – WEDI is an organization working to foster widespread support for the adoption of electronic commerce within health care and SNIP is a collaborative health care industry–wide process resulting in the implementation of standards and furthering the development and implementation of future standards. This Web site contains various resources on HIPAA administrative simplification.

  Find out if your state has a local WEDI SNIP affiliate – Go to ***http://www.wedi.org/snip/public/articles/index%7E8.htm***

  A resource for information on health plan electronic transaction changes – Go to ***http://www.wedi.org/snip/CAQHIMPTOOLS/***

CMS Southern Consortium's FREE HIPAA Presentations

There is an informative series of HIPAA presentations that can be accessed via the Internet at no cost. To access these presentations, simply visit: *http://www.eventstreams.com/cms/tm_001/*

You can choose any of the following presentations:

1) HIPAA Message to Providers From the Southern Consortium Administrator (Coming Soon)
2) HIPAA Basics
3) Provider Steps to Getting Paid Under HIPAA
4) HIPAA Security (Coming Soon)

If you would like to have a standalone version of these presentations via a CD, please contact Dale Ivey at 1-404-562-7221 or *Divey@cms.hhs.gov*.

If you would like to access transcripts of the HIPAA Educational Audio Conferences that were held in partnership with the industry workgroups, WEDI and SHARP, they are available via *www.sharpworkgroup.com.*

- 3/19/03 "Software Requirements for the 837p" - Audience: Small Vendors
- 3/24/03 "How Will HIPAA Affect Your Group?" - Audience: Employer Groups, TPA, Plan Sponsors, and Plan Administrators
- 3/26/03 "HIPAA Privacy" - National OCR Audio Conference - Audience: All Covered Entities and Interested Stakeholders
- 3/31/03 "How to Get Paid Under HIPAA" - Audience: Nursing Homes, HHAs, and Hospice Organizations
- 4/02/03 "How to Get Paid Under HIPAA" - Audience: Physicians and their office staff
- 4/15/03 "How to Get Paid Under HIPAA" follow-up call. Audience: Physicians and their office staff
- 4/23/03 "HIPAA Security: The Final Rule" - Audience: All covered entities and interested stakeholders
- 4/30/03 "National CMS HIPAA Roundtable" - Focus: Administrative Simplification, specifically electronic transactions and code sets, and security - Audience: All covered entities and interested stakeholders
- 5/1/03 "HIPAA Refresher Series - HIPAA Basics" - Audience: Indian Health Service; all covered entities and interested stakeholders
- 5/7/03 "HIPAA Administrative Simplification" (Spanish) - Audience: All covered entities and interested stakeholders whose primary language is Spanish
- 5/8/03 "HIPAA Refresher Series: How to get paid" - Audience: Indian Health Service; all covered entities and interested stakeholders
- 5/14/03 "HIPAA Privacy and Security" (Spanish) - Audience: all covered entities and interested stakeholders whose primary language is Spanish
- 5/15/03 "HIPAA Refresher Series: HIPAA Security and Privacy" - Audience: Indian Health Service; all covered entities and interested stakeholders

The HIPAA Information Series for Providers is a series of ten short papers gets straight to the point describing HIPAA and what it means to providers. Papers are available in both English and Spanish at: *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/*.

FREE Listserves provide notices on HIPAA announcements, new tools and educational material, and related information.

- Regulations - *http://www.cms.hhs.gov/hipaa/hipaa2/regulations/Isnotify.asp*
- Outreach - *http://list.nih.gov/archives/hipaa-outreach-l.html*

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.*

Free CMS HIPAA Training

The CMS Southern Consortium's Achieving Compliance Together Team has developed a series of HIPAA presentations. They can be accessed via the Internet and there is no cost to you. To access these presentations, simply go to: *http://www.eventstreams.com/cms/tm_001/*. You can choose any of the following presentations:

1) HIPAA Message to Providers from the Southern Consortium Administrator (coming soon)
2) HIPAA Basics
3) Provider Steps to Getting Paid under HIPAA
4) HIPAA Security (coming soon)

Free Fax Back Service

The CMS Southern Consortium's Achieving Compliance Together Team has developed a HIPAA resource in an effort to reach those without Internet/email access! Have your fax number handy and call 1-800-874-5894.

Select Option 1 for the starter set: HIPAA information, resources, and transactions checklist, then follow the prompts. It's that easy! Other documents are also available (for example, information on Medicare's free billing software and a HIPAA glossary).

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HIPAA Information Series for Providers

To assist Medicare providers with being ready for this important initiative, the Centers for Medicare & Medicaid Services (CMS) has developed a series of user friendly documents to communicate to the health care community key concepts and requirements contained in HIPAA. This series of ten short papers gets straight to the point describing HIPAA-AS and what it means to providers, and what providers need to know to prepare for the electronic transactions and code sets requirements for October 16, 2003. Below is a synopsis of the *HIPAA Information Series for Providers* available at *www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/*:

1. **HIPAA 101** – Educate yourself and your staff on the basics of HIPAA law.
   Everyone covered by HIPAA will be required to provide the same information – standard formats for processing claims and payments, as well as for the maintenance and transmission of electronic health care information and data.
2. **Are You a Covered Entity?** – Determine whether you are a covered entity under HIPAA.
   HIPAA law affects many health care industries – health plans, clearinghouses, and health care service providers (including hospitals and doctors and the companies that furnish information technology products and services to them). HIPAA law and regulations apply to several different types of organizations commonly referred to as "covered entities."
3. **Key HIPAA Dates and Tips for Getting Ready** – Be aware of the HIPAA deadlines right around the corner and take steps to prepare for compliance.
   This series focuses in particular on HIPAA's electronic transactions and codes sets requirements and what providers need to know to prepare for them.
4. **What Electronic Transactions and Code Sets Are Standardized Under HIPAA?** – Review your business operations and the HIPAA Electronic Transactions & Code Sets.
   This paper discusses the various electronic transactions and code sets requirements and how they may be used in your office.
5. **Is Your Software Vendor or Billing Service Ready for HIPAA?** – Communicate with your vendors, billing services, and clearinghouses. Know what questions you should be asking them.
   This paper discusses the relationship between providers and vendors, billing services, and clearinghouses and the importance of two-way communication for HIPAA compliance.
6. **What to Expect from Your Health Plans** – Insure you have the necessary two-way communication with each of your health plans. This is essential for compliance.
   This paper discusses the provider/health plan relationship and the importance of on-going communication in the HIPAA implementation process.
7. **What you Need to Know About Testing** – Test your office operations and insure that those who electronically process claims on your behalf have a testing plan in place.
   The testing process is a critical aspect of HIPAA implementation. It is where trading partners find errors, omissions, and conflicts in their systems — and correct them before the actual standard transactions are used.
   Health plans, clearinghouses, and vendors should be in the testing stage of HIPAA implementation for October 16, 2003 compliance. This includes actively testing with their providers.
8. **Trading Partner Agreements** – Investigate and understand your trading partner agreements with your health plans. This paper focuses on the role of trading partner agreements in HIPAA implementation. TPA can provide valuable information about how electronic data interchange (EDI) will be conducted.
9. **Final Steps for Compliance with Electronic Transactions and Code Sets** – Take those final steps towards compliance and do not hesitate to get the help you need. This paper highlights the final steps for complying with the electronic transactions and code sets requirements.
10. **Enforcement** – Learn about CMS' enforcement approach. This paper describes CMS' role and approach to enforcing HIPAA's electronic transactions and codes sets requirements. CMS will be responsible for developing and enforcing the administrative simplification requirements of HIPAA with the exception of the privacy requirements, which are overseen and enforced by the Department of Health & Human Services' Office for Civil Rights (OCR).

HIPAA Information Series for Providers Now Available in Spanish

CMS' *HIPAA Information Series for Providers* series is also available in a Spanish-language version at *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserieesp/*.

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ELECTRONIC MEDIA CLAIMS

PC-ACE Pro32® May Be The Solution

PC-ACE Pro32® software is a comprehensive claims management system. The software has been tested and is approved for transmitting both Medicare A and Medicare B claims in the ANSI4010 A1 format.

You may want to consider PC-ACE Pro32® if you do not have HIPAA-compliant software, you need an alternative solution while your current software vendor is creating HIPAA-compliant software, or as part of your contingency plan.

PC-ACE Pro32® does not contain a communication software package. It does contain scripting for use with Procomm versions 4.6-4.8. The software also will not automatically post payments from your remittance, but does allow you to manually post payments.

Features include:

- Can be used in a stand-alone configuration or in conjunction with your existing claims management system utilizing the Import feature
- Comprehensive claims editing and validation, minimizing rejected claims
- Detailed claim import and edit validation error reporting
- Remittance retrieval
- Context-sensitive pop-up selection list speed claim entry and promote accuracy
- Integrated backup, restore, and file maintenance functions
- Technical support through direct customer service line and email

Production versions of the software are available via Internet download or CD-ROM. You can learn more about the software at *www.fcso.com*, select "Online Services;" there is a link to PC-ACE Pro32® under "Medicare Provider Services." If additional marketing information is needed, please contact 1-904-791-8767, option 1.

Ensuring Your PC-ACE Pro32® Software Is HIPAA Compliant for Medicare Part B

If you are using the PC-ACE Pro32® software to transmit your Medicare Part B claims, you are now required to prepare them in the ANSI 4010A1 format. Failure to use this format will cause you to receive a TA1 claims reject with error code R024.

If error code R024 is received, ensure you have the current version (version 1.56.0.300) of the software installed. Once the current version is installed, ensure the required field updates have been made (utilizing documentation provided with the software). Any claims that reject with error code R024 must be reactivated through the programs "List Claims" button. Once reactivated, utilize the "Process" and "Prepare" functions prior to selecting the Data Communications Function for transmission.

Note: Reactivation of the entire batch from the Transmission Log will cause your claims to continue to reject, as it will resend the file previously sent prior to the required fields being updated.

Transmissions successfully received by the Gateway may be identified by locating AK5*A and AK9*A on your 997 acknowledgement.

If you receive a message containing "No files queued," this means your file acknowledgement was not ready for you to retrieve (preparation sometimes takes longer during busy periods of file transmissions). You should confirm the acceptance or rejection of your transmissions using one of the following methods:

1. Wait at least 30 minutes and then select the "997 – 997 ANSI Initial Acknowledgement" option within your Data Communications Retrieve function. If the acknowledgement is now ready, this action will allow it to be retrieved.
   or,
2. **Connecticut** customers may contact the EDI Helpdesk (available Monday – Friday 8:30-4:30 except 1:20-3:30 on Thursday) for verbal confirmation at 1-904-905-8880; then select option 1 and option 3.
   Florida customers may contact the EDI Helpdesk IVR (available 24 hours a day) for automated verbal confirmations at 1-904-905-8880; then select option 1 and option 1 again.

Do not resend a transmission that receives the "No files queued" message until you have confirmed the status of your file.

If assistance is needed in obtaining the current version of the software, or with updating your program to produce the ANSI 4010A1 format, feel free to contact Technical Support at:

Connecticut - 1-203-639-3160, option 2; or email *CTEnrollment@fcso.com*.
Florida - 1-904-355-0313; or email *pcace@fcso.com.*

GENERAL INFORMATION

CMS Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare Program.
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions.
- Ensure that providers have time to react and prepare for new requirements.
- Announce new or changing Medicare requirements on a predictable schedule.
- Communicate the specific days that CMS business will be published in the *Federal Register*.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list at *http:list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1*.

The Quarterly Provider Update can be accessed at *http://www.cms.gov/providerupdate*.

We encourage you to bookmark this Web site and visit it often for this valuable information.

Source: CMS Transmittal AB-03-075, CR 2686

National Participating Physician Directory

The National Participating Physician Directory contains valuable information about Medicare participating physicians for the use of beneficiaries, their families, and their caregivers. In order to ensure that the Directory includes the most up-to-date information, practicing physicians should check the accuracy of their listings and use the feedback tool on our Web site to notify CMS about any information that is incorrect, has changed, or to advise us if you are not listed in the Directory.

Information Included in the Directory

The following information is available regarding Medicare participating physicians (those who have agreed to always accept assignment):

- Name and address (including a mapping feature)
- Medical specialty
- Business telephone number
- Medical school and year of graduation
- Board certification in a medical specialty
- Gender
- Hospital affiliation
- Foreign language
- Residency and internship program (coming soon)
- Sanctions against individual physicians (coming soon)
- Whether accepting new Medicare patients (coming soon)

How to Check Accuracy of Your Information

The accuracy of your listing can be checked by clicking on the “Participating Physician Directory” from the home page of *www.medicare.gov*. Our feedback tool is available to correct any information that is incorrect, has changed, or to advise us if you are not listed in the Directory. The Directory will be updated on a monthly basis. For additional information about the Directory, click on “Physician Note” at the bottom of the page. You may also link to the Directory from the CMS Web site at *www.cms.hhs.gov/physicians* (under “Participation”).

> **Note**: Only participating physicians who have agreed to accept assignment on all Medicare claims and covered services are included in the Directory. Assignment does not apply to Medicare managed care or private fee-for-service plans.

Source: CMS Notification Dated June 9, 2003

Remittance Advice Remark and Reason Code Update

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010 Implementation Guide (IG). Under the Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X12-recognized maintainers instead of proprietary codes to explain any adjustment in the payment. As a result, CMS received a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities. These additions and modifications may not impact Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. Contractors are notified of those new/modified codes in the corresponding implementation instructions in the form of a Program Memorandum (PM) or manual instruction implementing the policy change, in addition to the

regular code update PM. The code changes initiated by Medicare have been identified in this article, in accordance with PM AB-03-095, to single out codes implemented by contractors effective October 1, 2003.

In the current database, five new codes are duplicative, and will be deactivated in the next update. These duplicate codes are shown in this PM in italics, and do not need to be implemented. Use codes N157, N158, N159, N160, N161 in lieu of N164, N165, N166, N168, and N169. If a modification has been initiated by an entity other than Medicare for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare. If a new code is not initiated by Medicare, contractors do not have to use it unless otherwise instructed by Medicare. Contractors must stop using codes that have been retired on or before the date in the comment section if they are currently being used.

The list of remark codes is available at *http://www.cms.gov/providers/edi/hipaadoc.asp* and *http://www.wpc-edi.com/hipaa/*, and the list is updated each March, July, and November. The following list summarizes changes made through February 28, 2003.

New Remark Codes

Code	Current Narrative	Medicare Initiated
N157	Transportation to and from this destination is not covered.	YES
N158	Transportation in a vehicle other than an ambulance is not covered.	YES
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	YES
N160	The beneficiary/patient must choose an option before this procedure/equipment/supply/service can be covered.	YES
N161	This drug/service/supply is covered only when the associated service is covered.	YES
N162	This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.	YES
N163	Medical record does not support code billed per the code definition.	YES
N164	*Transportation to/from this destination is not covered.*	*YES*
N165	*Transportation in a vehicle other than an ambulance is not covered.*	*YES*
N166	*Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.*	*YES*
N167	Charges exceed the post-transplant coverage limit.	YES
N168	*The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/service.*	*YES*
N169	*This drug/service/supply is covered only when the associated service is covered.*	*YES*
N170	A new/revised/renewed certificate of medical necessity is needed.	YES
N171 price.	Payment for repair or replacement is not covered or has exceeded the purchase	YES
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.	YES
N173	No qualifying hospital stay dates were provided for this episode of care.	YES
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group “PR”.	YES
N175	Missing/incomplete/invalid Review Organization Approval.	YES
N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.	YES
N177	We did not send this claim to beneficiary’s other insurer. They have indicated no additional payment can be made.	YES
N178	Missing/invalid/incomplete pre-operative photos or visual field results.	YES

Code	Current Narrative	Medicare Initiated
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	
N180	This item or service does not meet the criteria for the category under which it was billed.	
N181	Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.	
N182	This claim/service must be billed according to the schedule for this plan.	
N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.	
N184	Rebill technical and professional components separately.	
N185	Do not resubmit this claim/service.	
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	
N187	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or lan benefit documents.	
N188	The approved level of care does not match the procedure code submitted.	
N189	This service has been paid as a one-time exception to the plan's benefit restrictions.	
N190	Missing/incomplete/invalid contract indicator.	
N191	The provider must update insurance information directly with payer.	
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	
N193	Specific federal/state/local program may cover this service through another payer.	
N194	Technical component not paid if provider does not own the equipment used.	
N195	The technical component must be billed separately.	
N196	Patient eligible to apply for other coverage which may be primary.	
N197	The subscriber must update insurance information directly with payer.	
N198	Rendering provider must be affiliated with the pay-to provider.	
N199	Additional payment approved based on payer-initiated review/audit.	
N200	The professional component must be billed separately.	
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M19	Missing/incomplete/invalid oxygen certification/re-certification.	(Modified 2/28/03)
M20	Missing/incomplete/invalid HCPCS.	(Modified 2/28/03)
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	(Modified 2/28/03)
M22	Missing/incomplete/invalid number of miles traveled.	(Modified 2/28/03)
M23	Invoice needed for the cost of the material or contrast agent.	
M24	Missing/incomplete/invalid number of doses per vial.	(Modified 2/28/03)
M29	Missing/incomplete/invalid operative report.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
M30	Missing/incomplete/invalid pathology report.	(Modified 2/28/03)
M31	Missing/incomplete/invalid radiology report.	(Modified 2/28/03)
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	(Modified 2/28/03)
M34	Claim lacks the CLIA certification number.	
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	(Modified 2/28/03)
M44	Missing/incomplete/invalid condition code.	(Modified 2/28/03)
M45	Missing/incomplete/invalid occurrence codes or dates.	(Modified 2/28/03)
M46	Missing/incomplete/invalid occurrence span code or dates.	(Modified 2/28/03)
M47	Missing/incomplete/invalid internal or document control number.	(Modified 2/28/03)
M49	Missing/incomplete/invalid value code(s) or amount(s).	(Modified 2/28/03)
M50	Missing/incomplete/invalid revenue code(s).	(Modified 2/28/03)
M51	Missing/incomplete/invalid procedure code(s) and/or rates.	(Modified 2/28/03)
M52	Missing/incomplete/invalid “from” date(s) of service.	(Modified 2/28/03)
M53	Missing/incomplete/invalid days or units of service.	(Modified 2/28/03)
M54	Missing/incomplete/invalid total charges.	(Modified 2/28/03)
M56	Missing/incomplete/invalid payer identifier.	(Modified 2/28/03)
M57	Missing/incomplete/invalid provider identifier.	(Modified 2/28/03)
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	(Modified 2/28/03)
M59	Missing/incomplete/invalid “to” date(s) of service.	(Modified 2/28/03)
M62	Missing/incomplete/invalid treatment authorization code.	(Modified 2/28/03)
M64	Missing/incomplete/invalid other diagnosis.	(Modified 2/28/03)
M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	(Modified 2/28/03)
M68	Missing/incomplete/invalid attending or referring physician identification.	(Modified 2/28/03)
M76	Missing/incomplete/invalid diagnosis or condition.	(Modified 2/28/03)
M77	Missing/incomplete/invalid place of service.	(Modified 2/28/03)
M78	Missing/incomplete/invalid HCPCS modifier.	(Modified 2/28/03)
M79	Missing/incomplete/invalid charge.	(Modified 2/28/03)
M81	Patient’s diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.	(Modified 2/28/02)
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	(Modified 2/28/03)
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	(Modified 2/28/03)
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	(Modified 2/28/03)
M119	Missing/incomplete/invalid National Drug Code (NDC).	(Modified 2/28/03)
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	(Modified 2/28/03)
M122	Missing/incomplete/invalid level of subluxation.	(Modified 2/28/03)
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
M124	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	(Modified 2/28/03)
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	(Modified 2/28/03)
M126	Missing/incomplete/invalid individual lab codes included in the test.	(Modified 2/28/03)
M127	Missing/incomplete/invalid patient medical record for this service.	(Modified 2/28/03)
M128	Missing/incomplete/invalid date of the patient's last physician visit.	(Modified 2/28/03)
M129	Missing/incomplete/invalid indicator of X-ray availability for review.	(Modified 2/28/03)
M130	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	(Modified 2/28/03)
M131	Missing/incomplete/invalid physician financial relationship form.	(Modified 2/28/03)
M132	Missing/incomplete/invalid pacemaker registration form.	(Modified 2/28/03)
M135	Missing/incomplete/invalid plan of treatment.	(Modified 2/28/03)
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	(Modified 2/28/03)
M141	Missing/incomplete/invalid physician certified plan of care.	(Modified 2/28/03)
M142	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.	(Modified 2/28/03)
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	(Modified 2/28/03)
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	(Modified 2/28/03)
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	(Modified 2/28/03)
MA30	Missing/incomplete/invalid type of bill.	(Modified 2/28/03)
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	(Modified 2/28/03)
MA32	Missing/incomplete/invalid number of covered days during the billing period.	(Modified 2/28/03)
MA33	Missing/incomplete/invalid noncovered days during the billing period.	(Modified 2/28/03)
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	(Modified 2/28/03)
MA35	Missing/incomplete/invalid number of lifetime reserve days.	(Modified 2/28/03)
MA36	Missing/incomplete/invalid patient name.	(Modified 2/28/03)
MA37	Missing/incomplete/invalid patient's address.	(Modified 2/28/03)
MA38	Missing/incomplete/invalid birth date.	(Modified 2/28/03)
MA39	Missing/incomplete/invalid gender.	(Modified 2/28/03)
MA40	Missing/incomplete/invalid admission date.	(Modified 2/28/03)
MA41	Missing/incomplete/invalid admission type.	(Modified 2/28/03)
MA42	Missing/incomplete/invalid admission source.	(Modified 2/28/03)
MA43	Missing/incomplete/invalid patient status.	(Modified 2/28/03)
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	(Modified 2/28/03)
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	(Modified 2/28/03)
MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	(Modified 2/28/03)
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
MA52	Missing/incomplete/invalid date.	(Modified 2/28/03)
MA58	Missing/incomplete/invalid release of information indicator.	(Modified 2/28/03)
MA60	Missing/incomplete/invalid patient relationship to insured.	(Modified 2/28/03)
MA61	Missing/incomplete/invalid social security number or health insurance claim number.	(Modified 2/28/03)
MA63	Missing/incomplete/invalid principal diagnosis.	(Modified 2/28/03)
MA65	Missing/incomplete/invalid admitting diagnosis.	(Modified 2/28/03)
MA66	Missing/incomplete/invalid principal procedure code or date.	(Modified 2/28/03)
MA69	Missing/incomplete/invalid remarks.	(Modified 2/28/03)
MA70	Missing/incomplete/invalid provider representative signature.	(Modified 2/28/03)
MA71	Missing/incomplete/invalid provider representative signature date.	(Modified 2/28/03)
MA75	Missing/incomplete/invalid patient or authorized representative signature.	(Modified 2/28/03)
MA76	Missing/incomplete/invalid provider identifier for HHA or hospice when physician is performing care plan oversight services.	(Modified 2/28/03)
MA81	Missing/incomplete/invalid provider/supplier signature.	(Modified 2/28/03)
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.	(Modified 2/28/03)
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	(Modified 2/28/03)
MA87	Missing/incomplete/invalid insured's name for the primary payer.	(Modified 2/28/03)
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	(Modified 2/28/03)
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.	(Modified 2/28/03)
MA90	Missing/incomplete/invalid employment status code for the primary insured.	(Modified 2/28/03)
MA92	Missing/incomplete/invalid primary insurance information.	(Modified 2/28/03)
MA95	De-activate and refer to M51.	(Modified 2/28/03)
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.	(Modified 2/28/03)
MA99	Missing/incomplete/invalid Medigap information.	(Modified 2/28/03)
MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.	(Modified 2/28/03)
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.	(Modified 2/28/03)
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	(Modified 2/28/03)
MA105	Missing/incomplete/invalid provider number for this place of service.	(Modified 2/28/03)
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	(Modified 2/28/03)
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	(Modified 2/28/03)
MA112	Missing/incomplete/invalid group practice information.	(Modified 2/28/03)
MA114	Missing/incomplete/invalid information on where the services were furnished.	(Modified 2/28/03)
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
MA120	Missing/incomplete/invalid CLIA certification number.	(Modified 2/28/03)
MA121	Missing/incomplete/invalid date the X-Ray was performed.	(Modified 2/28/03)
MA122	Missing/incomplete/invalid initial date actual treatment occurred.	(Modified 2/28/03)
MA128	Missing/incomplete/invalid six-digit FDA approved, identification number.	(Modified 2/28/03)
MA129	This provider was not certified for this procedure on this date of service.	(Modified 2/28/03)
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	(Modified 2/28/03)
N3	Missing/incomplete/invalid consent form.	(Modified 2/28/03)
N4	Missing/incomplete/invalid prior insurance carrier EOB.	(Modified 2/28/03)
N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	(Modified 2/28/03)
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	(Modified 2/28/03)
N26	Missing/incomplete/invalid itemized bill.	(Modified 2/28/03)
N27	Missing/incomplete/invalid treatment number.	(Modified 2/28/03)
N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	(Modified 2/28/03)
N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	(Modified 2/28/03)
N37	Missing/incomplete/invalid tooth number/letter.	(Modified 2/28/03)
N38	Missing/incomplete/invalid place of service.	(Modified 2/28/03)
N40	Missing/incomplete/invalid X-Ray.	(Modified 2/28/03)
N50	Missing/incomplete/invalid discharge information.	(Modified 2/28/03)
N53	Missing/incomplete/invalid point of pick-up address.	(Modified 2/28/03)
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	(Modified 2/28/03)
N57	Missing/incomplete/invalid prescribing/dispensed date.	(Modified 2/28/03)
N58	Missing/incomplete/invalid patient liability amount.	(Modified 2/28/03)
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	(Modified 2/28/03)
N66	Missing/incomplete/invalid documentation.	(Modified 2/28/03)
N70	Home health consolidated billing and payment applies.	(Modified 2/28/02)
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claim.	(Modified 2/28/03)
N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	(Modified 7/24/01, 2/28/03)
N75	Missing/incomplete/invalid tooth surface information.	(Modified 2/28/03)
N76	Missing/incomplete/invalid number of riders.	(Modified 2/28/03)
N77	Missing/incomplete/invalid designated provider number.	(Modified 2/28/03)
N80	Missing/incomplete/invalid prenatal screening information.	(Modified 2/28/03)
N95	This provider type/provider specialty may not bill this service.	(New code 7/31/01, Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
N103	Social Security records indicate that this beneficiary was a prisoner when the service was rendered. This payer does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	(New code 12/05/01 Modified 4/8/02, Modified 2/28/03)
N108	Missing/incomplete/invalid upgrade information.	(Modified 2/28/03)

Retired Remark Codes

Code	Current Narrative	Comment
M72	Did not enter full 8-digit date (MM/DD/CCYY).	(M72 will no longer be valid effective 10/16/03. Use MA52)
MA05	Incorrect admission date patient status or type of bill entry on claim.	(MA05 will no longer be valid effective 10/16/03. Use MA30 or MA40 or MA43.)
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	(MA98 will no longer be valid effective 10/16/03. Use MA 97)
N41	Authorization request denied.	(N41 will no longer be valid effective 10/16/03. Use Claim Adjustment Reason Code 39)
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	(N44 will no longer be valid effective 10/16/03. Use Claim Adjustment Reason Code 137)

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. An updated list is posted three times a year after each X12 trimester meeting at *http://www.wpcedi.com/hipaa/*. The committee did not approve any reason code change in February 2003. The current reason code set was installed April 1, 2003.

Source: CMS Transmittal AB-03-095, CR 2788

***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.*

Update of the Place of Service (POS) Code Set

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) will become effective October 16, 2003, for all covered entities. Medicare is a covered entity under HIPAA. The final rule, "Health Insurance Reform: Standards for Electronic Transactions," published in the August 17, 2000, *Federal Register,* adopts the standards to be used under HIPAA and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting health care claims electronically, and its implementation guide requires the use of POS codes from the National POS code set, currently maintained by CMS. As a covered entity, Medicare must use the POS codes from the National POS code set for processing its electronically submitted claims. Medicare must also recognize as valid POS codes from the POS code set when these codes appear on such a claim. In addition, Medicare will adjudicate paper claims with codes from the National POS code set the same as for electronic claims.

National POS Code Set

The following is the current National POS code set, with facility and nonfacility designations noted for Medicare payment for services on the Physician Fee Schedule:

POS Code/Name Description *= New code or code not previously implemented by Medicare	**Payment Rate** Facility = F Nonfacility = NF
01-02/Unassigned	—
03/School A facility whose primary purpose is education.	**NF**
04/Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	**NF**
***05/Indian Health Service Free-standing Facility** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
***06/Indian Health Service Provider-based Facility** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
***07/Tribal 638 Free-Standing Facility** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
***08/Tribal 638 Provider-Based Facility** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
09-10/Unassigned	—
11/Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	**NF**
12/Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	**NF**
***13/Assisted Living Facility** Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.	**NF**
***14/Group Home** Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.	**NF**
15/Mobile Unit A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	**NF**
16-19/Unassigned	—
20/Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	**NF**

POS Code/Name	Payment Rate
21/Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	**F**
22/Outpatient Hospital A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	**F**
23/Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	**F**
24/Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	**F (Note: paid at the non-facility rate for payable procedures not on the ASC list)**
25/Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.	**NF**
26/Military Treatment Facility A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	**F**
27-30/Unassigned	—
31/Skilled Nursing Facility A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	**F**
32/Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	**NF**
33/Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	**NF**
34/Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	**F**
35-40/Unassigned	—
41/Ambulance—Land A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.	**F**
42/Ambulance—Air or Water An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.	**F**
43-48/Unassigned	—
***49/Independent Clinic** A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	**NF**

POS Code/Name	Payment Rate
50/Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	**NF**
51/Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	**F**
52/Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	**F**
53/Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.	**F**
54/Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	**NF**
55/Residential Substance Abuse Treatment Facility A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	**F**
56/Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	**F**
***57/Non-residential Substance Abuse Treatment Facility** A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	**NF**
58-59/Unassigned	—
60/Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	**NF**
61/Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	**F**
62/Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	**NF**
63-64/Unassigned	—

POS Code/Name	Payment Rate
65/End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	**NF**
66-70/Unassigned	—
71/State or Local Public Health Clinic A facility maintained by either a state or local health department that provides ambulatory primary medical care under the general direction of a physician.	**NF**
72/Rural Health Clinic A certified facility that is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	**NF**
73-80/Unassigned	—
81/Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	**NF**
82-98/Unassigned	—
99/Other Place of Service Other place of service not identified above.	**NF**

Source: CMS Transmittal B-03-040, CR 2730

ACCOUNTING/FINANCIAL SERVICES

Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR) or the current value of funds rate (2 percent for calendar year 2003).

The Secretary of the Treasury has notified the Department of Health and Human Services that **effective April 28, 2003**, the PCR has been changed to **11.625 percent**. The notice of the PCR was published in the *Federal Register* dated April 28, 2003. Therefore, the PCR will remain in effect until a new rate change is published. Reaffirmed interest rates for prior periods are available at *http://cms.hhs.gov/manuals/pm_trans/AB03051.pdf*.

Source: CMS Transmittal AB-03-051, CR 2431

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CONNECTICUT ONLY

News from the Accounting Department

We have reorganized the Accounting department to allow handling of your inquiries in a more efficient and timely manner. **Effective June 18, 2003**, Accounting converted to a *written only* inquiry department.

What does this mean? It means our call center customer service representatives (CSRs) have expanded their roles to include responding to financial inquiries.

How Does This Affect Me?

You may now contact a CSR toll-free at 1-866-419-9455 with most of your financial inquiries. However, inquiry types identified below *must* be submitted in writing to the attention of the Accounting department.

- requests for copies of overpayment letters
- requests for the identity of patients included in an overpayment involving more than one claim.
- request to reissue a Medicare check that is too old to cash. The check must be returned with written request to Accounting.

Written inquiries involving any outstanding overpayments are considered a priority. Outstanding overpayments are those for which Medicare has issued an overpayment letter and remain unpaid. These requests along with a copy of the overpayment letter should be faxed to the attention of Accounting at 1-203-634-5493. Some examples of these inquiry types are:

- physician/supplier is requesting an overpayment be collected by offset
- requests for Extended Repayment Plans (ERP) to refund Medicare for an overpayment
- incorrect claims adjustments completed by Accounting specialist involving an overpayment request

All other written inquiries should be mailed to:

Attention: Accounting
First Coast Service Options, Inc.
Medicare Part B
P.O. Box 9000
Meriden, CT 06454-9000

How Does This Improve Service?

- You no longer have to dial a separate telephone number to reach the Accounting staff.
- Your issue will be addressed by the customer service call center without having to be transferred to Accounting.
- The Accounting staff will focus 100 percent of their efforts on working written requests, which in turn will improve timeliness for completing these requests.

How Can I Assist?

Please refer to the Second Quarter 2001 *Medicare B Update!* (pages 26-30) for information concerning the process for returning Medicare overpayments. You can access this publication on our provider education Web site at *www.connecticutmedicare.com*. Click on "Newsletters," and then select the Second Quarter 2001 *Medicare B Update!*

Home Health Consolidated Billing

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

In April 2001, CMS established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including Durable Medical Equipment Regional Carriers (DMERCs), will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Note that therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

A subsequent instruction, published July 2, 2002, established that updates of the HH consolidated billing code list would occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes). These temporary codes may describe services subject to consolidated billing in addition to the permanent list of HCPCS codes that is updated annually.

This is the third quarterly HH consolidated billing update for calendar year 2003. (The second update occurred in April 2003; there was no update in July 2003.) This update adds three non-routine supply codes to the list of codes subject to consolidated billing. It also removes two codes that are no longer valid for Medicare billing. The next update to the list of codes subject to consolidated billing will be the calendar year 2004 annual update.

The new codes to be added are:
K0614 chem/antiseptic solution, 8oz
K0620 tubular elastic dressing
K0621 gauze, non-impreg pack strip

The codes to be deleted are:
A4421 Ostomy Supply misc
97014 Electric stimulation therapy

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.

The complete list of codes subject to HH consolidated billing to the HH consolidated billing master code list available at *cms.hhs.gov/medlearn/refhha.asp*.

Source: CMS Transmittal AB-03-096, CR 2776

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MEDICARE SECONDARY PAYER (MSP)

Multiple Primary Payers on Part B Claims

When Medicare is the Secondary Payer Following *One* Primary Payer

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. Physicians and suppliers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at *http://hipaa.wpc-edi.com/HIPAA_40.asp*). Providers must follow model 1 in section 1.4.2.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Providers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837.

Primary Payer Paid Amount

For line level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837. For claim level information, physicians and suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount

For line level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837. For claim level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF)

For line level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero. For claim level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero.

When Medicare is the Secondary Payer Following *More Than One* Primary Payer

Submission of Hardcopy MSP Claims with Multiple Primary Payers

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500. Physicians and suppliers must attach the other payers' EOB, or remittance advice, to the claim when sending it to Medicare for processing.

Source: CMS Transmittal B-03-050, CR 2758

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PROVIDER ENROLLMENT

Provider Enrollment Information for the Railroad Medicare Carrier

The Provider Enrollment, Chain and Ownership System (PECOS) is CMS' new national database of Medicare provider, physician, and supplier enrollment information. Beginning October 6, 2003, carriers will use PECOS to collect and maintain the data submitted on Form CMS-855 enrollment application. The Railroad Medicare Carrier (RMC) will now obtain their enrollment information from this database.

As of October 6, 2003, you will no longer be required to submit an RMC application for enrollment/ changes. All enrollment information will be captured through your Medicare Part B enrollment process**.** You will still be required to submit your claims to the RMC. Make sure that prior to submitting your claims the provider/supplier information is the same as that used to submit claims to your Medicare carrier. New providers/ suppliers should obtain a Medicare Part B Provider Identification Number (PIN). This will give an assurance that you are enrolled at the Part B carrier.

New RMC provider/suppliers will be issued an RMC PIN once a claim has been submitted. Established and new Railroad Medicare providers/suppliers should use their RMC provider/supplier PIN when submitting claims to the RMC for railroad retirement beneficiaries.

Source: CMS Transmittal B-03-054, CR 2777

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

Quarterly Update for Skilled Nursing Facility (SNF) Consolidated Billing

Section 4432(b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit Medicare claims to the fiscal intermediary (FI) for all the Part A and Part B services that its residents receive during the course of a covered Part A stay except for a small number of excluded services. For beneficiaries in a Part B stay, only physical, occupational, and speech therapy services must be consolidated.

Effective March 1, 2003, the payment status on the Medicare Physician Fee Schedule Database for procedure code *92597 (Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech)*, changed from "Not valid for Medicare purposes" to "Active." Effective for services rendered on or after October 1, 2003, this procedure code is considered part of speech therapy services consolidated in either a Part A or Part B stay.

The list of codes billable to carriers is updated by CMS quarterly and may be found at *www.cms.hhs.gov/medlearn/snfcode.asp*.

Source: CMS Transmittal AB-03-094, CR 2781

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THE PATIENT FRIENDLY ADVISORY

New Medicare Limits on Therapy Services

The information on the following page was provided by the Centers for Medicare & Medicaid Services (CMS) on its beneficiary Web site, *www.medicare.gov*, to provide beneficiaries with details about the new limits on Medicare's coverage of physical therapy, speech-language pathology, and occupational therapy services. We encourage you to reproduce this information and share it with your patients.

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New Medicare Limits on Therapy Services

Starting on September 1, 2003, Medicare limits how much it covers for outpatient

- Physical Therapy (PT),
- Speech-Language Pathology (SLP), and
- Occupational Therapy (OT)

The limits are:

- $1,590 per year for PT and SLP combined, and
- $1,590 per year for OT

After you pay your $100 yearly Medicare Part B deductible, Medicare pays its share (80%) and you pay your share (20%) of the cost. **In 2003, the limits only apply to therapy services you get between September 1 and December 31, 2003**. This means that you can get the full amount of the annual limits for this four month period.

The limits generally don't apply to the therapy services you get at hospital outpatient departments. Medicare should continue to pay for therapy services if you get them in a hospital outpatient department unless you reside in a Medicare-certified bed in a skilled nursing facility (SNF).

The therapy limits apply to outpatient therapy you get

From:

- Doctors,
- Physical therapists,
- Occupational therapists,
- Speech-language pathologists,
- Nurse practitioners,
- Clinical nurse specialists, and
- Physician assistants.

At:

- Private practices of therapists, physicians and nonphysician practitioners,
- Outpatient rehabilitation facilities/rehabilitation agencies,
- Comprehensive outpatient rehabilitation facilities,
- SNF for outpatients or residents who aren't in Medicare-covered stays, and
- Home, from home health agencies for outpatients who aren't getting Medicare-covered home health care.

Example 1:

Mr. Jones has Medicare Part A and Part B. He has already paid his yearly Part B deductible ($100 in 2003). In September and October 2003, he got medically necessary PT and SLP at his therapists' private offices.

Mr. Jones' combined outpatient PT and SLP costs total $2,000.
The Medicare-approved limit is $1,590.
Medicare pays 80% of the $1,590 limit ($1,272).

- Mr. Jones pays 20% of the limit ($318) and the extra amount over the limit ($410).
- Mr. Jones pays a total of $728 for these services.

Medicare won't cover any more outpatient PT or SLP for Mr. Jones until 2004, unless he gets it at a hospital outpatient department.

Example 2:

Ms. Jackson gets outpatient OT, which costs $1,000.
The Medicare-approved limit is $1,590.

- Medicare pays 80% of the $1,000 cost ($800).
- Ms. Jackson pays 20% of the cost ($200).

If Ms. Jackson needs more OT in 2003, Medicare will cover 80% of up to $590 in additional OT costs (reaching the $1,590 limit). After she reaches the limit, she can choose to go to a hospital outpatient department to get therapy services. Ms. Jackson would still have to pay the copayment for these services.

Any outpatient PT, SLP, or OT received before September 1, 2003 doesn't count toward the outpatient therapy limit for 2003. In 2004, the limits will apply to therapy services for the whole calendar year.

Remember: In most cases, the therapy limits don't apply to outpatient therapy you get at hospital outpatient departments. However, the $1,590 limits do apply if you get therapy services at the hospital outpatient department if you are in the Medicare-certified part of a skilled nursing facility.

For more information, look at *www.medicare.gov* on the Web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Source: Publication No. CMS – 10988, June 2003

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 66
Hand Carried Ultrasound (Hand Held Ultrasound) 67
Investigational Device Exemption (IDE) Revised Requirements 67
Uterine Artery Embolization 68
J9217: Leuprolide Acetate (for Depot Suspension), 7.5 mg. 68

Comprehensive Data Analysis

88311, *88312-88314*: Additional Clarification 68

Local Medical Review Policy (New)

J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) 69
J1563: Intravenous Immune Globulin 69
55700: Biopsy of Prostate Using Image Guidance 69
61862: Deep Brain Stimulation 69
63650: Spinal Cord Stimulation 69
64400: Peripheral Nerve Blocks 69
72141: Magnetic Resonance Imaging (MRI) of the Spine 70
73218: Magnetic Resonance Imaging (MRI) of Upper Extremity 70
93925: Duplex Scan of Lower Extremity Arteries 70
93930: Duplex Scan of Upper Extremity Arteries or Arterial Bypass Grafts 70
93975: Duplex Scanning 70
93990: Duplex Scan of Hemodialysis Access 70

Local Medical Review Policy (Revised)

Additional Policies Affected by 2003 HCPCS and ICD-9-CM Updates 71
G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes 71
J9202: Luteinizing Hormone-Releasing Hormone Analogs for Treatment of Malignant Neoplasm of the Prostate 71
J9999: Antineoplastic Drugs 72
Q4053: Pegfilgrastim (Neulasta™)–formerly J3490 72
VISCO: Viscosupplementation Therapy for Knee (formerly J7317: Intra-articular Injections of Hyaluronates in the Knee Joints) 72
11600: Excision of Malignant Skin Lesions 72
20550: Trigger Point Injections (formerly *20551*) 72
27096: Sacroiliac Joint Injection (formerly *20550*) 72
61850: Implantation of Neurostimulator Electrodes (formerly Deep Brain Stimulation) 73
62263: Epidural 73
62311: Epidural/Intrathecal Infusions, Catheters and Pumps (formerly *62318*: Implanted Catheters/Pumps for Intrathecal Opioid Infusions) 73
64405: Greater Occipital Nerve Block/Neurolysis 73
64415: Sympathetic Blocks (formerly *64510*) 73
64420: Intercostal Nerve Blocks/Neurolysis 73
64470: Paravertebral Facet Joint Blocks (formerly *64475*) 73
64555: Implanted Peripheral/Sacral Electrical Nerve Stimulation (formerly Percutaneous Peripheral Electrical Nerve Stimulation) 73
64622: Paravertebral Facet Joint, Nerve Destruction by a Neurolytic Agent 74
65855: Laser Trabeculoplasty (formerly 96LMRP019EV1.0-Argon Laser Trabeculoplasty) 74
66761: Iridotomy by Laser Surgery (formerly 96LMRP019CV1.0-Iridotomy/ Iridectomy by Laser) 74
70544: Magnetic Resonance Angiography (MRA) 74
90801: Psychiatric Diagnostic Interview Examination; PSYCH/CHRONIC PAIN: Behavioral and Psychiatric/Psychological Assessment and Psychotherapy in the Management of Chronic Pain 74
92136: Optical Coherence Biometry 74
94004G V1.2: Treatment of Ulcers of the Feet 75
97001: Physical Medicine and Rehabilitation 75

Local Medical Review Policy (Retired)

Q0091: Pap Smears, Obtaining and Sending 75
11420: Treatment Benign Skin Lesions of the Feet 75
95LMRP013 V1.4: PRN Orders 75
99.11 V1.1: Dialysis Shunt Maintenance (Percutaneous and/or Open Surgical Procedures) 75

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 Ultrasound (Hand Held Ultrasound)

Medical equipment described as "hand carried ultrasound," "HCU," or "hand held ultrasound" ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only the probe itself is hand-held. Appropriate use of a specific ultrasound *CPT* code is not determined by the equipment used, but rather by the extent, quality, completeness, and documentation of the procedure.

Providers should only use a *CPT* code where they have performed the full extent, quality, completeness, and documentation necessary for use of that code. Studies that are significantly more limited in scope or quality, are less well-documented, or performed in any less comprehensive or less skilled manner than the full study described by an accepted *CPT* code should not be billed under traditional diagnostic ultrasound codes (*93303-93350, 93875-93990,* or *76506-76999*).

For example, an emergency room "quick look" ultrasound to briefly assess a chest for the presence of fluid, blood, pus, or a foreign body, should not be coded as *CPT 76604 (Ultrasound, chest, B-scan [includes mediastimum] and/or real time with image documentation)*, since it has not met the full extent quality, completeness, and documentation of that procedure. Instead, until more limited, specific codes are available, such a study is bundled into the reimbursement for the physical examination.

Consistent with this policy, *CPT 51798 (Measurement of post voiding residual urine and/or bladder capacity by ultrasound, non-imaging)* - formerly HCPCS G0050 - describes a limited, specific procedure, which may be performed by either comprehensive or more limited-capability ultrasounds. *CPT 51798* may be separately covered, as long as all of the criteria and documentation referenced in the code are fulfilled.

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Investigational Device Exemption (IDE) Revised Requirements

In an effort to decrease the administrative burden on providers wishing to apply for Medicare coverage of Category B investigational devices, we are reducing the documentation required to approve Investigational Device Exemption (IDE) requests.

Effective August 1, 2003, any provider participating in a clinical study involving a Food and Drug Administration (FDA) IDE who submits claims for these services must furnish only the following information *before claims are submitted*:

1. Provider name and provider number.
2. The number of cases the institution is planning to perform.
3. A narrative description of the device sufficient to make a payment determination (including planned diagnosis, procedure codes, and charges as relevant).
4. A statement indicating how the device is similar to and/or different from other comparable products.
5. A signed copy of the FDA approval letter demonstrating Category B, IDE status and approval from the FDA to the participating company or manufacturer (including the name and number of the device).
6. Submit the following planned billing information: *CPT* code(s) as applicable - if using an unlisted *CPT* code(s) to report the service performed, identify the expected charges.
7. *Attestation of having the following:*
   The manufacture's or primary investigator's letter containing the most current approved number of institutions and subjects, and the number of cases the institution is planning to perform.

All information specified above must be submitted to this contractor in the form of a letter. The required information should be received before claims may be submitted.

The following items must be *maintained by the provider and readily available upon request* if more information about the IDE is needed to evaluate for coverage:

1. The protocol for performing the procedure utilizing the Category B, IDE device and a summary of the results of patients who have undergone the procedure(s) described within the protocol.
2. The agreement between the company or manufacturer and the provider, furnishing the details of provider participation in the study.
3. At least two peer-reviewed publications (abstracts are not acceptable) addressing the topic of the study.
4. Any product literature illustrating the device and/or the procedure.
5. The protocol used for obtaining informed consent from beneficiaries for their participation in the study.
6. An institutional review board approval letter or a statement from the provider assuring that approval has been obtained from the study institution.
7. A signed copy of the FDA approval letter demonstrating Category B, IDE status and approval from the FDA to the participating company or manufacturer.
8. The manufacture's or primary investigator's approval letter containing the most current approved number of institutions and subjects, and the number of cases the institution is planning to perform.

When filing claims for the IDE and related services, use modifier "QA" should be used on all procedures for investigational devices and/or services. Enter the IDE number for claims related to investigational devices in Item 23 on Form CMS-1500.

Reimbursement for a device will be limited to what Medicare would have paid for a comparable approved device. Costs associated with the investigational protocol, which are for research purposes and are not reasonable and necessary for the management of the patient, are not covered by Medicare.

Should the protocol for this investigation be altered or should the sponsor lose its category B status or violates FDA requirements, please notify us in writing at:

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

Uterine Artery Embolization

Uterine artery embolization (UAE) is an existing technology that represents a fundamentally new approach to the treatment of symptomatic fibroid disease. Medicare considers UAE medically reasonable and necessary for the treatment of symptomatic uterine fibroids.

The UAE procedure is usually done in the hospital with an overnight stay post-procedure. Initially, a needle is used to enter the femoral artery to provide access for the catheter. The catheter is advanced over the branch of the aorta and into the uterine artery on the side opposite the puncture. An arteriogram is performed to provide a road map of the blood supply to the uterus and fibroids. After the arteriogram, particles of polyvinyl alcohol (PVA) are injected slowly with X-ray guidance. Because fibroids are very vascular, the particles flow to the fibroids first and wedge in the vessels. Over several minutes the arteries are slowly blocked and the embolization is continued until there is complete blockage of flow to the fibroids. After the embolization, another arteriogram is performed to confirm the completion of the procedure.

It would be expected that this procedure would be billed under *CPT* code *37204 (Transcatheter occlusion or embolization [eg, for tumor destruction, to achieve hemostatis, to occlude a vascular malformation], percutaneous, any method, non-central nervous system, non-head or neck).* Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.

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J9217: Leuprolide Acetate (for Depot Suspension), 7.5 mg.

Goserelin acetate (HCPCS code J9202) and leuprolide acetate (J9217) are synthetic luteinizing hormone-releasing hormone analogs indicated in the palliative treatment of advanced carcinoma of the prostate. Both offer an alternative treatment of prostatic cancer when orchiectomy or estrogen administration is either not indicated or unacceptable to the patient.

The local medical review policy (LMRP) (J9202 – Luteinizing Hormone-Releasing Hormone Analogs for Treatment of Malignant Neoplasm of the Prostate) currently in existence states that there is no demonstrable difference in clinical efficacy between goserelin acetate (J9202) and leuprolide acetate (J9217) in the treatment of malignant neoplasm of the prostate.

In order to be covered by Medicare, drugs and biologicals must be safe, effective, and medically reasonable and necessary. FDA approval determines safety and efficacy, but medical necessity is determined by the Carrier. Section 1862(a)(1)(A) of the Social Security Act states that Medicare excludes coverage for "items or services that are not reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The underlying issue in this statute, as it applies to this policy, is that if two services are clinically comparable, Medicare does not cover the additional expense of the more costly one, because this additional expense is not attributable to an item or service that is medically reasonable and necessary.

Therefore, Connecticut Medicare will make payment for the least costly medically appropriate alternative. When leuprolide depot is administered, payment for code J9217 (leuprolide, depot, 7.5 mg) will be based on the allowance for code J9202 (goserelin implant, 3.6 mg). When leuprolide is administered but is paid comparable to goserelin, if the beneficiary has signed a proper Advance Beneficiary Notice, the provider may collect from the beneficiary the difference between what would have been the allowed charge for the leuprolide and the allowed charge for the goserelin. HCPCS codes J9202 and J9217 are both subject to mandatory assignment for drugs and biologicals.

If there are medical indications requiring the use of leuprolide acetate instead of goserelin acetate, such as cachexia, infection, or allergy to goserlin acetate, Medicare will consider payment for the difference in cost if documentation of medical necessity accompanies the claim.

LMRP J9202 has been effective since 1998, and was most recently revised in January 2003 when it was reformatted. LMRP J9202 is based upon CMS Payment Policy, MCM Sections 2049, 2050.5D, and 7501.1. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

COMPREHENSIVE DATA ANALYSIS

88311, 88312-88314: Additional Clarification

Articles published in the Third Quarter 2003 and Third Quarter 2002 issues of the *Medicare B Update!* clarified the billing units for the pathology special staining procedures. However, the titles of these articles may appear misleading. *CPT* code *88311* refers to decalcification procedures performed on pathology specimens and not the special staining procedures. Although the articles discussed staining procedures and not decalcification procedures, both titles should have clearly indicated that *CPT 88312* through *88314* were the codes at issue. We apologize for any confusion this may have caused.

Local Medical Review Policy (New)

J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])

Darbepoetin alfa, produced under the name Aranesp®, is a modified form of recombinant human erythropoietin. This drug was approved by the Food and Drug Administration for the treatment of anemia associated with chronic renal failure and chemotherapy induced anemia associated with malignancy. To ensure access to care and to communicate the covered indications, local medical review policy has been developed.

This new LMRP is effective for claims processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

J1563: Intravenous Immune Globulin

Intravenous Immune Globulin (IVIG) is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens. According to data from July to December 2001, HCPCS code J1561 (Injection, immune globulin, intravenous, 500 mg) is aberrant with a carrier to nation ratio of allowed dollars of 1.76. HCPCS code J1563 (Injection, immune globulin, intravenous, 1g), although not aberrant at this time, is included in the policy since the coverage criteria are the same as for HCPCS code J1561. 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 IVIG.

This new LMRP is effective for claims processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

55700: Biopsy of Prostate Using Image Guidance

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 in order to make a definitive diagnosis of prostate cancer. Statistical medical data obtained for dates of service from January 1, 2002 to June 30, 2002, the use of *CPT* code *55700 (Biopsy, prostate, needle or punch, single or multiple, any approach)* was found to have an aberrancy ratio of 1.67 per 1000 enrollees. 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 a biopsy of prostate using image guidance (*CPT* codes *55700* and *76942*).

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

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61862: Deep Brain Stimulation

Deep brain stimulation (DBS) is a neurological procedure where electrical stimulation of deep brain structures takes place. Certain regions within the thalamus or the basal ganglia are the usual subcortical structures that are currently the therapeutic targets for DBS. Although DBS may be helpful in many clinical situations, a new local medical review policy (LMRP) has been developed, based on CMS Transmittal AB-03-003, CR 2553, to define the indications and limitations of coverage for DBS of the ventral intermediate nucleus (VIM) of the thalamus for intractable tremors of Parkinson's disease (332.0) and essential tremor (333.1).

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

63650: Spinal Cord Stimulation

Spinal cord stimulation blocks pain conduction, and may increase both endorphins and blood flow (through sympatholysis). The neurostimulator electrodes used for this purpose are placed into the epidural space either percutaneously or through a laminotomy.

A new local medical review policy (LMRP) has been developed, effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

64400: Peripheral Nerve Blocks

Peripheral nerves can be the cause of pain in a variety of conditions (e.g., post-herniorrrhaphy pain [ilioinguinal/iliohypograstric/genitofemoral], iliac crest harvest syndromes [supracluneal nerve, lateral femoral cutaneous nerve], carpal tunnel syndrome [median nerve], Morton's neuroma, facial pain, and headaches [trigeminal and occipital nerve]). When the patient's pain appears to be due to a classic mononeuritis but the neurodiagnostic studies have failed to provide a structural explanation, selective peripheral nerve blockade can usually clarify the situation. Peripheral nerve injuries/entrapment can lead to complex regional pain syndrome in certain patients. Selective peripheral nerve blockade may also be used diagnostically in those cases in which the clinical picture is unclear.

A new local medical review policy (LMRP) has been developed for peripheral nerve blocks, effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com.*

72141: Magnetic Resonance Imaging (MRI) of the Spine

MRI is used to diagnose a variety of central nervous system disorders. This local medical review policy (LMRP) was originally presented to the Carrier Advisory Committee on December 1, 2001, under policy number 2001.15. That draft was revised based on numerous comments received from providers.

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

73218: Magnetic Resonance Imaging (MRI) of Upper Extremity

MRI is a noninvasive imaging technique used for a variety of diagnostic visualizations. Unlike computed tomography (CT) scanning, MRI does not make use of ionizing radiation or require iodinated contrast material to distinguish normal from pathologic tissue. Rather, the process employs the magnetic properties of the hydrogen nucleus (proton) and its interaction with strong external magnetic fields and radio frequency signal, which is processed by a computer to produce an image.

MRI provides superior tissue contrast when compared to CT, is able to image in multiple planes, is not affected by bone artifact, provides vascular imaging capability, and makes use of safer contrast media. Its major disadvantages over CT include longer scanning times, which make MRI less useful in emergency evaluation. The use of MRI on certain soft tissue structures for the purpose of detecting disruptive, neoplastic, degenerative, or inflammatory lesions has now become established in medical practice.

A new local medical review policy (LMRP) has been developed to establish a list of appropriate indications and propose a diagnosis list for these services. This LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com.*

93925: Duplex Scan of Lower Extremity Arteries

Duplex scanning is a technique that combines the information provided by two-dimensional imaging with pulsed-wave Doppler techniques, which allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Local medical review policy (LMRP) has been developed to provide indications and limitations for duplex scanning of the lower extremity arteries.

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

93930: Duplex Scan of Upper Extremity Arteries or Arterial Bypass Grafts

Duplex scan describes an ultrasonic procedure for characterizing the pattern and direction of blood flow in arteries or veins with the production of real time images intergrading B-mode two-dimensional vascular studies with spectral and/or color flow Doppler mapping or imaging. This technique allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Local medical review policy (LMRP) has been developed to provide indications and limitations for duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study unilateral, or limited studies.

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

93975: Duplex Scanning

Duplex scanning is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging.

Local medical review policy has been developed to provide indications and limitations for; duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs, complete or limited study, and duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts, complete, unilateral or limited study.

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

93990: Duplex Scan of Hemodialysis Access

Duplex scanning is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging. This technique allows sampling of a particular imaged blood vessel with analysis of the blood flow velocity.

Local medical review policy (LMRP) is being developed to provide indications and limitations for the evaluation of endogenous arteriovenous fistulae and synthetic polytetrafluoroethylene (PTFE) grafts, which are the two principal means of creating permanent vascular access for hemodialysis, using duplex scanning.

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

LOCAL MEDICAL REVIEW POLICY (REVISED)

Additional Policies Affected by 2003 HCPCS and ICD-9-CM Updates

The following local medical review policies (LMRPs) have been updated to conform to the HCPCS and ICD-9-CM changes through January 1, 2003:

Policy Number	Policy Name
71010	Radiologic Examination of the Chest
94004A V1.2	Coverage for Services for Trimming, Reduction of Non-dystrophic and Dystrophic Toenails, Reduction of Corns and Calluses of the Feet.
94LMRP005 V1.0-90802	Special Clinical Psychiatric Diagnostic or Evaluative Procedures
94LMRP005 V1.0-90845	Medical Psychoanalysis
94LMRP005 V1.0-90865	Narcosynthesis
94LMRP005 V1.0-90870	Electroconvulsive therapy
94LMRP005 V1.0-90880	Medical Hypnotherapy
94LMRP005 V1.0-90887	Care Givers Education for Psychiatric Patients
94LMRP005 V1.0-90889	Report Preparation
94LMRP005 – 96100	Psychological Exam
95LMRP005 V1.0-96105	Neuropsychological Exam
95LMRP010-V1.0-97010	Physical Medicine Therapy for Chronic Pain
95LMRP010 V1.0	Electrical Neurostimulation

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

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

The local medical review policy (LMRP) for peripheral neuropathy with LOPS in people with diabetes was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 35-36). Effective for services rendered on or after March 1, 2003, a revision has been made to the "*CPT*/HCPCS Codes" section of the LMRP. The descriptor for procedure code G0247 has been changed. The new descriptor reads:

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:

(1) local care of superficial (i.e., wounds superficial to fascia and muscle) wounds,
(2) debridement of corns and calluses, and
(3) trimming and debridement of nails.

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

Source: CMS Transmittal AB-03-070, CR 2734

J9202: Luteinizing Hormone-Releasing Hormone Analogs for Treatment of Malignant Neoplasm of the Prostate

The local medical review policy (LMRP) for luteinizing hormone-releasing hormone analogs for treatment of malignant neoplasm of the prostate was published in the February 1998 *Medicare Provider News* (pages 31-33). Since that time, information has been added to the Utilization Guidelines section of the policy.

The revised local medical review policy (LMRP) is effective for services processed on or after June 2, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

J9999: Antineoplastic Drugs

The local medical review policy (LMRP) for antineoplastic drugs has been revised. The following chemotherapy agents have been added:

Fulvestrant (Faslodex®) J9999

Fulvestrant is an estrogen receptor antagonist without known agonist effects. The Food and Drug Administration (FDA) approved Fulvestrant for the treatment of hormone receptor positive metastatic breast cancer in postmenopausal women with disease progression following antiestrogen therapy.

Oxaliplatin (Eloxatin™) J9999

Oxaliplatin is a chemotherapeutic agent. The FDA approved Oxaliplatin for injection with infusional 5-Fluorouracil/Leucovorin (5FU/LV) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during or within 6 months of completion of first line therapy with the combination of bolus 5-FU/LV and Irinotecan.

Floxuridine (FUDR) J9200

Floxuridine (FUDR) is an antimetabolite of the pyrimidine analog type. The monophosphate of the drug, 5-fluoro-2'-deoxyuridine-5'-phosphate (FUDR-MP), inhibits thymidylate synthetase, thus inhibiting methylation of deoxyuridylic acid to thymidylic acid, thereby, interfering with the synthesis of DNA. Floxuridine, given by continuous intra-arterial infusion, is FDA approved for the palliative management of colorectal carcinoma metastatic to the liver that has not responded to other treatment. Intra-arterial Floxuridine is also indicated for the palliative treatment of primary and secondary carcinomas of the liver.

These revisions are effective for claims 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.

Q4053: Pegfilgrastim (Neulasta™)– formerly J3490

Notification of the local medical review policy (LMRP) for Pegfilgrastim (Neulasta™) was published in the Third Quarter 2003 *Medicare B Update!* (page 69). Since that time, the policy has been revised based on CMS Program Memorandum B-03-048 (CR 2798) dated June 20, 2003. The HCPCS code for Pegfilgrastim has been changed to Q4053 (Injection, Pegfilgrastim, 1 mg); the policy number has been changed to reflect the new code. In addition, the "*CPT*/HCPCS Section and Benefit Category" been changes to Drugs and Biologicals.

This revision is effective for dates of service on or after July 1, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

VISCO: Viscosupplementation Therapy for Knee (formerly J7317: Intra-articular Injections of Hyaluronates in the Knee Joints)

Viscosupplementation therapy includes *CPT*/HCPCS codes J7317, J7320, and *20610*. Sodium hyaluronate and Hylan G-F 20 are purified natural hyaluronates, which have been approved by the FDA for the treatment of osteoarthritis of the knee joints in patients who have failed to respond, or who have had inadequate responses to other treatments.

Major revisions have been made to the local medical review policy (LMRP) to further define the indications and limitations of coverage and/or medical necessity, to clarify appropriate ICD-9-CM codes to use when billing these drugs, and to provide access to care. In addition, the policy number and title have been changed.

The revised LMRP 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.

11600: Excision of Malignant Skin Lesions

The local medical review policy (LMRP) for excision of malignant skin lesions has been revised. Additional ICD-9-CM diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

This revision is effective for services processed on or after August 19, 2003. The full-text LMRP will be available on the provider education Web site *www.connecticutmedicare.com* on or after that date.

20550: Trigger Point Injections (formerly *20551*)

The local medical review policy (LMRP) for Trigger Point Injections has been revised to incorporate current standards for pain management treatments and update policy format. Revisions also include a change in the policy number to *20550*.

These revisions are 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.

27096: Sacroiliac Joint Injection (formerly *20550*)

The local medical review policy (LMRP) for sacroiliac joint injection has been revised to incorporate current standards for pain management treatments and to update policy format. Revisions also include a change in the policy number from *20550* to *27096*.

The revised LMRP 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.

61850: Implantation of Neurostimulator Electrodes (formerly Deep Brain Stimulation)

The local medical review policy for *CPT* code *61850* has been revised. The title of the policy has been changed because a new policy was developed specifically for deep brain stimulation (code *61862*).

This revision is effective for services processed on or after May 12, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

62263: Epidural

The local medical review policy (LMRP) for epidural has been revised to incorporate current standards for pain management treatments and update policy format.

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.

62311: Epidural/Intrathecal Infusions, Catheters and Pumps (formerly *62318*: Implanted Catheters/Pumps for Intrathecal Opioid Infusions)

The local medical review policy (LMRP) for implanted catheters/pumps for intrathecal opioid infusions has been revised to incorporate current standards for pain management treatments and to update policy format. Revisions also include a change in the policy number and title.

The revised LMRP 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.

64405: Greater Occipital Nerve Block/Neurolysis

The local medical review policy (LMRP) for greater occipital nerve block has been revised. Changes include:

- Revision of LMRP description,
- Revision of LMRP title,
- Clarification of indications and limitations, and
- Addition of coding guidelines.

These revisions are 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.

64415: Sympathetic Blocks (formerly *64510*)

The local medical review policy (LMRP) for sympathetic blocks has been revised to incorporate current standards for pain management treatments and to update policy format. Revisions also include a change in the policy number to *64415*.

The revised (LMRP) 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.

64420: Intercostal Nerve Blocks/ Neurolysis

The local medical review policy (LMRP) for Intercostal Nerve Blocks/Neurolysis has been revised to incorporate current standards for pain management treatments and to update policy format.

The revised LMRP 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.

64470: Paravertebral Facet Joint Blocks (formerly *64475*)

The local medical review policy (LMRP) for paravertebral facet joint blocks has been revised to incorporate current standards for pain management treatments and update policy format. Revisions also include a change in the policy number from *64475* to *64470*.

This local medical review policy (LMRP) 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.

64555: Implanted Peripheral/Sacral Electrical Nerve Stimulation (formerly Percutaneous Peripheral Electrical Nerve Stimulation)

The local medical review policy (LMRP) for percutaneous peripheral electrical nerve stimulation has been revised to incorporate current standards for pain management treatments and update policy format. Revisions also include a change in the policy name.

The revised LMRP 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.

64622: Paravertebral Facet Joint, Nerve Destruction by a Neurolytic Agent

The local medical review policy (LMRP) for paravertebral facet joint, nerve destruction by a neurolytic agent has been revised to incorporate current standards for pain management treatments and to update policy format.

The revised LMRP 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.

65855: Laser Trabeculoplasty (formerly 96LMRP019EV1.0-Argon Laser Trabeculoplasty)

The local medical review policy (LMRP) for argon laser trabeculoplasty has been updated. Changes include:

- Revision of LMRP title
- Revision of LMRP number
- Expansion of LMRP description
- Clarification of indications and limitations, coding guidelines, and documentation requirements
- Additional ICD-9-CM codes that support medical necessity were added

This revised LMRP is effective for services processed on or after July 21, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com.*

66761: Iridotomy by Laser Surgery (formerly 96LMRP019CV1.0-Iridotomy/Iridectomy by Laser)

The local medical review policy (LMRP) for iridotomy/iridectomy by laser has been updated. Changes include:

- Revision of LMRP title
- Revision of LMRP number
- Expansion of LMRP description
- Clarification of indications and limitations, and coding guidelines
- Additional ICD-9-CM codes that support medical necessity were added

This revised LMRP is effective for services processed on or after July 21, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com.*

70544: Magnetic Resonance Angiography (MRA)

The local medical review policy (LMRP) for Magnetic Resonance Angiography (MRA) - policy number 97030V11 - was published in the *Medicare Provider News,* No. 40, August 1999 (pages 68-71). Since that time, additional indications and ICD-9-CM codes have been added for procedure code *74185*. In addition, the policy name and number have been changed to reflect the *CPT* code for this procedure.

This LMRP revision is effective for services processed on or after June 9, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com.*

90801: Psychiatric Diagnostic Interview Examination; PSYCH/CHRONIC PAIN: Behavioral and Psychiatric/Psychological Assessment and Psychotherapy in the Management of Chronic Pain

The local medical review policy (LMRP) for psychiatric diagnostic interview examination was published in the July 1995 *Medicare News* special edition. The LMRP for behavioral and psychiatric/ psychological assessment and psychotherapy in the management of chronic pain was published in the April 1998 *Medicare News.* Effective for services rendered on or after March 1, 2003 these policies have been revised to reflect the addition of psychiatric diagnostic interview examination (*90801*) as a Medicare telehealth service with modifier GT.

The full-text of these revised LMRPs may be found on the provider education Web site *www.connecticutmedicare.co*m.

Source: CMS Transmittal AB-03-070, CR 2734

92136: Optical Coherence Biometry

The local medical review policy (LMRP) for optical coherence biometry has been revised, per CMS transmittal B-03-001, dated January 17, 2003, which indicates coding guidelines for this service.

This revision is effective for services processed on or after March 1, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com.*

94004G V1.2: Treatment of Ulcers of the Feet

This local medical review policy (LMRP) for treatment of ulcers of the feet was published in the February 1998 *Medicare Provider News*. The policy has been revised to include an additional indication: ICD-9-CM diagnosis code 707.14 (Ulcer of heel and midfoot) has been added under the "ICD-9-CM Codes that Support Medical necessity" section of the policy.

The revised LMRP is effective for services processed on or after May 27, 2003. The full-text LMRP is available on the provider education Web site *www.connecticutmedicare.com*.

97001: Physical Medicine and Rehabilitation

Physical medicine and rehabilitation (PM&R) services are designed to improve or restore physical functioning following disease, injury, or loss of a body part. These services utilize the therapeutic properties of exercise, heat, cold, electricity, ultraviolet, ultrasound, hydrotherapy, massage, and manual therapy to improve circulation, strengthen muscles, maintain or restore motion, and train or retrain an individual to perform the activities of daily living.

Using statistical medical data analysis, several codes in the local medical review policy (LMRP) for PM&R services were found to have aberrancies between 1.63 and 3.96 for services rendered from January 1, 2002 through June 30, 2002. Due to these findings, the LMRP has been revised to define the indications and limitations of coverage, define the specific procedures and modality guidelines, and clarify the appropriate use of the PM&R codes.

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.

Local Medical Review Policy (Retired)

Q0091: Pap Smears, Obtaining and Sending

Effective for services processed on or after June 2, 2003, the local medical review policy (LMRP) for Pap smears, obtaining and sending is retired.

Indications and limitations for this service may be found in policy *88141*: Pap Smears Laboratory Testing. The full text of this LMRP may be found on the provider education Web site *www.connecticutmedicare.com*.

11420: Treatment Benign Skin Lesions of the Feet

It has been determined that the local medical review policy (LMRP) for treatment benign skin lesions of the feet is no longer relevant, based on the descriptions for *CPT* codes *11420–11426*. Therefore, this LMRP is retired, effective for services processed on or after July 21, 2003.

95LMRP013 V1.4: PRN Orders

The local medical review policy (LMRP) for PRN Orders is retired, effective for services rendered on or after June 2, 2003. It has been determined that the indications and limitations of coverage in this LMRP are no longer relevant based on local standards of care.

99.11 V1.1: Dialysis Shunt Maintenance (Percutaneous and/or Open Surgical Procedures)

It has been determined that the local medical review policy (LMRP) for Dialysis Shunt Maintenance (Percutaneous and/or Open Surgical Procedures) is no longer relevant based on local medical practice patterns. Therefore, this LMRP is retired, effective for services processed on or after July 28, 2003.

CONNECTICUT EDUCATIONAL RESOURCES

Claim Submission Tips

Avoid unprocessable claims. Get your claims processed faster!

Connecticut Medicare Education and Outreach offers the following tips to help you avoid claim denials:

Ambulance	Origin and destination modifiers - Paper claims: Submit *appropriate* two-digit modifier in Item 24d in the first modifier field immediately following the procedure code with no spaces - Refer to *Medicare B Update! Special Issue October 2002 "Conversion to Medicare's Multi-Carrier System"* for further EMC filing guidelines
Anesthesia units	Must be billed in minutes in Item 24g Medicare Remittance Notice will show units (not minutes) - 15 minutes = 1 unit
Dates of service format	Paper claims: - Item 24a ("from" and "to" date of service) must be reported as one continuous number (MMDDYYYY) without any spaces or slashes between month, day, and year - If an 8-digit date is used, an 8-digit date must be used for all completed items - If a 6-digit date is used, a 6-digit date must be used for all completed items Electronic claims: - All electronic claims must use an 8-digit date (YYYYMMDD)
Diagnosis codes	Make sure you apply the diagnosis code with the appropriate 4th or 5th digit level of specificity (e.g., 123.4 or 123.45) to describe the medical necessity Link one of the four diagnosis codes listed in Item 21 on the claim form as the primary diagnosis that creates the medical necessity of the service listed on the detail line (Item 24e) Be aware of applicable local medical review policy and national coverage determinations for appropriate, specific procedure-to-diagnosis code relationships
Duplicate claims	Use the IVR system (toll-free at 1-866-419-9455) to check the status of your claim before resubmitting
Flu roster billing	Each claims limits number of beneficiaries to "100" for each roster billing claim form
Fragmented billing	List all services provided on same date of service on one claim or claims will take longer to process
Group/Clinic Numbers.	Identify your group/clinic number MUST be reported in Item 33 of Form CMS-1500 This number begins with a "C" and may be found on your Medicare Remittance Notice (e.g., C12345)
Health Insurance Claim Number (HIC) example: 12345678A	Identify correct Medicare number, including the correct alpha suffix (found on the patient's red, white, and blue Medicare card)
Medicare Providers	Medicare will only reimburse claims to providers actively enrolled in the Medicare program and have received their Medicare provider identification number with the Connecticut carrier Providers moving from another state must obtain carrier enrollment for each state they will provide services Providers that are not enrolled in the Medicare program cannot bill Medicare to obtain a Medicare denial in order to bill a secondary insurance

Medigap ID numbers	Must use carrier-assigned 5-digit Medigap insurer number found on the *www.connecticutmedicare.com* under Crossover link
Modifier 59	Used to indicate that a procedure was distinct or independent from other services performed on the same day and not normally reported together by the same physician - Different session or patient encounter - Different procedure or surgery - Different site or organ system - Separate incision, excision, lesion, or injury Used to separate procedures bundled under Correct Coding Initiative and neither procedure was performed as a component of the other May also be used for Clinical Laboratory Services National Coverage Determinations to specify different site or organ, etc. - Used to report instances when distinct and separate multiple services are provided to a patient on a single date of service - Performing the same procedure such as procedures (which use the same code) for a different specimen
Modifier 91	Use modifier 91 when billing repetitive laboratory services (not 76)
Modifiers	Identify the proper use of all modifiers Modifiers are added or deleted annually Identify that modifier is still in use Determine if modifier needs to be placed in the first or second position modifier field on the claim form
Other Insurance	Send only Medicare claims to First Coast Service Options, Inc.
Place of service codes (POS)	POS 21 Inpatient and POS 22 Outpatient: - Claims for lab services provided in place of service 21 and 22 must have modifier 26 in the *first* modifier position
Provider Identification Number (PIN)	Identify valid PIN for each performing provider Match PIN for performing provider Item 24k with group number on claim Item 33 Electronic claims must be batched according to group number and those performing providers actively enrolled in the group
Referring UPIN	Place the referring UPIN in Item 17 and the *full name* of the referring physician in Item 17a
Routine Venipuncture for Collection of Specimen (G0001)	*Do not* use Modifier 90 (Reference Outside Laboratory) - used when laboratory procedures are performed by a provider other than the treating or reporting provider)
Surrogate UPIN	MUST include the surrogate UPIN *and* name of the surrogate provider on claim form

Source: Connecticut Medicare Education and Outreach

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 78
Hand Carried Ultrasound (Hand Held Ultrasound) 79
Investigational Device Exemption (IDE) Revised Requirements 79
Uterine Artery Embolization 80
J9217: Leuprolide Acetate (for Depot Suspension), 7.5 mg. 80
78460, *78461*, *78464*, *78465*: Myocardial Perfusion Imaging 81
85651, *85652:* Sedimentation Rates 81
93224-93227, *93230-93237*: Event Recording/24-Hour ECG Monitoring 81
93880, *93882*: Duplex Scans, Extracranial 81

Comprehensive Data Analysis

88311, *88312-88314*: Additional Clarification 81
Inappropriate Billing of Lacrimal Duct Procedures Discovered Through Data Analysis 82
Skilled Nursing Facility Admissions by Advanced Registered Nurse Practitioners and Physician Assistants 83

Local Medical Review Policy (New)

J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) 83
J1955: Levocarnitine (Carnitor®, L-carnitine®) 83
11730: Surgical Treatment of Ingrown Nails 83
27096: Sacroiliac Joint Injections 83
55700: Biopsy of Prostate Using Image Guidance 84
64405: Greater Occipital Nerve Block/Neurolysis 84
65855: Laser Trabeculoplasty 84
66761: Iridotomy by Laser Surgery 84
70540: Magnetic Resonance Imaging of the Orbit, Face, and Neck 84
73218: Magnetic Resonance Imaging of Upper Extremity 85
76536: Ultrasound, Soft Tissues of Head and Neck 85
92506: Speech-Language Pathology Services 85

Local Medical Review Policy (Revised)

G0108: Diabetes Outpatient Self-Management Training 85
G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes 86
J9999: Antineoplastic Drugs 86
NCSVCS: The List of Medicare Noncovered Services 86
Q4053: Pegfilgrastim (Neulasta™)–formerly J3490 86
00001: Independent Diagnostic Testing Facility (IDTF) 87
11600: Excision of Malignant Skin Lesions 87
20550: Injection of Tendon Sheath, Ligament, Trigger Points, or Ganglion Cyst 87
70544: Magnetic Resonance Angiography (MRA) 87
70551: Magnetic Resonance Imaging of the Brain 87
72141: Magnetic Resonance Imaging of the Spine 87
72192: Computed Tomography of the Pelvis 87
90801: Psychiatric Diagnostic Interview Examination 88
92136: Optical Coherence Biometry 88
93784: Ambulatory Blood Pressure Monitoring 88
95900: Nerve Conduction Studies 88
95934: H-Reflex Study 88

Local Medical Review Policy (Retired)

11765: Nail Excision—Policy Retired 88

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 Ultrasound (Hand Held Ultrasound)

Medical equipment described as "hand carried ultrasound," "HCU," or "hand held ultrasound" ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only the probe itself is hand-held. Appropriate use of a specific ultrasound *CPT* code is not determined by the equipment used, but rather by the extent, quality, completeness, and documentation of the procedure.

Providers should only use a *CPT* code where they have performed the full extent, quality, completeness, and documentation necessary for use of that code. Studies that are significantly more limited in scope or quality, are less well-documented, or performed in any less comprehensive or less skilled manner than the full study described by an accepted *CPT* code should not be billed under traditional diagnostic ultrasound codes (*93303-93350, 93875-93990* or *76506-76999*).

For example, an emergency room "quick look" ultrasound to briefly assess a chest for the presence of fluid, blood, pus, or a foreign body, should not be coded as *CPT 76604 (Ultrasound, chest, B-scan [includes mediastimum] and/or real time with image documentation)*, since it has not met the full extent quality, completeness, and documentation of that procedure. Instead, until more limited, specific codes are available, such a study is bundled into the reimbursement for the physical examination.

Consistent with this policy, *CPT 51798 (Measurement of post voiding residual urine and/or bladder capacity by ultrasound, non-imaging)* - formerly HCPCS G0050 - describes a limited, specific procedure, which may be performed by either comprehensive or more limited-capability ultrasounds. *CPT 51798* may be separately covered, as long as all of the criteria and documentation referenced in the code are fulfilled.

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Investigational Device Exemption (IDE) Revised Requirements

In an effort to decrease the administrative burden on providers wishing to apply for Medicare coverage of Category B investigational devices, we are reducing the documentation required to approve Investigational Device Exemption (IDE) requests.

Effective August 1, 2003, any provider participating in a clinical study involving a Food and Drug Administration (FDA) IDE who submits claims for these services must furnish only the following information *before claims are submitted*:

1. Provider name and provider number.
2. The number of cases the institution is planning to perform.
3. A narrative description of the device sufficient to make a payment determination (including planned diagnosis, procedure codes, and charges as relevant).
4. A statement indicating how the device is similar to and/or different from other comparable products.
5. A signed copy of the FDA approval letter demonstrating Category B, IDE status and approval from the FDA to the participating company or manufacturer (including the name and number of the device).
6. Submit the following planned billing information: *CPT* code(s) as applicable - if using an unlisted *CPT* code(s) to report the service performed, identify the expected charges.
7. *Attestation of having the following:*
   The manufacture's or primary investigator's letter containing the most current approved number of institutions and subjects, and the number of cases the institution is planning to perform.

All information specified above must be submitted to this contractor in the form of a letter. The required information should be received before claims may be submitted.

The following items must be *maintained by the provider and readily available upon request* if more information about the IDE is needed to evaluate for coverage:

1. The protocol for performing the procedure utilizing the Category B, IDE device and a summary of the results of patients who have undergone the procedure(s) described within the protocol.
2. The agreement between the company or manufacturer and the provider, furnishing the details of provider participation in the study.
3. At least two peer-reviewed publications (abstracts are not acceptable) addressing the topic of the study.
4. Any product literature illustrating the device and/or the procedure.
5. The protocol used for obtaining informed consent from beneficiaries for their participation in the study.
6. An institutional review board approval letter or a statement from the provider assuring that approval has been obtained from the study institution.
7. A signed copy of the FDA approval letter demonstrating Category B, IDE status and approval from the FDA to the participating company or manufacturer.
8. The manufacture's or primary investigator's approval letter containing the most current approved number of institutions and subjects, and the number of cases the institution is planning to perform.

When filing claims for the IDE and related services, use modifier "QA" should be used on all procedures for investigational devices and/or services. Enter the IDE number for claims related to investigational devices in Item 23 on Form CMS-1500.

Reimbursement for a device will be limited to what Medicare would have paid for a comparable approved device. Costs associated with the investigational

protocol, which are for research purposes and are not reasonable and necessary for the management of the patient, are not covered by Medicare.

Should the protocol for this investigation be altered or should the sponsor lose its category B status or violates FDA requirements, please notify us in writing at:

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

Uterine Artery Embolization

Uterine artery embolization (UAE) is an existing technology that represents a fundamentally new approach to the treatment of symptomatic fibroid disease. Medicare considers UAE medically reasonable and necessary for the treatment of symptomatic uterine fibroids.

The UAE procedure is usually done in the hospital with an overnight stay post-procedure. Initially, a needle is used to enter the femoral artery to provide access for the catheter. The catheter is advanced over the branch of the aorta and into the uterine artery on the side opposite the puncture. An arteriogram is performed to provide a road map of the blood supply to the uterus and fibroids. After the arteriogram, particles of polyvinyl alcohol (PVA) are injected slowly with X-ray guidance. Because fibroids are very vascular, the particles flow to the fibroids first and wedge in the vessels. Over several minutes the arteries are slowly blocked and the embolization is continued until there is complete blockage of flow to the fibroids. After the embolization, another arteriogram is performed to confirm the completion of the procedure.

It would be expected that this procedure would be billed under *CPT* code *37204 (Transcatheter occlusion or embolization [eg, for tumor destruction, to achieve hemostatis, to occlude a vascular malformation], percutaneous, any method, non-central nervous system, non-head or neck).* Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure.

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J9217: Leuprolide Acetate (for Depot Suspension), 7.5 mg.

Goserelin acetate (HCPCS code J9202) and leuprolide acetate (J9217) are synthetic luteinizing hormone-releasing hormone analogs indicated in the palliative treatment of advanced carcinoma of the prostate. Both offer an alternative treatment of prostatic cancer when orchiectomy or estrogen administration is either not indicated or unacceptable to the patient.

The local medical review policy (LMRP) (J1950 - Leuprolide Acetate) currently in existence states that there is no demonstrable difference in clinical efficacy between goserelin acetate and leuprolide acetate in the treatment of malignant neoplasm of the prostate.

In order to be covered by Medicare, drugs and biologicals must be safe, effective, and medically reasonable and necessary. FDA approval determines safety and efficacy, but medical necessity is determined by the Carrier. Section 1862(a)(1)(A) of the Social Security Act states that Medicare excludes coverage for "items or services that are not reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The underlying issue in this statute, as it applies to this policy, is that if two services are clinically comparable, Medicare does not cover the additional expense of the more costly one, because this additional expense is not attributable to an item or service that is medically reasonable and necessary.

Therefore, Florida Medicare will make payment for the least costly medically appropriate alternative. When leuprolide depot is administered, payment for code J9217 (leuprolide, depot, 7.5 mg) will be based on the allowance for code J9202 (goserelin implant, 3.6 mg). When leuprolide is administered but is paid comparable to goserelin, if the beneficiary has signed a proper Advance Beneficiary Notice, the provider may collect from the beneficiary the difference between what would have been the allowed charge for the leuprolide and the allowed charge for the goserelin. HCPCS codes J9202 and J9217 are both subject to mandatory assignment for drugs and biologicals.

If there are medical indications requiring the use of leuprolide acetate instead of goserelin acetate, such as cachexia, infection, or allergy to goserlin acetate, Medicare will consider payment for the difference in cost if documentation of medical necessity accompanies the claim.

LMRP J1950 has been effective since 1995, and was most recently revised in January 2002, because of the annual HCPCS update. LMRP J1950 is based upon CMS Payment Policy, MCM Sections 2049, 2050.5D, and 7501.1. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

78460, *78461*, *78464*, *78465*: Myocardial Perfusion Imaging

If you are performing myocardial perfusion imaging (*CPT* codes *78460*, *78461*, *78464*, or *78465*) 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
V67.51 Follow-up examination following completed treatment with high-risk medications, not elsewhere classified
V67.59 Follow-up examination following other treatment

This information is outlined in local medical review policy (LMRP) ***78460*: Myocardial Perfusion Imaging**. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

85651, *85652*: Sedimentation Rates

If you are performing sedimentation rates (*CPT 85651* or *85652*) to monitor a patient for adverse effects of drugs, medicinal, or biological substances, one of the following ICD-9-CM diagnoses codes should be used when billing Medicare Part B:

E933.1 Drugs, medicinal, or biological substances causing adverse effects in therapeutic use, antineoplastic and immunosuppressive drugs
E935.6 Drugs, medicinal, or biological substances causing adverse effects in therapeutic use, antirheumatics (antiphlogistics)
E947.2 Drugs, medicinal, or biological substances causing adverse effects in therapeutic use, antidotes and chelating agents, not elsewhere classified

This information is outlined in local medical review policy (LMRP) ***85651*: Sedimentation Rate, Erythrocyte**. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

93224-93227, *93230-93237*: Event Recording/24-Hour ECG Monitoring

If you are performing event recording/24-hour ECG monitoring (*CPT 93224-93227*, *93230-93237*) to monitor a patient to determine the effects of cardiac medications on a patient's cardiac rhythm and/or conditions, one of the following ICD-9-CM diagnoses codes should be used when billing Medicare Part B:

E942.0 Cardiac rhythm regulators
E942.1 Cardiotonic glycosides and drugs with similar action

This information is outlined in local medical review policy (LMRP) ***93224*: Electrocardiographic Monitoring for 24 hours (Holter Monitoring)**. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

93880, *93882*: Duplex Scans, Extracranial

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
V67.51 Follow-up examination following completed treatment with high-risk medications, not elsewhere classified
V67.59 Follow-up examination following other treatment

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*.

Comprehensive Data Analysis

88311, 88312-88314: Additional Clarification

Articles published in the Third Quarter 2003 and Third Quarter 2002 issues of the *Medicare B Update!* clarified the billing units for the pathology special staining procedures. However, the titles of these articles may appear misleading. *CPT* code *88311* refers to decalcification procedures performed on pathology specimens and not the special staining procedures. Although the articles discussed staining procedures and not decalcification procedures, both titles should have clearly indicated that *CPT 88312* through *88314* were the codes at issue. We apologize for any confusion this may have caused.

Inappropriate Billing of Lacrimal Duct Procedures Discovered Through Data Analysis

The Comprehensive Data Analysis Department recently reviewed several *CPT* codes used for billing services related to procedures involving the lacrimal ducts. The following codes were included in the analyses:

Code	Descriptor
68760	*Closure of the lacrimal punctum, by thermocauterization, ligation, or laser surgery*
68761	*by plug, each*
68770	*Closure of lacrimal fistula (separate procedure)*
68801	*Dilation of lacrimal punctum, with or without irrigation*
68810	*Probing of nasolacrimal duct, with or without irrigation;*
68811	*requiring general anesthesia*
68815	*with insertion of tube or stent*
*68840**	*Probing of lacrimal canaliculi, with or without irrigation*

(***Note**: *CPT* code *68840* was not considered aberrant according to certain criteria and was included in the analysis for comparison only).

The following are highlights of the key issues identified through the analyses:

- Insertion of Punctum Plugs - Procedure code 68761 represents the insertion of and payment for a single punctum; and each eye has two puncta (one punctum in both the upper and lower eyelids). Bilateral surgery rules, not multiple surgery rules, should be applied first, where applicable. Therefore, the billing and reimbursement rules for insertion of lacrimal punctum plugs are as follows:

Punctum Treated	How Billed	Payment Rules Applied
Single punctum	68761	Standard – 100 % of the fee schedule amount
Two puncta (one in each eye)	68761-50	Bilateral surgery – 150 % of the fee schedule amount
Two puncta (both in same eye)	68761 on first detail line of claim 68761-51 on second detail line of claim	Multiple surgery 100 % of fee schedule for first procedure 50 % of fee schedule for second procedure
Three puncta (two in same eye and one in the opposite eye)	68761-50 on the first detail line of claim 68761-51 on the second detail line of claim	Bilateral surgery for 68761-50, then multiple surgery 100 % of fee schedule amount for 68761-50 50 % of fee schedule amount for 68761-51
Four puncta (two in each eye)	68761-50 on first detail line of claim 68761-5051 on second detail line of claim	Bilateral surgery for both lines, then multiple surgery 100 % of fee schedule amount for first 68761-50 50 % of bilateral amount for second 68761-50

- Claims for the treatment of multiple puncta should include all services performed on that date of service to ensure proper payment. In addition, billed charges on nonassigned claims for the treatment of multiple puncta should reflect any applicable bilateral or multiple surgery reductions to prevent potential limiting charge violations.
- Prior to January 1, 2002, payment for HCPCS procedure code A4263 (permanent, long term, non-dissolvable lacrimal duct implant, each) was made when provided in an office setting with *CPT* code 68761. However, as of January 1, 2002, payment for A4263 is bundled into the reimbursement for 68761 (CMS Program Memorandum AB 01-177). Silicone plugs are considered permanent plugs. Temporary collagen plugs (HCPCS code A4262) are not separately covered, as they too are considered bundled into the professional services of the physician.
- Providers may be bypassing traditional standards of care (according to national guideline recommendations) and resorting to surgical closure of the puncta as a first-line treatment.
- Several providers are billing for dilation and probing of the lacrimal gland/punctum as well as plugging the punctum on the same date of service, therefore appearing to unbundle these services as defined in the Correct Coding Initiative.

Skilled Nursing Facility Admissions by Advanced Registered Nurse Practitioners and Physician Assistants

The Statistical and Medical Data Analysis department conducted an analysis of *CPT* code *99303 (Evaluation and management of a patient involving a nursing facility assessment at the time of initial admission or readmission to the facility)* during calendar year 2002. The data demonstrated that Florida expended $2,494 per 1,000 enrollees, opposed to the national expenditure of $1,650 per 1,000 enrollees. An increasing number of ARNPs and PAs were observed in the data. Florida providers performed 46,036 services and were paid $4,863,434. If practice patterns in Florida were similar to the rest of the nation, Medicare would not have expended $1,646,946 in this state.

Based on regulatory conditions of participation for SNFs and Medicare reimbursement guidelines, the first (admitting) visit in a SNF must be conducted by a physician. Nonphysician practitioners may provide visits *after* the initial physician visit if delegated. Therefore, admitting services performed by nonphysician practitioners will be denied, effective for services processed on or after August 19, 2003.

LOCAL MEDICAL REVIEW POLICY (NEW)

J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])

Darbepoetin alfa, produced under the name Aranesp®, is a modified form of recombinant human erythropoietin. This drug was approved by the Food and Drug Administration for the treatment of anemia associated with chronic renal failure and chemotherapy induced anemia associated with malignancy. Local medical review policy (LMRP) has been developed to ensure access to care and to communicate the covered indications.

This new LMRP is effective for claims processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

J1955: Levocarnitine (Carnitor®, L-carnitine®)

CMS recently issued Program Memorandum (PM) AB-02-165, CR 2438, which established a national coverage decision expanding coverage for levocarnitine for use in the treatment of carnitine deficiency in ESRD patients. Local medical review policy (LMRP) for levocarnitine (HCPCS code J1955) was subsequently developed to communicate the coverage guidelines provided in the PM and to define the appropriate diagnoses for this procedure.

The new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

11730: Surgical Treatment of Ingrown Nails

CPT codes *11730*, *11732*, *11750*, and *11765* represent the surgical management of ingrown nails. These codes, with the exception of *11765*, may be used to represent fingernails or toenails; however an ingrown fingernail is an extremely uncommon condition and these codes primarily represent procedures performed on the nails of the toes. Based on data for services performed from January 1, 2001 to June 30, 2001 *CPT* codes *11730*, *11750*, and *11765* were identified as being aberrant. Because of these aberrancy findings, a widespread probe was conducted on these three codes. The finding of the probe revealed a high overutilization of these codes. Local medical review policy (LMRP) was subsequently developed to provide indications and limitations for coverage, and utilization guidelines.

This new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

27096: Sacroiliac Joint Injections

Sacroiliac (SI) joint injection describes the injection of contrast for radiologic evaluation associated with SI joint arthrography and/or therapeutic injection of an anesthetic/steroid. *CPT* code 27096 was new for year 2000 and has been identified as being significantly aberrant per statistical medical data obtained for dates of service from July 1, 2001, through December 30, 2001. Local medical review policy (LMRP) has been developed to describe the service, define the indications and limitations of coverage, define appropriate diagnoses, and clarify appropriate use of procedure code 27096.

The new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

55700: Biopsy of Prostate Using Image Guidance

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 in order to make a definitive diagnosis of prostate cancer. Statistical medical data obtained for dates of service from January 1, 2002 to June 30, 2002, indicates *CPT* code *55700 (Biopsy, prostate, needle or punch, single or multiple, any approach)* was found to have an aberrancy ratio of 1.67 per 1000 enrollees. 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 a biopsy of prostate using image guidance (*CPT* codes *55700* and *76942*).

The new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

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64405: Greater Occipital Nerve Block/Neurolysis

Nerve blocks may be used for therapeutic analgesia of central or peripheral nerves or diagnostically to determine the pain generator. *CPT* code *64405* represents greater occipital nerve block using local anesthetics and cortisteroids, alone or in combination. This procedure may be useful in the management of patients with chronic and intractable pain from occipital neuralgia. Local medical review policy (LMRP) has been developed to provide indications and limitations for the use of occipital nerve blocks or neurolysis in the diagnosis and treatment of occipital neuralgia.

This new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

65855: Laser Trabeculoplasty

Argon laser trabeculoplasty (ALT), selective laser trabeculoplasty (SLT), and diode laser trabeculoplasty (DLT) are options used in the treatment of primary open-angle glaucoma (POAG). These procedures may be performed as the initial treatment, when medical therapy fails, or when a patient is unable to tolerate medications. These laser procedures improve the outflow of aqueous humor by photocoagulation of the trabecular meshwork to lower intraocular pressure.

A new local medical review policy (LMRP) has been developed, effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

66761: Iridotomy by Laser Surgery

Iridotomy by laser surgery is a procedure to treat a variety of angle-closure glaucomas that have at least some component of pupillary block. This procedure allows the aqueous to bypass the pupillary block and eliminates the pressure gradient between the posterior and anterior chambers. The iridotomy reverses the appositional angle closure, and it prevents or retards formation of peripheral anterior synechiae.

A new local medical review policy (LMRP) has been developed, effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

70540: Magnetic Resonance Imaging of the Orbit, Face, and Neck

CPT code *70540* was chosen for focused medical review for fiscal year 2002 based on the January through June 2001 data revealing an aberrancy ratio of 3.12 per 1000 enrollees. Based on this review, utilization of this service was considered a widespread problem; therefore, a probe was conducted to determine the medical conditions for which the service was being performed. Using the results of the widespread probe, a local medical review policy (LMRP) has been developed to address the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of code *70540*.

The new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

73218: Magnetic Resonance Imaging of Upper Extremity

Magnetic resonance imaging (MRI) is a non-invasive imaging technique used for a variety of diagnostic visualizations, Unlike computed tomography (CT) scanning, MRI does not make use of ionizing radiation or require iodinated contrast material to distinguish normal from pathologic tissue. Rather, the process employs the magnetic properties of the hydrogen nucleus (proton) and its interaction with strong external magnetic fields and radio frequency signal, which is processed by a computer to produce an image.

MRI provides superior tissue contrast when compared to CT, is able to image in multiple planes, is not affected by bone artifact, provides vascular imaging capability, and makes use of safer contrast media. Its major disadvantages over CT include longer scanning times, which make MRI less useful in emergency evaluation. The use of MRI on certain soft tissue structures for the purpose of detecting disruptive, neoplastic, degenerative, or inflammatory lesions has now become established in medical practice.

A new local medical review policy (LMRP) has been developed to establish a list of appropriate indications and propose a diagnosis list for these services. This LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

76536: Ultrasound, Soft Tissues of Head and Neck

CPT code *76536* was chosen for focused medical review for fiscal year 2002 based on January 2001 through June 2001 data revealing an aberrancy ratio of 2.25 per 1000 enrollees. Based on this review, utilization of this service was considered a widespread problem; therefore, a probe was conducted to determine the medical conditions for which the service was being performed. Using the results of the widespread probe, local medical review policy (LMRP) has been developed to address the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of code *76536*.

The new LMRP is effective for services processed on or after September 29, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

92506: Speech-Language Pathology Services

This new local medical review policy (LMRP) describes the services that may be furnished under the Medicare Part B benefit by or under the supervision of speech-language pathologists. Speech-language pathology services are those services necessary for the diagnosis and treatment of speech-language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. This policy applies to all services speech-language pathologists furnish regardless of whether they are employees of or subcontractors to institutions (e.g., hospitals, skilled nursing facilities), or they provide the services incident to a physician's service in a doctor's practice. This policy includes reference to medical equipment / supplies that may be related to the speech/language pathology plan of treatment. This policy does not address dysphagia (swallowing) services rendered by speech-language pathologists.

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

LOCAL MEDICAL REVIEW POLICY (REVISED)

G0108: Diabetes Outpatient Self-Management Training

The local medical review policy (LMRP) for Diabetes Outpatient Self-Management Training (DSMT) has been revised per CMS transmittal B-03-043, dated May 23, 2003, which indicates the "incident to" provisions do not apply to DSMT services.

This revision is effective for services processed on or after January 1, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

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

The local medical review policy (LMRP) for peripheral neuropathy with LOPS in people with diabetes was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 32-33). **Effective for services rendered on or after March 1, 2003**, a revision has been made to the "*CPT*/HCPCS Codes" section of the LMRP. The descriptor for procedure code G0247 has been changed. The new descriptor reads:

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:

(1) local care of superficial (i.e., wounds superficial to fascia and muscle) wounds,
(2) debridement of corns and calluses, and
(3) trimming and debridement of nails.

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

J9999: Antineoplastic Drugs

The local medical review policy (LMRP) for antineoplastic drugs has been revised. The following chemotherapy agents have been added:

Fulvestrant (Faslodex®) J9999

Fulvestrant is an estrogen receptor antagonist without known agonist effects. The Food and Drug Administration (FDA) approved Fulvestrant for the treatment of hormone receptor positive metastatic breast cancer in postmenopausal women with disease progression following antiestrogen therapy.

Oxaliplatin (Eloxatin™) J9999

Oxaliplatin is a chemotherapeutic agent. The FDA approved Oxaliplatin for injection with infusional 5-Fluorouracil/Leucovorin (5FU/LV) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during or within 6 months of completion of first line therapy with the combination of bolus 5-FU/LV and Irinotecan.

Floxuridine (FUDR) J9200

Floxuridine (FUDR) is an antimetabolite of the pyrimidine analog type. The monophosphate of the drug, 5-fluoro-2'-deoxyuridine-5'-phosphate (FUDR-MP), inhibits thymidylate synthetase, thus inhibiting methylation of deoxyuridylic acid to thymidylic acid, thereby, interfering with the synthesis of DNA. Floxuridine, given by continuous intra-arterial infusion, is FDA approved for the palliative management of colorectal carcinoma metastatic to the liver that has not responded to other treatment. Intra-arterial Floxuridine is also indicated for the palliative treatment of primary and secondary carcinomas of the liver.

These revisions are effective for claims processed on or after September 29, 2003. The full-text LMRP will be available on the provider education Web site *www.floridamedicare.com* on or after that date.

NCSVCS: The List of Medicare Noncovered Services

The List of Medicare Noncovered Services local medical review policy (LMRP) has been revised to reflect the addition of procedure code *0029T* to local noncoverage; the deletion of procedure code *72198* from national noncoverage; and the addition of procedure codes *92015* and V5274 to national noncoverage. Codes identified with an asterisk (*) are noncovered due to being experimental/investigational.

Local Noncoverage

Additions

*0029T** *Treatments for incontinence, pulsed magnetic neuromodulation, per day*

(Effective for services rendered on or after September 29, 2003)

National Noncoverage

Deletions

72198 *Magnetic resonance angiography, pelvis, with or without contrast materials*

(Effective for services rendered on or after July 1, 2003, per Change Request 2673)

Additions

92015 *Determination of refractive state.*

(This service is already nationally noncovered by Medicare.)

V5274 Assistive learning device, not otherwise specified

(Effective for services rendered on or after January 1, 2003, per Change Request 2734)

The revised LMRP will be available on the provider education Web site *www.floridamedicare.com* on or after September 29, 2003.

Q4053: Pegfilgrastim (Neulasta™)– formerly J3490

Notification of the local medical review policy (LMRP) for Pegfilgrastim (Neulasta™) was published in the Third Quarter 2003 *Medicare B Update!* (page 84). Since that time, the policy has been revised based on CMS Program Memorandum B-03-048 (CR 2798) dated June 20, 2003. The HCPCS code for Pegfilgrastim has been changed to Q4053 (Injection, Pegfilgrastim, 1 mg); the policy number has been changed to reflect the new code. In addition, the "*CPT*/ HCPCS Section and Benefit Category" been changes to Drugs and Biologicals.

This revision is effective for dates of service on or after July 1, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com.*

00001: Independent Diagnostic Testing Facility (IDTF)

The local medical review policy (LMRP) for IDTF was published in the Third Quarter 2002 *Medicare B Update!* (pages 37-52). Since that time, CMS Transmittal AB-03-070, CR 2734 changed the physician supervision indicator to “5” for the following procedure codes:

92601 *Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming*
92602 *subsequent reprogramming*
92603 *Diagnostic analysis of cochlear implant, age 7 years or older; with programming*
92604 *subsequent reprogramming*

A physician supervision indicator of “5” means, “Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.”

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

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11600: Excision of Malignant Skin Lesions

The local medical review policy (LMRP) for excision of malignant skin lesions has been revised. Additional ICD-9-CM diagnosis codes have been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy.

This revision is effective for services processed on or after July 7, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

20550: Injection of Tendon Sheath, Ligament, Trigger Points, or Ganglion Cyst

The local medical review policy (LMRP) for injection of tendon sheath, ligament, trigger points, or ganglion cyst was published in the May/June 2000 *Medicare B Update!* (pages 38-39). Prior to 2002, *CPT* code *20550* described an injection of various anatomic sites (i.e., tendon sheath, ligament, ganglion, and trigger points). Effective January 1, 2002, trigger points were excluded from the descriptor. *CPT* codes *20552* and *20553* were established to differentiate the muscle groups, procedure code *20551* was established to describe therapeutic injection of a tendon at its origin/insertion, and procedure code *20550* has been revised to describe only injections of a tendon sheath, ligament, or ganglion cyst. This LMRP describes the procedures, defines the indications and limitations of coverage, establishes a procedure to diagnosis application, and clarifies the appropriate use of procedure codes *20550*, *20551*, *20552*, and *20553*.

The revised LMRP 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.floridamedicare.com* on or after that date.

70544: Magnetic Resonance Angiography (MRA)

The local medical review policy (LMRP) for MRA was published in the Second Quarter 2001 *Medicare B Update!* (pages 67-69). Since that time, additional indications and ICD-9-CM codes have been added to the policy for procedure code *74185*.

This revision is effective for services processed on or after June 9, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

70551: Magnetic Resonance Imaging of the Brain

The local medical review policy (LMRP) for magnetic resonance imaging of the brain has been revised. Additional ICD-9-CM diagnosis codes have been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy.

This revision is effective for services processed on or after July 21, 2003. The full-text LMRP will be available on the provider education Web site *www.floridamedicare.com* on or after that date.

72141: Magnetic Resonance Imaging of the Spine

The local medical review policy (LMRP) for Magnetic Resonance Imaging of the Spine has been revised. ICD-9-CM code 721.0 (Cervical spondylosis without myelopathy) has been added to the “ICD-9-CM Codes that Support Medical Necessity” section of the policy.

This revision is effective for services processed on or after June 9, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

72192: Computed Tomography of the Pelvis

The local medical review policy (LMRP) for computed tomography of the pelvis was published in the Second Quarter 2001 *Medicare B Update!* (pages 71-73). Since that time, the following ICD-9-CM codes have been added to the policy for procedure codes *72192*, *72193*, and *72194*:

016.00-016.06	Tuberculosis of genitourinary system
171.5	Malignant neoplasm of connective and other soft tissues, abdomen
189.0-189.1, 189.4	Malignant neoplasm of kidney and other and unspecified urinary organs
195.2	Malignant neoplasm of abdomen
197.4	Secondary malignant neoplasm, of small intestine, including duodenum
197.5	Secondary malignant neoplasm of large intestine and rectum
215.5	Other benign neoplasm of abdomen
215.7	Other benign neoplasm of trunk, unspecified

This revision is effective for claims processed on or after June 9, 2003. The full-text of this local medical review policy is available on the provider education Web site *www.floridamedicare.com.*

90801: Psychiatric Diagnostic Interview Examination

The local medical review policy (LMRP) for psychiatric diagnostic interview examination was published in the March/April 2000 *Medicare B Update!* (pages 41-42). Effective for services rendered on or after March 1, 2003, the policy has been revised to reflect the addition of psychiatric diagnostic interview examination (*90801*) as a Medicare telehealth service with modifier GT.

The full-text LMRP may be found on the provider education Web site *www.floridamedicare.co*m.

Source: CMS Transmittal AB-03-070, CR 2734

92136: Optical Coherence Biometry

The local medical review policy (LMRP) for optical coherence biometry has been revised per CMS Transmittal B-03-001, dated January 17, 2003. Coding guidelines for this service have been revised.

This revision is effective for services processed on or after March 1, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

93784: Ambulatory Blood Pressure Monitoring

The local medical review policy (LMRP) for Ambulatory Blood Pressure Monitoring (ABPM) was published in the Fourth Quarter 2002 *Medicare B Update!* Since that time, CMS Transmittal 168, dated March 28, 2003, was issued to specify a physician is required to perform the interpretation of the data obtained through ABPM, but there are no requirements regarding the setting in which the interpretation is performed.

This revision is effective for services processed on or after July 1, 2003. The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

95900: Nerve Conduction Studies

The local medical review policy (LMRP) for nerve conduction studies was published in the Fourth Quarter 2002 *Medicare B Update!* Since then, the policy has been revised to include additional indications. ICD-9-CM diagnosis codes 724.2, 724.3, 728.2, 728.85, 736.05, 736.79, and 781.3 have been added to the policy for *CPT* codes *95900*, *95903*, and *95904*. In addition, the policy language has been updated to reflect the latest guidelines from the American Association of Electrodiagnostic Medicine.

These revisions are effective for services processed on or after September 11, 2003. The full-text LMRP will be available on the provider education Web site *www.floridamedicare.com* on or after that date.

95934: H-Reflex Study

The local medical review policy (LMRP) for H-Reflex Study was published in the September/October 2000 *Medicare B Update!* Effective for claims processed on or after April 7, 2003, diagnosis codes 724.2 (Lumbago), 728.2 (Muscular wasting and disuse atrophy, not elsewhere classified), 728.85 (Spasm of muscle), 736.79 (Other acquired deformities of ankle and foot [drop foot]), 780.79 (Other malaise and fatigue [weakness, generalized]), and 781.3 (Lack of coordination) have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

The revised full-text LMRP may be found on the provider education Web site *www.floridamedicare.co*m.

Local Medical Review Policy (Retired)

11765: Nail Excision—Policy Retired

The local medical review policy (LMRP) for *CPT* code *11765 (wedge excision of skin of nail fold [e.g. For ingrown toenail])* is being retired effective September 28, 2003. Indications and limitations for services related to procedure code *11765* may be found in a new LMRP – *11730*: Surgical Treatment of Ingrown Nails.

For more information concerning the new LMRP, please see the related article in this issue.

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Florida Educational Resources

Medicare Education and Outreach Will Hold August Medifest in Tampa

MEDIFEST Class Schedule

The price for the MEDIFEST Event is $159 per person.

August 26 -27, 2003
Marriott Tampa Airport
Tampa International Airport
Tampa, FL 33607
Please contact hotel for directions and/or reservations 1-813-879-5151

Select one class per session (time slot).

DAY 1
Tuesday, August 26

8:30AM - 10:00AM SESSION 1/DAY 1

- ❑ E/M Documentation (B)
- ❑ Fraud & Abuse (A/B)
- ❑ HOPPS: Outpatient Coding (A)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ Medicare Secondary Payer (B)

10:30AM - 12:00PM SESSION 2/DAY 1

- ❑ Global Surgery/Modifiers (B)
- ❑ HOPPS: Legislative Update (A)
- ❑ Medical Review/Data Analysis (A/B)
- ❑ Medicare Secondary Payer (A)
- ❑ Navigating FCSO's Web Site (A/B)

1:30PM - 4:30PM SESSION 3/DAY 1

- ❑ CMS-1500/EMC (B)
- ❑ CPT for Beginners (A/B)*
- ❑ E/M Coding/Primary Care (B)
- ❑ ICD-9-CM for Beginners (A/B)*
- ❑ UB-92/DDE (A)

6:00PM - 7:30PM SESSION 4/DAY 1

- ❑ E/M Documentation (B)*

**This session is designed for physicians only. There is no charge to attend this session.*

DAY 2
Wednesday, August 27

9:00AM – 12:00PM SESSION 1/DAY 2

- ❑ CMS-1500/EMC (B)
- ❑ CPT for Beginners (A/B)**
- ❑ E/M Coding/Primary Care (B)
- ❑ ICD-9-CM for Beginners (A/B)**
- ❑ UB-92/DDE (A)

1:30AM - 3:00PM SESSION 2/DAY 2

- ❑ Fraud & Abuse (A/B)
- ❑ Global Surgery/Modifiers (B)
- ❑ Medicare Secondary Payer (B)
- ❑ Navigating FCSO's Web Site (A/B)
- ❑ Reimbursement Efficiency (A)

3:30PM - 5:00PM SESSION 3/DAY 2

- ❑ E/M Documentation (B)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ Part A Modifiers (A)
- ❑ Provider Enrollment (B)
- ❑ Rehabilitative Services (A)

***Participants are required to bring their 2003 CPT and ICD-9-CM books.*

For complete class descriptions, please visit our provider education Web site *www.floridamedicare.com.*

	MEDIFEST REGISTRATION FORM	

August 26 - 27, 2003
Marriott Tampa Airport
Tampa International Airport
Tampa, FL 33607
Please contact hotel for directions and or reservations 1-813-879-5151

ON-LINE REGISTRATION	FAXED REGISTRATION
1. Register through the Web site. A computer-generated confirmation will be sent via email.	1. Fax both registration form and class schedule(s) to 1-904-791-6035.
2. An invoice will be faxed or emailed to you.	2. A confirmation and invoice will be faxed or emailed to you.
3. Make checks payable to: FCSO Account #700390	3. Make checks payable to: FCSO Account #700390
4. Mail a copy of the invoice and the check to: **Medifest Registration** **P.O. Box 45157** **Jacksonville, FL 32232-5157**	4. Mail the forms (after you have faxed them) and payment to: **Medifest Registration** **P.O. Box 45157** **Jacksonville, FL 32232-5157**
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For registration information, please visit our Web site at *www.floridamedicare.com* or call our registration hotline at 1-904- 791-8103.

Registration is on a first come, first served basis. Please register as soon as possible.

ORDER FORM — 2003 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to BCBSFL – FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
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❒	**2003 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered March 1, 2003, through December 31, 2003, 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 2003 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)

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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

A

Advance Beneficiary Notices (ABNs) .... 1st QTR 2003 5
.... 2nd QTR 2003 5
.... 3rd QTR 2003 6
Ambulance Fee Schedule Implementation, Second Clarification Regarding .... 2nd QTR 2003 7
Appeals Process, New Rules for the Medicare .... 1st QTR 2003 42 CT
.... 1st QTR 2003 44 FL
Appeal, Time Limit for Filing a Request for .... 3rd QTR 2003 11
ASC, Procedures Approved in for 2002—Correction ... 3rd QTR 2003 13

B

Beneficiary Has an Out-of-State Address, Carrier Jurisdiction for Medicare Payments When the ...... 2nd QTR 2003 6

C

CB, Proper Use of Modifier .... 3rd QTR 2003 51
Claims Mistakenly Submitted to the Local Carrier Will Be Returned as Unprocessable .... 3rd QTR 2003 10
Clinical Diagnostic Laboratory Services Based on the Negotiated Rulemaking, Claims Processing Requirements for .... 1st QTR 2003 14 CT
.... 1st QTR 2003 12 FL
Clinical Diagnostic Laboratory Services, Questions and Answers Related to Implementation of National Coverage Determinations (NCDs) for .... 1st QTR 2003 15 CT
.... 1st QTR 2003 13 FL
Clinical Laboratory Fee Schedule .... Jan 2003* 14 CT
.... Jan 2003* 22 FL
CLIA Waived Tests, New .... 2nd QTR 2003 12
.... 3rd QTR 2003 26
Colorectal Cancer (CRC) Screening for Health Care Professionals, Materials on .... 3rd QTR 2003 62
Colorectal Cancer (CRC) Screening Publications .... 3rd QTR 2003 61
Colorectal Cancer Screening Awareness for Health Care Providers .... 3rd QTR 2003 58
Correct Coding Initiative .... 1st QTR 2003 6 CT
.... 1st QTR 2003 7 FL
.... 2nd QTR 2003 6
.... 3rd QTR 2003 10

D

Deep Brain Stimulation for Essential Tremor and Parkinson's Disease .... 3rd QTR 2003 31
Denial Messages, Research All Remittance Notice .... 2nd QTR 2003 30
Deported Medicare Beneficiaries .... 3rd QTR 2003 43
Diabetes Outpatient Self-Management Training (DSMT) Services, Payment to Registered Dietitians for ..... 1st QTR 2003 7 CT
.... 1st QTR 2003 7 FL
Diabetes Outpatient Self-Management Training Services (DSMT) Program and Common Working File Edits for DSMT & Medical Nutrition Therapy (MNT), Clarification Regarding Nonphysician Practitioners Billing on Behalf of a .... 2nd QTR 2003 14
Clarification, Billing on Behalf of a .... 3rd QTR 2003 14
Diagnostic Services Ordered with Surrogate Unique Physician Identification Numbers (Surrogate UPINs) .... 2nd QTR 2003 10
Diagnostic Tests, Ordering .... 2nd QTR 2003 11
Diagnostic Tests, Revised Guidelines for Purchased Diagnostic Tests and Purchased Interpretations of 1st QTR 2003 8 CT
.... 1st QTR 2003 8 FL
Dietitians for Diabetes Outpatient Self-Management Training (DSMT) Services, Payment to Registered 1st QTR 2003 7 CT
.... 1st QTR 2003 7 FL
Distribution and Format of the FCSO *Medicare B Update!* .... 3rd QTR 2003 5
Durable Medical Equipment Ordered with Surrogate Unique Physician Identification Numbers (UPIN) .. 1st QTR 2003 11 CT
.... 1st QTR 2003 11 FL
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) .... Jan 2003* 27 FL
.... Jan 2003* 19 CT
DMEPOS Fee Schedule, April Quarterly Update for 2003 .... 3rd QTR 2003 22

E

Electrical Stimulation for the Treatment of Wounds, Coverage and Billing Requirements for .... 2nd QTR 2003 15
Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator: *93724* .... 1st QTR 2003 27 CT
.... 1st QTR 2003 31 FL
Eligibility Benefit Inquiry and Response Transaction, ASCX12N 270/271—Real Time Access .... 3rd QTR 2003 39

F

Fee Schedule, Medicare Physician .... Jan 2003* 8
Foot and Nail Care Services, Requirements for Payment of Medicare Claims for .... 2nd QTR 2003 17
Form CMS-1500, Item 32 of .... 1st QTR 2003 7 CT
.... 1st QTR 2003 6 FL

H

Hardcopy Format, Providers Must Qualify and Register to Receive the *Medicare B Update!* in .... 3rd QTR 2003 7
Hardcopy Issue Registration Form, *Medicare B Update!* .... 3rd QTR 2003 8
HCPCS Update, Annual .... Jan 2003* 2
Health Care Claim Status Request and Response ASC X12N 276/277 .... 3rd QTR 2003 40
Health Insurance Portability and Accountability Act (HIPAA) Transaction 835v4010 Completion Update, Remittance Advice Coding and .... 1st QTR 2003 38 CT
.... 1st QTR 2003 41 FL
Health Insurance Portability and Accountability Act—Administrative Simplification (HIPAA–AS), The ..... 2nd QTR 2003 20
Health Insurance Portability and Accountability Act—Administrative Simplification (HIPAA–AS) Update . 1st QTR 2003 29 CT
.... 1st QTR 2003 32 FL
Helpful Hints for Working with Medicare .... 3rd QTR 2003 3
HIPAA 101 For Health Care Providers' Offices .... 2nd QTR 2003 24
HIPAA-AS Addenda Transactions, FCSO to Begin Testing and Support of .... 3rd QTR 2003 38
HIPAA-AS Transactions and Code Sets: Testing and Updates .... 3rd QTR 2003 38
HIPAA, Important Information for Providers about .... 3rd QTR 2003 41
HIPAA Information, General .... 3rd QTR 2003 42
HIPAA Information Series .... 3rd QTR 2003 40
HIPAA Makes Electronic Claims Submission the Best Choice .... 3rd QTR 2003 37
HIPAA Provider Readiness Checklist—Getting Started .... 2nd QTR 2003 22
HIPAA Readiness Checklist, Provider .... 3rd QTR 2003 40
HIPAA Resources .... 2nd QTR 2003 23
.... 3rd QTR 2003 40
HMO for only a Portion of the Claim, Services Furnished to a Beneficiary Who is a Member of an ...... 3rd QTR 2003 11
Home Health Consolidated Billing, Additional Remark Code for Claims of Therapy Services Possibly Subject to .... 1st QTR 2003 34 CT
.... 1st QTR 2003 37 FL

Home Health Consolidated Billing Enforcement, Annual Update of Procedure Codes Used for .... 1st QTR 2003 32 CT
.... 1st QTR 2003 35 FL
Home Health Consolidated Billing Enforcement, Quarterly Update of HCPCS Codes Used for .... 2nd QTR 2003 28
Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management, Coverage and Billing for —Correction .... 2nd QTR 2003 12
Hospice Care Enhances Dignity and Peace As Life Nears Its End .... 3rd QTR 2003 57
Hyperbaric Oxygen Chamber, Change in Jurisdiction for Topical .... 1st QTR 2003 12 CT
.... 1st QTR 2003 12 FL

I

ICD-9-CM Coding Changes, 2003 .... 1st QTR 2003 19 CT
.... 1st QTR 2003 18 FL
ICD-9-CM Coding for Diagnostic Tests—Additional Instruction to Determine the Reason for the Test .. 1st QTR 2003 8 CT
.... 1st QTR 2003 8 FL
Important Addresses, Phone Numbers, and Web sites 1st QTR 2003 44 CT
.... 1st QTR 2003 47 FL
Independent Therapists and DME Suppliers—Billing for Services That May Be Part of a Home Health Stay .... 3rd QTR 2003 44
Index to Connecticut and Florida *Medicare B Update!* - Fiscal Year 2003 .... 2nd QTR 2003 58
.... 3rd QTR 2003 92
Infliximab (Remicade™): J1745 .... 1st QTR 2003 23 CT
.... 1st QTR 2003 22 FL
Injectable Drugs and Biologicals, 2003 Connecticut and Florida Allowances for .... Jan 2003* 9
Injectable Drugs, Medicare Payment Allowance for .... 1st QTR 2003 9 CT
.... 1st QTR 2003 9 FL
Intracoronary (Intravascular) Brachytherapy .... 1st QTR 2003 22 CT
.... 1st QTR 2003 21 FL
Item 32 of Form CMS-1500 .... 1st QTR 2003 7 CT
.... 1st QTR 2003 6 FL
Interest Rate for Medicare Overpayments and Underpayments, Notice of .... 2nd QTR 2003 30
.... 3rd QTR 2003 51

J

J3490 or J9999, Are You Getting the Correct Reimbursement When Billing for Drugs Using HCPCS Codes? .. Mar 2003
Jurisdiction for Topical Hyperbaric Oxygen Chamber, Change in .... 1st QTR 2003 12 CT
.... 1st QTR 2003 12 FL
Jurisdiction List, 2003 .... 3rd QTR 2003 15

L

Laboratory National Coverage Determination (NCD) Edit Software for April 1, 2003, Changes to the .... 3rd QTR 2003 24
Laboratory Services, Additional Documentation Requests (ADR) for Ordering Providers of .... 3rd QTR 2003 24
Levocarnitine for use in Treatment of Carnitine Deficiency in End-Stage Renal Disease (ESRD) Patients ..... 2nd QTR 2003 11
Local Medical Review Policy Reconsideration Process 1st QTR 2003 19 CT
.... 1st QTR 2003 17 FL

M

Mammography Claims, Screening and Diagnostic ..... 3rd QTR 2003 30
Mammography Quality Standards Act File for Certified Digital Mammography Centers, Update to the ...... 3rd QTR 2003 31
Medicare B Update!, About the .... 1st QTR 2003 4 CT
.... 1st QTR 2003 4 FL
Medicare B Update!, New Format for Your .... 1st QTR 2003 1 CT
.... 1st QTR 2003 1 FL
Medicare Covered Drugs—Quarterly Pricing Update ... 3rd QTR 2003 14
Medicare Participating Physician/Supplier Directory (MEDPARD), 2003—Revised Availability .... 3rd QTR 2003 50
Medicare Participation for 2003, Announcement About .... 3rd QTR 2003 12
Medicare Physician Fee Schedule .... Jan 2003* 8
Second Update to the .... June 2003* 1-3
Medicare Secondary Payer (MSP) and the Debt Collection Improvement Act of 1996 (DCIA) .... 3rd QTR 2003 45
Medicare Stop Smoking Program .... 3rd QTR 2003 63
Mental Health Services, Medicare Payments for Part B .... 3rd QTR 2003 27
Microvolt T-wave Alternans: *93025* .... 1st QTR 2003 27 CT
.... 1st QTR 2003 31 FL
Modifier CB, Proper Use of .... 3rd QTR 2003 51
Modifiers and Procedure Codes Added for 2003 .... Jan 2003* 4
Modifiers and Procedure Codes Discontinued for 2003 .... Jan 2003* 7
Modifiers and Procedure Codes Revised for 2003 .... Jan 2003* 5
Multiple Electroconvulsive Therapy (MECT), Noncoverage of .... 2nd QTR 2003 14

N

Neuromuscular Electrical Stimulation, Coverage and Billing for .... 2nd QTR 2003 16
New Data Findings Surfaced: *76375* .... 1st QTR 2003 25 CT
.... 1st QTR 2003 28 FL

O

Ocular Photodynamic Therapy (OPT) with Verteporfin: 67221 .... 1st QTR 2003 24 CT
.... 1st QTR 2003 26 FL
OIG Warns against Misuse of HHS Words, Symbols, Emblems .... 3rd QTR 2003 43
Order Form – 2003 Part B Materials .... 1st QTR 2003 43 CT
.... 1st QTR 2003 46 FL
.... 2nd QTR 2003 63
.... 3rd QTR 2003 96
Outpatient Physical or Speech Therapy Certification—Clarification .... 3rd QTR 2003 36
Outpatient Rehabilitation Services, Implementation of the Financial Limitation for .... 3rd QTR 2003 33

P

Penal Authority, Claims for Medicare Beneficiaries in State or Local Custody under a .... 1st QTR 2003 38 CT
.... 1st QTR 2003 40 FL
Percutaneous Image-Guided Breast Biopsy, Coverage and Billing for .... 1st QTR 2003 17 CT
.... 1st QTR 2003 15 FL
Clarification .... 2nd QTR 2003 19
Positron Emission Tomography (PET) Scans: G0030 1st QTR 2003 23 CT
.... 1st QTR 2003 22 FL
Primary Payers, How to Submit Claims to Medicare When There are Multiple .... 3rd QTR 2003 44
Prosthetics and Orthotics, Billing - HCPCS Updates .. 1st QTR 2003 11 CT
.... 1st QTR 2003 11 FL
Psychotropic Drug Use in Skilled Nursing Facilities (SNF) .... 1st QTR 2003 36 CT
.... 1st QTR 2003 38 FL

R

Reader Survey Results, *Medicare B Update!* .... 3rd QTR 2003 9
Remark Code for Claims of Therapy Services Possibly Subject to Home Health Consolidated Billing, Additional .... 1st QTR 2003 34 CT
.... 1st QTR 2003 37 FL
Remittance Advice Coding and Health Insurance Portability and Accountability Act (HIPAA) Transaction 835v4010 Completion Update .... 1st QTR 2003 38 CT
.... 1st QTR 2003 41 FL
Remittance Advice Notices, Changes to Medicare Provider .... 3rd QTR 2003 56
Remittance Advice Remark and Reason Code Update 3rd QTR 2003 51
Reviews, Widespread Probe .... 1st QTR 2003 18 CT
.... 1st QTR 2003 17 FL

S

Skilled Nursing Facilities (SNF), Psychotropic Drug Use in .... 1st QTR 2003 36 CT
.... 1st QTR 2003 38 FL
Skilled Nursing Facility (SNF) Consolidated Billing (CB) to Permit Payment for Certain Diagnostic Services Furnished to Beneficiaries Receiving Treatment for End Stage Renal Disease (ESRD) at an Independent or Provider-Based Dialysis Facility, Revisions to Common Working File (CWF) Edits for .. 2nd QTR 2003 29

Skilled Nursing Facility (SNF) Consolidated Billing (CB), Notification of Updates to Coding Files on CMS Web Site for .... 2nd QTR 2003 28
Skilled Nursing Facility (SNF) Stay, Physicians Rendering Services To Patients in a Covered Part A .... 1st QTR 2003 35 CT
.... 1st QTR 2003 37 FL
Smoke, New Demonstration Project Available for Seniors with Medicare Who .... 3rd QTR 2003 63
Specialty Codes Update .... 3rd QTR 2003 50
Stop Smoking Program, Medicare .... 3rd QTR 2003 63
Surrogate Unique Physician Identification Numbers (Surrogate UPINs), Diagnostic Services Ordered with ..... 2nd QTR 2003 10
Surrogate Unique Physician Identification Numbers (UPIN), Durable Medical Equipment Ordered with .... 1st QTR 2003 11 CT
.... 1st QTR 2003 11 FL
Survey, Reader —*Medicare B Update!* .... 2nd QTR 2003 31

T

Telehealth Services, Psychatric Diagnostic Interview Examination .... June 2003* 3
Telehealth Update, Medicare .... 2nd QTR 2003 19
Topical Hyperbaric Oxygen Chamber, Change in Jurisdiction for .... 1st QTR 2003 12 CT
.... 1st QTR 2003 12 FL
Tympanometry: *92567* .... 1st QTR 2003 26 CT
.... 1st QTR 2003 31 FL

U

Unique Physician Identification Number (UPIN) Directory Access, FCSO Announces Change in .... 3rd QTR 2003 50

V

Vaccines, Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus —Correction to Article .... 2nd QTR 2003 6

W

Weekly Radiation Therapy Management .... 2nd QTR 2003 19
Widespread Probe Review Results: *88108* .... 1st QTR 2003 25 CT
.... 1st QTR 2003 30 FL
Widespread Probe Review Results: Oral Surgery .... 1st QTR 2003 22 CT
.... 1st QTR 2003 22 FL
Widespread Probe Reviews .... 1st QTR 2003 18 CT
.... 1st QTR 2003 17 FL

Connecticut Only

A

Advance Notice Statement .... 2nd QTR 2003 34
.... 3rd QTR 2003 65
Ambulance Origin and Destination Modifiers in the MCS, Filing .... Oct 2002 4
Ambulatory Surgical Centers (ASCs) Must Submit Modifier SG .... Jan 2003 2
Anesthesia Units Displayed on Remittance Notices .... Oct 2002 3
ANSI Record/Field Changes for MCS, Specific NSF/ ...... Dec 2002 2
Antineoplastic Drugs–Additions to Policy: J9999 .... 1st QTR 2003 23

B

Basic Radiation Dosimetry Calculation: *77300* .... 2nd QTR 2003 37
Beta2 Microglobulin: *82232* .... 2nd QTR 2003 38
Bone Mineral Density Studies: *76075* .... 1st QTR 2003 24

C

Carrier Jurisdiction for Medicare Payments .... Nov 2002 2
Checks and Remittance Advices, Changes to Medicare ... Oct 2002 2
Claim Filing Requirements, Form CMS-1500 .... 3rd QTR 2003 73
Claim Filing Requirements, Multi-Carrier System Processing and CMS-1500 .... Nov 2002 3
Clinical Laboratory Fees, 2003 Connecticut .... Jan 2003* 16
Clinical Psychologists and Clinical Social Workers, 2003 Fee Schedule for Connecticut .... Jan 2003* 13
Clinics, Provider Numbers for Professional Association Groups .... Oct 2002 1

Comprehensive Data Analysis
Article Clarification: *88311* .... 3rd QTR 2003 67
Comprehensive Data Analysis Findings—Eye Exams .... 3rd QTR 2003 67
Widespread Probe—Eye Exam Codes .... 3rd QTR 2003 68
Correct Payment of January and February 2003 Physician Services .... 3rd QTR 2003 12
Customer Service Needs Your Help .... Jan 2003 1

D

Date Last Seen, Practitioners Who Are Required To Submit a .... Oct 2002 5
Denials Based on Local Medical Review Policy, Provider Notification of .... 2nd QTR 2003 36
Diabetic Testing Supplies, New Medicare Medical Review Guidelines for Claims for .... 1st QTR 2003 12
DMERC A Publications for Fiscal Year 2003, Changes to .... 2nd QTR 2003 32
DMERC A, Establishment of New P.O. Boxes for ...... 2nd QTR 2003 32
DMERC Provider Communications (PCOM) Advisory Group, The Region A .... 2nd QTR 2003 33
DMEPOS Fees, 2003 Connecticut .... Jan 2003* 20
Duplicate Claim Receipts, Help us Reduce .... 3rd QTR 2003 11

E

EDI Alert, Special: Avoiding Rejects in the MCS .... Dec 2002 1
EDI Contact Information .... Dec 2002 1
EDI Process Changes, Other .... Dec 2002 7
EDI Software Vendors, Billing and Clearinghouse Entities, Important Information for Independent .... Nov 2002 7
Electronic Claim Submitters, Important Notice To All .... Jan 2003 3
Electronic Data Interchange (EDI) Information for Providers, Vendors, Clearinghouses, Billing Services, Service Bureaus, and In-house Programmers, Important Medicare .... Dec 2002
Email Notification Service Available, Free Automatic .... Jan 2003 3
Evaluation and Management Services in Ophthalmology and Optometry: *92002* .... 2nd QTR 2003 39
Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterizations, *36245* .... 3rd QTR 2003 66

F

FDA Approvals,. Recent .... 2nd QTR 2003 40
Fluorescein Angiography: *92235* .... 1st QTR 2003 26
Frequently Asked Questions and Answers .... Nov 2002 6

G

Groups/Clinics, Provider Numbers for Professional Association .... Oct 2002 1
Group Psychotherapy: *90853* .... 2nd QTR 2003 39

H

HCPCS Update, Policy Changes Related to the 2003 2nd QTR 2003 34

I

ICD-9-CM Codes Will Be Date of Service Driven, Annual Updating of .... Nov 2002 3
Important Addresses, Phone Numbers, And Web Sites—Connecticut .... 3rd QTR 2003 97
Independent Diagnostic Testing Facilities (IDTFs), Change In Billing the Place of Service for .... Jan 2003 2
Index to Fiscal Year 2002 Connecticut *Medicare B Update!* .... Jan 2003* 29
Individual Psychotherapy: *90804* .... 2nd QTR 2003 38
Intensity Modulated Radiation Therapy (IMRT): 77302 2nd QTR 2003 38
Interactive Group Psychotherapy: *90857* .... 2nd QTR 2003 39
Interactive Individual Psychotherapy: *90810* .... 2nd QTR 2003 39
Interactive Voice Response System, The New Multi-Carrier System Digital .... Nov 2002 4
Internal Control Numbers (ICN) and Correspondence Control Numbers (CCN) .... Oct 2002 2

J

Jurisdiction for Medicare Payments, Carrier .... Nov 2002 2

L

Local Medical Review Policy

New

Cytogenetic Studies: *88230* .... 3rd QTR 2003 70
G-CSF (Filgrastim, Neupogen®): J1440: .... 3rd QTR 2003 69
Ibritumomab Tiuxetan (Zevalin™): ZEVALIN: .... 3rd QTR 2003 69
Pegfilgrastim (Neulasta™): J3490 .... 3rd QTR 2003 69

Revised

Ground Ambulance Services: A0425 .... 3rd QTR 2003 70
Hyperbaric Oxygen Therapy (HBO Therapy): *99183* . 3rd QTR 2003 71
Mammography: *98041* V1.1 FINAL .... 3rd QTR 2003 71
Medical Nutrition Therapy (MNT): *97802* .... 3rd QTR 2003 71
Pamidronate (Aredia®, APD): J2430 .... 3rd QTR 2003 70
Physical Medicine and Rehabilitation: *97001* .... 3rd QTR 2003 71

Retired

Clinical Diagnostic Laboratory Services, Retirement of Local Medical Review Policies for Certain .... 3rd QTR 2003 71
Evaluation and Management Services, Retirement of Local Medical Review Policies for .... 3rd QTR 2003 72

M

Mail Directory, Connecticut Medicare Part B .... 2nd QTR 2003 61
MCS Pre-Pass Edits .... Dec 2002 3
MCS Transition, First Coast Service Options, Inc., (FCSO) Answers Questions about the .... Oct 2002 6
MCS, Multiple Months Cannot Be Grouped on Claims in .. Oct 2002 4
MCS, Special EDI Alert: Avoiding Rejects in the .... Dec 2002 1
MCS, Specific NSF/ANSI Record/Field Changes for .... Dec 2002 2
Medical Director, from the .... 1st QTR 2003 3
Medical Review Table of Contents .... 3rd QTR 2003 65
Medicare Secondary Payer— Frequently Asked Questions .... 1st QTR 2003 34
Medigap, Filing Your Patient's .... Oct 2002 5
Metabolically Active Human Dermal/Epidermal Replacements: MAHD/ER .... 2nd QTR 2003 37
Modifier Billing Errors Identified in MCS .... Jan 2003 2
Modifier Requirements .... Nov 2002 2
Modifier Requirements in the MCS .... Oct 2002 3
Modifier SG, Ambulatory Surgical Centers (ASCs) Must Submit .... Jan 2003 2
Modifiers in the MCS, Filing Ambulance Origin and Destination .... Oct 2002 4
Multi-Carrier System (MCS) Post Transition Issues Log ... Jan 2003 3
Multi-Carrier System (MCS) Seminar, **Free** Medicare Part B .... Oct 2002 7
Multi-Carrier System Digital Interactive Voice Response System, The New .... Nov 2002 4
Multi-Carrier System Processing and CMS-1500 Claim Filing Requirements .... Nov 2002 3
Multiple Months Cannot Be Grouped on Claims in MCS ... Oct 2002 4

N

Names, Potential Truncation of .... Oct 2002 3
Non-Invasive Evaluation of Extremity Veins: *93965* ..... 2nd QTR 2003 40
Non-Invasive Physiologic Studies of the Upper or Lower Extremity Arteries: *93922* .... 2nd QTR 2003 39
NSF/ANSI Record/Field Changes for MCS, Specific .... Dec 2002 2

P

Patient Name, Address and Gender Information, Requirements for Submitting .... 1st QTR 2003 6
.... Nov 2002 4
Payments, Carrier Jurisdiction for Medicare .... Nov 2002 2
Pegfilgrastim (Neulasta™), Coverage and Billing for .... 2nd QTR 2003 36
Phone Numbers, Connecticut Medicare .... 2nd QTR 2003 61
Place of Service, Change In Billing the Independent Diagnostic Testing Facilities (IDTFs) for .... Jan 2003 2
Policy Changes Related to the 2003 HCPCS Update . 2nd QTR 2003 34
Portable X-Ray Equipment and Personnel to a Patient's Home or Nursing Facility, HCPCS Codes for Transportation of .... Nov 2002 7
Post Transition Issues Log, Multi-Carrier System (MCS) .. Jan 2003 3
Practitioners Who Are Required To Submit a Date Last Seen .... Oct 2002 5
Pre-Pass Edits, MCS .... Dec 2002 3
Preview® Treatment Planning Software .... 2nd QTR 2003 36
Professional Association Groups/Clinics, Provider Numbers for .... Oct 2002 1
Program Safeguards Contractor for Connecticut, Tri-Centurion Selected as .... 1st QTR 2003 32
Prostate Treatments: *53850* .... 2nd QTR 2003 37
Provider Notification of Denials Based on Local Medical Review Policy .... 2nd QTR 2003 36
Provider Numbers for Professional Association Groups/ Clinics .... Oct 2002 1
Psychiatric Diagnostic Interview Examination: *90801* . 2nd QTR 2003 38

Q

Questions and Answers, Frequently Asked .... Nov 2002 6

R

Radiation Physics Consult: *77336* .... 2nd QTR 2003 38
Record/Field Changes for MCS, Specific NSF/ANSI .... Dec 2002 2
Rejects in the MCS, Avoiding: Special EDI Alert .... Dec 2002 1
Remittance Advices, Changes to Medicare Checks and ... Oct 2002 2
Remittance Notices, Anesthesia Units Displayed on .... Oct 2002 3
Reviews, Telephone .... Jan 2003 1

S

Self Administered Drugs (SAD) List .... 3rd QTR 2003 66
Seminars 2003 Medicare Made Easy Seminars On-site Training .... 2nd QTR 2003 41
Seminars Medicare Education & Outreach Event Registration Form .... 2nd QTR 2003 43
Seminars Medicare Made Easy Seminars Five-Part Series for Part B Providers .... 2nd QTR 2003 43
Seminars Medicare Part B Provider Communications Advisory Group .... 2nd QTR 2003 42

T

Telephone Reviews .... Jan 2003 1
Therapeutic Radiology Simulation-Aided Field Setting: *77280* .... 2nd QTR 2003 37
Treatment Devices, Design and Construction: *77332* .. 2nd QTR 2003 38
Treprostinil (Remodulin®), Durable Medical Equipment Regional Carrier (DMERC) Coverage and Billing of 1st QTR 2003 13
TriCenturion Selected as Program Safeguards Contractor for Connecticut .... 1st QTR 2003 32

W

Web sites, Connecticut Medicare .... 2nd QTR 2003 61
Widespread Probe Review Results: *88311-88313* ...... 1st QTR 2003 26
93922, 93923, 93924 ...... 1st QTR 2003 27
93965, 93970, 93971 ...... 1st QTR 2003 28
Wireless Capsule Endoscopy: G0262 .... 2nd QTR 2003 37

Florida Only

A

Advance Notice Statement .... 2nd QTR 2003 45
.... 3rd QTR 2003 76
Ambulance Claims, Changes in Adjudication Procedures for .... 1st QTR 2003 21
Anesthesia Services (Ocular Procedures): *00103* ...... 1st QTR 2003 24
Antineoplastic Drugs: J9999 .... 1st QTR 2003 23
.... 2nd QTR 2003 51
Apligraf® (Graftskin): J7340—Policy Retired .... 2nd QTR 2003 51
Arthrocentesis: *20600* .... 1st QTR 2003 25

B

Basic Radiation Dosimetry Calculation: *77300* .... 2nd QTR 2003 53
Beneficiary and Provider Customer Service Call Centers, New Telephone Hours of Operation for the Medicare Parts A & B .... 1st QTR 2003 40

C

Calendar of Upcoming Events, Medicare Education and Outreach— .... 1st QTR 2003 45
Claims Delayed but Not Denied or Finalized .... 1st QTR 2003 6

Clinical Diagnostic Laboratory Services, Retirement of
  Local Medical Review Policies for Certain .... 2nd QTR 2003 53
Clinical Laboratory Fees, 2003 Florida .... Jan 2003* 24
Clinical Psychologists and Clinical Social Workers,
  2003 Fee Schedule for Florida .... Jan 2003* 21
Comprehensive Data Analysis .... 3rd QTR 2003 78
  Article Clarification: *88311* .... 3rd QTR 2003 80
  Laboratory Procedures .... 3rd QTR 2003 79
  Myocardial Perfusion Studies .... 3rd QTR 2003 78
  New and Established Physician Home Visit Services
    to Undergo Widespread Probe of Multiple Providers
    in Florida: *99341-99350* .... 3rd QTR 2003 82
Pulmonary Function Tests .... 3rd QTR 2003 80

Computerized Axial Tomography of the Abdomen:
  74150 .... 2nd QTR 2003 53
Computerized Tomography Scans: *70450*—
  Correction to Policy .... 2nd QTR 2003 52
Correct Payment of January and February 2003
  Physician Services .... 3rd QTR 2003 12
Customer Service Call Centers, New Telephone Hours
  of Operation for the Medicare Parts A & B Beneficiary
  and Provider .... 1st QTR 2003 40

D

Deep Brain Stimulation: *61862* .... 1st QTR 2003 26
Denials Based on Local Medical Review Policy,
  Provider Notification of .... 2nd QTR 2003 49
Diabetes Outpatient Self-Management Training:
  G0108 .... 2nd QTR 2003 50
DMEPOS Fees, 2003 Florida .... Jan 2003* 28

E

Extracardiac Arteriography Associated and Billed with
  Primary Cardiac Catheterizations: *36245* .... 1st QTR 2003 25

F

Faxes, Provide Complete Cover Information on .... 2nd QTR 2003 44
FDA Approvals, Recent .... 2nd QTR 2003 51

G

Group Psychotherapy: *90853* .... 2nd QTR 2003 54

H

HCPCS Update, Policy Changes Related to the 2003 2nd QTR 2003 45
HIV-1 Viral Load Testing: *87536* .... 1st QTR 2003 30

I

ICD-9-CM Codes Must Be Date of Service Driven,
  Annual Updating of .... 1st QTR 2003 6
Important Addresses, Phone Numbers, And Web Sites—
  Florida .... 3rd QTR 2003 98
Incision and Drainage of Abscess of Skin, Subcutaneous
  and Accessory Structures: *10060* .... 1st QTR 2003 24
Independent Diagnostic Testing Facility (IDTF): 00001 1st QTR 2003 24
Index to Fiscal Year 2002 Florida *Medicare B Update!* ..... Jan 2003* 33
Individual Psychotherapy: *90804* .... 2nd QTR 2003 53
Interactive Individual Psychotherapy: *90810* .... 2nd QTR 2003 54
Interferon: J9212 .... 1st QTR 2003 23
Intravenous Immune Globulin (IVIG), J1561 .... 1st QTR 2003 22

L

Laboratory Services, Temporary Suspension of Utilization
  Screens for .... 1st QTR 2003 21
Local Medical Review Policy
  Corrections
  Clinical Diagnostic Laboratory Services, Retirement
    of Local Medical Review Policies for Certain—
    Correction .... 3rd QTR 2003 90
  Group Psychotherapy: *90853* .... 3rd QTR 2003 90
  Individual Psychotherapy: *90804* .... 3rd QTR 2003 90
  Interactive Individual Psychotherapy: *90810* .... 3rd QTR 2003 90
  New
  Bone and/or Joint Imaging: *78300* .... 3rd QTR 2003 85
  Comprehensive Motion Analysis: *96000* .... 3rd QTR 2003 85
  Ibritumomab Tiuxetan (Zevalin™) Therapy: ZEVALIN 3rd QTR 2003 84
  Laser Treatment for Psoriasis: *96920* .... 3rd QTR 2003 85
  Leucovorin (Wellcovorin®): J0640 .... 3rd QTR 2003 83
  Pegfilgrastim (Neulasta™): J3490 .... 3rd QTR 2003 84
  Specialty Care Transport: A0434 .... 3rd QTR 2003 83
  Revised
  Air Ambulance Services: A0430 .... 3rd QTR 2003 86
  Botulinum Toxin Type A (Botox): J0585 .... 3rd QTR 2003 86
  Computed Tomography of the Abdomen, *74150* .... 3rd QTR 2003 89
  Deep Brain Stimulation, *61862* .... 3rd QTR 2003 88
  Diabetes Outpatient Self-Management Training (DSMT):
    G0108 .... 3rd QTR 2003 86
  Dysphagia/Swallowing Diagnosis and Therapy, *70370* 3rd QTR 2003 88
  G-CSF (Filgrastim, Neupogen): J1440 .... 3rd QTR 2003 87
  Ground Ambulance Services: A0425 .... 3rd QTR 2003 86
  Hyperbaric Oxygen Therapy (HBO Therapy), *99183* . 3rd QTR 2003 89
  Independent Diagnostic Testing Facility (IDTF),
    00001 .... 3rd QTR 2003 88
  Interactive Group Psychotherapy, *90857* .... 3rd QTR 2003 89
  Interferon, J9212 .... 3rd QTR 2003 87
  Magnetic Resonance Imaging (MRI) of Any Joint of the
    Lower Extremities, *73721* .... 3rd QTR 2003 89
  Medical Nutrition Therapy (MNT), *97802* .... 3rd QTR 2003 89
  Noncovered Services, The List of Medicare:
    NCSVCS .... 3rd QTR 2003 87
  Physical Medicine and Rehabilitation, *97010* .... 3rd QTR 2003 89
  Protein A Column Apheresis, *36515* .... 3rd QTR 2003 88
  Psychiatric Diagnostic Interview Examination, *90801* 3rd QTR 2003 89
  Scanning Computerized Ophthalmic Diagnostic
    Imaging, *92135* .... 3rd QTR 2003 89
  Vitamin D Analogs in Chronic Renal Disease: J0636 3rd QTR 2003 86
  Retired
  Insulin Injection: J1820 .... 3rd QTR 2003 90
  Self-Administered Drugs: J0001 .... 3rd QTR 2003 90

M

Medicare Education and Outreach—Calendar of
  Upcoming Events .... 1st QTR 2003 45
  .... 2nd QTR 2003 55
Medical Review-Table of Contents .... 3rd QTR 2003 76
Metabolically Active Human Dermal/Epidermal
  Replacements: MAHD/ER .... 2nd QTR 2003 52
Myocardial Perfusion Imaging: *78460* .... 1st QTR 2003 30

N

Noncovered Services, the List of Medicare: NCSVCS . 1st QTR 2003 23
  .... 2nd QTR 2003 52
Non-Invasive Evaluation of Extremity Veins: *93965* ..... 2nd QTR 2003 54

O

Osteogenic Stimulation: *20974* .... 1st QTR 2003 25

P

Pamidronate (Aredia®, APD): J2430 .... 2nd QTR 2003 51
Part B Mail Directory, Florida Medicare .... 2nd QTR 2003 62
Pegfilgrastim (Neulasta™), Coverage and Billing for ... 2nd QTR 2003 50
Peripheral Neuropathy with Loss of Protective Sens-
  ation (LOPS): G0245 .... 2nd QTR 2003 51
Phone Numbers, Florida Medicare .... 2nd QTR 2003 62
Physician's Focus, A .... 1st QTR 2003 3
  .... 2nd QTR 2003 3
Policy Changes Related to the 2003 HCPCS Update . 2nd QTR 2003 45
Preview® Treatment Planning Software .... 2nd QTR 2003 50
Program Safeguards Contractor for Florida, TriCenturion
  Selected as .... 1st QTR 2003 35
Proper Billing for Correction of Trichiasis—Clarification 3rd QTR 2003 77
Proper Reporting of Electrocardiac Mapping System .. 3rd QTR 2003 77
Proper Reporting of Quantitative Sensory Testing .... 3rd QTR 2003 77
Prostate Treatments: *53850* .... 2nd QTR 2003 52
Provider Customer Service Call Center, New Changes
  for Florida Medicare Part B .... 1st QTR 2003 40
Provider Customer Service Call Centers, New Telephone
  Hours of Operation for the Medicare Parts A & B
  Beneficiary and .... 1st QTR 2003 40
Provider Notification of Denials Based on Local Medical
  Review Policy .... 2nd QTR 2003 49
Ptosis/Blepharoplasty Procedures .... 3rd QTR 2003 77

Q

Qualitative Drug Screen: *80100* .... 2nd QTR 2003 53

R

Retirement of Local Medical Review Policies for Certain Clinical Diagnostic Laboratory Services .... 2nd QTR 2003 53

S

Sedimentation Rate, Erythrocyte: *85651* .... 1st QTR 2003 30
Self Administered Drugs (SAD) List .... 3rd QTR 2003 77
Seminars Medifest 2003 .... 2nd QTR 2003 55
Seminars Medifest Class Schedule .... 2nd QTR 2003 56
Seminars Medifest Registration Form .... 2nd QTR 2003 57
Strapping: *29540* .... 1st QTR 2003 25
.... 2nd QTR 2003 52

T

Telephone Hours of Operation for the Medicare Parts A & B Beneficiary and Provider Customer Service Call Centers, New .... 1st QTR 2003 40
Therapeutic Radiology Simulation-Aided Field Setting: *77280* .... 2nd QTR 2003 53
TriCenturion Selected as Program Safeguards Contractor for Florida .... 1st QTR 2003 35

V

Viscosupplementation: VISCO .... 1st QTR 2003 23

W

Web Cast Schedule and Registration Information ...... 3rd QTR 2003 90
Web sites, Florida Medicare .... 2nd QTR 2003 62
Widespread Probe Review Results:
11730, 11750, 11765 .... 1st QTR 2003 24
66761 .... 1st QTR 2003 26
70450 .... 1st QTR 2003 27
76375 .... 1st QTR 2003 28
76536 .... 1st QTR 2003 29
78306 .... 1st QTR 2003 29
Wireless Capsule Endoscopy: G0262 .... 2nd QTR 2003 51

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.

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: Accounting

Use this attention line to return duplicate payments or overpayment refunds.

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: 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

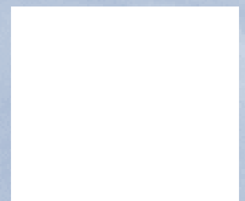
BENEFICIARY

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 ***