Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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

The *Medicare B Update!* should be shared with all healthcare 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
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- ❑ Other _____

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The *Medicare B Update!* is published quarterly by the Medicare Publications Department of First Coast Service Options, Inc., to provide timely and useful information to Medicare Part B providers in Connecticut and Florida.

Questions concerning this publication or its contents may be directed in writing to:

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Jacksonville, FL
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A Physician's Focus

A note for our readers: The *Medicare B Update!* is now consolidated for Connecticut and Florida. Dr. Sidney R. Sewell, who is Contractor Medical Director for First Coast Service Options, Inc. (FCSO) and Carrier Medical Director for Florida, and Dr. Frank A. Delli Carpini, Carrier Medical Director for Connecticut, will at times alternate providing the Medical Director's column for the quarterly publication. Other times, they may both provide a column for the *Medicare B Update!*

Dr. Sewell provided the Medical Director's column for this quarter's issue.

"The 2003 Physician Fee Schedule and Participation Enrollment"

Due to publication of the final regulation being delayed past November 1, 2002, the calendar year (CY) 2003 Medicare Physician Fee Schedule (MPFS), which contains participation enrollment materials, was distributed late. Providers should have received a copy of the MPFS booklet by now. If not, a copy may be printed free of charge from our provider educationWeb sites, *wwww.connecticutmedicare.com* and *www.floridamedicare.com*.

There are several unusual factors affecting this year's fee schedule and participation enrollment. Some of them are:

- Physicians/practitioners will have until February 28, 2003 to make their decision on Medicare participation for 2003. **This enrollment period differs from what is printed in the MPFS booklets**. This is because the booklets were printed before the final rule was delayed. Enrollment decisions are effective January 1, 2003, regardless of the date they are submitted.
- **The CY 2003 MPFS fees are not effective until March 1, 2003**. Claims for physician services for dates of service in January and February 2003 that are *processed* before March 1, 2003 will be paid at the **CY 2002 payment rates**.
- Claims for physician services for dates of service in January and February 2003 that are processed *after* March 1, 2003, will initially be paid at the **CY 2003 payment rates**. Beginning in July 2003, we will automatically make adjustments to pay providers the difference between what was initially paid for these claims and what should have been paid based on the 2002 rates.
- **Physicians/practitioners should not use the new CY 2003 HCPCS codes for MPFS services performed during the months of January and February 2003**. If claims for the new HCPCS codes are submitted before March 1, 2003, carriers will hold the claims until March 1, 2003 and then pay the code at the 2003 rate. If a January or February 2003 service must be billed with a new HCPCS code, it should be billed on a separate claim so that other services, with 2002 HCPCS, will not be held for payment until March 1.
- **The CY 2003 payment amounts for all other services (i.e., services not paid under the physician fee schedule such as covered drugs) are effective January 1, 2003**.

Under current law, the 2003 MPFS implements an overall payment reduction of 4.4%. This is not across the board and some fees may be reduced by more than 4.4% while other fees may actually increase. The overall 4.4% negative fee update reflects a defect in the statutory formula for computing Medicare physician fees. The Centers for Medicare & Medicaid Services (CMS) is working with Congress on legislation to correct this error.

Sincerely,

Sidney R. Sewell, M.D.
Contractor Medical Director

ADMINISTRATIVE

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	November 2002	January 1, 2003
Second Quarter 2003	February 2003	April 1, 2003
Third Quarter 2003	May 2003	July 1, 2003
Fourth Quarter 2003	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?*

Distribution of the *Update!* is limited to individual providers and professional association (PA) groups who bill 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 sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing copies to *all* practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. For additional copies, providers may purchase a separate annual subscription for $70 (order form on page 66). Issues published since 1997 may be downloaded from the provider education Web sites, free of charge.

FCSO Medicare Part B uses the same mailing address for *all* correspondence, and cannot designate that each issue of the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department.

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 and focused medical review** 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 provider education 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 healthcare treatment decisions. An ABN must meet the following requirements:

- The ABN must be on an approved Form CMS-R-131 (see "New Patient Liability Notice" below)
- The ABN must be given in writing, in advance of furnishing the service or item.
- The ABN must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., the service is not covered based on the patient's diagnosis, the frequency of the service was in excess of accepted standards of medical practice, etc.).
- The notice must be signed and dated by the patient, indicating the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for reason(s) indicated on the ABN. The signature of the provider of service is not required.
- The ABN should be maintained with the patient's medical record.

New Patient Liability Notice

Form CMS-R-131 is the new approved ABN, ***required for services provided on or after January 1, 2003***. Form CMS-R-131 was developed as part of the Centers for Medicare & Medicaid Services' (CMS) Beneficiary Notices Initiative (BNI), and was approved by OMB (Office of Management and Budget) on June 18, 2002. The new ABNs are designed to be more beneficiary-friendly, more readable and understandable, with patient options more clearly defined.

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

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

ABN Modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

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

CLAIMS

Carrier Jurisdiction for Medicare Payments When the Beneficiary Has an Out-of-State Address

The jurisdictional payment policy for Medicare payments was implemented with conversion to the Multi-Carrier System (MCS). Connecticut Medicare converted on February 3, 2003; in Florida the conversion took place March 8, 2002. However, this national policy is effective for all claims received on or after July 1, 2001. Information concerning this policy was furnished to Connecticut providers in the November 2002 *Medicare B Update!* special issue, "Conversion to Medicare's Multi-Carrier System" (pages 1-2). Florida providers were notified in the December 2001 *Medicare B Update!* MCS special issue (pages 1-2), and in the Second Quarter 2002 *Update!* (page 6).

Based on the jurisdictional pricing policy, the MCS refers to the beneficiary's home address to determine carrier payment jurisdiction. If a carrier's beneficiary information reflects an out-of-state address, the services are considered to be outside that carrier's jurisdiction and would be correctly denied as unprocessable.

However, in the case of a beneficiary whose claims are being denied for jurisdictional pricing when the carrier's records reflect he/she has an out-of-state address but is in state temporarily, that beneficiary can have a temporary address added to our files. In these cases, the MCS will look at the temporary address and process the claim accordingly. **The beneficiary or his/her representative must contact our office to provide us with their temporary address. To expedite these requests, the beneficiary (or authorized representative) is encouraged to call our office toll-free*.** In Connecticut, the beneficiary number is 1 (800) 982-6819; in Florida, it is 1 (800) 333-7586.

Once our records have been updated to reflect the temporary address, denied claims can be reopened for payment.

***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.

Correct Coding Initiative

Version 9.1 of the Correct Coding Initiative (CCI) will be implemented April 1, 2003, and includes all previous versions and updates from January 1996 to the present.

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

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

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

Information related to CCI may be obtained by ordering a national correct coding policy manual from NTIS.

- Single issues of the national correct coding policy manual may be requested by calling (703) 605-6000.
- Subscriptions to the national correct coding policy may be requested by calling (703) 605-6060 or (800) 363-2068.
- To receive information from NTIS by mail, call (800) 553-6847.
- Ordering and product information is also available online at *http://www.ntis.gov/products/families/cci/index.asp*

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

As a reminder, FCSO Medicare is not liable for information provided and/or published by AdminaStar Federal and/or NTIS.

Source: CMS Transmittal B-02-088 CR 2477

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Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines—Correction to Article

It has been noted that contradictory information was provided in the Fourth Quarter 2002 *Medicare B Update!* regarding the unique physician identification number (UPIN) requirements when billing for pneumococcal pneumonia vaccinations (PPV). Specifically, the text on page 15 indicates that a UPIN is no longer required; however, the table that follows the article states a UPIN is required in item 17A of Form CMS-1500.

Per section 4480.3 of the Medicare Carriers Manual (MCM), the text on page 15 is correct. Effective for claims with dates of service on or after July 1, 2000, no UPIN is required for PPV claims; Medicare no longer requires that the vaccine be administered under a physician's order or supervision.

We apologize for any inconvenience this may have caused.

Source: MCM section 4480.3

COVERAGE/REIMBURSEMENT

AMBULANCE

Second Clarification Regarding Ambulance Fee Schedule Implementation

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen that require clarification. This article provides additional guidance on these issues, and supplements previously issued instructions regarding the implementation of the ambulance fee schedule.

Change in Medicare Policy Concerning Bed-Confinement

The final rule published in the *Federal Register* on February 27, 2002 (67 FR 9100) supersedes earlier Medicare policy on the issue of bed-confinement. The preamble of the final rule states that the beneficiary is bed-confined if he/she is: unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair. As defined in the preamble, the term "bed confined" is not synonymous with "bed rest" or "nonambulatory." Medicare's current policy is that bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's/carrier's determination. Therefore, the current regulations (42 CFR section 410.40(d)) provide that a Medicare ambulance transport may only be payable if other forms of transportation are contraindicated by the beneficiary's condition. This policy is effective with the implementation of the Medicare fee schedule on April 1, 2002.

Mandatory Assignment Rules

Mandatory Assignment and Claim Submittal Requirements

When an ambulance provider/supplier, or a third party under contract with the provider/supplier, furnishes a Medicare-covered ambulance service to a Medicare beneficiary and the service is not statutorily excluded under the particular circumstances, the provider/supplier must submit a claim to Medicare and accept assignment of the beneficiary's right to payment from Medicare.

Mandatory Assignment for Managed Care Providers/Suppliers

Mandatory assignment for ambulance services, in effect with the implementation of the ambulance fee schedule on April 1, 2002, applies to ambulance providers/suppliers under managed care as well as under fee-for-service. (The ambulance fee schedule is effective for claims with a date of service on or after April 1, 2002.) During the fee schedule transition period, Medicare payment for ambulance services is a blend of the reasonable cost/charge and fee schedule amount (80 percent reasonable cost/charge amount, and 20 percent fee schedule amount for services furnished in 2002).

Per 42 CFR section 422.214, any provider or supplier without a contract establishing payment amounts for services provided to a beneficiary enrolled in a Medicare + Choice (M+C) coordinated care plan or M+C private fee-for-service plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare. The provider or supplier can collect from the M+C plan enrollee the cost-sharing amount required under the M+C plan, and collect the remainder from the M+C organization.

Mandatory Assignment and Beneficiary Signature Requirements

Medicare requires the signature of the beneficiary, or that of his/her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, a representative payee, relative, friend, representative of the institution providing care, or a government agency providing assistance may sign on his/her behalf. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his/her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment. (Per 42 CFR section 424.44, there is a 15 to 27 month period for filing a Medicare claim.)

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary (or his/her estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

Claims Jurisdiction for Air Ambulance Suppliers During the Transition Period

During the transition period, air ambulance suppliers must continue to submit claims to the carrier that has jurisdiction for the locality in which its air ambulance is based (i.e., garaged or hangared), per MCM sections 3102.C.1 and 2. Payment of a claim during the transition period is determined in part by the reasonable charge amount established in the carrier jurisdiction where the ambulance is based (i.e., garaged or hangared) and in part by the fee schedule amount in the jurisdiction of the point-of-pickup, as represented by its ZIP code.

For suppliers that provide services in multiple states, no additional enrollment is necessary for claims submission until the end of the transition period unless the supplier has established a base in another state. (Only if the supplier has established a base/hangar in another state, must it then also enroll with the carrier for the other state.) The carrier with jurisdiction for the claim has the supplier's reasonable charge amount and also the fee schedule amounts for all states in which the ambulance supplier provides services to determine the blended payment.

Payment for Services Performed Under Standing Orders

Under the Medicare ambulance fee schedule, payment for the transport includes payment for all medically necessary services and supplies. However, during the transition period, a supplier that had previously billed separately for medically necessary services may continue to do so. In situations where a supplier provides a service under a standing order (e.g., a standing order for performing a rhythm strip, placing oxygen, and starting an intravenous line when an advanced life support [ALS] ambulance is called), Medicare payment for such a service depends on whether it is medically necessary.

Under Medicare rules, whether a particular separately billable service is medically necessary is dependent on the particular circumstances of the beneficiary's condition at the time of transport. For the purpose of Medicare payment, services furnished pursuant to a standing order requiring that something be done regardless of the patient's needs are not recognized as being medically necessary on the basis of such an order. Services furnished by licensed personnel based on recognition of patient need and authorized by standing order, such as in an algorithm, or that are consistent with EMT protocols established in that state, can be paid for, provided the services are reasonable and necessary based on the patient's condition at the time they are furnished.

Transport of Persons Other than the Beneficiary

Medicare payment policy remains unchanged with respect to the transport of persons other than the beneficiary. That is, no payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports.

Effect of Beneficiary Death on Medicare Payment for Ground and Air Ambulance Transports

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the state to make such pronouncements.

The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

Ground Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Before dispatch	None
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup).	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim.
After pickup, prior to or upon arrival at the facility.	Medically necessary level of service receiving furnished.

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the Medicare payment determination is based on whether the beneficiary was onboard the air ambulance. (See "Payment for Air Ambulance… Canceled due to Weather…" below.)

Air Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	None. **Note:** This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.)
After takeoff to point-of-pickup, but before the beneficiary is loaded.	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim.
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the beneficiary had not died.

Payment for Air Ambulance Transports Canceled Due to Weather or Other Circumstance Beyond the Pilot's Control

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather, or other circumstance beyond the pilot's control.

Air Ambulance Scenarios: Aborted Flights	
Aborted Flight Scenario	**Medicare Payment Determination**
Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup.)	None.
Transport after the beneficiary is loaded onboard.	Appropriate air base rate, mileage, and rural adjustment.

Payment When More than One Ambulance Arrives at the Scene

The general Medicare program rule is that the Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport. Ambulance providers/suppliers that arrive on the scene but do not furnish a transport are not due payment from Medicare.

Billing for Ground-to-Air Ambulance Transports

For situations in which a beneficiary is transported by ground ambulance to or from an air ambulance, the ground and air ambulance providers/suppliers providing the transports must bill Medicare independently. Under these circumstances, Medicare pays each provider/supplier individually for its respective services and mileage. Each provider/supplier must submit a claim for its respective services/mileage to the intermediary/carrier that has jurisdiction for the locality in which its ambulance is based. (See "Claims Jurisdiction for Air Ambulance…" above.)

Resident and Nonresident Billing

The ambulance fee schedule has no effect on Medicare's longstanding policy concerning resident versus nonresident billing. In areas that distinguish between residents and nonresidents, Medicare beneficiaries must be charged the same rate as all others in the same category. That is, all residents of a particular jurisdiction must be charged the same "resident" rate and all nonresidents of that city and state must be charged the same "nonresident" rate.

Reasonable Charge Amount for ALS Mileage During the Transition Period

During the transition period, the HCPCS ground mileage code A0425 reasonable charge amount for the blended payment is calculated using a simple average (not a weighted average) of the 2001 reasonable charge allowances for HCPCS codes A0380 and A0390, updated by the ambulance inflation factor. (HCPCS codes A0380 and A0390 are invalid for dates of service on or after April 1, 2002).

If a supplier has established a customary charge for only ALS mileage or only BLS mileage, then that customary charge, subject to the inflation indexed charge (IIC) rules, is used to establish the supplier-specific customary charge amount for the reasonable charge portion of the blended payment for A0425 during the transition period. However, the program's payment allowance for the reasonable charge portion of the blended transition rate for A0425 is based on the lower of the supplier's customary charge (subject to the IIC rules), the prevailing charge, or the prevailing IIC. Therefore, the payment allowance under the reasonable charge portion of the blended payment for A0425 during the transition period will not exceed the prevailing charge or prevailing IIC that includes both BLS mileage and ALS mileage charge data for the locality in which the charge data was accumulated. The program's payment allowance for A0425 is then based on the lower of the blended rate and the actual charge on the claim.

Physician Certification Statement Requirements

The current regulations governing physician certification statement (PCS) requirements are specified at 42 CFR section 410.40(d). A PCS is required for the following ambulance services:

- Nonemergency, scheduled, repetitive ambulance services
- Unscheduled, nonemergency ambulance services or nonemergency ambulance services scheduled on a nonrepetitive basis for a resident of a facility who is under the care of a physician.

Note: For nonemergency, scheduled, repetitive ambulance services, the physician's order must be dated no earlier than 60 days before the date that the service is furnished.

A PCS is not required for the following ambulance services:

- Emergency
- Nonemergency, unscheduled ambulance services for a beneficiary who, at the time of the transport, was residing either at home or in a facility and who was not under the direct care of a physician.

If unable to obtain the physician's signature, it is acceptable to obtain a signed certification statement from the physician assistant, nurse practitioner, registered nurse, or clinical nurse specialist (where all applicable state licensure or certification requirements are met), or discharge planner, who has personal knowledge of the beneficiary's condition at the time that the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported.

For nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis, providers/suppliers must obtain a written order from the beneficiary's attending physician, within 48 hours after the transport, per 42 CFR section 410.40(d)(3). If unable to obtain a written order from the attending physician within 48 hours, providers/suppliers may submit a claim for the service if a PCS or certification from an acceptable alternative person as described in

42 CFR section 410.40(d)(3)(iii) has been obtained, or after 21 days if acceptable documentation of attempts to obtain the certification has been obtained. This policy also applies in a situation where a provider/supplier responds to a nonemergency call and, upon arrival at the point-of-pickup, the condition of the beneficiary requires emergency care.

Note: Although the condition of the beneficiary in this scenario would require the provider/supplier to concentrate on the emergent treatment of the patient upon arrival at the scene, the claim for this service would not qualify as an "emergency transport," as defined in program memorandum AB-02-130.

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.

Source: CMS Transmittal AB-03-007, CR 2470

DIAGNOSTIC TESTS

Diagnostic Services Ordered with Surrogate Unique Physician Identification Numbers (Surrogate UPINs)

Medicare Part B carriers were recently instructed by the Centers for Medicare & Medicaid Services (CMS) to identify excessive use of surrogate UPINs among its provider base. Upon identification, these providers have been or will be addressed individually for education related to appropriate UPIN usage.

In addition, recent comprehensive data analyses (CDA) results indicate abnormally high usage of surrogate UPINs. The number one UPIN found on claims associated with diagnostic laboratory procedures was "OTH000."

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

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

Providers who are using the surrogate UPIN OTH000 can utilize the searchable UPIN database on our provider education Web sites, *www.connecticutmedicare.com* and *www.floridamedicare.com,* to obtain the referring physician's UPIN . Providers may also access one of the following Web sites for UPIN information in states other than Connecticut and Florida (see third party Web site disclaimer, below):

http://upin.ecare.com
http://www.accuchecker.com/UPIN
http://www.hmedata.com/free
http://www.icd9.com/FUPIN.html
http://www.benchmark-systems.com/upin/index.cfm

When you locate a UPIN for the ordering/referring physician you should update your records to ensure that a valid UPIN is used in place of the surrogate UPIN OTH000. You should have a process in place to update your UPIN references when new physicians are ordering tests at your site. When new physicians order tests at your facility and you cannot obtain his/her UPIN you can call our customer service department and we will determine if the physician has a UPIN . (In Connecticut, call 1(866) 419-9455; in Florida, call 1(866) 454-9007.)

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

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

***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.*

Ordering Diagnostic Tests

Effective for services provided on or after January 1, 2003, the Centers for Medicare & Medicaid Services (CMS) has revised section 15021(C) of the Medicare carriers manual (MCM) to broaden the instructions to include additional physicians as interpreting physicians.

For purposes of ordering diagnostic tests, an interpreting physician is defined as a: radiologist, cardiologist, family practitioner, general internist, neurologist, obstetrician, gynecologist, ophthalmologist, thoracic surgeon, or vascular surgeon.

Source: CMS Transmittal 1787, CR 2410

DRUGS AND BIOLOGICALS

Deletion of Q Codes and Reactivation of *CPT* Codes for Hepatitis B Vaccine

On November 1, 2002, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 2392, which provided information concerning new codes to be used in billing for hepatitis B vaccine effective January 1, 2003. The decision to make these changes has been reconsidered. Codes Q3021, Q3022, and Q3023 will *not* be established as new codes for Medicare purposes at this time. Therefore, CMS is reactivating *CPT* (*Current Procedural Terminology*) codes *90740*, *90743*, *90744*, *90746*, and *90747* effective January 1, 2003.

Source: CMS Transmittal AB-02-185, CR 2356

END-STAGE RENAL DISEASE

Levocarnitine for use in Treatment of Carnitine Deficiency in End-Stage Renal Disease (ESRD) Patients

Carnitine is a naturally occurring substance that functions in the transport of long-chain fatty acids for energy production by the body. Deficiency can occur due to a congenital defect in synthesis or utilization, or from dialysis. The causes of carnitine deficiency in hemodialysis patients include dialytic loss, reduced renal synthesis, and reduced dietary intake.

Effective January 1, 2003, intravenous levocarnitine is covered only for those ESRD patients who have been on dialysis for a minimum of three months for one of the following indications:

Patients must have documented carnitine deficiency, defined as a plasma free carnitine level<40 micromol/L (determined by a professionally accepted method as recognized in current literature), along with signs and symptoms of:

1. Erythropoietin–resistant anemia (persistent hematocrit <30 percent with treatment) that has not responded to standard erythropoietin dosage (that which is considered clinically appropriate to treat the particular patient) with iron replacement, and for which other causes have been investigated and adequately treated, or
2. Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management). Such episodes of hypotension must have occurred during at least two dialysis treatments in a 30-day period.

Continued use of levocarnitine will not be covered if improvement has not been demonstrated within six months of initiation of treatment. All other indications for levocarnitine are noncovered in the ESRD population.

For a patient currently receiving intravenous levocarnitine, Medicare will cover continued treatment if:

1. Levocarnitine has been administered to treat erythropoietin-resistent anemia (persistent hematocrit <30 percent with treatment) that has not responded to standard erythropoietin dosage (that which is considered clinically appropriate to treat the particular patient) with iron replacement, and for which other causes have been investigated and adequately treated, or hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management) and such episodes of hypotension occur during at least two dialysis treatments in a 30-day period; and
2. The patient's medical record documents a pre-dialysis plasma free carnitine level <40 micromol/L prior to the initiation of treatment; or

3. The treating physician certifies (documents in the medical record) that in his/her judgment, if treatment with levocarnitine is discontinued, the patient's pre-dialysis carnitine level would fall below 40 micromol/L and the patient would have recurrent erythropoietin-resistant-anemia or intradialytic hypotension.

Claims for levocarnitine are to be submitted on health insurance claim Form CMS-1500 or electronic equivalent. Coinsurance and deductible apply.

Source: CMS Transmittal AB-02-165, CR 2438

LABORATORY/PATHOLOGY

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

Information provided by the Centers for Medicare & Medicaid Services (CMS) in Program Memorandum (PM) AB-02-064 (Change Request [CR] 2071) was published in the May 2002 special issue *Medicare B Update!* (page 3). CMS recently issued PM AB-02-180 (CR 2323), which supersedes previously published information regarding home prothrombin time INR monitoring for anticoagulation management.

Specifically, the statement that says, "this is a CLIA waived test" has been deleted. All other information remains the same, including the effective date (July 1, 2002).

Source: CMS Transmittal AB-02-180, CR 2323

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 September 27, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

- Roche Diagnostics CoaguChek PST, effective: May 7, 1999, *CPT* code: 85610QW;
- Quidel QuickVue Advance pH and Amines Test, effective: June 13, 2002, *CPT* codes: 82120QW and 83986QW;
- Cholestech GDX A1C Test (Prescription Home Use), effective: July 1, 2002, *CPT* code: 83036QW;
- Quidel QuickVue® In-Line Strep A, effective: July 8, 2002, *CPT* code: 87880QW;
- HemoCue® Glucose 201 Microcuvettes and Glucose 201 Analyzer, effective: July 12, 2002, *CPT* codes: 82947QW, 82950QW, 82951QW, and 82952QW;
- Genzyme OSOM® Strep A Ultra Test – 25 Test Kit Size, effective July 19, 2002, *CPT* code: 87880QW;
- O2 Unlimited Donna Ovulation Tester, effective: August 26, 2002, *CPT* code: 87210QW;
- Stesans Maybe?Mom Mini Ovulation Microscope, effective: August 26, 2002, *CPT* code: 87210QW; and
- Diagnostic Chemicals ImmunoDip™ Urinary Albumin Test, effective: August 29, 2002, *CPT* code: 83518QW.

New waived codes have been assigned for the following tests:

- 82274QW for the Enterix InSure™ Fecal Occult Blood Test that was listed as a new waived test in transmittal AB-02-091, change request 2263; and
- 87210QW for the O2 Unlimited Donna Ovulation Tester and Stesans Maybe?Mom Mini Ovulation Microscope.

Please refer to the table on the next page. The information in the "Use" column explains the purpose of the waived test.

TEST NAME	MANUFACTURER	*CPT* CODE(S)	USE
Roche Diagnostics Coaguchek PST	Roche Diagnostics	85610QW	Aid in screening for congenital deficiencies of factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency
Quidel QuickVue Advance pH and Amines Test	Quidel Corporation	82120QW 83986QW	Qualitative test of a vaginal fluid sample for elevated pH (pH greater than or equal to 4.7) and the presence of volatile amines
Cholestech GDX A1C Test (Prescription Home Use)	Cholestech Corporation	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Quidel QuickVue® In-Line Strep A	Quidel Corporation	87880QW	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
HemoCue® Glucose 201 Microcuvettes and Glucose 201 Analyzer	HemoCue, Inc.	82947QW 82950QW 82951QW 82952QW	Measures glucose levels in whole blood
Genzyme OSOM® Strep A Ultra Test – 25 Test Kit Size	Genzyme Corporation	87880QW	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
O2 Unlimited Donna Ovulation Tester	O2 Unlimited Corp.	87210QW	Detects ferning pattern in saliva which is used in the determination of ovulation (optimal for conception)
Stesans Maybe?Mom Mini Ovulation Microscope	LEC Associates	87210QW	Detects ferning pattern in saliva which is used in the determination of ovulation (optimal for conception)
Diagnostic Chemicals ImmunoDip™ Urinary Albumin Test	Diagnostic Chemicals Limited	83518QW	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease

Source: CMS Transmittal AB-02-154, CR 2413

MENTAL HEALTH

Noncoverage of Multiple Electroconvulsive Therapy (MECT)

This is to provide notification MECT will be noncovered by Medicare for services performed on or after April 1, 2003, in any setting or under any procedure code.

Per section 35-103 of the Medicare coverage issues manual, the clinical effectiveness of multiple-seizure electroconvulsive therapy has not been verified by scientifically controlled studies. In addition, studies have demonstrated an increased risk of adverse effect with multiple seizures. Accordingly, MECT cannot be considered reasonable and necessary and is noncovered.

The following *CPT* code will be noncovered effective April 1, 2003:

90871 Electroconvulsive therapy (includes necessary monitoring); multiple seisures, per day

Source: Transmittal AB-03-003, CR 2499

NONPHYSICIAN PRACTITIONERS

Clarification Regarding Nonphysician Practitioners Billing on Behalf of a Diabetes Outpatient Self-Management Training Services (DSMT) Program and Common Working File Edits for DSMT & Medical Nutrition Therapy (MNT)

The Centers for Medicare & Medicaid Services (CMS) has confirmed that Medicare nonphysician practitioners, such as nurse practitioners or registered dietitians who are eligible to render other Medicare services, may bill on behalf of a DSMT program. Payment to nonphysician practitioners billing on behalf of the DSMT program will be made as if rendered by a physician. In addition, some outstanding issues regarding DSMT and MNT have been clarified.

Policy Clarification

All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are part of a multidisciplinary team that provides DSMT services for the DSMT program. A dietitian may not be the sole provider of the DSMT service unless they are performing the service in a rural area as defined in 42 CFR 410.144. The accreditation organizations, the American Diabetes Association (ADA) or the Indian Health Service (IHS), will determine if the program can qualify to have a single-member team. The program may also include a program coordinator, physician advisor, and other trainers. However, only one person or entity from the program bills Medicare for the whole program. The benefit provided by the program may not be subdivided for the purposes of billing Medicare.

A hospital that has a DSMT program (accredited by the ADA or IHS) can be the biller without any reassignment. If a dietitian or certified diabetic educator has a DSMT program accredited under his/her name and he/she works for a hospital, then he/she would need to reassign his/her benefits to the hospital. If a physician is part of the DSMT program, (i.e., a physician advisor), he/she can be the certified provider and bill Medicare using the physician's Medicare provider number. A registered dietitian, who has a Medicare provider number and is part of the DSMT program, can bill on behalf of the DSMT program.

The MNT benefit is a completely separate benefit from the DSMT benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same time period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full three hours of MNT. However, it is not allowed for both DSMT and MNT to bill on the same date of service. In subsequent years, the beneficiary can receive two hours of DSMT (with a referral) and two hours of MNT (with a referral).

Medicare covers three hours of MNT in the beneficiary's initial calendar year. There will be no carrying over of initial hours to the next calendar year. For example, if a physician gives a referral to a beneficiary for three hours of MNT but a beneficiary only uses

two hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for two follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.

Payment to nonphysician practitioners billing on behalf of a DSMT program (procedure codes G0108 or G0109) will be made at the full fee schedule rate and will not be paid at 85 percent of the fee schedule like other nonphysician practitioner services. This is because the payment is for the DSMT program and is not being made for the services of a single practitioner.

Nonphysician practitioners who bill on behalf of a DSMT program are subject to mandatory assignment.

New MNT Codes

Two new G codes have been created for MNT when there is a change in condition of the beneficiary:

G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

G0271 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

The new G codes for additional hours of coverage should be used after the completion of the 3 hours of basic coverage under *CPT* codes 97802-97804 when a second referral is received during the same calendar year. No specific limit is set for the additional hours.

These new codes are part of the annual 2003 HCPCS update. Therefore, the codes are effective for dates of service on or after January 1, 2003.

Advance Beneficiary Notice (ABN)

The beneficiary is liable for services denied over the limited number of hours with referrals for DSMT or MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable. An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

Source: CMS Transmittal AB-02-151, CR 2373

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Coverage and Billing Requirements for Electrical Stimulation for the Treatment of Wounds

For services performed on or after April 1, 2003, Medicare will cover electrical stimulation for the treatment of wounds only for chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. All other uses of electrical stimulation for the treatment of wounds are not covered by Medicare. Electrical stimulation will not be covered as an initial treatment modality.

The use of electrical stimulation will only be covered after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician, but no less than every 30 days by a physician. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100 percent epithelialzed wound bed.

CPT/HCPCS Codes

G0281 Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

G0282 Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

G0295 Electromagnetic stimulation, to one or more areas (not covered by Medicare)

97014 *Application of a modality to one or more areas; electrical stimulation unattended* (not covered by Medicare)

97032 *electrical stimulation (manual), each 15 minutes.*

Note: *CPT* code 97032 should NOT be reported for wound care of any sort because wound care does not require constant attendance.

The Centers for Medicare & Medicaid Services (CMS) will provide payment and pricing information in the April update of the Medicare Physician Fee Schedule Database (MPFSDB). Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge.

Source: CMS Transmittal AB-02-161, CR 2313

Coverage and Billing for Neuromuscular Electrical Stimulation

Neuromuscular electrical stimulation (NMES) involves the use of a device that transmits an electrical impulse to activate muscle groups by way of electrodes. Coverage of NMES to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy. The type of NMES that is used to enhance walking in spinal cord injury (SCI) patients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

For services performed on or after April 1, 2003, Medicare will cover NMES/FES to enhance walking for SCI patients who have completed a training program, which consists of at least 32 physical therapy sessions with the device over a period of three months.

Note: Contractors may establish local edits to ensure weekly sessions during the three-month period.

Coverage Requirements

Coverage for NMES/FES for walking will be limited to SCI patients with all of the following characteristics:

1) persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);
2) persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;
3) persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction;
4) persons that possess high motivation, commitment, and cognitive ability to use such devices for walking;
5) persons that can transfer independently and can demonstrate standing independently for at least three minutes;
6) persons that can demonstrate hand and finger function to manipulate controls;
7) persons with at least six-month post recovery spinal cord injury and restorative surgery;
8) persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
9) persons who have demonstrated a willingness to use the device long-term.

NMES/FES to enhance walking for SCI patients will *not* be covered for SCI patients with any of the following:

1) presence of cardiac pacemakers or cardiac defibrillators;
2) severe scoliosis or severe osteoporosis;
3) irreversible contracture;
4) autonomic dysreflexia; or
5) skin disease or cancer at area of stimulation.

See section 35-77 of the Medicare coverage issues manual (CIM) for further coverage limitations.

CPT Code

97116 *Therapeutic procedure, one or more areas, each 15 minutes; gait training (include stair climbing)*

Note: This is the only code to be billed. It must be used for one-on-one face-to-face services provided by the physician or therapist.

ICD-9-CM Diagnosis Codes

Diagnosis code 344.1 must be present for payment to be made. However, while paraplegia of both lower limbs is a necessary condition for coverage, the nine criteria listed above are also required. Carriers will deny payment for patients with any of the following diagnoses:

1) presence of cardiac pacemakers (V45.89 & V53.31) or cardiac defibulators (V45.00, V45.01, V45.02, and V45.09);
2) severe scoliosis or severe osteoporosis (733.00-733.09, 736.89, 736.9, 737.30 – 737.39, 7 37.40, 737.43, 738.4, 738.5, and 754.2);
3) irreversible contracture (736.00 – 736.09, 736.30 – 736.39, 736.6, 736.70 - 736.79, 736.81, and 736.89);
4) autonomic dysreflexia (337.3); or
5) skin disease or cancer at area of stimulation.

Source: CMS Transmittal AB-02-156, CR 2314

PODIATRY

Requirements for Payment of Medicare Claims for Foot and Nail Care Services

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare nail debridement payments, which is the single largest paid podiatric service. The OIG found that about one in every four claims did not include documentation of medical need for nail debridement in beneficiaries' medical records and that more than half of these inappropriate payments included other related inappropriate payments. This article explains the requirements for payment of Medicare claims for foot and nail services including information about routine foot care exclusion, exceptions to routine foot care exclusion, class findings, billing instructions, required claim information, and documentation on file.

Routine Foot Care Exclusion

Except as noted in "Exceptions to Routine Foot Care Exclusion" section, routine foot care is excluded from coverage. Services that are normally considered routine and not covered by Medicare include:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care such as cleaning and soaking the foot, use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

Exceptions to Routine Foot Care Exclusion

- Services performed as a necessary and integral part of otherwise covered services such as diagnosis and treatment of ulcers, wounds, infections, and fractures.
- The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease that may require scrupulous foot care by a professional. Certain procedures that are otherwise considered routine may be covered when systemic condition(s), demonstrated through physical and/or clinical findings, result in severe circulatory embarrassment or areas of diminished sensation in the legs or feet and may pose a hazard if performed by a nonprofessional person on patients with such systemic conditions. In the case of patients with systemic conditions such as diabetes mellitus, chronic thrombophlebitis, and peripheral neuropathies involving the feet associated with malnutrition and vitamin deficiency, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, and uremia, they must also be under the active care of a doctor of medicine or doctor of osteopathy and who documents the condition in the patient's medical record.
- Services performed for diabetic patients with a documented diagnosis of peripheral neuropathy and loss of protective sensation (LOPS) and no other physical and/or clinical findings sufficient to allow a presumption of coverage as noted in the Medicare Carriers Manual. This class of patients can receive an evaluation and treatment of the feet no more often than every six months as long as they have not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) guidelines.
- Five sites should be tested on the plantar surface of each foot, according to NIDDK guidelines.
- Treatment of warts, including plantar warts, may be covered. Coverage is to the same extent as services provided for in treatment of warts located elsewhere on the body.
- Treatment of mycotic nails for an ambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Note: Active care is defined as treatment and/or evaluation of the complicating disease process during the six-month period prior to rendition of the routine care or had come under such care shortly after the services were furnished, usually as a result of a referral.

Class Findings

A presumption of coverage may be made by Medicare where the claim or other evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, the following findings are pertinent:

- **Class A Findings**
  Nontraumatic amputation of foot or integral skeleton portion thereof

- **Class B Findings**
  Absent posterior tibial pulse
  Advanced trophic changes; three of the following are required: hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), skin color (rubor or redness)
  Absent dorsalis pedis pulse
- **Class C Findings**
  Claudication
  Temperature changes
  Edema
  Paresthesia
  Burning

Billing Instructions

The following are the main Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes for billing of foot and nail care services (additional codes can be found in the CPT and/or HCPCS code books):

11719	*Trimming of nondystrophic nails, any number*
11720	*Debridement of nail(s) by any method(s); one to five*
11721	*Debridement of nail(s) by any method(s); six or more*
11730	*Avulsion of nail plate, partial or complete, simple; single*
11732	*Avulsion of nail plate, partial or complete, simple; each additional nail plate (list separately in addition to code for primary procedure)*

Required Claim Information

Note: Program Memoranda AB-02-096 dated July 17, 2002 and AB-02-109 dated July 31, 2002 contain claim and billing instructions for peripheral neuropathy. For information on completing the CMS-1500 form, see the "Medicare Made Easy" publication (or other carrier-specific guides) at *www.connecticutmedicare.com* and *www.floridamedicare.com*. You may also contact our Customer Service department, toll-free. In Connecticut, call 1(866) 419-9455; in Florida, call 1(866) 454-9007. The following requirements are of particular importance to podiatrists:

Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. A referring physician is a physician who requests an item or service for the patient for which payment may be made under the Medicare program.

Item 17a. Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17.

Item 19. Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims.

Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties must be submitted on an attachment.

Item 24d. Enter the procedures, services, or supplies using the CPT/HCPCS code. When applicable, show CPT/HCPCS modifiers with the code. Enter the Q7 – One Class A finding; Q8 – Two Class B findings; or Q9 – One Class B and two Class C findings as appropriate.

Enter the specific procedure code without a narrative description.

Item 24e. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; enter either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses in item 21.

Documentation on File

Podiatrists may submit claims using the Q7, Q8, or Q9 modifiers to indicate to the carrier the findings they have made on the patient's condition. This does not relieve them of the responsibility of maintaining documentation on file. This documentation must be maintained and made available to the carrier at their request. Failure to produce appropriate documentation may result in denial of the claim. Podiatrists should consult their carrier to verify that they are meeting the documentation requirements for Medicare claims.

Source: CMS Transmittal B-02-091, CR 2374

RADIOLOGY

Weekly Radiation Therapy Management

The Centers for Medicare & Medicaid Services (CMS) has revised section 15021(D)(1) of the Medicare carriers manual (MCM) to remove weekly radiation therapy management codes 77419-77430 that were deleted and replaced by code 77427 (effective January 1, 2000). The revision to this section is as shown below in *italics*:

> A weekly unit of treatment management is equal to five fractions or treatment sessions. A week for the purpose of making payments under these codes is comprised of five fractions regardless of the actual time period in which the services are furnished. It is not necessary that the radiation therapist personally examine the patient during each fraction for the weekly treatment management code to be payable. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. *Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consist of: Review of port films; review of dosimetry, dose delivery, and treatment parameters; review of patient treatment set-ups; examination of patient for medical evaluation and management, (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results).*

Source: CMS Transmittal 1787, CR 2410

SURGERY

Coverage and Billing for Percutaneous Image-Guided Breast Biopsy—Clarification

Information concerning Medicare coverage and billing instructions for percutaneous image-guided breast biopsy was published in the First Quarter 2003 *Medicare B Update!* (page 15 FL 17 CT). Since that time, it has come to our attention that providers need to submit documentation to verify the diagnosis for which the service is being performed. The provider should include as an attachment to Form CMS-1500 (or in the narrative record for its electronic equivalent) office records, progress notes, history and physical notes, operative report, and laboratory report.

In addition, providers are reminded that 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.

TELEHEALTH SERVICES

Medicare Telehealth Update

Section 1834(m) of the Social Security Act (the Act) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2003 is 3.0 percent.

Additionally, the psychiatric diagnostic interview examination was added to the list of Medicare telehealth services as specified at 42 CFR Subpart B, Section 410.78.

Originating Site Facility Fee Payment Amount Update

For calendar year 2003, the payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $20.60.

Addition to the List of Medicare Telehealth Services

Effective January 1, 2003, the psychiatric diagnostic interview examination (*CPT* code 90801) is a Medicare telehealth service. Physicians and practitioners at the distant site should use the applicable telehealth modifiers to identify this as a telehealth service.

Source: CMS Transmittal AB-02-160, CR 2403

ELECTRONIC MEDIA CLAIMS

HIPAA

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

The Health Insurance Portability and Accountability Act—Administrative Simplification (HIPAA–AS)

HIPAA-AS Overview

The Health Insurance Portability and Accountability Act of 1996–Administrative Simplification (HIPAA–AS) was enacted to promote standardization and efficiency in the health care industry. It is important for providers to know how this law will impact them, and what the key requirements and dates are. Providers can gain an overview of HIPAA–AS requirements by reviewing key resources published by the Centers for Medicare & Medicaid Services (CMS). These publications are reprinted in this edition of the *Medicare B Update!* and are available on First Coast Service Options, Inc.'s (FCSO) provider education Web sites, *www.connecticutmedicare.com* and *www.floridamedicare.com.*

- **CMS HIPAA Electronic Transactions & Code Sets Information Series – *HIPAA 101***
  This resource provides direction about the who, what, why, and how of HIPAA–AS. *HIPAA 101* is the first in a series of ten informational publications to be issued by CMS about Electronic Transactions. This initial document is reprinted beginning on page 24. The topics covered in the series are summarized in *HIPAA 101*. As further installments are published by CMS, we will post them to the provider education Web sites.

- **Provider HIPAA Readiness Checklist – Getting Started**
  This resource uses a checklist approach to help a healthcare provider tackle the HIPAA Transactions requirement. First, it helps determine if a provider is covered by the requirement, then recommends the appointment of a 'HIPAA Point Person' to work the requirement on the provider's behalf. The tool goes on to familiarize the provider with key HIPAA deadlines, how it affects provider operations and guides providers on what kind of questions to ask their payers and health plans. This document is available on the provider education Web sites, and is reprinted on page 22.

- **HIPAA Resources** is a comprehensive list of Internet links and phone numbers that can be used to get more information needed to accomplish compliance with HIPAA–AS. Please note that there is contact information to learn more about the HIPAA Privacy requirement, which is effective April 14, 2003. This document available on the provider education Web sites, and is reprinted on page 22.

  Technical information about the Electronic Transactions requirements can be found in the ANSI X12N Implementation Guides which are available on the provider education Web sites on the "HIPAA" page in the section titled: "Links to Other Related Web Sites."

- **Medicare companion documents** to these guides are also available on the FCSO Medicare Web sites on the "Electronic Data Interchange" page in the section titled "News." These statements contain supplemental contractor expectations regarding data submission, processing and adjudication. Refer to the document dated 1/31/02.

Medicare Contractor Status

Electronic Transactions and Code Sets: FCSO Medicare is implementing requirements per CMS guidelines. We are conducting trading partner testing on the X12N 4010 version of the 837 Claim, 835 Remittance, and 837 Coordination of Benefits (COB). FCSO expect to be implementing the addenda updates to the standards (version 4010A1) when they are final. Current estimates from CMS indicate trading partner testing may begin in April. Dates are subject to change depending on the release of the final rule.

CMS filed for a one-year extension for all Medicare contractors before the Administrative Simplification Compliance Act (ASCA) deadline of October 15, 2002.

The following table indicates FCSO's testing status and expected dates. The 276/277 Claim Status Inquiry/Response and 270/271 Eligibility Benefit Inquiry/Response transactions will not be tested with trading partners until the addenda updates are implemented.

Look for further information on the new 4010A1 updates to all affected transactions, as well as specifics on the 270/271 Eligibility Inquiry/Response, in the upcoming Medicare EDI Bulletin on our provider education Web sites.

Medicare's Trading Partner Testing

Transaction	4010	4010A1 Addenda (Estimate)
X12N 837 Inbound Claims	Ongoing	4/2003
X12N 835 Remittance	Ongoing	4/2003
X12N 837 Outbound COB	Ongoing	4/2003
X12N 276/277 Claim Status/Response	N/A	4/2003
X12N 270/271 Eligibility Request/Response	N/A	4/2003

Privacy: HIPAA restricts the release of a patient's protected health information (PHI) without the consent of that patient where the release goes beyond the need to provide for patient care. PHI must be more carefully handled in all respects. The deadline for compliance with the Privacy provisions of HIPAA-AS is April 14, 2003.

Contracts are required to be drawn up and executed between covered entities and those business associates with whom PHI is sent for the performance of a service. When drawing up such contracts, covered entities should clearly identify the organization with which they share PHI.

A provider that submits a claim to a health plan (such as Medicare) and a health plan that assesses and pays the claim are both acting on their own behalf as a covered entity, and not as the "business associate" of the other. If a health plan were to perform a service on behalf of a provider using PHI (e.g., billing service for provider or quality improvement initiative on behalf of provider), then a business associate agreement would be needed. For example, FCSO performs services for Medicare (CMS). FCSO is expected to be "classified" as a "business associate" of CMS (the covered entity), for the purposes of the HIPAA Privacy Rule. For more information, please refer to *http://www.hhs.gov/ocr/hipaa/*.

Responsibility for the enforcement of the Privacy requirements belongs to the U.S. Department of Health & Human Services' Office of Civil Rights. Privacy-related questions should be directed to *OCRPrivacy@hhs.gov* or call 1-866-627-7748. Another resource for information is *http://www.hhs.gov/ocr/hipaa/whatsnew.html.*

Security: HIPAA security requirements will outline measures to prevent unauthorized access to PHI. FCSO intends to comply with the Security requirements, which had not been finalized as of the end of 2002.

National Identifier: HIPAA calls for providers, plans, and employers to have standard national numbers that identify them on standard transactions. The standard for plans and providers is expected in 2003. Employers will use the employer identification number (EIN).

Key Requirement of HIPAA-AS Electronic Transactions

A key requirement of the law is for covered entities to begin testing the new format for the electronic claim transaction (837) by **April 16, 2003**. FCSO expects to begin trading partner testing of the 837 **version 4010A1** (addenda) in April, depending on when the rule is released. Those submitters who have successfully completed testing on version 4010 are not required to re-test for version 4010A1; FCSO will, however, schedule re-testing upon request. Please be aware that until April 1, 2003, your transactions may reject unless you enter the value '004010X098' in the REF02 in Table 1-015.

FCSO's strategy for 837 testing involves testing billing software used by providers and submitters. In the very near future FCSO will be contacting providers, billing services, clearinghouses, and software vendors to discuss HIPAA readiness and schedule 837 Claim testing. Due to the large volume of senders required to test, Medicare encourages senders to begin their implementation and testing now. Providers who utilize a clearinghouse, billing service, or vendor software, should contact them to determine their plans for HIPAA and their status. Encourage them to test.

It is very important that those submitting electronic claims test with Medicare as soon as possible. Testing will occur on a first-come, first-served basis. Senders who wait until the last months before the due date may not have enough time to prepare and test. HIPAA-AS requires exclusive use of the ANSI X12N version 4010A1 as of October 2003. To schedule testing call:

Medicare Part B Connecticut: Michelle Hackett @ 904-791-6250
Medicare Part B Florida: Floyd Rosenberger @ 904-791-6055

Other Important Things to Know about HIPAA Transactions Requirements

PC-ACE Pro32® is a low-cost electronic claims submission software package offered by Medicare. Version 4010 has been tested and is being rolled out to current customers. When the 4010A1 version is final and implemented, the update will be distributed.

FCSO Medicare Provider Education Web Sites
FCSO's provider education Web sites provide up-to-date information about HIPAA and Medicare at: *www.connecticutmedicare.com* and *www.floridamedicare.com*. Refer to the "HIPAA – Hot Topics" at the top of the "What's New" page for a set of basic, "getting started" instructions from CMS. The HIPAA page also provides a comprehensive list of resources helpful for providers to become compliant with HIPAA Transactions.

Electronic Billing Vendor List
Billing vendors have begun to test their software for compliance with the HIPAA Transactions requirement. A directory of those who have successfully tested with FCSO can be found on the *www.connecticutmedicare.com* and *www.floridamedicare.com* provider education Web sites. Refer to the "ANSI 4010 Approved Vendor List" in the "Electronic Data Interchange (EDI)" section under "Other." This list is updated every two weeks.

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.*

Provider HIPAA Readiness Checklist—Getting Started

Moving toward Compliance with the Electronic Transactions and Code Sets Requirements

- The Administrative Simplification Requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will have a major impact on healthcare providers who do business electronically as well as many of their healthcare business partners. Many changes involve complex computer system modifications. Providers need to know how to make their practices compliant with HIPAA. The Administrative Simplification Requirements of HIPAA consist of four parts:

  1) Electronic transactions and code sets;
  2) Security;
  3) Unique identifiers; and
  4) Privacy.

- HIPAA does not require a healthcare provider to conduct all transactions listed under #1 electronically. Rather, if you are going to conduct any one of these business transactions electronically they will need to be done in the standard format outlined under HIPAA. Whether or not you contract a third party biller or clearinghouse to conduct any of these transactions for you, it is up to you as the healthcare provider to see to it that your transactions are being conducted in compliance with HIPAA. The checklist provided below is designed to help you start thinking about what you need to do to prepare for meeting the **electronic transactions and code sets requirements.**

1. Determine, as a healthcare provider if you are covered by HIPAA

❑ If you conduct, or a third party biller or clearinghouse conducts on your behalf, any one of the following business transactions electronically you are most likely covered by HIPAA:

- Claims or equivalent encounter information
- Payment and Remittance Advice
- Claim Status Inquiry/Response
- Eligibility Inquiry/Response
- Referral Authorization Inquiry/Response

If you do not conduct any one of the above transactions electronically, you are most likely not covered by HIPAA and you do not need to continue with the checklist.

2. Assign a HIPAA Point Person to handle the remaining checklist items

❑ Assign a staff person to be your ***HIPAA Point Person*** (HPP), such as your office manager, to keep abreast of HIPAA and what is required of your office.
❑ Give this individual the authority, resources, and time to prepare for HIPAA changes.
❑ Use this staff person to educate others in your office on the impact of HIPAA on your practice.

3. Familiarize yourself with the key HIPAA deadlines

❑ April 16, 2003 – You (or your software vendors) need to start testing your software and computer systems internally ***no later*** than this date. By testing this means ensuring your software is capable of sending and receiving the transactions you do electronically in the standard HIPAA format.
❑ October 16, 2003 – This is the date you must be ready to conduct transactions electronically in the standard HIPAA format with your health plans/payers.

4. How HIPAA Affects What You Do

- ❑ Determine if your software is ready for HIPAA (each healthcare provider is responsible for making sure the software they use will be compliant with HIPAA according to the key deadlines above).
- ❑ Speak with your practice management software vendors (or billing agent or clearing house if you use one) to assess which items under #1 you conduct on paper and which you conduct electronically. Determine what you will need to do differently. For instance, under HIPAA additional data may be required and data fields you use now may no longer be required.
- ❑ Ask your vendor how and when they will be making HIPAA changes and document this in your files.
- ❑ Remind your vendors you must start testing your systems *no later* than April 16, 2003. Similarly, if you use a third party billers or clearinghouses, remind them of this testing deadline.

5. Talk to the health plans and payers you bill (especially the ones you bill most frequently)

- ❑ Ask them what they are doing to get ready for HIPAA and what they expect you to do.
- ❑ Ask them if they will have a HIPAA companion guide that specifies their coding and transaction requirements that are not specifically determined by HIPAA (while HIPAA mandates standard transactions, some health plans may not require data elements for every field). For instance, ask your payers for billing instructions on how to code for services that were previously billed using local codes (under HIPAA local codes are eliminated).
- ❑ Ask them whether they will have "Trading Partner Agreements" that specify transmission methods, volumes, and timelines as well as coding and transaction requirements that are not specifically determined by HIPAA. These may also specify how HIPAA compliance testing and certification are to be done.
- ❑ Ask them about testing your software to make sure, for instance, that they will be able to receive a claim you submit with your updated software.
- ❑ If you use software or systems provided by the health plan/payer (such as online direct data entry) to conduct transactions, ask whether they intend on continuing to support these systems.

For more information on HIPAA please visit CMS' Web site at* http://www.cms.hhs.gov/hipaa*, send an email to* askhipaa@cms.hhs.gov*, or call 1 (866) 282-0659.

This is an informational checklist and does not constitute legal advice.

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HIPAA Resources

1) **CMS Website** – ***http://www.cms.hhs.gov/hipaa*** - Answers to Frequently Asked Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.
2) **Covered Entity Decision Tool** – ***http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp***. Use this tool to help determine if you are a "covered entity" under HIPAA.
3) **FREE HIPAA Roundtable Conference Call** – This is a good source of information and a forum to get answers to your questions on HIPAA Administrative Simplification. At this time we have not scheduled our next call, but stay tuned!
4) **FREE Video** – CMS' Meeting the HIPAA Challenge: Implementing the Administrative Simplifications of HIPAA. For free video, e-mail your request to ***askhipaa@cms.hhs.gov*** or call **1 (866) 282-0659**. Stay tuned for information on our new video, which is in the works.
5) **FREE Listserve** – ***http://aspe.hhs.gov/admnsimp/lsnotify.htm*** - 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).
6) **CMS E-Mail box** – ***askhipaa@cms.hhs.gov***. Send your questions on HIPAA administrative simplification here.
7) **CMS HIPAA Hotline – 1 (866) 282-0659** – This hotline has been established to help answer your HIPAA administrative simplification questions.
8) **CMS Medicaid HIPAA Web address** – ***www.cms.hhs.gov/medicaid/hipaa/adminsim/***
9) **Privacy-related information** – ***http://www.hhs.gov/ocr/hipaa/whatsnew.html*** - The U.S. Department of Health & Human Services' Office for Civil Rights oversees the privacy requirements. Visit their Web site for more information. Privacy-related questions should be directed to ***OCRPrivacy@hhs.gov*** or call **1 (866) 627-7748**.
10) **Other information on "administrative simplification" requirements of HIPAA** – ***http://aspe.hhs.gov/admnsimp/*.**

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CMS HIPAA Electronic Transactions & Code Sets Information Series

HIPAA 101 For Health Care Providers' Offices

Complying with HIPAA's Electronic Transactions and Code Sets Standards Requirements

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THE 10-PART INFORMATION SERIES:

1 HIPAA 101

2 Are You a Covered Entity?

3 Enforcement

4 Key HIPAA Dates and Tips for Getting Ready

5 What Electronic Transactions and Code Sets are Standardized Under HIPAA?

6 Is Your Software Vendor or Billing Service Ready for HIPAA?

7 What to Expect from your Payers

8 What do you Need to Know about Testing

9 Trading Partner Agreements

10 Final Steps for Compliance with Electronic Transactions and Code Sets

The law known as "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996. This law was passed to promote more standardization and efficiency in the health care industry.

There are four parts to HIPAA's Administrative Simplification:

1. Electronic Transaction and Code Sets Standards requirements
2. Privacy requirements
3. Security requirements
4. National Identifier requirements

This is the first informational paper in a series of ten. Collectively, the papers provide information, suggestions, tips, guidance and checklists to assist health care providers in understanding what they need to focus on to become HIPAA compliant. Each paper deals with one significant topic related to the HIPAA electronic transaction and code set rule.

HIPAA will directly impact health care providers who transmit any health care information in electronic form in connection with a covered transaction, as well as indirectly impacting their business partners. But these impacts will eventually result in overall improvements in many areas of the health care industry.

WHAT is HIPAA Administrative Simplification?

The requirements for each area of HIPAA Administrative Simplification are:

1) Electronic Transaction and Code Sets Standards Requirements

National standards (for formats and data content) are the foundation of this requirement. HIPAA requires every provider who does business electronically to use the same health care transactions, code sets, and identifiers. Many of the electronic changes required under HIPAA are highly technical. But, it is important for you to know about the HIPAA Administrative Simplification requirements and how they will impact your office.

Transaction and code set standards requirements were created to give the health care industry a common language to make it easier to transmit information electronically (for instance, when a physician's office inquires about a patient's insurance eligibility, or a dentist submits a bill to a health plan for payment).

Standard Transactions

==========

1 Claims or equivalent Encounter Information

2 Payment and Remittance Advice

3 Claim Status Inquiry and Response

4 Eligibility Inquiry and Response

5 Referral Certification and Authorization Inquiry and Response

6 Enrollment and Disenrollment in a Health Plan

7 Health Plan Premium Payments

8 Coordination of Benefits

9 Claims Attachments

10 First Report of Injury

Standard Code Sets

==========

1 Physician Services and other Health Care Services - **Combination of HCPCS and CPT-4**
2 Medical Supplies, Orthotics, and DME - **HCPCS**
3 Conditions, & other health problems & their manifestations – **ICD-9-CM, Vols 1&2**
4 Dental Services – **Code on Dental Procedures and Nomenclature**
5 Drugs/Biologics – **NDC**

2) Privacy Requirements

The privacy requirements limit the release of patient protected health information without the patient's knowledge and consent beyond that required for patient care. Patient's personal information must be more securely guarded and more carefully handled when conducting the business of health care.

3) Security Requirements

The security regulation will outline the minimum administrative, technical, and physical safeguards required to prevent unauthorized access to protected health care information. The Department of Health & Human Services will be publishing the final instructions on security requirements.

4) National Identifier Requirements

HIPAA will require that health care providers, health plans, and employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The remaining identifiers are expected to be determined in the coming year.

WHO is Impacted by HIPAA?

The law applies directly to three specific groups commonly referred to as "covered entities." These three groups include:

1) Health Care Providers who transmit any health information in electronic form in connection with a transaction for which standards requirements have been adopted.

2) Health Plans

3) Health Care Clearinghouses

~ TIPS ~
For Your Information

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TIP 1

The U.S. Department of Health and Human Services has proposed changes to the transactions standards requirements to facilitate their implementation. This includes for instance, repealing the National Drug Code (NDC) standard except for retail pharmacy transactions, although this has not been adopted.

TIP 2

Something to keep in mind is that with HIPAA, local codes are replaced by standard codes.

TIP 3

It is important to know that as a health care provider, it is your responsibility to make sure that the software you use or the third party biller or clearinghouse you use to help process your claims, is compliant with HIPAA. If you are unsure as to whether or not they are able to produce HIPAA compliant transactions, call them and ask!

HIPAA, however, indirectly impacts many others in the health care field. For instance, software billing vendors and third party billing services that are not clearinghouses are not required to comply with the law; however, they may need to make changes in order to be able to continue do business with someone who is "covered" by HIPAA.

WHY HIPAA?

HIPAA requirements should help providers take advantage of new technologies to make doing business with health plans less costly and more efficient. Right now, there are over 400 different ways to submit a claim! With HIPAA there will be one way to submit a claim. This should make getting paid quicker and easier. With these standards requirements in place, your office staff may spend less time on the phone getting information they need for patients' paperwork.

If you have access to the Internet and would like to receive a free e-mail notification of when new HIPAA rules are published, simply sign up for the "free" listserv (e-mail communication list). This will let you know, for instance, when the security rule is published. For instructions about how to join, visit:

http://aspe.os.dhhs.gov/admnsimp/lsnotify.htm.

For more information on HIPAA……

E-mail your questions to *askhippa@cms.hhs.gov*

Join the HIPAA Listserv to find out when new HIPAA rules are published: *http://aspe.hhs.gov/admnsimp/lsnotify.htm*

Call the CMS HIPAA HOTLINE 1-866-627-7748

Log onto the CMS HIPAA Web site *http://www.cms.hhs.gov/hipaa/*

For Privacy inquiries only: *http://www.hhs.gov/ocr/hipaa/whatsnew.html*

Compliance Deadlines for Covered Providers

==========

April 14, 2003

The deadline for compliance with the privacy requirements.

April 16, 2003

For those who submitted a "compliance plan" and received a one-year extension to get ready to meet the standards requirements for electronic transactions and code sets, you should start testing your software no later than (or make sure your third party billers/ clearinghouses do so) this date to ensure you will be able to move the health care data in the new standardized format.

October 16, 2003

The deadline for complying with the electronic transaction and code set standards requirements for those who requested an extension.

NEXT STEPS?

To help you get started preparing for compliance with electronic transaction and code sets, follow these next steps:

- ❑ Find out if HIPAA applies to you.
- ❑ Determine the gaps between how you do business now and what HIPAA requires. In the column on the left are the HIPAA compliance dates you should be aware of.
- ❑ Find out what your health plans and payers' HIPAA implementation and testing plans are.
- ❑ Find out what your billing service is doing for HIPAA.
- ❑ Talk with your provider associations about HIPAA.
- ❑ Find out from your regional "Strategic National Implementation Process" (SNIP) representatives about regional HIPAA efforts. They are local groups with extensive knowledge of HIPAA.
- ❑ To find your local SNIP, go to: h*ttp://snip.wedi.org/public/articles/index.cfm?cat=5*
- ❑ Use the CMS HIPAA Checklist for Small Providers: *http://www.cms.hhs.gov/hipaa/hipaa2/ReadinessChkLst.pdf*

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.*

GENERAL INFORMATION

HOME HEALTH CONSOLIDATED BILLING

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

In April 2001, the Centers for Medicare & Medicaid Service (CMS) established, via Program Memorandum (PM), the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing (CB) 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 items incidental to physician services, as well as supplies used in institutional settings, are not subject to HH CB.

A subsequent PM, AB-02-092 (Change Request 2247) published July 2, 2002, established that updates of the HH CB code list would occur as frequently as quarterly to reflect the creation of temporary HCPCS codes (e.g., 'K' codes). These temporary codes may describe services subject to CB in addition to the permanent list of HCPCS codes that is updated annually.

Update to the List of Codes Subject to CB

This article provides the second quarterly HH CB update for calendar year 2003. This update adds a single non-routine supply code to the list of codes subject to CB, effective for services processed on or after April 1, 2003. **The new code to be added is: A6440 (Zinc Paste >=3" <5" w/roll).** This code was identified through additional review of the annual HCPCS update that was reflected in the first quarterly update. However, it was identified too late for inclusion in Medicare systems changes for the January quarter.

Other updates for the remaining quarters of the calendar year will occur as needed due to the creation of new temporary codes representing services subject to HH CB prior to the next annual update. 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 CB are being redefined.

Providers and suppliers interested in an updated complete list of codes subject to HH CB should refer to the HH consolidated billing master code list available at *cms.hhs.gov/medlearn/refhha.asp.*

Source: CMS Transmittal AB-03-002, CR 2515

SKILLED NURSING FACILITY (SNF)

Notification of Updates to Coding Files on CMS Web Site for Skilled Nursing Facility (SNF) Consolidated Billing (CB)

The SNF CB coding files on the CMS Web site at *www.cms.gov/medlearn/refsnf.htm* have been updated to reflect a number of corrections and policy changes. These code changes will be effective with the April 2002 implementation of Program Memorandum (PM) AB-01-159, CR 1764, dated November 1, 2001, titled "Common Working File (CWF) Reject and Utilization Edits and Carrier Resolution for Consolidated Billing for SNF Residents."

Update to Coding Files

Add to file: Part A Stay, Always Submit to Carrier/DMERC (PCTC=0)
A4651, A4709, A4725, A4911, G0124, A4652, A4719, A4726, A4928, G0141, A4656, A4720, A4736, A4929, G0245, A4657, A4721, A4737, E1500, G0246, A4706, A4722, A4766, E1637, G0247, A4707, A4723, A4801, E1638, P3001, A4708, A4724, A4802, E1639, V5299

Remove from file: Part A Stay, Always Submit to Carrier/DMERC (PCTC= 0)
G0117, G0197, 83020, 86255, 87207, 96003, G0118, G0198, 83912, 86256, 88371, 97601, G0121, G0199, 84165, 86320, 88372, G0193, G0200, 84181, 86325, 89060, G0194, G0201, 84182, 86327, 95833, G0195, J3370, 85390, 86334, 95834, G0196, L5669, 85576, 87164, 96002

Add to file: Part A Stay, Only Submit to Carrier with a 26 Modifier (PCTC=1)
G0131, 83912, 86256, 88371, G0132, 84165, 86320, 88372, 76075, 84181, 86325, 89060, 76977, 84182, 86327, 93770, 78890, 85390, 86334, 94150, 78891, 85576, 87164, 83020, 86255, 87207

Add to file: Part B stay only, Always Consolidated - Rehab B
G0193, G0200, 96003, G0194, G0201, 97601, G0195, 95833, G0196, 95834, G0197, 96000, G0198, 96001, G0199, 96002

Source: CMS Transmittal AB-02-035, CR 2085

Revisions to Common Working File (CWF) Edits for 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

Beginning April 1, 2003, for dates of service on or after April 1, 2001, CWF will not apply SNF CB edits to line items for diagnostic services where modifier **CB** (services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable) is placed on the line item to indicate the service was rendered to an ESRD beneficiary in a SNF Part A stay who is receiving chronic dialysis related services at an independent or provider-based dialysis facility.

The SNF CB provision requires a SNF to include on its Part A bill almost all of the services that its residents receive during the course of a Part A covered stay. However, there are several categories of services that the law (section 1888(e)(2)(A)(ii) of the Social Security Act) specifically excludes from this provision, and these excluded services remain separately billable under Part B by the outside supplier that furnishes them. One of the excluded categories encompasses those items and services that fall within the scope of the Part B benefit that covers chronic dialysis for beneficiaries with ESRD (section1861(s)(2)(F) of the Act). In addition to covering the ESRD-related dialysis services themselves, the Part B benefit also covers any associated diagnostic tests (see regulations at 42 CFR 410.50(b) - (c) and 410.52(a)(3)).

SNF CB applies to diagnostic tests that are not ESRD-related. As such, SNF CB applies to diagnostic tests for beneficiaries that do not have ESRD. This would include tests related to "acute dialysis" (that is, dialysis for a beneficiary who is not an ESRD beneficiary), because non-ESRD dialysis services and associated diagnostic tests do not fall within the scope of the Part B dialysis benefit. In addition, SNF CB applies to a diagnostic test for an ESRD beneficiary if the test is unrelated to the beneficiary's ESRD. The SNF CB does not apply to diagnostic tests that are ESRD dialysis-related. "ESRD-related" means that:

- the beneficiary must be an ESRD beneficiary,
- the test must have been ordered by an ESRD facility, and
- the test must relate directly to the dialysis treatment of the beneficiary's ESRD.

A supplier or provider may bill the carrier or intermediary, respectively, for an ESRD dialysis-related diagnostic test, provided the test is outside the ESRD-facility composite rate, notwithstanding that the beneficiary is a SNF Part A resident. A supplier or provider *may not* bill Medicare separately for a diagnostic test for a SNF Part A resident if the test is either within the ESRD facility composite rate, or not an ESRD dialysis-related diagnostic test.

Appropriate Use of Modifier CB

CMS is not requiring that a provider or supplier report modifier CB for every service rendered to a ESRD beneficiary; however, the provider or supplier must be aware that SNF CB editing will be applied if the line item does not contain the modifier. Indeed, the provider or supplier may use the modifier *only* when it has determined that:

- the beneficiary has ESRD entitlement,
- the test is related to the dialysis treatment for ESRD,
- the test is ordered by a dialysis facility,
- the test is not included in the dialysis facility's composite rate payment, and
- the beneficiary is in a Part A stay.

A provider or supplier must secure this information from the dialysis facility and use the modifier for only those line items for which all these factors are present. Use of modifier CB is inappropriate unless the provider or supplier has exercised due diligence to confirm that:

- the beneficiary is a resident in a SNF Part A stay,
- the beneficiary has ESRD entitlement,
- the test has been ordered by a dialysis facility,
- the test is not included in the dialysis facility's composite rate payment, and
- the test is related to the dialysis treatment of the beneficiary's ESRD.

Unless the supplier or provider has received this information from the dialysis facility, or has otherwise confirmed this information through other credible sources, it is improper to submit a claim to Medicare with modifier CB, and doing so without good faith belief in the legitimacy of using modifier CB may constitute a false claim.

Denied Claims

Providers that have had claims denied due to SNF CB and provided a diagnostic service to a beneficiary who has ESRD in an independent or provider-based dialysis facility for dates of service April 1, 2001 and later should resubmit these claims with modifier CB for each line item. For claims with dates of service beyond the timely filing deadline, the claim(s) may be reopened by the contractor or appealed for payment.

Source: CMS Transmittal AB-02-175, CR 2475

GENERAL INFORMATION

Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR), or the current value of funds rate (5 percent for calendar year 2001). The Secretary of the Treasury has notified the Department of Health and Human Services that the PCR has been changed to 11.25 percent, effective November 19, 2002. The PCR notice was published in the *Federal Register* (See Vol. 67, No. 223 dated 11/19/02).

Therefore, the PCR will remain in effect until a new rate change is published. In addition, this reaffirms interest rates for prior periods.

INTERESTRATE TABLE

Period	Interest Rate
November 19, 2002	**11.25%**
August 8, 2002 – November 18, 2002	12.625%
May 8, 2002 – August 7, 2002	11.75%
February 1, 2002—May 7, 2002	12.625%
October 31, 2001—January 31, 2002	13.25%
August 7, 2001—October 30, 2001	13.25%
April 26, 2001—August 6, 2001	13.75%
February 7, 2001—April 25, 2001	14.125%
October 24, 2000—February 6, 2001	13.875%
August 1, 2000—October 23, 2000	13.875%
May 3, 2000—July 31, 2000	13.75%
February 2, 2000—May 2, 2000	13.5%
October 28, 1999—February 1, 2000	13.375%
August 04, 1999—October 27,1999	13.25%
May 05, 1999—August 03, 1999	13.375%
February 01, 1999—May 04. 1999	13.75%
October 23, 1998—January 31, 1999	13.50%
July 31, 1998—October 22, 1998	13.75%
May 13, 1998—July 30, 1998	14.00 %
January 28, 1998—May 12, 1998	14.50%
October 24, 1997—January 27, 1998	13.875%
July 25, 1997—October 23, 1997	13.75%
April 24, 1997—July 24, 1997	13.50%
January 23, 1997—April 23, 1997	13.625%
October 24, 1996—January 22, 1997	13.375%

Source: CMS Transmittal AB-02-167, CR 2429

Research All Remittance Notice Denial Messages

The Medicare remittance notice (MRN) provides valuable information on denied claims. Most providers are familiar with the claim adjustment reason code (the CO or PR code), which is on the line of the claim information. Providers should also look at the *remark codes* (the end of the top line, at the M and/or MA code) before calling Medicare. Descriptors for these codes are found on the last page of the MRN, in the glossary section. Most claims will have remark codes MOA and MA01, but additional codes may be present as well.

Please review *all* codes and descriptors prior to calling to find out the reason for denial. If the provider still has a question after doing this research, assistance is always available at 1 (866) 454-9007 toll free.

The Multi-Carrier System (MCS) is coming to Railroad Medicare!

Under the direction of the Centers for Medicare & Medicaid Services (CMS), Medicare carriers are standardizing their Part B Medicare claims processing systems. The MCS, maintained by Electronic Data Systems (EDS), has been selected as the national standard Part B system. A single system will help reduce system maintenance costs, and will standardize the way Medicare claims are processed.

Many Medicare contractors have already converted to the MCS. Palmetto Government Benefits Administrators (Palmetto GBA), the carrier for Railroad Retirement Board Medicare beneficiaries, is currently in the process of converting its claims processing system to the MCS. Work will continue over the next five months until the planned cutover date of June 2, 2003.

There will be a new telecommunications gateway for providers to submit Railroad Medicare claims and receive electronic remittance notices (ERNs). In February, electronic submitters will receive a special mailing providing specific information about these gateway changes. This will provide ample time for affected submitters to take the necessary actions to ensure there is no interruption to their electronic processes.

To ensure accurate, informative, and timely communication to the provider community, Railroad Medicare will keep providers informed through a variety of educational sources:

- Palmetto GBA will post and maintain any new billing or claim filing requirements for Railroad Medicare on their Web site, *www.palmettogba.com*.
- Palmetto GBA will issue a special mailing to electronic submitters with specific information related to electronic claim submission.
- Providers may join Railroad Medicare's free electronic mail list and receive periodic email notification of messages posted to the Web site, including key program alerts, educational tips, and other critical informational articles. This is an excellent way to stay informed on information related to the MCS conversion.

To ensure a successful move to the MCS, it is imperative that providers and billing agencies stay informed of new claim filing requirements. Palmetto GBA's Web site will be a major source of information to keep providers informed about the Railroad Medicare transition to the MCS. Please visit the Palmetto GBA Web site (*www.palmettogba.com*) often for updates regarding the Railroad Medicare MCS conversion.

If you have questions that cannot be answered by visiting the Palmetto GBA Medicare web site, please contact the Railroad Medicare customer service department at 1 (877) 288-7600.

Source: Palmetto GBA Railroad Medicare

***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.*

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 March 31, 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 remove this page and mail it to:

Attention: Jarretta Stone
Medicare Part B
Medicare Communication and Education
P.O. Box 2078
Jacksonville, FL 32231-0048

or you may **fax** your survey to (904) 791-6292.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) – CONNECTICUT ONLY

*Most claims for DMEPOS are processed by the durable medical equipment regional carriers (DMERCs). The DMERC that serves Connecticut (Region A) is HealthNow (*www.umd.nycpic.com*). The articles that follow were furnished by HealthNow and are intended to provide information to those providers who bill to the DMERC, as well as to local carriers. For more information concerning contractor jurisdiction for a specific service, refer to the Third Quarter 2002* Medicare B Update! *(pages 12-20).*

Changes to DMERC A Publications for Fiscal Year 2003

IMPORTANT NOTICE TO SUPPLIERS

For fiscal year 2003 (FY03), the Centers for Medicare & Medicaid Services (CMS) have given a specified maximum budget for each contractor's level of effort used to provide educational services. The Region A Durable Medical Equipment Regional Carrier (DMERC A) is changing its publication processes to make the most of the available funding; most notably, as related to the Program Safeguard Contractor (PSC).

As previously published in the DMERC Medicare News, CMS awarded a Medicare Program Safeguard Task Order to TriCenturion, LLC. As the PSC for Region A, TriCenturion assumed responsibility for medical policy development, medical review, and benefit integrity for Region A durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims. TriCenturion maintains a Web site at *www.tricenturion.c*om. The PSC Web site contains information on:

- Fraud and abuse
- Healthcare Common Procedure Coding System (HCPCS)
- Local medical review policies (LMRPs) [draft and final]

Updates and changes involving the above topics will no longer be published in the quarterly bulletins, nor posted to our Web site at *www.umd.nycpic.com*. Instead, suppliers should visit the PSC Web site to access this information directly from the PSC. Suppliers should continue to visit the DMERC A Web site for information regarding billing, educational updates and events, electronic data interchange (EDI), fee schedules, what's new, etc. Providers can obtain additional information by visiting the following CMS Web sites:

- *cms.hhs.gov/providerupdate* (CMS Quarterly Provider Update)
- *cms.hhs.gov/medicare* (Medicare Professional and Technical Information)
- *cms.hhs.gov/manuals/memos* (Program Memos)
- *cms.hhs.gov/manuals/transmittals* (Program Transmittals)
- *cms.hhs.gov/manuals/108_pim* (Medicare Program Integrity Manual)
- *cms.hhs.gov/manuals/14_car* (Medicare Carriers Manual)

Source: Region A DMERC

Establishment of New P.O. Boxes

Effective December 1, 2002, the Region A Durable Medical Equipment Regional Carrier (DMERC A) implemented new post office (P.O.) boxes. The purpose of the new P.O. boxes is to enhance customer service, save time on processing, and expedite payment. The following new P.O. boxes are to be utilized:

P.O. Box 1246 Specialty Claims
All other claim types not listed below

P.O. Box 599 Mobility/Support Surfaces Claims
Power Operated Vehicle (POV); Hospital Beds and Accessories; Repairs; Motorized/Power Wheelchair Base; Manual Wheelchair Base; Wheelchair Options and Accessories; Seating Systems, Back Module; Pressure Reducing Support Surfaces-Groups I, II and III; Miscellaneous Support Surfaces; Pneumatic Compression Device (for Lymphedema)

P.O. Box 587 Drugs Claims
Infusion; Immunosuppressive; Nebulizers; Oral Anti-Cancer; Oral Anti-Emetic; End-Stage Renal Disease (ESRD); Epoetin (EPO)

P.O. Box 877 PEN Claims
Parenteral Nutrition; Enteral Nutrition (including E0776 and A5200)

P.O. Box 508 Oxygen Claims
Oxygen and Oxygen Equipment; Respiratory Assist Device (RAD); Continuous Positive Airway Pressure (CPAP) System; Ventilators; Cough Stimulating Device; Intrapulmonary Percussive Ventilation (IPV) System

P.O. Box 1068 Reviews

P.O. Box 450 Hearings and Administrative Law Judge
Hearings (ALJs)

P.O. Box 1363 General Correspondence Inquiries

Please refer to the above to identify the types of claims, categorized by policy group, for the proper P.O. box. **Note:** If there are several policy groups on a claim, submit the claim to the P.O. box referencing the policy group on the first claim line.

P.O. Box 6300 will remain in effect for accounting issues (e.g., refund checks), and P.O. Box 6800 will remain in effect for all other correspondence issues. Updates to the P.O. box listing will be posted to the DMERC A Web site (*www.umd.nycpic.com*).

Source: Region A DMERC

The Region A DMERC Provider Communications (PCOM) Advisory Group

One of the primary responsibilities of Program Education & Training (PET) is to assure that suppliers are fully knowledgeable about Medicare provisions and the proper claim submission requirements. Each fiscal year, the expectations of the Centers for Medicare & Medicaid Services (CMS) relative to the educational responsibilities of PET are clearly addressed in the Region A Durable Medical Equipment Regional Carrier (DMERC A) Budget and Performance Requirements (BPRs). In conjunction with the BPRs, a Statement of Work is developed by CMS to outline DMERC initiatives established to achieve the goal of providing superior customer service while protecting the integrity and promoting the success of the Medicare Trust Fund. One of these initiatives is for the DMERC A to maintain a PCOM Advisory Group, which was referred to as the Program Education & Training Advisory Group (PETAG) in fiscal year 2002. The purpose of the PCOM Advisory Group is to provide opportunities for the supplier community to:

- Offer advice and recommendations for selection of provider education and training topics;
- Propose suggestions for dissemination methods and/or locations for educational forums; and
- Interact directly with DMERC A and CMS staff to discuss current trends and global concerns within the industry.

PCOM Advisory Group membership is open to representatives from state medical societies, state supplier associations, manufacturers, billing services, and all other appropriate supplier organizations and third party entities. Current participation includes representatives from the New York Medical Equipment Dealers Association (NYMEP), Jersey Association of Medical Equipment Suppliers (JAMES), Pennsylvania Association of Medical Suppliers (PAMS), New England Medical Equipment Dealers (NEMED) Association, Pennsylvania Orthotics & Prosthetics Society (POPS), and American Orthotics & Prosthetics Association (AOPA). Membership also includes representation from the New York and Pennsylvania medical societies and several individual provider and billing service organizations.

PCOM Advisory Group meetings occur on a quarterly basis, with location selections made to best meet the needs of the participants while staying within funding limitations. Meetings held during the 2002 fiscal year took place on October 12, 2001, and January 9, 2002, in Philadelphia, PA, and on March 13, 2002, in Scranton, PA. The first meeting for fiscal year 2003 was held on October 9, 2002, at the Adam's Mark Hotel in Philadelphia, PA. The meetings generally consist of a morning DMERC A session that includes DMERC updates/issues, an educational forum, and an open question/discussion period. Some featured topics presented at the past meetings have been data analysis information, provided by the DMERC A Data and Practice Analysis (DAPA) Team, (e.g., the top five claim denials, top five procedure codes billed, state-by-state listings of new and active providers, etc.) and its many uses by PET for educational initiatives; discussions involving CMS on issues submitted by various PCOM Advisory Group members; and "hot topic issues," such as the Health Insurance Portability and Accountability Act (HIPAA).

The DMERC A has also worked in collaboration with TriCenturion, LLC, the Program Safeguard Contractor (PSC) for Region A, to include their participation as well. Afternoon sessions have typically been held by TriCenturion with the PCOM Advisory Group members to discuss issues within the responsibility of the PSC, such as medical policies and benefit integrity initiatives. More information on the PSC can be obtained via the DMERC A Web site (*www.umd.nycpic.com*) or from the PSC Web site (*www.tricenturion.com*).

The PET Team encourages any and all interested representatives to become a member of the PCOM Advisory Group. It is important to ensure our targeted educational efforts are both meaningful and helpful to the supplier community as a whole. If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please contact the PET Team at 570-735-9666 and select Option 1. Membership is FREE. The following are the meetings scheduled for the remainder of fiscal year 2003:

Date	Location
January 8, 2003	Teleconference
April 9, 2003	Newark, NJ
July 9, 2003	Philadelphia, PA

The sites are yet to be determined and will be posted on our Web site at a later date. Members will be notified via email of the details and registration process prior to each meeting.

Check our Web site for the development of a PCOM Advisory Group page, which will feature details on upcoming meetings, online membership and registration, and meeting minutes, including the materials distributed at each meeting.

DMERC A PCOM Advisory Group Mission Statement:

- In partnership, we define effective educational forums for the Region A provider community.
- Together we will address the educational needs of providers through regular briefings, recommendations and requests from the provider community and through assessment of DMERC tracking initiatives.
- We do this with the support of the Centers for Medicare & Medicaid Services (CMS) in order to assure that providers are fully knowledgeable about Medicare provisions.

Source: Region A DMERC

CONNECTICUT LOCAL AND FOCUSED MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies developed as a result of either local medical review or focused medical review initiatives. Both initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), 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, *wwwconnecticutmedicare.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: (866) 419-9455

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Advance Notice Statement

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

Policy Changes Related to the 2003 HCPCS Update

The table on the following page provides a list of local medical review policies (LMRPs) affected by the 2003 Healthcare Common Procedure Coding System (HCPCS) update, which is effective for services rendered on or after January 1, 2003. The full-texts of these LMRPs my be found on the provider education Web site *www.connecticutmedicare.com.*

Policy/Title	Changes
94004F: Treatment Benign Skin Lesions of the Feet	-Descriptor changes for codes 11420, 11421, 11422, and 11423 -Added codes 11424 and 11426 -Changed policy identification number to 11420
2001.3: Excision of Malignant Skin Lesions	-Descriptor changes for codes 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, and 11646 -Changed policy identification number to 11600
20550: Sacroiliac Joint Injection	-Descriptor changes for codes 20550 and 76499
20551: Trigger Point Injections	-Descriptor changes for codes 20550, 20552, and 20553 -Removed ganglion cyst related diagnosis codes 727.41 and 727.42
22899: Kyphoplasty	-Descriptor change for code 76499 -Language in Coding Guidelines section changed to reflect descriptor change
29540: Strapping	-Descriptor change for code 29540 -Added diagnosis 459.81 to ICD-9 Codes that Support Medical Necessity section for code 29580 **(Not related to 2003 HCPCS Update)** -Language in LMRP Description and Indications and Limitations of Coverage and/or Medical Necessity sections changed to reflect descriptor change -Language added to Utilization Guidelines section
44388: Colonoscopy	-Added codes 45381 and 45386
62263: Epidural	-Descriptor changes for codes 62263, 01996, and 96530 -Added code 62264
95010 F V1.3: Implanted Catheters and Pumps for Intrathecal Opioid Infusions	-Descriptor changes for codes 76499 and 96530 -Changed policy identification number to 62277
95010 L V1.2: Paravertebral Facet Joint Blocks	-Descriptor change for code 76499 -Changed policy identification number to 64441
95010 M V1.2: Paravertebral Facet Joint, Nerve Destruction, by a Neurolytic Agent	-Descriptor change for code 76499 -Changed policy identification number to 64622
71250: Computerized Axial Tomography of the Thorax	-Descriptor change for code 71250 -Changed policy title to Computed Tomography of the Thorax
76075: Bone Mineral Density Studies	-Deleted codes G0131 and G0132 -Added code 76070 and 76071 -Changed policy identification number to 76070
88141: Pap Smears Laboratory Testing	-Descriptor changes for codes G0144 and G0145 -Deleted codes 88144 and 88145 -Added codes 88174 and 88175
99 1 V1.0 FINAL: Biofeedback Therapy for Urinary Incontinence	-Added codes 51701 and 51702 -Deleted code 53670 -Changed policy identification number to 90911
97802: Medical Nutrition Therapy (MNT)	-Added codes G0270 and G0271
G0030: Positron Emission Tomography (PET) Scans	-Descriptor changes for codes G0125, G0210-G0218, G0220-G0230 -Descriptor change in Reasons for Denials section for code G0219
J2915: Ferrlecit®	-Deleted code J2915 -Added code J2916 -Language in Coding Guidelines section changed -Changed policy identification number to J2916
J7316: Intra-articular Injections of Hyaluronates in the Knee Joints	-Descriptor change for code J7317 -Changed policy identification number to J7317
J9212: Interferon	-Added code Q3025 -Removed code J1825 **(Not related to 2003 HCPCS Update)**
J9999: Antineoplastic Drugs	-Deleted code J9999 (Alemtuzumab) -Added code J9010 -Language in Coding Guidelines section changed

Provider Notification of Denials Based on Local Medical Review Policy

On November 1, 2002, the Centers for Medicare & Medicaid Services (CMS) issued Change Request 2081, Transmittal AB-02-155, requiring contractors to give notice to beneficiaries when claims are denied in part or in whole based on application of local medical review policy (LMRP) under circumstances detailed in the transmittal. Beginning April 1, 2003, contractors are required to give similar notice to Medicare providers.

Providers must know why their claims are denied so they can decide whether to appeal those claim denials, and so they will know how to avoid such denials, if desired, in the future. Therefore, CMS created a new Remittance Advice (RA) remark code to be used in conjunction with existing messages.

Beginning April 1, 2003, all *newly established* LMRP edits will contain the new RA remark code (if applicable), in addition to the current applicable message(s). By October 1, 2003, *all* LMRP edits will contain the new RA remark code (if applicable) in addition to the current applicable message(s).

New RA Remark Code

N115 This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at *www.LMRP.net*, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP.

Source: CMS Transmittal AB-02-184, CR2305

Preview® Treatment Planning Software

Preview® is a software package used for the evaluation of abdominal aortic aneurysms (AAA) and other procedures for advanced imaging and computer-aided treatment planning. This system transforms data derived from a conventional CT or volumetric MR scan into a patient-specific computer model that allows clinicians to obtain measurements, plan incisions, resections, implant locations, and create a virtual graph. The Preview® system is marketed to completely replace angiography preoperatively and to provide ongoing surveillance of AAA stent grafts.

The information supplied by the manufacturer supports that the Preview® software package allows for the creation of 3D models of the aorta and iliac arteries with significantly greater ease than currently available systems that have been used; the program provides for greater accuracy in measuring the aneurysm and adjacent vessels as well as providing a hypothetical "test-fit" scenario for the endovascular stent graft for various stent component sizes; and the program can produce volumetric measurements of the aneurysm before and after stent graft placement not available on some of the current software.

The hospital is paid under the outpatient prospective payment system utilizing code C9708, and is reimbursed under APC 975. However, the reimbursement of the professional fee for this service is already included in the fee for the computed tomographic angiography service. The computed tomographic angiography already accounts for the extra work of evaluating the post-processed images and obtaining the requisite measurements.

Coverage and Billing for Pegfilgrastim (Neulasta™)

Pegfilgrastim (Neulasta™) is a colony stimulating factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby stimulating proliferation, differentiation, commitment, and end cell functional activation. The Food and Drug Administration (FDA) approved this drug on January 31, 2002, to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia. Current Medicare coverage is for the FDA-approved indication only.

First Coast Service Options, Inc. (FCSO) has received inquiries from providers and medical reviewers regarding the appropriate codes to use when billing for this drug, as well as the documentation requirements. Pegfilgrastim (Neulasta™) is billed using code J3490 (Unclassified drugs). In the appropriate narrative field, include the name of the drug, strength, and dosage given. In addition, include in the appropriate field *at least one* ICD-9-CM code from *each* of the following lists, that most appropriately reflects the patient's medical necessity.

ICD-9-CM codes that represent **non-myeloid malignancies** include, *but are not limited to*, the following (not an all-inclusive list):

140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin and breast
179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites
200.00-202.08	Malignant neoplasm of lymphatic and hematopoietic tissue
203.00-203.81	Multiple myeloma and immunoproliferative neoplasms
204.00-204.81	Lymphoid leukemia
273.3	Waldenström's macroglobulinemia

ICD-9-CM codes that represent **an encounter for myelosuppressive anti-cancer drugs** (chemotherapy) include, *but are not limited to*, the following (not an all-inclusive list):

995.2	Unspecified adverse effect of drug, medicinal, and biological substance
V58.1	Encounter for chemotherapy
V66.2	Convalescence and palliative care following chemotherapy

G0262: Wireless Capsule Endoscopy

Wireless capsule endoscopic imaging is intended as an adjunctive tool in detection of abnormalities of the small bowel. This procedure requires that a patient ingest a small capsule containing a disposable light source, miniature color video camera, battery, antenna, and a data transmitter. Following ingestion of the capsule, natural contraction and relaxation of the gastrointestinal tract propels the camera forward. The camera contained in the capsule records images of the intestinal mucosa as it travels the length of the digestive system. During the entire procedure, which normally takes approximately eight hours, the patient wears a data recorder around the waist to capture and store images transmitted by the capsule's camera. After completion of the procedure, the data recorder is connected to a computer workstation where the images are downloaded and the physician makes a diagnosis. The capsule is excreted naturally from the body. HCPCS code G0262 is new for 2003, and is intended to represent this new technology in the field of gastrointestinal endoscopy. Local medical review policy (LMRP) has been developed to provide indications and limitations of coverage for this new technology, effective services rendered on or after March 24, 2003.

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

MAHD/ER: Metabolically Active Human Dermal/Epidermal Replacements

Bioengineered human dermal replacements (Dermagraft), and human skin equivalents (Apligraf and OrCel) contain the characteristics of dermal, or both dermal and epidermis and have been shown to be effective in the treatment of open wounds. These products function not only as biological dressings, but also act as a delivery system for growth factors and extracellular matrix components through the activity of live human fibroblast contained in their dermal element. HCPCS code J7340 is used to describe the products Apligraf and OrCel, and code J7342, which is new for 2003, is used to describe Dermagraft. Local medical review policy (LMRP) has been developed to provide indications and limitations of coverage for these products, effective for services rendered on or after March 24, 2003.

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

53850: Prostate Treatments

The local medical review policy (LMRP) for prostate treatments was published in the Second Quarter 2002 *Medicare B Update!* (pages 52-53). Since that time, information has been received that supports deletion of the contraindication of "prostate gland with an obstructive median lobe" for patients undergoing transurethral needle ablation (TUNA). Therefore, the LMRP is revised effective for services processed on or after January 20, 2003.

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

77280: Therapeutic Radiology Simulation-Aided Field Setting

Local medical review policy (LMRP) has been developed to define the indications and limitations of coverage and to provide coding guidelines for procedure codes 77280, 77285, 77290, and 77295. This LMRP is based on the American Society for Therapeutic Radiology and Oncology (ASTRO) and the American Radiology Society (ARC) Radiation Oncology Coding Users Guide, and is effective for services rendered on or after March 24, 2003.

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

77300: Basic Radiation Dosimetry Calculation

Local medical review policy (LMRP) has been developed for radiation dosimetry calculations, *CPT* code 77300, to define the indication and limitations of coverage and to provide coding guidelines regarding this service. The LMRP is based on the American Society for Therapeutic Radiology and Oncology (ASTRO) and the American Radiology Society (ARC) Radiation Oncology Coding Users Guide, and is effective for services rendered on or after March 24, 2003.

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

77302: Intensity Modulated Radiation Therapy (IMRT)

Intensity modulated radiation therapy (IMRT) is a new technology that utilizes a computer-based method of planning for and delivery of narrow, patient specific, spatially and temporally modulated beams of radiation to solid tumors. This therapy delivers a more precise radiation dose to the tumor while sparing the surrounding normal tissues by using non-uniform radiation beam intensities.

A local medical review policy (LMRP) has been developed to define the indication and limitations of coverage, and to provide coding guidelines for *CPT* codes used to describe IMRT, 77301 and 77418. These are new *CPT* codes for 2002. The LMRP is based on the American Society for Therapeutic Radiology and Oncology (ASTRO) and the American Radiology Society (ARC) Model policy on Intensity Modulated Radiation Therapy, and is effective date for services rendered on or after March 24, 2003.

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

77332: Treatment Devices, Design and Construction

The local medical review policy (LMRP) for treatment devices, design and construction, was developed to define the indications and limitations of coverage and to provide coding guidelines for procedure codes 77332, 77333, and 77334. This LMRP is based on the American Society for Therapeutic Radiology and Oncology (ASTRO) and the American Radiology Society (ARC) Radiation Oncology Coding Users Guide, and is effective date for services rendered on or after March 24, 2003.

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

77336: Radiation Physics Consult

Local medical review policy (LMRP) has been developed for medical physics consultations, procedure codes 77336 and 77370, to define the indication and limitations of coverage and to provide coding guidelines regarding these services. This LMRP is based on the American Society for Therapeutic Radiology and Oncology (ASTRO) and the American Radiology Society (ARC) Radiation Oncology Coding Users Guide, and is effective date for services rendered on or after March 24, 2003.

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

82232: Beta2 Microglobulin

This laboratory chemistry code was identified as aberrant based on statistical medical data obtained during the first half of 2001. As a result of analysis of the data, local medical review policy (LMRP) was developed to define the indication and limitations of coverage and to provide coding guidelines regarding this service. This LMRP is effective for services rendered on or after March 24, 2003.

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

90801: Psychiatric Diagnostic Interview Examination

The local medical review policy (LMRP) for this service was published in the July 1995 *Medicare News* special edition. Effective for claims processed on or after March 24, 2003, the policy has been revised to further define the indications and limitations of coverage for initial psychiatric diagnostic interview.

Although the emphasis, types of details, and style of a psychiatric interview differ from the medical interview, the purpose is the same: to establish a therapeutic provider-patient relationship, gather accurate data in order to formulate diagnoses, and initiate an effective treatment plan.

A psychiatric diagnostic interview examination consists of elicitation of a complete medical and psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians, other clinicians or community providers, and/or family. There may be overlapping of the medical and psychiatric history depending upon the problem.

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

90804: Individual Psychotherapy

Psychotherapy is the treatment of mental illness and behavior in which the provider establishes a professional contact with the patient and through therapeutic communication and techniques, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Effective for claims processed on or after March 24, 2003, the local medical review policy (LMRP) for this service has been revised to further define the limitations of coverage for individual psychotherapy.

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

90810: Interactive Individual Psychotherapy

The local medical review policy (LMRP) for interactive individual psychotherapy was published in the July 1995 *Medicare News* special edition. Effective for claims processed on or after March 24, 2003, this policy has been revised to further define the indications and limitations of coverage for interactive individual psychotherapy.

Psychotherapy is the treatment of mental illness and behavior disturbances in which the provider establishes a professional contact with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Interactive individual psychotherapy is used when the patient does not have the ability to interact by ordinary verbal communication; therefore, non-verbal communication skills are employed, or an interpreter may be necessary. Interactive procedures are distinct forms of diagnostic procedures and psychotherapeutic procedures which predominately is non-verbal communication (e.g., sign interpreters, visual aids, computer monitors, etc.) and physical aids (e.g., dolls, toys, inanimate objects) to overcome barriers to therapeutic interaction between the physician and the patient who has lost or who has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician if he/she were to use verbal communication.

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

90853: Group Psychotherapy

The local medical review policy (LMRP) for this service was published in the July 1995 *Medicare News* special edition. Effective for claims processed on or after March 24, 2003, the policy has been revised to further define the indications and limitations of coverage for group psychotherapy.

Psychotherapy is the treatment of mental illness and behavior disturbances in which the provider establishes a professional contact with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Group psychotherapy is administered in a group setting with a trained group leader in charge of several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing catharsis instruction and support.

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

90857: Interactive Group Psychotherapy

The local medical review policy (LMRP) for interactive group psychotherapy was published in the *Medicare News*, July 1995 special edition. Since that time, the policy has been revised to further define the indications and limitations of coverage for interactive group psychotherapy.

This revision is effective for claims processed on or after March 24, 2003. The full-text LMRP may be found on the provider education Web site *www.connecticutmedicare.com.*

92002: Evaluation and Management Services in Ophthalmology and Optometry

The local medical review policy (LMRP) for evalualtion and management services in ophthalmology and optomerty is retired, effective for services rendered on or after February 1, 2003. For services provided prior to that date, the full-text LMRP will continue to be available on the provider education Web site *www.connecticutmedicare.com.*

93922: Noninvasive Physiologic Studies of the Upper or Lower Extremity Arteries

Based on information obtained from statistical medical data analysis, procedure codes 93922, 93923, and 93924 (noninvasive physiologic studies of the upper or lower extremity arteries) were identified as aberrant. The focus of the data analysis took place from January 1, 2001 to June 30, 2001. Utilizing this information, a widespread probe of providers was conducted to review the medical documentation on a randomly selected sample of beneficiaries who had these procedures performed during the time of the data analysis. As a result of the finding from this probe review, local medical review policy (LMRP) has been developed to identify indications and limitations of coverage for procedure codes 93922, 93923, and 93924, effective for services on or after March 23, 2003.

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

93965: Noninvasive Evaluation of Extremity Veins

Based on information obtained from statistical medical data analysis, procedure codes 93965, 93970, and 93971 (noninvasive physiologic studies of the extremity veins), were identified as aberrant. The focus of the data analysis took place from January 1, 2001 to June 30, 2001. Utilizing this information a widespread probe of providers was conducted to review the medical documentation on a randomly selected sample of beneficiaries who had these procedures performed during the time of the data analysis. As a result of the finding from this probe review, Local medical review policy (LMRP) has been developed to identify indications and limitations of coverage for procedure codes 93965, 93970, and 93971, effective for services on or after March 23, 2003.

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

Recent FDA Approvals

Fulvestrant (Faslodex®) is an estrogen receptor antagonist without known agonist effects. On April 25, 2002, 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 anti-estrogen therapy. Currently, Connecticut Medicare covers the FDA-approved indication only. Fulvestrant should be billed using code J3490 (unclassified drugs).

Oxaliplatin (Eloxatin™) is a chemotherapeutic agent. On August 25, 2002, the FDA approved Oxaliplatin for injection in combination 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 six months of completion of first line therapy with the combination of bolus 5-FU/LV and Irinotecan. Currently, Connecticut Medicare covers the FDA-approved indication only. Oxaliplatin should be billed using code J9999 (not otherwise classified, antineoplastic drugs).

CONNECTICUT EDUCATIONAL RESOURCES

First Coast Service Options, Inc.
Connecticut Medicare Education and Outreach
2003 *Medicare Made Easy* Seminars Onsite Training

The mission of First Coast Service Options, Inc. Medicare Education and Outreach (MEO) is to create models of excellence in educational programs to foster interactive learning opportunities that meet the needs of the Connecticut provider community. ***Medicare Made Easy*** seminars are provided ***free of charge***, in an effort to reduce billing and payment errors.

The MEO staff is available to facilitate a ***Medicare Made Easy*** presentation to your staff at your facility for groups of 50 or more health professionals. To provide this valuable onsite training to a wider network of suppliers, we kindly ask the requesting organization to assume the responsibility of printing the handouts, providing a location, inviting the attendees, and making available any necessary audio-visual tools.

Your group may select a seminar from the following 1.5-hour modules. A typical ***Medicare Made Easy*** presentation includes two modules delivered during a three-hour segment. All courses are recommended for professionals with beginner to intermediate experience with the Medicare program. Advanced specialty-specific courses are not available at this time. If your group would like to request a speaker, please contact the Education Coordinator at (203) 634-5430, Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m.

1. **CMS-1500 Claims Processing:** This course provides a background of Form CMS-1500, rules for mandatory claims submission, how to avoid claim denials, and comprehensive instructions for completing the form. In addition, this course addresses roster billing for influenza and pneumonia vaccines.

2. **Reimbursement Office Efficiency:** Participants will be able to define participation vs. nonparticipation; identify tools for effective claim submission; review reason for claim duplicates and denials; respond effectively to development letters; and learn how to access Medicare program information.

3. **Medical Review:** At the end of this session, participants will be able to identify the benefits of understanding the progressive corrective action process; identify aberrancy evaluation considerations; identify aberrancy corrective actions; explain the local medical review policy process from draft to implementation of final policy; identify prepayment and postpayment review activities; identify elements of medical review documentation; and identify compliance monitoring activities.

4. **Inquiries, Appeals, and Overpayments**: This course considers who to contact to resolve issues relating to claims; the steps necessary to request a review; the five levels of the appeal process; and how to detect and refund overpayments.

5. **Fraud, Abuse, and Compliance:** This course considers government legislation relating to fraud and abuse; what constitutes Medicare fraud and abuse; penalties associated with fraud and abuse; and proactive measures providers can take to protect their organizations from possible fraudulent activities. The course provides an overview of model compliance program and privacy guidelines of the Health Insurance Portability and Accountability Act (HIPAA).

6. **Provider Enrollment Guidelines:** This session is designed to provide instructions on how to complete and submit the Medicare enrollment forms to the Medicare Part B contractor. The enrollment process is the process through which providers and suppliers register with Medicare in order to bill the Medicare program for products and services they provide to Medicare beneficiaries.

7. ***Current Prodedural Terminology (CPT)* Coding for Beginners:** This session is designed to provide the beginning coder with valuable techniques necessary to perform concise and accurate coding. The session presents a step-by-step review of the format of the *CPT* book, including an overview and history of *CPT*, structure and usage of the appendices, alphabetical index, cross reference, and other helpful aides. Participants learn how to identify additions, deletions, and revisions and identify the appropriate procedure code(s) via practical applications. This hands-on session requires the use of the latest *CPT* manual.

8. **ICD-9-CM Coding for Beginners:** This "hands-on" course provides you with an introduction to the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) manual. We discuss Volumes 1 and 2 at length, including the coding tables in Volume 2. You learn to code to the

"highest level of specificity" using practical examples. We address difficult diagnosis coding areas such as diabetes and burns. We review the claim completion requirements for reporting diagnoses and discuss how the advanced beneficiary notice is related to accurate diagnosis reporting. Finally, you leave with an understanding of the importance of diagnosis coding as it relates to medical documentation.

9. **Global Surgery/Modifiers:** During this session you will learn about the global surgery concept, the correct use of modifiers for visits and other procedures during the global period, and other frequently used common modifiers. In addition, you will learn the billing and reimbursement methodology for other surgical situations such as multiple surgery, bilateral surgery, secondary procedures, split care, facility pricing, co-surgery, surgical assistant, surgical team, assistant at surgery, and surgical trays.

10. **Incident To Guidelines/Non Physician Practioners:** Medicare Part B covers services rendered by employees of physicians or physician directed clinics when the services provided are an integral, although incidental, part of the physician's professional service. This session will review the requirements of this provision for services billable to the contractor by physician assistants, nurse practitioners and other non-physician assistants.

11. **Evaluation and Management Coding**: Presents a review of E/M codes by category; filing requirements; conditions of coverage; and instructions for coding office, hospital, home, and nursing home visits. Guidelines for concurrent care situations, hospital observations, and care plan oversights are included. Emphasis is placed on noncovered services and when to submit these types of services to Medicare.

12. **Evaluation and Management Documentation:** Presents the latest Medicare guidelines for selecting and documenting the appropriate level of E/M code (i.e., office visit, hospital, visit, nursing home visit); guidelines for concurrent care situations, hospital observations, and care plan oversights; introduction to the three elements that are required for selecting the appropriate level of history, the different tables that are considered for selecting the level of "examination," and the three elements that are necessary in the selection of the appropriate level of medical decision making is provided.

13. **Advanced Modifiers**: This course is designed for physicians, office managers, medical coders, and billing staff for Medicare Part B. A modifier is a two-position alpha or numeric code that is added to the end of a procedure code to clarify the service being billed. This course contains a comprehensive list and explanation of the more difficult modifiers. Using the correct modifier on an initial claim will maximize timeliness of reimbursement to a provider.

Visit our provider education Web site, *www.connecticutmedicare.com*, and register online, or use the form on the bottom of the following page and fax your paper registration. For more information call our Education and Outreach department at 203-634-5430.

Medicare Part B Provider Communications Advisory Group

Is your medical specialty, society, or organization being represented at the Provider Communications Advisory Group (PCOM)? Would you like to become a Medicare Educational Ambassador? If you would like to register for and participate in the next meeting, please call Medicare Education at (203) 634-5430. Leave your name, phone number, and fax number, or email address, and a registration form will be sent to you.

What is the Provider Communications Advisory Group?

The PCOM Advisory Group is a panel of representatives from state medical societies, provider offices, billing organizations, and consulting firms that meets quarterly to:

- Review new and existing Medicare education programs
- Recommend changes to these programs
- Alert Medicare to problems or concerns affecting providers
- Network with other professionals interested in Medicare
- Disseminate information from the advisory group to other key organizations

How does membership in the PCOM Advisory Group benefit you?

Participation in the PCOM Advisory Group will allow you to:

- Provide feedback/suggestions to Medicare on important issues such as topics and/or locations for educational activities
- Be closely involved in the development of educational materials from the Medicare carrier
- Make recommendations (as a group) for solutions to problems or concerns affecting providers
- Network with other providers and your Medicare contractor
- Be involved in decisions about education and training activities that directly affect you as a provider

Where and when does the PCOM Advisory Group meet for FY 2003?

Where:
First Coast Service Options, Inc.
321 Research Parkway
Meriden, CT 06450

When:
Quarterly, the first Wednesday of the month from 8:30 to 10:30 a.m.

March 5, 2003
(Teleconference Meeting)

June 4, 2003
(Teleconference Meeting)

September 3, 2003
(Regular Meeting)

December 3, 2003
(Regular Meeting)

Medicare Made Easy Seminars
Five Part Series for Part B Providers

Presented by First Coast Service Options, Inc., Your Connecticut Medicare Carrier

Designed for Beginners and Intermediate Office Personnel!

Five Reasons Why You Should Attend:

1. Receive answers to your most frequently asked Medicare billing questions
2. Learn the latest Medicare program changes
3. Avoid the most common billing errors
4. Receive training by FCSO subject matter experts
5. Attend all five sessions & receive a 15-hour Medicare Certificate of Achievement

Session 1 CMS 1500 Claims Processing, Reimbursement Office Efficiency, Provider Enrollment

Session 2 *CPT* Coding and ICD-9-CM Coding for Beginners

Session 3 Evaluation/Management Coding, Advanced Modifiers, "Incident To" Guidelines, Nonphysician Practitioners

Session 4 Evaluation/Management Documentation, Benefit Integrity and Compliance Guidelines, Medical Reviews

Session 5 Global Surgery, Inquiries, Appeals and Overpayments

Don't Delay—Register Today. All Sessions are Free of Charge!

Visit our provider education Web site at *www.connecticutmedicare*.com and register online or fax your paper registration. For more information call our Education and Outreach department at 203-634-5430.

MEDICARE EDUCATION & OUTREACH EVENT REGISTRATION FORM

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

1. PLEASE complete all portions of this form.

2. ONLY one form per-person, per-registration, please.

3. WHO are you? ❑ Mr. ❑ Mrs. ❑ Ms. ❑ MD ❑ DO ❑ DC

Name Provider #

Title/Position

Company/Organization

Address

City State ZIP Code

Phone Number ( ) Fax Number ( )

Email Address

4. WHICH event do you want to attend? (One form per event, please).

Event Name

Event Date

City State

5. IMPORTANT!

Bring Your Confirmation An event confirmation notice will be faxed for each paper registration received. Please be sure to bring your event confirmation notice with you to the event.

Substitutions If you cannot attend an event, you may send *only one* person to substitute in your place for the duration of the event.

Questions? Call Medicare Education and Outreach at 203-634-5430.

6. FAX your completed form to (203) 634-5493.

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

www.ConnecticutMedicare.com — Connecticut Medicare's Provider Education Web Site

The following outlines the types of information available on the First coast Service Options, Inc. (FCSO) Connecticut Medicare provider education Web site.

New Releases

Pages within the site containing information of immediate interest.

- ***What's New*** - Recent additions to specific areas within the site, as well as other pertinent Medicare program change headlines and highlights.
- ***MCS*** - Publications relative to FCSO's conversion to the Multi-Carrier System (MCS), which includes the Part B System Issues Log.
- ***HIPAA*** - Information about the Health Insurance Portability and Accountability Act

Content

- ***Crossover/Medigap*** - A listing of Medigap insurers and supplemental insurers (automatic crossover), and other helpful information.
- ***CMS Pubs*** - Publications of immediate interest issued by the Centers for Medicare & Medicaid Services (CMS), and Department of Health and Human Services (HHS).
- ***Education & Training*** - Educational resources and calendar of events featuring online registration.
- ***Electronic Data Interchange (EDI)*** - Publications/news, forms/applications, specification manuals for programmers and guidelines relevant to electronic transactions.
- ***FAQs*** - Customers' frequently asked questions and answers.
- ***Fee Schedules*** - Medicare Physician Fee Schedule files and links to CMS files for download for Medicare payment systems.
- ***Forms*** - Various enrollment applications and forms.
- ***General Info*** - Information about other Medicare topics (not inclusive):
  - ***Ambulance*** - Information of concern to suppliers of ambulance services.
  - ***COB/MSP*** - Coordination of Benefits/Medicare Secondary Payer.
  - ***MEDPARD*** - Medicare Participating Physician and Supplier Directory.
  - ***HPSA*** - Health Professional Shortage Areas.
  - ***HH PPS*** - Information concerning the role of the physician in the Home Health Prospective Payment System.
  - ***Program Safeguards*** - Articles and resources relative to Medicare providers.
  - ***Self-Administered Drugs*** - Medicare payment for drugs and biologicals furnished incident to a physician's service.
  - ***Medical Policy*** - FCSO Medicare final and draft local medical review policies (LMRP), FCSO's list of self-administered drugs, links to CMS national coverage files, and more.
  - ***Medicare Enrollment*** - CMS-855 applications and instructions.
  - ***Newsletters*** - FCSO Medicare quarterly and special issue publications.
  - ***Special/Pre-Release Articles*** - Articles of immediate interest that will also be published in the next regularly scheduled quarterly publication.
  - ***UPIN*** - Access to FCSO and national UPIN (unique physician identification number) directories.

Extras

- ***eNews*** - FCSO electronic mailing list. Sign up to receive automatic email notification when new or updated information is posted to Connecticut Medicare's provider education Web site.
- ***Search*** - Enables visitors to search the entire site or individual areas within the site for specific topics or subjects.
- ***Links*** - Valuable links to resources on other Web sites.
- ***Contact Us*** - Important telephone numbers and addresses.

GENERAL INFORMATION- FLORIDA ONLY

Provide Complete Cover Information on Faxes

Florida Medicare's Part B Appeals Department is asking for providers' assistance when faxing documentation to Medicare. Control clerks must often guess as to whom the fax is intended. Many times it is faxed simply to "Medicare," with no other information on the cover sheet.

Providers should furnish informative cover sheets on documents being faxed to Medicare. The review analyst, when requesting information, will also help by asking the provider to place the analyst's first and last name, cubicle number, and clerk number on the fax cover sheet.

Enhanced communications and clarity of information will help us prevent delays and repeat efforts, as we strive to provide quality customer service to our providers and beneficiaries.

FLORIDA LOCAL AND FOCUSED MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies developed as a result of either local medical review or focused medical review initiatives. Both initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), 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

Or call (904) 791-8465

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Advance Notice Statement

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

Policy Changes Related to the 2003 HCPCS Update

The table that follows provides a list of local medical review policies (LMRPs) affected by the 2003 Healthcare Common Procedure Coding System (HCPCS) update, which is effective for services rendered on or after January 1, 2003. The full-texts of these LMRPs may be found on the provider education Web site *www.floridamedicare.com*.

Policy/Title	Changes
00001: Independent Diagnostic Testing Facility (IDTF)	-Descriptor changes for codes G0125, G0210, G0211, G0212, G0213, G0214, G0215, G0216, G0217, G0218, G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228, G0229, G0230, G0236, 70450, 70480, 70486, 70490, 71250, 72125, 72128, 72131, 72192, 73200, 73700, 74022, 74150, 76070, 76355, 76380, 76499, 76805, 76810, 76815, 76816, 76999,93012, 93268, 93620, 94664, 95027, 95812, 95816, 95819, 95822, and 95827 **(Note: narrative CPT description is not included in policy)** -Deleted codes G0004, G0005, G0006, G0015, G0050, G0131, G0132, G0195, G0196, and 94665 -Added codes 51798, 76071, 92610, 92611, 76801, 76802, 76811, 76812, and 76817
01996: Concurrent Care	-Descriptor changes for codes 01996, 99295, 99296, and 99298 -Added code 99299 -Policy converted to new format
11600: Excision of Malignant Skin Lesions	-Descriptor changes for codes 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646 -Language in Indications and Limitations of Coverage and/or Medical Necessity and Coding Guidelines sections changed to reflect descriptor changes.
17000: Benign or Premalignant Skin Lesion Removal/Destruction	-Descriptor changes for codes 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446
17304: Mohs Micrographic Surgery (MMS)	-Descriptor changes for codes 17304 and 17310 -Policy converted to new format
20550: Injection of Tendon Sheath, Ligament, Trigger Points, or Ganglion Cysts	-Descriptor changes for codes 20550, 20552, and 20553 -All references to ganglion cyst have been removed from the policy -Removed ganglion cyst related diagnosis codes 727.42 and 727.43 -Changed policy name to “Injections of Tendon Sheath, Ligament, or Trigger Points”
20600: Arthrocentesis	-Descriptor changes for codes 20600 and 20605 -All references to ganglion cyst have been removed from the policy -Removed ganglion cyst related diagnosis code 727.41
22899: Kyphoplasty	-Descriptor change for code 76499
29540: Strapping	-Descriptor change for code 29540 -Language in LMRP Description and Indications and Limitations of Coverage and/or Medical Necessity sections changed to reflect descriptor change
33216: Implantation of Automatic	-Descriptor change for code 33216 -Added code 33215 -Changed policy identification number to 33215 -Policy converted to new format
36430: Transfusion Medicine	-Descriptor change for code 86930-86932 -Deleted code 86915 -Added code G0267
36520: Therapeutic Apheresis (Plasma and/or Cell Exchange)	-Deleted code 36520 -Added codes 36511, 36512, 36513, and 36514 -Changed policy identification number to 36511 -Policy converted to new format
36521: Protein A Column Apheresis (Prosorba®)	-Deleted code 36521 -Added codes 36515 and 36516 -Changed policy identification number to 36515 -Policy converted to new format
38230: Stem Cell Transplantation	-Deleted code 38231 -Added codes 38205, 38206, and 38242
40000: Digestive System	-Descriptor change for code 49905
43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy	-Added code 43236
44388: Colonoscopy	-Added code 45381 and 45386
58340: Infertility	-Descriptor change for code 89310 -Deleted code G0027 -Policy converted to new format
61793: Stereotactic Radiosurgery	-Descriptor change for code 76355

62263: Percutaneous Lysis of Epidural Adhesions	-Descriptor change for code 62263 -Added code 62264 -Language in Coding Guidelines section changed to reflect descriptor change -Policy converted to new format
62310: Epidural/Subarachnoid Injections	-Language in Coding Guidelines section changed to reflect descriptor change for code 01996 -Policy converted to new format
64550: Application of Surface (Transcutaneous) Neurostimulator	-Removed code 97014 from Indications and Limitations of Coverage and/or Medical Necessity section -Added code G0283 to Indications and Limitations of Coverage and/or Medical Necessity section
69210: Impacted Cerumen Removal	-Added code G0268 -Policy converted to new format
69930: Cochlear Implant Surgery/ Device/Rehab	-Descriptor change for code L7510 -Deleted code 92510 -Added code 92507 -Policy converted to new format
70370: Dysphagia/Swallowing Diagnosis and Therapy	-Deleted codes G0195 and G0196 -Added codes 92610 and 92611 -Language in Coding Guidelines section changed to reflect deletion of procedure code 92525
70450: Computerized Tomography Scans	-Descriptor changes for codes 70450, 70480, 70486, 70490, 72125, 72128, 72131, 73200, and 73700 -Language in Indications and Limitations of Coverage and/or Medical Necessity section changed to reflect descriptor changes -Changed policy title to Computed Tomography Scans
71250: Computerized Axial Tomography of the Thorax	-Descriptor change for code 71250 -Changed policy title to Computed Tomography of the Thorax
72192: Computed Tomography of the Pelvis	-Descriptor change for code 72192
74150: Computerized Axial Tomography of the Abdomen	-Descriptor change for code 74150 -Changed policy title to Computed Tomography of the Abdomen
76075: Bone Mineral Density Studies	-Deleted codes G0131 and G0132 -Added code 76070 and 76071 -Changed policy identification number to 76070
76090: Diagnostic Mammography	-Descriptor change for code G0236 -Language in Coding Guidelines section changed to reflect code G0236
76092: Screening Mammograms	-Descriptor change for code 76085 -Language in Coding Guidelines section changed to reflect code 76085 and G0236
77280: Therapeutic Radiology Simulation-Aided Field Setting	-Descriptor change for code 76370 in Coding Guidelines section
77326: Brachytherapy Isodose Calculation	-Descriptor change for code 77326 -Language in Indications and Limitations of Coverage and/or Medical Necessity section changed to reflect descriptor change -Policy converted to new format
77427: Weekly Radiation Therapy Management	-Deleted codes 53670 and 53675 from Coding Guidelines section -Added codes 51701, 51702, and 51703 to the Coding Guidelines section
80500: Clinical Pathology Consultations and Clinical Laboratory Interpretation Services	-Descriptor change for code 87207
85044: Reticulocyte Count	-Descriptor changes for codes 85044 and 85045 -Policy converted to new format
88141: Pap Smears	-Descriptor changes for codes G0144 and G0145 -Deleted codes 88144 and 88145 -Added codes 88174 and 88175
88230: Cytogenetic Studies	-Added codes G0265 and G0266 -Policy converted to new format
90901: Biofeedback	-Added code 51798 to Coding Guidelines section -Language in Coding Guidelines section changed to reflect deletion of code G0236

90999: ESRD Laboratory Services and Diagnostic Services	-Deleted code 85031 from the Indications and Limitations of Coverage and/or Medical Necessity section and replaced with codes 85014, 85018, and 85032 -Deleted codes 85585, 85590, and 85595 from the Coding Guidelines section and replaced with codes 85008, 85032, and 85049 -Policy converted to new format
92502: Special Otorhinolaryngologic Services	-Deleted code 92599 and replaced with code 92700 in Reason for Denials section
93268: Patient Demand Single or Multiple Event Recorder	-Descriptor changes for codes 93012 and 93268 -Deleted codes G0004, G0005, G0006, G0007, and G0015 -Policy converted to new format
93619: Intracardiac Electrophysiological Evaluation	-Descriptor change for code 93620
94664: Diagnostic Aerosol or Vapor Inhalation	-Deleted codes 94664 and 94665 -Added code 94640 -Language in Coding Guidelines section deleted -Changed policy identification number to 94640 -Policy converted to new format
95004: Allergy Skin Tests	-Descriptor change for code 95027
95805: Sleep Testing	-Descriptor change for code 95822 -Language in Coding Guidelines section changed to reflect descriptor change -Policy converted to new format
95816: Electroencephalography (EEG)	-Descriptor change for code 95816, 95819, 95822, and 95827
97010: Physical Medicine and Rehabilitation	-Removed code 97014 -Added code G0283
97802: Medical Nutrition Therapy (MNT)	-Added codes G0270 and G0271
A0425: Ground Ambulance Services	-Descriptor change for code A0424
A4300: Implantable Vascular Access Devices	-Descriptor change for code A4300 -Descriptor change for code A4301 **(Not related to 2003 HCPCS changes)** -Policy converted to new format
A9600: Metastron C Strontium-89 Chloride	-Descriptor change for code A9600 **(Not related to 2003 HCPCS changes)** -Descriptor change for diagnosis code 198.5 (Not related to 2003 HCPCS changes) -Policy converted to new format
D0110: Dental Services	-Descriptor changes for codes D0150, D4273, D4355 -Deleted codes D7110, D7120, D6543, D6544 -Added codes 38242, D7140, D0180, D2390, D2391, D2392, D2393, D2394, D4241, D4261, D4265, D4275, D4276, D4342, D5670, D5671, D6053, D6054, D6253, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6793, D6985, D7282 -Policy converted to new format
E0782: Implantable Infusion Pumps	-Descriptor changes for codes E0782 and 96530 -Policy converted to new format
G0030: Positron Emission Tomography (PET) Scan	-Descriptor changes for codes G0125, G0210-G0218, G0220-G0230 -Descriptor change in Reasons for Denials section for code G0219 -Descriptor changes for codes G0232 and G0233 **(Not related to 2003 HCPCS changes)**
G0104: Colorectal Cancer Screening	-Code range 45330-45339 was changed to 45330-45345 and procedure code range 45378-45385 was changed to 45378-45386 in the Indications and Limitations of Coverage and/or Medical Necessity section
J0585: Botulinum Toxin Type A (Botox)	-Descriptor change for code 95869
J0587: Botulinum Toxin Type B (Myobloc™)	-Descriptor changes for codes 95867 and 95869 in the Coding Guidelines section
J0635: Vitamin D Analogs in Chronic Renal Disease	-Deleted codes J0635, J2500, and J3490 -Added codes J0636 and J2501 -Changed policy identification number to J0636
J1561: Intravenous Immune Globulin	-Deleted code J1561 -Added code J1564 -Language in Coding Guidelines section related to number of units was deleted -Changed policy identification number to J1563

J2915: Ferrlecit®	-Deleted code J2915 -Added code J2916 -Language in Coding Guidelines section changed -Changed policy identification number to J2916
J3240: Thyrotropin Alfa (Thyrogen®)	-Descriptor change for code J3240 -Language in Coding Guidelines section changed to reflect descriptor change -Policy converted to new format
J3490: Zoledronic Acid (Zometa®)	-Deleted code J3490 -Added code J3487 -Language in Coding Guidelines section changed -Changed policy identification number to J3487
J9212: Interferon	-Added code Q3025
J9999: Antineoplastic Drugs	-Deleted code J9999 (Alemtuzumab) -Added code J9010 -Language in Coding Guidelines section changed
NCSVCS: The List of Medicare Noncovered Services	-Descriptor change for code G0255 in National Noncoverage Decisions section **(Not related to 2003 HCPCS changes)** -Added codes 83880, J1051, 0028T, 0031T, 0032T, 92612, 92613, 92614, 92615, 92616, and 92617 to Local Noncoverage Decisions section -Added codes 90473, 90474, G0282 and G0295 to the National Noncoverage Decisions section -Deleted codes G0185, G0193, and G0194 from Local Noncoverage Decisions section -Deleted codes 86910 and 86911 from Local Noncoverage Decisions section as they are in National Noncoverage Decisions section -Deleted code G0192 from National Noncoverage Decisions section -Changed code 92599 (Politzer procedure) to 92700 in Local Noncoverage Decisions section -Changed code 92599 (Tinnitus masking) to 92700 in National Noncoverage Decisions section -Changed code 97014 (Electrotherapy for the treatment of facial nerve paralysis [Bell's Palsy]) to G0238 and 97014 (Treatment of motor function disorders with electrical nerve stimulation) to G0238 in National Noncoverage Decisions section
VISCO: Viscosupplementation Therapy For Knee	-Deleted code Q3030 -Added code J7317

Provider Notification of Denials Based on Local Medical Review Policy

On November 1, 2002, the Centers for Medicare & Medicaid Services (CMS) issued Change Request 2081, Transmittal AB-02-155, requiring contractors to give notice to beneficiaries when claims are denied in part or in whole based on application of local medical review policy (LMRP) under circumstances detailed in the transmittal. Beginning April 1, 2003, contractors are required to give similar notice to Medicare providers.

Providers must know why their claims are denied so they can decide whether to appeal those claim denials, and so they will know how to avoid such denials, if desired, in the future. Therefore, CMS created a new Remittance Advice (RA) remark code to be used in conjunction with existing messages.

Beginning April 1, 2003, all *newly established* LMRP edits will contain the new RA remark code (if applicable), in addition to the current applicable message(s). By October 1, 2003, *all* LMRP edits will contain the new RA remark code (if applicable) in addition to the current applicable message(s).

New RA Remark Code

N115 This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at *www.LMRP.net*, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP.

Source: CMS Transmittal AB-02-184, CR2305

Preview® Treatment Planning Software

Preview® is a software package used for the evaluation of abdominal aortic aneurysms (AAA) and other procedures for advanced imaging and computer-aided treatment planning. This system transforms data derived from a conventional CT or volumetric MR scan into a patient-specific computer model that allows clinicians to obtain measurements, plan incisions, resections, implant locations, and create a virtual graph. The Preview® system is marketed to completely replace angiography preoperatively and to provide ongoing surveillance of AAA stent grafts.

The information supplied by the manufacturer supports that the Preview® software package allows for the creation of 3D models of the aorta and iliac arteries with significantly greater ease than currently available systems that have been used; the program provides for greater accuracy in measuring the aneurysm and adjacent vessels as well as providing a hypothetical "test-fit" scenario for the endovascular stent graft for various stent component sizes; and the program can produce volumetric measurements of the aneurysm before and after stent graft placement not available on some of the current software.

The hospital is paid under the outpatient prospective payment system utilizing code C9708, and is reimbursed under APC 975. However, the reimbursement of the professional fee for this service is already included in the fee for the computed tomographic angiography service. The computed tomographic angiography already accounts for the extra work of evaluating the post-processed images and obtaining the requisite measurements.

Coverage and Billing for Pegfilgrastim (Neulasta™)

Pegfilgrastim (Neulasta™) is a colony stimulating factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby stimulating proliferation, differentiation, commitment, and end cell functional activation. The Food and Drug Administration (FDA) approved this drug on January 31, 2002, to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia. Current Medicare coverage is for the FDA-approved indication only.

First Coast Service Options, Inc. (FCSO) has received inquiries from providers and medical reviewers regarding the appropriate codes to use when billing for this drug, as well as the documentation requirements. Pegfilgrastim (Neulasta™) is billed using code J3490 (Unclassified drugs). In the appropriate narrative field, include the name of the drug, strength, and dosage given. In addition, include in the appropriate field *at least one* ICD-9-CM code from *each* of the following lists, that most appropriately reflects the patient's medical necessity.

ICD-9-CM codes that represent **non-myeloid malignancies** include, *but are not limited to,* the following (not an all-inclusive list):

140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin and breast
179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites
200.00-202.08	Malignant neoplasm of lymphatic and hematopoietic tissue
203.00-203.81	Multiple myeloma and immunoproliferative neoplasms
204.00-204.81	Lymphoid leukemia
273.3	Waldenström's macroglobulinemia

ICD-9-CM codes that represent **an encounter for myelosuppressive anti-cancer drugs** (chemotherapy) include, *but are not limited to,* the following (not an all-inclusive list):

995.2	Unspecified adverse effect of drug, medicinal, and biological substance
V58.1	Encounter for chemotherapy
V66.2	Convalescence and palliative care following chemotherapy

G0108: Diabetes Outpatient Self-Management Training

The local medical review policy (LMRP) for diabetes outpatient self-management training (DSMT) was published in the March/April 2000 *Medicare B Update!* (pages 23-26). Since that time, the Centers for Medicare & Medicaid Services (CMS) issued Transmittal 1762, dated August 21, 2002, the purpose of which is to manualize Transmittals AB-00-66 (Change Request [CR] 199), AB-00-67 (CR 606), and B-01-40 (CR 1455). This update to the Medicare carriers manual (MCM) adds "in the 12 months" to the "Medical Eligibility for Coverage section of this policy."

In addition, per Transmittal B-02-062 (CR 2386), a statement was added to the policy that for services rendered on or after January 1, 2002, registered dieticians are eligible to bill on behalf of an entire DSMT program. For more information, please see the related article on page 14 of this issue.

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

Source: CMS Transmittal 1762; MCM section 4280

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

The local medical review policy (LMRP) for peripheral neuropathy with LOPS was published in the Fourth Quarter 2002 *Medicare B Update!* (pages 32-33). Effective for services rendered on or after January 1, 2003, a revision has been made to the "Coding Guidelines" section of the LMRP. In order to be considered for payment, code G0247 must be billed on the same claim with the same date of service as either G0245 or G0246.

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

Source: CMS Transmittal AB-02-109, CR 2150

G0262: Wireless Capsule Endoscopy

Wireless capsule endoscopic imaging is intended as an adjunctive tool in the detection of abnormalities of the small bowel. This procedure requires that a patient ingest a small capsule containing a disposable light source, miniature color video camera, battery, antenna, and a data transmitter. Following ingestion of the capsule, natural contraction and relaxation of the gastrointestinal tract propels the camera forward. The camera contained in the capsule records images of the intestinal mucosa as it travels the length of the digestive system. During the entire procedure, which normally takes approximately eight hours, the patient wears a data recorder around the waist to capture and store the images transmitted by the capsule's camera. After completion of the procedure, the patient data recorder is connected to a computer workstation where the images are downloaded and the physician makes a diagnosis. The capsule is excreted naturally from the body. HCPCS code G0262 is new for 2003 and is intended to represent this new technology in the field of gastrointestinal (GI) endoscopy. Local medical review policy (LMRP) has been developed to provide indications and limitations of coverage for this new technology, effective for services processed on or after March 24, 2003.

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

J2430: Pamidronate (Aredia®, APD)

The local medical review policy (LMRP) for pamidronate was published in the June/July 2000 *Medicare B Update!* (page 28). Effective for claims processed on or after February 7, 2003, diagnosis code V10.3 (personal history of malignant neoplasm; breast) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.

Pamidronate is FDA approved as an adjunct treatment of osteolytic lesions of breast cancer and myeloma. Billing of pamidronate for metastatic breast cancer requires a dual diagnosis. To ensure reimbursement for this indication, the primary site or personal history (V10.3) *and* secondary site of the malignancy must both be billed to indicate that the breast malignancy is metastatic (i.e., both ICD-9-CM codes 198.5 and 174.0-175.9 or V10.3 must be billed).

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

Recent FDA Approvals

Fulvestrant (Faslodex®) is an estrogen receptor antagonist without known agonist effects. On April 25, 2002, 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 anti-estrogen therapy. Currently, Florida Medicare covers the FDA-approved indication only. Fulvestrant should be billed using code J3490 (unclassified drugs).

Oxaliplatin (Eloxatin™) is a chemotherapeutic agent. On August 25, 2002, the FDA approved Oxaliplatin for injection in combination 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 six months of completion of first line therapy with the combination of bolus 5-FU/LV and Irinotecan. Currently, Florida Medicare covers the FDA-approved indication only. Oxaliplatin should be billed using code J9999 (not otherwise classified, antineoplastic drugs).

J7340: Apligraf® (Graftskin)—Policy Retired

The local medical review policy (LMRP) for Apligraf® is retired, effective for services processed on or after March 24, 2003. Indications and limitations for this service may be found in policy MAHD/ER: Metabolically Active Human Dermal/Epidermal Replacement (see page 52).

The full-text of the LMRP for MAHD/ER may be fiund on the provider education Web site *www.floridamedicare.com*.

J9999: Antineoplastic Drugs

Correction to Policy

The local medical review policy (LMRP) for antineoplastic drugs was published in the First Quarter 2002 *Medicare B Update!* (pages 31-36). The diagnosis for secondary malignant neoplasm of other specified sites (198.89) for procedure code J9355 (Trastuzumab [Herceptin®]) was inadvertently omitted from publication of the policy. Florida Medicare apologizes for any inconvenience this may have caused.

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

MAHD/ER: Metabolically Active Human Dermal/Epidermal Replacements

Bioengineered human dermal replacements (Dermagraft), and human skin equivalents (Apligraf® and OrCel) contain the characteristics of dermal, or both dermal and epidermis and have been shown to be effective in the treatment of open wounds. These products function not only as biological dressings, but also act as a delivery system for growth factors and extracellular matrix components through the activity of live human fibroblast contained in their dermal element. HCPCS code J7340 is used to describe the products Apligraf and OrCel, and code J7342, which is new for 2003, is used to describe Dermagraft. Local medical review policy (LMRP) has been developed to provide indications and limitations of coverage for these products, effective for services processed on or after March 24, 2003.

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

NCSVCS: The List of Medicare Noncovered Services

The following changes have been made to the local medical review policy (LMRP) for Medicare noncovered services.

Local Noncoverage

Additions

99199 Pulsatile Intravenous Insulin Therapy (PIVIT) also referred to as Hepatic Activation Therapy (HAT), Metabolic Activation Therapy (MAT), or Chronic Intermittent Intravenous Insulin Therapy (CIIIT). The services associated (i.e. office visits, physician directed infusions, blood glucose monitoring) with this therapy are noncovered, as they are associated with the administration of a usually self-administered drug (i.e., insulin). All services associated with therapy should be bundled and billed under the *CPT* code 99199. Individual services should not be billed under their respective payable *CPT* codes. PIVIT is added to the local noncoverage section of the LMRP effective for services rendered on or after March 24, 2003; however, services rendered prior to that date will also be considered noncovered.

Deletions

Effective for services rendered on or after November 25, 2002 the following *CPT* codes for clinical laboratory services were removed from local noncoverage. Indications and limitations for these services are included in the administrated policies for the Negotiated Rulemaking for Clinical Diagnostic Laboratory Services published in the Federal Register on November 23, 2001. For more information, please refer to the Centers for Medicare & Medicaid Services' (CMS) Web site at *http://cms.hhs.gov/ncd/default.asp*.

82523, 86301, 87534, 87537, 87538, 87539

In addition, effective for services rendered on or after January 1, 2003, *CPT* code *53899 Neocontrol (Magnetic Incontinence Chair)* has been deleted from local noncoverage.

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

29540: Strapping

The local medical review policy (LMRP) for strapping was published in the First Quarter 2002 *Medicare B Update!* (pages 41-43). However, section 2323 of the Medicare Carriers Manual (MCM) specifically excludes coverage for the treatment of flat foot. Therefore, effective for claims processed on or after January 27, 2003, diagnosis code 734 (flat foot) has been removed from the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.

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

Source: MCM section 2323

53850: Prostate Treatments

The local medical review policy (LMRP) for prostate treatments was published in the Second Quarter 2002 *Medicare B Update!* (pages 46-48). Since that time, information has been received that supports deletion of the contraindication of "prostate gland with an obstructive median lobe" for patients undergoing transurethral needle ablation (TUNA). Therefore, the LMRP is revised effective for services processed on or after December 16, 2002.

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

70450: Computerized Tomography Scans—Correction to Policy

The local medical review policy (LMRP) for computerized tomography scans (70450) was published in the June 2001 special issue *Medicare B Update!* (pages 16 and 17). The diagnosis range for neoplasm of uncertain behavior of endocrine glands and nervous system (237.5-237.9) was inadvertently omitted from publication of the policy. Florida Medicare apologizes for any inconvenience this may have caused.

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

74150: Computerized Axial Tomography of the Abdomen

The local medical review policy (LMRP) for computerized axial tomography of the abdomen was published in the June 2001 special issue *Medicare B Update!* Effective for claims processed on or after January 27, 2003, diagnosis codes 162.2-162.9 (Malignant neoplasm of lung) and 202.83 (other lymphoma, intra-abdominal lymph nodes) have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

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

77280: Therapeutic Radiology Simulation-Aided Field Setting

This local medical review policy (LMRP) has been revised to clarify the indications and limitations for therapeutic radiology simulation-aided field settings. This service will be considered medically reasonable for patients, including those with certain benign conditions, for whom a radiation therapy course of treatment needs to be established, effective for services processed on or after February 1, 2003.

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

77300:Basic Radiation Dosimetry Calculation

To provide clarification of those persons qualified to perform basic radiation dosimetry calculations, the local medical review policy (LMRP) for this service has been revised, effective for services processed on or after February 1, 2003.

Calculations may be performed by a radiation oncologist, a qualified medical physicist, or qualified medical dosimetrist under the technical supervision of the radiation oncologist. Documentation should indicate that the calculations were reviewed, signed, and dated by both the qualified medical physicist or dosimetrist and the physician.

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

80100: Qualitative Drug Screen

The local medical review policy (LMRP) for qualitative drug screen has been revised to allow coverage for patients receiving active treatment for substance abuse, when the results of the drug screen are utilized in the management of the patient's care.

Language changes were made to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the policy.

In addition, ICD-9-CM codes V70.4 (Examination for medicolegal purposes) and V70.5 (Health examination of defined subpopulation [occupational or pre-employment]) were added to the "ICD-9-CM Codes that DO NOT Support Medical Necessity" section of the policy and were added to the policy effective February 17, 2003. **Note**: these screening diagnoses have *always* been noncovered.

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

Retirement of Local Medical Review Policies for Certain Clinical Diagnostic Laboratory Services

The local medical review policies (LMRPs) listed here relating to clinical laboratory services have been retired, effective for services rendered on or after November 25, 2002. Indications and limitations for these services are included in the administrated policies for the Negotiated Rulemaking for Clinical Diagnostic Laboratory Services published in the *Federal Register* on November 23, 2001.

For more information regarding the national coverage decisions that replace these LMRPs, please refer to the First Quarter 2003 *Medicare B Update!* (pages 12-14), and the Centers for Medicare & Medicaid Services' (CMS) Web site at *http://cms.hhs.gov/ncd/default.asp*.

87086: Urine Bacterial Culture
84436: Thyroid Function Test
87536: HIV-1 Viral Load Testing
80162: Digoxin
85007: Complete Blood Count
82105: Tumor Markers
85610: Prothrombin Time
82378: Carcinoembryonic Antigen (CEA)
82728: Serum Ferritin
82270: Fecal Occult Blood
82947: Blood Glucose Testing
84153: Prostate Specific Antigen
82985: Glycated Protein
83036: Glycated Hemoglobin
80061: Lipid Profile / Cholesterol Testing

90804: Individual Psychotherapy

The local medical review policy (LMRP) for individual psychotherapy was published in the December 1996 special issue *Medicare B Update!* Effective for claims processed on or after March 24, 2003, the policy has been revised to provide further clarification regarding documentation requirements for individual psychotherapy services and provide coverage for Alzheimer's disease (ICD-9-CM code 331.0).

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

90810: Interactive Individual Psychotherapy

The local medical review policy (LMRP) for interactive group psychotherapy was published in the October 1996 *Medicare B Update!* Effective for claims processed on or after March 24, 2003, this policy has been revised to provide further clarification regarding documentation requirements for interactive group psychotherapy, and to provide coverage for Alzheimer's disease (ICD-9-CM code 331.0).

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

90853: Group Psychotherapy

Effective for claims processed on or after March 24, 2003, the local medical review policy (LMRP) for group psychotherapy has been revised, to provide further clarification regarding documentation requirements for group psychotherapy, and to allow coverage for Alzheimer's disease (ICD-9-CM code 331.0).

Psychotherapy is the treatment of mental illness and behavior disturbances in which the physician establishes a professional contact with the patient through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Group psychotherapy is administered in a group setting with a trained group leader in charge of several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, and support.

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

93965: Noninvasive Evaluation of Extremity Veins

The local medical review policy (LMRP) for non-invasive evaluation of extremity veins has been revised to include venous mapping for the selection of a vein suitable for creation of a dialysis fistula or prior to surgical revascularization as a covered indication, effective for services processed on or after February 3, 2003.

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

FLORIDA EDUCATIONAL RESOURCES

Medicare Education and Outreach—Upcoming Events

A calendar for upcoming Medicare Education and Outreach events in 2003 is posted to our provider education Web site, *www.floridamedicare.com*. Events scheduled through June 2003 are listed below.

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

Date	Event	Location
March		
5	Beyond the Basics Workshop	St Petersburg FL
12	Basic Skills Workshop	Panama City FL
13	Beyond the Basics Workshop	Panama City FL
April		
9	Beyond the Basics Workshop	Naples FL
May		
15	PCOM (Provider Communications-formerly PET Advisory Group)	
20-22	Medifest	Orlando FL
June		
18	Basics Skills Workshop	Sarasota FL
19	Beyond the basics Workshop	Sarasota FL

FCSO Announces *Free* Online Education

During the months of April through September 2003, First Coast Service Options, Inc. (FCSO) will offer live online instructor-led educational sessions, at no charge, through our Florida provider education Web site (*www.floridamedicare*.com). Following Connecticut's conversion to the Multi-Carrier System (MCS), we will begin working to develop similar sessions for our Connecticut customers.

The educational sessions may be accessed from any location, including the provider's office or residence, which eliminates travel time and other related expenses. A personal computer (PC) with an Internet connection via telephone or other modem device, plus an additional telephone connection to listen to the audio portion, is required for participation.

Registration for these events will occur through the Florida provider education Web site. FCSO is in the process of creating a schedule and list of topics, for these 60- to 90-minute sessions. As soon as the schedule is finalized, it will be posted to the Web site, published in future issues of the *Medicare B Update!* and communicated through the *FCSO eNews* electronic mailing lists.

Providers should continue to monitor our Web site for more information in the coming months. If you have not already done so, subscribe to the *eNews* electronic mailing list so you can receive automatic notification of important updates to this information.

MEDIFEST 2003

You asked for it and it's back!

Medicare Education and Outreach is proud to announce the return of this popular event! This 2½ day symposium is designed with the provider in mind.

- You will have the opportunity to select 10 classes from 31 different topics.
- You will gain an understanding of Medicare guidelines and Local Medical Review Policies.
- You will be able to take classes to understand ICD-9-CM and CPT coding, Fraud and Abuse, Medicare Secondary Payer, CMS-1500 claim form, Hospital Outpatient Prospective Payment System (HOPPS), Reason Code Resolution and much more!

FREE Exhibit Area

Everyone is invited to visit our free exhibit area to learn about office automation options available from vendor representatives and to speak with Medicare staff.

Continuing Education Units

Continuing education units (CEUs) are available for some Medifest classes. Details will be available at the event.

Tips for Registrants

- Pre-registration and pre-payment are required!
- Be sure to register for only one class per time slot.
- Register as early as possible, and no later than the deadline, to secure your space in the classes you want.
- Some classes require the use of current CPT or ICD-9-CM books. Check the class descriptions for more details; if in doubt, bring both books.

Classes, Schedules, and Registration

Complete class descriptions and schedules are available on our provider education Web site, *www.floridamedicare.com*; participants may register online via the Web site as well. Schedules and a registration form may be also found on the following pages.

MEDIFEST Class Schedule

The price for the MEDIFEST Event is $299 per person. Please keep in mind that you can register for only one class per time slot. If you register for a class that overlaps a second time slot (such as CMS-1500, *CPT* for Beginners, Primary Care and UB-92), you cannot register for another class until that class ends.

May 20-22, 2003
Orlando Airport Marriott
7499 Augusta National Blvd.
Orlando, FL 32822
Please contact hotel for directions and/or reservations (407) 851-9000

PLEASE MARK ONLY ONE CLASS PER TIME SLOT.

Tuesday

7:45 - 8:15
General Session (all participants)

9:00 - 10:30
❑ E/M Documentation/97 (B)
❑ Cardiology (B)
❑ Global Surgery (B)
❑ CMS-1500 (B)
(This class lasts until 12:15 pm)
❑ *CPT* for Beginners (A/B)
(This class lasts until 12:15 pm)
❑ Fraud & Abuse (A/B)
❑ Reason Code Resolution (A)

10:45 - 12:15
❑ ARNP (B)
❑ Reimbursement Efficiency (B)
❑ Medical Review/Data Analysis (A/B)
❑ ICD-9-CM Update (A/B)
❑ HOPPS (A)

1:30 - 3:00
❑ Provider Enrollment (B)
❑ Medicare Secondary Payer (B)
❑ Primary Care (B)
(This class lasts until 5:00 pm)
❑ Part A Modifiers (A)
❑ UB-92/DDE (A)
(This class lasts until 5:00 pm)
❑ Physical Medicine (B)

3:30 - 5:00
❑ E/M Coding (B)
❑ Vision (B)
❑ Anesthesia (B)
❑ Inquiries, Appeals & Overpayments (B)
❑ CORF/ORF (A)

Wednesday

8:30 - 10:00
❑ Radiology (B)
❑ Global Surgery (B)
❑ Inquiries, Appeals & Overpayments (B)
❑ Primary Care (B)
(This class lasts until 12:00 pm)
❑ Fraud & Abuse (A/B)
❑ UB-92/DDE (A)
(This class lasts until 12:00 pm)
❑ Medicare Secondary Payer (A)

10:30 - 12:00
❑ Cardiology (B)
❑ Reimbursement Efficiency (B)
❑ Medical Review/Data Analysis (A/B)
❑ Quality Improvement Organization
(Formerly known as the PRO)
❑ Physical Medicine (B)

1:30 - 3:00
❑ E/M Coding (B)
❑ Vision (B)
❑ Oncology (B)
❑ CMS-1500 (B)
(This class lasts until 5:00 pm)
❑ ICD-9-CM Update (A/B)
❑ *CPT* for Beginners (A/B)
(This class lasts until 5:00 pm)
❑ Reason Code Resolution (A)

3:30 - 5:00
❑ E/M Documentation/97 (B)
❑ Mental Health (B)
❑ Dermatology (B)
❑ Orthopedics (B)
❑ Reimbursement Efficiency (A)

Thursday

8:30 - 10:00
❑ E/M Coding (B)
❑ Provider Enrollment (A/B)
❑ Global Surgery (B)
❑ Inquiries, Appeals & Overpayments (B)
❑ *CPT* for Beginners (A/B)
(This class lasts until 12:00 pm)
❑ Fraud & Abuse (A/B)
❑ Medicare Secondary Payer (A)

10:30 - 12:00
❑ E/M Documentation/97 (B)
❑ Reimbursement Efficiency (B)
❑ Medicare Secondary Payer (B)
❑ ICD-9-CM Update (A/B)
❑ Part A Modifiers (A)
❑ Reimbursement Efficiency (A)

1:30 - 3:00
❑ HIPAA-AS (A/B)

Class Designations are:
Medicare Part A - (A)
Medicare Part B - (B)
Both - (A/B)

PLEASE PRINT

_____
Attendee Name

_____
Provider Name

_____
Billing Provider Number

For complete class descriptors, please visit our Web site at *www.floridamedicare.com*

MEDIFEST
REGISTRATION FORM

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

May 20-22, 2003
Orlando Airport Marriott
7499 Augusta National Blvd.
Orlando, FL 32822
Please contact hotel for directions and or reservations (407) 851 9000

ON-LINE REGISTRATION	FAXED REGISTRATION
1. Register through the Web site. A computer-generated confirmation will be sent via e-mail.	1. Fax both registration form and class schedule(s) to (904) 791-6035.
2. An invoice will be faxed or e-mailed to you.	2. A confirmation and invoice will be faxed or e-mailed 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**
5. Bring your Medifest confirmation notice to the event.	5. Bring your Medifest confirmation notice to the event.

Registrant's Name

Provider's Name

Medicare Billing Provider #

Street Address

City State ZIP Code

Phone ( ) Fax ( ) E-mail

Payment is being issued for:

Seminar/Material	Price each (include applicable sales tax)
Medifest **Note: Medifest Event Materials are not included**	**$299.00**
Medifest Part A Handbook ❑ OR ❑ CD	**$75.00**
Medifest Part B Handbook ❑ OR ❑ CD	**$75.00**

Important Registration Information:

Cancellations and Refunds	Substitutions	Confirmation Notice
Cancellation requests must be received in writing 14 days prior to the event. No refunds will be issued after that time. All refunds are subject to a $35.00 cancellation fee per person. (Rain checks will not be issued for cancellations. Additionally, rain checks issued for previous seminars may **not** be applied towards this event)	If you are unable to attend, your company may send one substitute to take your place for the entire seminar. Once you have signed in at the registration desk, substitutions will **not** be permitted during the remainder of the event. Remember: Registration must be informed of all changes in advance.	A confirmation notice will be faxed or emailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Outreach), please contact us at (904) 791-8141.

For registration information, please visit our Web site at *www.floridamedicare.com* or call our registration hotline at (904) 791-8103.

Registration is on a first come, first served basis. Please register as soon as possible.

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

www.FloridaMedicare.com — Florida Medicare's Provider Education Web Site

The following outlines the types of information available on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider education Web site.

New Releases

Pages within the site containing information of immediate interest.

- ***What's New*** - Recent additions to specific areas within the site as well as other pertinent Medicare program change headlines and highlights.
- ***HIPAA*** - Information about the Health Insurance Portability and Accountability Act.

Content–Part A and B

Both areas contain the following:

- ***Special Release Articles*** - Articles of immediate interest that will also be published in the next regularly scheduled quarterly publication.
- ***Bulletins/Publications*** - FCSO Medicare quarterly and special issue publications (*Medicare A Bulletin* and *Medicare B Update!*).
- ***CMS/DHHS Publications*** - Publications issued by the Centers for Medicare & Medicaid Services (CMS), and Department of Health and Human Services (DHHS).
- ***Medical Policy*** - FCSO Medicare final and draft local medical review policies (LMRP), FCSO's list of self-administered drugs, links to CMS national coverage files, and more.
- ***Fraud, Abuse, and Waste*** - Articles and resources relative to Medicare providers.
- ***Self-Administered Drugs*** - Medicare payment for drugs and biologicals furnished incident to a physician's service.

Part A

Additional information found within the Part A area of the site (not inclusive).

- ***PPS*** - Prospective Payment Systems.
- ***Issues*** - Document containing a status of the most commonly reported Part A claim and system issues.
- ***Reason Codes*** - Part A reason codes.

Part B

Additional information found within the Part B area of the site (not inclusive).

- ***Crossovers/Medigap*** - A listing of Medigap insurers and supplemental insurers (automatic crossover), and other helpful information.

MCS

- Contains publications relative to FCSO's conversion to the Multi-Carrier System (MCS). Also includes the Part B System Issues Log.

Shared Content

Provides information shared by Part A and Part B providers.

- ***Education & Training*** - Educational resources and calendar of events featuring online registration capabilities.
- ***Electronic Data Interchange (EDI)*** - Publications/news, forms/ applications, specification manuals for programmers and guidelines relevant to electronic transactions.
- ***FAQs*** - Providers' most frequently asked questions and answers.
- ***Fee Schedules*** - Medicare physicians fee schedule files and links to CMS files for download for Medicare payment systems.
- ***Forms*** - Various FCSO and CMS enrollment applications and forms.
- ***General Info*** - Information about other Medicare topics (not inclusive):
- ***COB/MSP*** - Coordination of Benefits/Medicare Secondary Payer.
- ***Medicare Enrollment*** - Medicare provider enrollment applications and forms with instructions, which include paper and electronic versions of the CMS-855s.
- ***MEDPARD*** - Medicare Participating Physician and Supplier Directory.
- ***UPIN*** - Access to FCSO and national UPIN (unique physician identification number) directories.

Extras

- ***eNews*** - FCSO electronic mailing list. Sign up to receive automatic email notification when new or updated information is posted to Florida Medicare's provider education Web site.
- ***Search*** - Enables visitors to search the entire site or individual areas within the site for specific topics or subjects.
- ***Links*** - Valuable links to resources on other Web sites.
- ***Contact Us*** - Important telephone numbers and addresses.

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*.

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CONNECTICUT MEDICARE PART B MAIL DIRECTORY

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Reviews and Medicare EDI, please submit all correspondence with the appropriate attention line to:

***Attention:* (*insert dept name*)**
First Coast Service Options, Inc. Medicare Part B
P.O. Box 9000
Meriden, CT 06454-9000

Attention: 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 six months of the date of the Explanation of Medicare Benefits. 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)*

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
Medicare Fraud Branch
P. O. Box 45087
Jacksonville, FL 32232-5087

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
(800) 333-7586
Hearing Impaired:
(800) 754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

PROVIDERS

Toll-Free
Customer Service:
(866) 454-9007
Interactive Voice Response (IVR):
(877) 847-4992

For Seminar Registration Only (*not* toll-free)**:**
(904) 791-8103

EMC

Format Issues & Testing:
(904) 354-5977 option 5
Start-Up & Front-End Edits/Rejects:
(904) 791-8767 option 4
Electronic Funds Transfer
(904) 791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Marketing:
(904) 791-8767 option 4
New Installations:
(new electronic senders; change of address or phone number for senders):
(904) 791-8608
Help Desk:
(Confirmation/Transmission):
(904) 905-8880 option 1

OCR

Printer Specifications/Test Claims:
(904) 791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
(803) 735-1034

MEDICARE PART A

Toll-Free:
(877) 602-8816

WEB SITES

PROVIDER

Florida
www.floridamedicare.com

Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARY

Florida
www.medicarefla.com

Centers for Medicare & Medicaid Services
www.medicare.gov

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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.

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❑	**2003 Fee Schedule –** One copy of the *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* is sent free of charge in mid-November to individual providers and professional association (PA) groups who bill at least one claim to FCSO Medicare Part B in Connecticut or Florida for processing during the preceding six months. The Fee Schedule contains calendar year 2003 payment rates for all localities. These fees apply to services performed between January 1 and December 31, 2003. 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	$20.00

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P.O. BOX 9000 MERIDEN, CT 06454-9000

* ATTENTION BILLING MANAGER*