Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

In This Issue...

Features

Please share the *Medicare B Update!* with appropriate members of your organization.

Routing Suggestions:

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

HCFA Health Care Financing Administration

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

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The *Medicare B Update!* is published bimonthly by the Medicare Publications Department, to provide timely and useful information to Medicare Part B providers in Florida.

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

Medicare Part B Publications
P.O. Box 2078
Jacksonville, FL 32231-0048

A PHYSICIAN'S FOCUS

Doctor, is it a Consult or a Visit?

Consultations are among the most frequently miscoded evaluation and management services. The following are some points to keep in mind when performing and billing consultations.

A consultation is a medically necessary professional service furnished to a patient at the request of the patient's attending physician. A consultation report must be furnished to the attending physician. When the consultation involves institutionalized patients, the written report must also be submitted to the institution that maintains the patient's permanent medical records.

A consulting physician may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits to manage a portion or all of the patient's conditions must be billed as subsequent visits, not as follow-up consultations.

Follow-up consultations may be billed if:

- A second visit is required to complete the initial consultation, or
- The attending physician requests a subsequent consultation.

A consultation is coded based on the level of the E&M service and the place of service (e.g., office or inpatient). The consultant's records must document the appropriate complexity for the history, physical, and decision making to support the level of services billed to Medicare.

For a clinical pathology consultation to be covered, the services must:

- Be requested by the patient's attending physician,
- Relate to a test result that lies outside the clinically significant normal or expected range, in view of the patient's condition,
- Result in a written narrative report included in the patient's medical record, and
- Require medical judgment by the consultant physician.

A clinical pathology consultation ordinarily requires the medical judgment of a pathologist. Where a nonphysician laboratory specialist could furnish the information, the physician's service is *not* a consultation payable under Medicare Part B. A clinical pathology consultation claim must include a diagnosis.

An extensive article on page 8 of this issue addresses consultation guidelines. This article includes several examples of visits that are consultations, and visits that do not satisfy the criteria for consultations. The article is an authoritative resource for you and your staff when billing for consultations.

I hope this information will be helpful to you in providing consultations to beneficiaries, and billing Medicare for those services.

Sincerely,

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

General Information About the *Medicare B Update!*

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. Medicare Part B of Florida maintains copies of the mailing lists for each issue, and inclusion on these mailing lists implies that the issue was received by the provider in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

Distribution of the *Update!* is limited to individual providers and professional association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the six months prior to the release of each issue. Providers meeting this criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit distributing a copy to all of a provider's 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 $75 (see order form on page 49), or download the text version from our online service, the Medicare Online BBS (see page 48 for information about the BBS).

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

About the Format

The *Update!* is divided into several sections, starting with an article by the carrier Medical Director. Following is administrative information, then "Claims," that provides claims submission requirements and tips. Correspondence (appeals and hearings) information is in this section. "Coverage" discusses CPT and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" presents coverage information of interest to psychiatrists, clinical psychologists and clinical social workers. "Reimbursement" presents changes to the Medicare Physician Fee Schedule (MPFS) and other pricing issues. Occasionally, these sections are combined. "Focused and Local Medical Review Policies" follows, then "Electronic Media Claims (EMC)," and "General Information," other information for Medicare Part B providers including Fraud and Abuse issues. "Educational Materials" includes Medifest schedules, information pertaining to the Medicare Online BBS (our online bulletin board service), and reproducible forms. Important addresses and phone numbers are on the back cover. ❖

Advance Notice Requirement

The following information applies to all articles in this publication referencing services that must meet medical necessity requirements (e.g., services with specific diagnosis requirements). Refer to this information for articles that indicate advance notice applies.

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for the treatment/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 (utilization screen - 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. The advance notice must meet the following requirements:

- The notice must be given in writing, in advance of furnishing the service or item.
- The notice 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 diagnosis of the patient, the frequency of the service was furnished in excess of the utilization screen, etc.).
- The notice must be signed and dated by the patient indicating that the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for the reason(s) indicated on the advance notice. The signature of the provider of service is not required.

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 procedure code modifier GA with the service or item. The advance notice form should be maintained with the patient's medical record.

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. ❖

YEAR 2000

Y2K "Freezes" System Changes

This issue of the *Medicare B Update!* contains fewer than normal articles pertaining to claims processing, coverage, and reimbursement changes. Because of Y2K testing, the Health Care Financing Administration (HCFA) has "frozen" implementation of any revisions that require contractors to make system changes until after January 1, 2000.

For this reason, there are no major coverage or reimbursement changes that will take effect prior to January 1, 2000. Contractors are permitted to make changes that can be completed through simple file maintenance; for example, a change to ICD-9-CM diagnosis requirements in local medical review policy (LMRP). Therefore, LMRPs will continue to be implemented. For new and updated LMRPs, refer to page 21.

More information concerning the annual changes scheduled to take effect January 1, 2000, can be found on page 7. ❖

Y2K Readiness for PC-ACE™ Software

The EMC software (PC-ACE™) that is distributed by Florida Medicare has been successfully tested regarding its Y2K readiness.

Providers that use the PC-ACE™ software bear the responsibility of determining and ensuring the Y2K readiness of their hardware. ❖

This document is a Year 2000 disclosure made pursuant to the Year 2000 Information and Readiness Disclosure Act (S.2392). Your legal rights regarding the use of the statements made herein may be substantially limited as provided in the Act.

Submit Enrollment Applications Before the Year 2000

The year 2000 is quickly approaching. Although the Medicare Registration Department does not expect to experience any delays in the processing of applications after December 31, 1999, we encourage providers to submit all applications as soon as possible. If you are not yet practicing at a particular address, DO NOT submit your application until you are. If you have changes to your enrollment information, e.g., change of address, phone number, ownership, status with a group, etc., or if you are starting a practice at a new location, these applications should be submitted as soon as possible.

Providers may obtain enrollment applications HCFA 855 (General Enrollment Application), HCFA 855R (Individual Reassignment of Benefits Form) and HCFA 855C (Change of Information Application), by contacting the Provider Customer Service Department at (904) 634-4994. When the applications have been completed, mail to:

Medicare Registration
PO Box 44021
Jacksonville, Fl. 32231-4021

Prevent Your Application From Being Returned

The Medicare Registration Department experiences a notable return rate for incomplete and inaccurate applications. To avoid having applications returned and not delay their processing, providers need to ensure that applications are complete and accurate. In an effort to reduce the number of returned applications, we are providing with the most common reasons for returning each type of application.

Chief Reasons for Return of General Enrollment Application (HCFA 855)

1. The need for a HCFA Form 855R

The most common reason for returning a HCFA 855 is that there was no Individual Reassignment of Benefits application (HCFA 855R) submitted with the HCFA 855. Any time a provider requests reimbursement under a particular tax identification number and the legal name belonging to that tax identification number is different than the individual's name (i.e., tax identification number issued in the name of John Smith, MD, PA; the application is for John Smith, MD), a HCFA 855R is required. Physicians who are joining a group practice must complete a HCFA form 855R.

2. The need for copies of applicable occupational licenses

In order to operate a business, occupational licenses are required in most cities and/or counties in the state of Florida. If you are located in a city and/or county that requires an occupational license, a copy must be submitted with the HCFA 855. The occupational license should show the exact address (including suite numbers) as given on the application. If you practice at multiple locations, an occupational license must be submitted for each practice location. The occupational license should reflect the actual physical address for each location. Receipts for occupational licenses are not acceptable.

3. The need for ownership information

Section 8 of the HCFA 855 requests ownership information. This information must be completed when applying for a Medicare provider number. If you are the sole owner, you should list yourself as the owner. If you were previously practicing as a group member and are now opening your own office, you must furnish ownership information. Any time a "legal business" (any entity operating under a tax identification number) enrolls into the Medicare Program, ownership information must be provided. Please ensure the ownership information you provide is complete and accurate.

4. The need for documentation from non-physician practitioners

Many applications are returned because required documentation was not attached when a non-physician practitioner applied for a Medicare provider number. Each application package mailed from the Medicare office contains specific documentation requirements for non-physician practitioners. Each non-physician practitioner must submit certain information in addition to completing the enrollment application. For example, a clinical social worker must submit a current state license, a copy of a masters or doctors degree in social work, and provide documentation of at least two years of supervised clinical social work. Prior to submission of the application package, review the documentation requirements to ensure everything has been included .

5. The need for IRS documents

A large majority of providers request reimbursement under a tax identification number, however, omit documentation from the Internal Revenue Service (IRS) showing the tax identification number and the legal business name. Any time a provider is requesting reimbursement under a specific tax identification number, documentation (CP575 or tax coupon) from the IRS is required. The document submitted with the application must have been generated by the IRS and show the provider's legal business name and tax identification number.

6. Omission of contractor information

Applications are frequently returned due to the omission of contractor information. Section 12 of the HCFA 855 requests specific information regarding organizations the applicant may contract with. If you are an individual or an organization that contracts services, this information must be provided. If you do not contract with organizations, this must also be indicated.

Chief Reasons for Return of Individual Reassignment of Benefits (HCFA 855R)

W2 and/or W4 forms must now be submitted with a HCFA 855R for all employee/employer relationships.

1. Lack of appropriate signatures

The number one reason for a HCFA 855R to be returned is the lack of appropriate signatures. Whenever a HCFA 855R is completed for submission to Medicare, the individual reassigning benefits must sign section 6 of the application, while an authorized representative of the group must sign section 7. For enrollment purposes an authorized representative is defined as:

> An officer, chief executive officer, senior or majority partner, president, vice-president, secretary (officer), treasurer, director, (board of directors), owner, or someone who can obligate and commit the individual or entity to Medicare laws and regulations.

Unacceptable signatures include: office manager, medical director, enrollment specialist, agent, manager, credentialing specialist, insurance specialist, consultant, receptionist, administrator, etc. Please ensure the appropriate individuals sign the HCFA 855R prior to submission to Medicare.

2. Group address is not enrolled

Whenever a provider submits an address on a HCFA 855R, the group and/or legal business must have already enrolled the practice location by submission of the HCFA 855. The group or legal business entity may enroll a location at the same time the HCFA 855R is submitted. If the group or legal business has not enrolled at the address indicated on the HCFA 855R, the application will be returned.

3. Individual reassigning benefits is not enrolled

Another chief reason for the return of HCFA form 855R, is that the individual submitting the form has not previously enrolled. An individual who does not have an active Medicare Part B provider number must submit a HCFA 855. If the individual is joining a group practice or contracting with a business, he/she may submit the HCFA 855R simultaneously with the HCFA 855.

HCFA Form 855C, Request for Changes

The Medicare Registration Department has experienced some difficulty processing requests for changes. Some providers are submitting HCFA 855C applications indicating a change to their practice location and/or mailing address has occurred. At the same time, a tax identification number and/or legal business name is indicated on the HCFA 855C form that Medicare does not have on file. In order to change a tax identification number and legal business name, a HCFA 855 and HCFA 855R must be completed for each physician or practitioner, reassigning benefits.

Given below are some helpful hints when requesting changes to a provider's file.

- If updating *only* the legal business name or tax identification number (no changes in ownership), submit a HCFA 855C with a copy of a CP575, or a tax coupon or other documentation from the IRS with the legal business name and tax identification number on it.
- If changing a physical address, ensure the correct billing and/or pay to address is indicated on the HCFA 855C. If you are intending to add a practice location, this must be accomplished by completing a HCFA 855.
- Ensure the HCFA 855C has been signed by the appropriate person(s).
- If ownership changes occur, these must be reported on a HCFA 855.
- If hiring a new billing agency or management service organization, these changes must be reported on a HCFA 855.

Things to keep in mind when submitting an application:

- It is always a good idea to submit a cover letter with the application stating your reasons for submitting the form.
- Medicare does not issue spare provider numbers, and providers who are not yet practicing should refrain from filing the application until such time as they are actively attending patients.
- Providers may begin attending patients whenever they are legally licensed to do so. You should file your application for enrollment as soon as possible after establishing your practice. There is no need to have the Medicare number issued before you begin attending and treating patients. The typical application process takes approximately four to six weeks to complete. Enrolling providers should hold any claims until the provider number has been issued.
- All providers are subject to a visit by representatives of the Medicare Registration Department. The visits are generally conducted during normal business hours and are intended to ensure that the provider meets the minimum qualifications for enrollment. ❖

Choose to Participate for the New Millennium!

It's time again for all Medicare providers to choose whether to participate in the Medicare program for the upcoming calendar year. Medicare Part B of Florida offers the following benefits to participating providers:

- **Access to Patient Eligibility Data.** Participating providers who file their claims electronically using a national standard format can obtain information about a patient's benefit eligibility. Contact Provider Electronic Services Marketing at (904) 791-8767 for more information.
- **Claim Filing Advantages.** Participating providers who file paper claims use a separate post office box established specifically for these claims.
- **Higher Payment Rates.** Participating providers are reimbursed directly by Medicare Part B at rates five percent higher than those paid to non-participating providers.
- **Automatic Medigap Claim Filing.** In most cases, Medicare Part B will automatically file claims to a patient's Medigap insurer (responsible for the 20 percent not covered by Medicare), eliminating the need to submit separate claims to both Medicare Part B and the insurer.
- **Inclusion in Participating Provider Directory.** All independently participating providers and groups are eligible for inclusion in the MEDPARD, a directory of participating providers available to Medicare beneficiaries. To be included in this directory, independently practicing physicians and groups must elect to participate during the upcoming year, actively file claims to Medicare Part B, provide their physical office address (where the office is located), and a telephone number for patients to use when scheduling appointments.

Enrollment Information

Enrollment materials for 2000 will be released in mid-November, in conjunction with the 2000 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule. We encourage you to register as a participating Medicare provider and to take advantage of these benefits. Don't wait too long to decide: your decision must be received by December 31, 1999, and will apply to services provided from January 1, 2000, through December 31, 2000.

Although the 2000 Part B provider/supplier payment and other January annual updates are being held until January 17, 2000, participation changes will be effective on January 1, just as in previous years. ❖

Implementation of Provider Payment Updates and Related Issues

The following information is being reprinted from the Important Year 2000 Information - Special Issue Update! *dated September 13, 1999.*

Provider/supplier payment and other January annual updates will not be made until January 17, 2000, but these updates will apply retroactively to all claims for services provided on or after January 1. HCFA is waiting until January 17 to make this change to reduce the risk of systems problems impacting the year 2000 rollover. The Part B updates that will be put into production are listed below:

- Coinsurance and Deductible Amounts
- Clinical Diagnostic Laboratory Fee Schedule
- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule
- HCFA Common Procedure Coding System (HCPCS)
- Inherent Reasonableness
- Medicare Physician Fee Schedule
- Reasonable Charge (Ambulance Services, Certain DME Supplies, Blood Supplies/Transfusion Medicine)
- Screening Mammography Limit

Submitting and Processing Claims in 2000

Claims With Year 2000 Service Dates. Beginning January 1, 2000, providers may file claims as usual, but Medicare will hold all claims with dates of service of January 1 or later until January 17 in order to correctly apply the year 2000 payment and other annual updates, including any changes in beneficiary coinsurance and deductibles. Providers need not take any action, other than submitting a millennium compliant claim, to receive the correct payment amount. By law, electronic clean claims must be held for at least 14 calendar days but no longer than 30 calendar days before payment can be made. The period of time from receipt of year 2000 claims will count toward these requirements. Beginning on January 17, all claims for services in the year 2000 will be released for processing, and claims are expected to be finalized for payment very quickly. Therefore, holding claims with year 2000 service dates until January 17 should only minimally affect their date of payment, if at all (because of the statutory requirement to hold claims payment for at least 14 calendar days).

Claims With Service Dates Prior to Year 2000. From January 1 until 17, claims having *only* dates of service occurring during calendar year 1999 or a previous year will continue to be processed and paid using the appropriate payment rates. However, any claim received from January 1 until January 17, 2000, that includes services occurring during calendar year 2000 and previous years will be held in its entirety until January 17. If providers have claims with dates of service occurring both in 2000 and a previous year, and do not wish the entire claim held until January 17, they should send in two separate claims: one for 1999 (or earlier) services, and one for 2000 services. In this way, the processing of claims for 1999 (or earlier) services will not be held.

Using CPT and HCPCS Codes in the Year 2000. More information regarding these updates will be provided in the annual *HCPCS Special Issue Update!* that will be released in late November. ❖

CLAIMS

Emergency Department Services, Consultations, and Critical Care Visits

The purpose of this article is to clarify questions that have been received related to physician billing for the evaluation and management (E/M) services referenced above. The following instructions are specified in the Medicare Carrier's Manual (MCM), sections 15506-15508.

99281-99288: Emergency Department Visits

Use of Emergency Department Codes by Physicians Not Assigned to Emergency Department.

Medicare can pay emergency department services codes regardless of whether the physician is assigned to the emergency department. Any physician seeing a patient registered in the emergency department can use these codes.

Use of Emergency Department Codes in Office.

Medicare cannot pay an emergency department code if the site of service is an office or outpatient setting or any site of service other than an emergency department. Emergency department codes should only be used if the patient is seen in the emergency department. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

Use of Emergency Department Codes to Bill Non-Emergency Services.

Medicare can pay emergency department codes regardless of whether the services were emergency services. The only requirement for using the emergency department codes is that the patient be seen in the emergency department for an unanticipated service. Normally a lower level emergency department code would be reported for such a non-emergency condition.

If a physician asks a patient to meet him or her in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes.

Emergency Department or Office/Outpatient Visits on Same Day as Nursing Facility Admission.

Medicare cannot pay for an emergency department visit provided on the same day as a comprehensive nursing facility assessment. Payment for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

Emergency Department and Critical Care Services Provided on the Same Day.

If critical care is required upon the patient's presentation to the emergency department, only critical care codes 99291-99292 can be reported. Emergency department codes will not be paid for the same day. More information on critical care is provided below.

Physician Billing for Emergency Department Services Provided to Patient by Both Patient's Personal Physician and Emergency Department Physician.

If a physician advises his/her own patient to go to an emergency department of a hospital for care and subsequently is asked by the emergency department physician to come to the hospital to evaluate the patient and to advise the emergency department physician whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221-99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The emergency department physician who saw the patient in the emergency department should bill the appropriate level of the emergency department codes.
- If the emergency department physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the emergency department physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. The patient's personal physician would not bill a consultation because he or she is not providing information to the emergency department physician for his or her use in treating the patient. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician cannot bill.

Reporting of Visit When Patient is Seen in Emergency Department and Emergency Department Physician Requests Another Physician to See the Patient In Emergency Department or Office/Outpatient Setting.

If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill a consultation if the criteria for consultation (see below) are met. If the criteria for a consultation are not met and the patient is discharged from the emergency department or admitted to the hospital by another physician, the physician contacted by the emergency department physician should bill an emergency department visit. If the consulted physician admits the patient to the hospital and the criteria for a consultation are not met, he/she should bill an initial hospital care code.

99241 - 99275: Consultations

Consultation Versus Visit.

Medicare can pay for a consultation when all of the criteria for the use of a consultation code are met:

- Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).
- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- After the consultation is provided, the consultant prepares a written report of his/her findings that is provided to the referring physician.

Consultation Followed by Treatment.

Medicare can pay for an initial consultation if all the criteria for a consultation are satisfied. Payment can be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years) and setting (e.g., office or inpatient).

A physician consultant can initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

Consultations Requested by Members of Same Group.

Medicare can pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the consultation codes are met.

Documentation for Consultations.

A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician. In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request can be documented as part of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report can consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement can be met by a specific written request for the consultation from the requesting physician or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician.

Consultation for Preoperative Clearance.

Medicare can pay for the appropriate consultation code for a pre-operative consultation for a new or established patient performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.

Post-Operative Care by Physician Who Did Pre-Operative Clearance Consultation.

If, subsequent to the completion of a pre-operative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s) during the post-operative period, the consultation codes should not be used. In the hospital setting, the physician who has performed a pre-operative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the post-operative period should use the appropriate subsequent hospital care codes (not follow-up consultation codes) to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit code should be used during the post-operative period.

A physician (primary care or specialist) who performs a post-operative evaluation of a new or established patient at the request of the surgeon can bill the appropriate consultation code for evaluation and management services furnished during the post-operative period following surgery as long as all of the criteria for the use of the consultation codes are met and that same physician has not already performed a pre-operative consultation.

Surgeon's Request That Another Physician Participate in Post-Operative Care.

If the surgeon asks a physician who had not seen the patient for a pre-operative consultation to take responsibility for the management of an aspect of the patient's condition during the post-operative period, the physician cannot bill a consultation because the surgeon is not asking the physician's opinion or advice for the surgeon's use in treating the patient. The physician's services would constitute concurrent care and should be billed using the appropriate level visit codes.

Examples of Consultations:

- An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. The patient exhibits a new skin lesion and the internist sends the patient to a dermatologist for further evaluation. The dermatologist examines the patient and removes the lesion that is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his evaluation and treatment of the patient.
- A general ophthalmologist diagnoses a patient with a retinal detachment. He sends the patient to a retinal subspecialist to evaluate the patient because the

general ophthalmologist does not treat this specific problem. The retinal subspecialist evaluates the patient and subsequently schedules surgery. He sends a report to the referring physician explaining his findings and the treatment option selected.

- A family physician diagnoses a patient with diabetes mellitus. The family physician asks the ophthalmologist for a base line evaluation to rule out diabetic retinopathy. The ophthalmologist examines the patient and sends a report to the family physician on his findings. The ophthalmologist tells the patient at the time of service to return in one year for a follow-up visit. This subsequent follow-up visit should be billed as an established patient visit in the office or other outpatient setting, as appropriate.
- A rural family practice physician examines a patient who has been under his care for 20 years and diagnoses a new onset of atrial fibrillation. The family practitioner sends the patient to a cardiologist at an urban cardiology center for advice on his care and management. The cardiologist examines the patient, suggests a cardiac catheterization and other diagnostic tests that he schedules and then sends a written report to the requesting physician. The cardiologist subsequently routinely sees the patient once a year as follow-up. Subsequent visits provided by the cardiologist should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the family practice physician.
- A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a breast biopsy, that he schedules, and then sends a written report to the requesting physician. The general surgeon subsequently performs a biopsy and then routinely sees the patient once a year as follow-up. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the family practice physician.
- An internist examines a patient who has been under his care for some time, and diagnoses and diagnoses a thyroid mass. The internist sends the patient to a general surgeon for advice on management of the mass and related patient care. The general surgeon examines the patient, orders diagnostic tests, and suggests a needle biopsy of the mass. The surgeon then schedules the procedure and sends a written report to the requesting physician. The general surgeon subsequently performs a thin needle biopsy and then routinely sees the patient twice as follow-up for the mass. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other or other outpatient setting, as appropriate. Other routine care continues to be followed by the internist.
- A patient with underlying diabetes mellitus and renal insufficiency is seen in the emergency room for the evaluation of fever, cough and purulent sputum. Since it is not clear whether the patient needs to be admitted, the emergency room physician requests an opinion by the on-call internist. The internist can bill a consultation regardless if the patient is discharged from the emergency room or whether the patient is admitted to the hospital as long as the criteria for consultation have been met. If the internist admits the patient to the hospital, he/she can bill either an initial inpatient consultation or initial hospital care code but not both for the same date of service.

Examples That Do Not Satisfy the Criteria for Consultations:

- Standing orders in the medical record for consultations.
- No order for a consultation.
- No written report of a consultation
- After hours, an internist receives a call from her patient about a complaint of abdominal pain. The internist believes this requires immediate evaluation and advises the patient to go to the emergency room where she meets the patient and evaluates him. The emergency room physician does not see the patient. The internist should bill for the appropriate level of emergency department service, or if the patient is admitted to the hospital she would bill this visit as an inpatient admission.

99291-99292: Critical Care Visits and Neonatal Intensive Care

Use of Critical Care in Cases That Are Not Medical Emergencies.

Critical care includes the care of critically ill and unstable patients who require constant physician attention, whether the patient is in the course of a medical emergency or not. It involves decision making of high complexity to assess, manipulate, and support circulatory, respiratory, central nervous, metabolic, or other vital system function to prevent or treat single or multiple vital organ system failure. It often also requires extensive interpretation of multiple data bases and the application of advanced technology to manage the critically ill patient.

Critical care is usually, but not always, given in a critical care area such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment can be made for critical care services provided in any location as long as the care provided meets the definition of critical care. Services for a patient who is not critically ill and unstable but who happens to be in a critical care, intensive care, or other specialized care unit are reported using subsequent hospital care codes (99231-99233) or hospital consultation codes (99251-99263).

Constant Attendance or Constant Attention as Prerequisite for Use of Critical Care Codes

The duration of critical care to be reported is the time the physician spent working on the critical care patient's case, whether that time was spent at the immediate bedside or elsewhere on the floor, but immediately available to the patient.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the

unit or at the nursing station on the floor would be reported as critical care, even if it does not occur at the bedside.

Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) cannot be reported as critical care since the physician is not immediately available to the patient. This work is the typical pre- and post-service work that accompanies any evaluation and management service. Time spent in activities that do not directly contribute to the treatment of the patient cannot be reported as critical care, even if they are performed in the critical care unit at a patient's bedside (e.g., telephone calls to discuss other patients, reviewing literature).

For critical care to be billed, the physician must devote his or her full attention to the patient and, therefore, cannot render evaluation and management services to any other patient during the same period of time.

The time spent with the individual patient and the service rendered should be recorded in the patient's record to support the claim for critical care services.

Hours and Days of Critical Care That Can Be Billed.

Payment for critical care is not restricted to a fixed number of days. As long as the critical care criteria are met and the services are reasonable and necessary to treat illness or injury, Medicare can pay for critical care services. However, claims for seemingly improbable amounts of critical care on the same date can be subjected to review to determine if the physician has filed a false claim.

Critical Care Visits and Other Procedures Provided on Same Day by Same Physician.

The following codes are not payable when they are provided on the same day by the same physician as the critical care codes: 36000, 36410, 36415, 36600, 71010, 71015, 71020, 91105, 92953, 93561, 93562, 94656, 94657, 94660, 94662, 94760, 94762, 99090, and G0001. Payment for these procedure codes is bundled into critical care codes 99291 and 99292.

No other procedure codes are bundled into the critical care codes. Therefore, other procedure codes can be billed separately. However, if the procedure that is provided on the same date as critical care has a global surgical period, payment for critical care is included in the payment for the procedure unless it is a separately identifiable evaluation and management service above and beyond the typical work associated with the procedure

Counting of Units of Critical Care Services.

Procedure code 99291 (critical care, first hour) is used to report the services of a physician providing constant attention to a critically ill patient for a total of 30 minutes to one hour on a given day. Only one unit of code 99291 can be billed by a physician for a patient on a given date.

If the total duration of critical care provided by the physician on a given day is less than 30 minutes, the appropriate evaluation and management code should be used. In the hospital setting, it is expected that the level 3 subsequent hospital care code 99233 would most often be used.

Procedure code 99292 (critical care, each additional 30 minutes) is used to report the services of a physician providing constant attention to the critically ill patient for 15 to 30 minutes beyond the first hour of critical care on a given day.

The following illustrates the correct reporting of critical care services. If the total duration of critical care is:

- Less than 30 minutes
  use 99232 *or* 99233
- 30-74 minutes
  use 99291 x 1
- 75-104 minutes
  use 99291 x 1 *and* 99292 x 1
- 105-134 minutes
  use 99291 x 1 *and* 99292 x 2
- 135-164 minutes
  use 99291 x 1 *and* 99292 x 3
- 165-194 minutes
  use 99291 x 1 *and* 99292 x 4

Critical Care Service and other Evaluation and Management Services Provided on Same Day.

If critical care is required upon the patient's presentation to the emergency department, only critical care codes 99291-99292 can be reported. Emergency department codes will not be paid for the same day. If there is a hospital or office/outpatient evaluation and management service furnished early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, both critical care and the evaluation and management service can be paid. Physicians should submit documentation when critical care is billed on the same day as other evaluation and management services.

Critical Care Services Provided During Pre-Operative Portion of Global Period of Procedure With 90 Day Global Period in Trauma and Burn Cases.

Pre-operative critical care can be paid in addition to a global fee if the patient is critically ill and requires the constant attendance of the physician, *and* the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met. Codes 99291/99292 *and* modifier 25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM diagnosis code in the range 800.0 through 959.9 (except 930-939) that clearly indicates that the critical care was unrelated to the surgery is acceptable documentation. For more information regarding use of modifier 25, refer to the following issues of the *Medicare B Update!* — May/June 1999 (page 23) and July/August 1999 (page 12).

Critical Care Services Provided During Post-Operative Period of Procedure With Global Period in Trauma and Burn Cases.

Medicare can pay for post-operative critical care in addition to a global fee if the patient is critically ill and requires the constant attendance of the physician, *and* the critical care is unrelated to the specific anatomic injury or general

surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met. Codes 99291/99292 *and* modifier 24 (Unrelated evaluation and management service by the same physician during a post-operative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM diagnosis code in the range 800.0 through 959.9 (except 930-939) that clearly indicates that the critical care was unrelated to the surgery is acceptable documentation. ❖

Guidelines for Purchased Diagnostic Tests

When the technical component of a procedure subject to purchased diagnostic test rules is obtained from another physician or outside supplier, it must be submitted on a separate line from the professional component and billed with modifier WU (Technical component - purchased test). The professional component must be billed with modifier 26 (Professional component only).

When a physician purchases the technical component from another physician or outside supplier, item 20 of the HCFA-1500 claim form (or electronic equivalent) must be checked "yes." The acquisition or purchase cost should be placed in item 20 under "$CHARGES." The name, Medicare provider number, and address of the supplier or physician from whom the test was purchased must be provided in item 32 of the HCFA-1500 claim form (or electronic equivalent). If this information is not provided, the technical component will be denied payment.

When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form. In the case of repeat procedures on the same day, modifier 76 (repeat procedure by same physician) must also be submitted. Supporting documentation for the use of modifier 76 must be provided.

Procedures Subject to Purchased Diagnostic Rules

Two categories of procedures are subject to purchased diagnostic rules:

- Diagnostic tests and radiology tests, and
- "Technical component only" procedures

Lists for both categories effective January 1, 1999, were published in the *1999 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Update - Special Issue Update!* (December 1998). Diagnostic tests and radiology tests are in Appendix XVI (pages 68-71); technical component only procedures are in Appendix XVIII (page 71). Purchased technical components of procedures on Appendix XVI require *both* the WU *and* TC modifiers. Those in Appendix XVIII by definition do not require modifier TC.

Additional procedure codes for diagnostic tests were provided in the May 26, 1999, *Medicare B Special Update!* - "Revisions to the 1999 Medicare Physician Fee Schedule Database." These include procedure codes G0160-G0165, and 78020. Also subject to purchased diagnostic requirements is procedure code M0302 (Cardiac output monitoring by electrical bioimpedance). These procedure codes are effective for services rendered on or after July 1, 1999.

Note: Inclusion of a procedure code on these lists does not constitute Medicare coverage. Services that are non-covered on the basis of local medical review policy are non-covered whether purchased or personally performed. Procedure codes listed are for 1999 dates of service only. Services subject to purchased diagnostic test rules for previous years may differ.

Personally Performed Diagnostic Tests

When a diagnostic test is personally performed, "no" must be indicated in item 20 of the HCFA-1500 claim form (or electronic equivalent). A "no" indicates that no purchased tests are included on the claim.

Diagnostic tests (professional, technical or global components) billed by one of the following providers are not subject to purchased diagnostic test rules:

- Portable X-ray suppliers
- Independent laboratories
- Independently practicing audiologists
- Independent diagnostic testing facilities ❖

Correct Use of Influenza Virus Vaccine Codes

The Health Care Financing Administration's Common Procedure Coding System (HCPCS) update for 1999 provided new procedure codes for influenza virus vaccines, effective for claims with 1999 service dates. Information regarding the 1999-2000 flu season, including roster billing guidelines, was provided in the September/October 1999 *Medicare B Update!* (pages 6-14). Since that publication, Medicare has received a number of claims that require additional information specific to the new procedure codes for the influenza virus vaccine. Many providers have received requests from Medicare that state:

> The procedure code submitted for the above named beneficiary does not correspond with their age. Please verify the age of the patient and procedure rendered on [*service date*] for [*submitted charge*] and indicate the correct procedure code.

The following are the procedure codes that may be used when billing for the influenza virus vaccine and its administration. Note that the majority of claims needing more information have been billed using procedure code 90657. However, as shown below, this code should only be used when ***the age of the patient*** is less than three years.

Code	Description
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use ***This code should be used when administering the split virus vaccine to a patient who is older than six months but less than three years old.***
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use ***This code should be used when administering the split virus vaccine to a patient who is older than three years old.***
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use ***This code should be used when administering the whole virus vaccine.***
G0008	Immunization, active; influenza virus vaccine ***This code should be used for the actual administration of any of the vaccines listed above.***

Influenza virus vaccine claims should be submitted using ICD-9-CM diagnosis code V04.8 (need for prophylactic vaccination and inoculation against certain viral diseases). The influenza virus vaccine is covered by Medicare Part B when it is furnished within the accepted standards of medical practice. For services that exceed the accepted standards of medical practice, an acceptable advance notice of Medicare's denial of payment must be provided to the patient when the provider does not want to accept financial responsibility for the service. Please note that neither deductible, coinsurance, nor limiting charges apply to these codes, and that no money may be collected from the beneficiary if the provider is accepting assignment and/or roster billing. ❖

COVERAGE/REIMBURSEMENT

AMBULATORY SURGICAL CENTER

Updated Facility Rates for Ambulatory Surgical Centers

Payment rates for Ambulatory Surgical Center (ASC) facility charges have been updated to reflect an inflation adjustment for services furnished on or after October 1, 1999. ASC rates are determined using an inpatient wage index for Metropolitan Statistical Areas (MSAs) and their constituent counties. For more information, refer to the *Federal Register* (62 FR 45965) published July 30, 1999.

The following tables list the new rates for each of the ASC payment groups listed for each MSA and constituent counties. A list of ASC-approved procedure codes and their payment groups was published in the September/October 1998 *Medicare B Update!* (pages 18-22). A new list will be published in the *Update!* after the 2000 HCPCS update has been completed.

ASC claims for services rendered on or after October 1, 1999, have already been processed using these updated rates, even if they were submitted with the previous fees. Claims should *not* be resubmitted with a corrected billed charge.

Urban Areas- MSA Name/ Constituent Counties	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8
DAYTONA BEACH Flagler Volusia	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61
FT. LAUDERDALE Broward	318.88	427.52	488.88	603.56	687.05	797.82	954.62	938.65
FT. MYERS CAPE CORAL Lee	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61
FT. PIERCE PORT ST. LUCIE Martin St. Lucie	318.19	426.60	487.82	602.25	685.56	796.42	952.56	936.94
FT. WALTON BCH. Okaloosa	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61
GAINESVILLE Alachua	318.11	426.49	487.71	602.11	685.40	796.26	952.33	936.75
JACKSONVILLE Clay Duval Nassau St. Johns	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61
LAKELAND WINTER HAVEN Polk	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61
MELBOURNE TITUSVILLE PALM BAY Brevard	309.31	414.69	474.21	585.45	666.44	778.38	925.98	914.99
MIAMI Dade	319.54	428.41	489.90	604.82	688.48	799.17	956.62	940.29
NAPLES Collier	315.24	422.64	483.30	596.67	679.21	790.43	943.74	929.65
OCALA Marion	312.80	419.36	479.55	592.04	673.94	785.46	936.41	923.60
ORLANDO Lake Orange Osceola Seminole	314.88	422.16	482.75	595.99	678.44	789.70	942.66	928.76
PANAMA CITY Bay	307.92	412.83	472.09	582.82	663.45	775.56	921.83	911.56
PENSACOLA Escambia Santa Rosa	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61

Urban Areas-MSA Name/ Constituent Counties	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8
PUNTA GORDA Charlotte	311.63	417.80	477.76	589.83	671.42	783.08	932.92	920.71
SARASOTA BRADENTON Manatee Sarasota	315.96	423.61	484.41	598.04	680.76	791.89	945.89	931.43
TALLAHASSEE Gadsden Leon	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61
TAMPA ST. PETE CLEARWATER Hernando Hillsborough Pasco Pinellas	307.38	412.10	471.25	581.79	662.27	774.45	920.20	910.21
WEST PALM BCH BOCA RATON Palm Beach	316.01	423.67	484.48	598.12	680.86	791.98	946.02	931.54
Rural Counties Whose Hospitals are Deemed Urban-County/Urban Area	**Group 1**	**Group 2**	**Group 3**	**Group 4**	**Group 5**	**Group 6**	**Group 7**	**Group 8**
Indian River/ FT. PIERCE	318.19	426.60	487.82	602.25	685.56	796.42	952.56	936.94
Rural Areas-	**Group 1**	**Group 2**	**Group 3**	**Group 4**	**Group 5**	**Group 6**	**Group 7**	**Group 8**
FLORIDA (Rest of State)	305.93	410.15	469.02	579.04	659.14	771.50	915.85	906.61

❖

CHIROPRACTIC

Chiropractic Services—X-ray No Longer Required

Effective for claims with dates of service on or after January 1, 2000, an X-ray is not required to demonstrate a subluxation of the spine. However, an X-ray may be used for this purpose if the chiropractor so chooses.

Coverage of chiropractic service is specifically limited to treatment of the spine by means of manual manipulation, i.e., by use of hands or handheld devices controlled manually. No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered. This means that if a chiropractor orders, takes, or interprets an X-ray, or any other diagnostic test, to demonstrate the subluxation, Medicare coverage and payment is not available for those services.

This does not affect the coverage of X-rays or other diagnostic tests furnished by other practitioners under the program. For example, an X-ray taken for the purpose of determining or demonstrating the existence of a subluxation of the spine is a diagnostic X-ray test that may be covered if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy. ❖

INJECTABLE DRUGS

Changes to Injectable Drugs Fees

The following table provides the procedure codes, descriptors, and associated fees for injectable drugs that have had recent pricing changes. These fees are effective for services processed on or after October 1, 1999. ❖

CODE	NAME OF INJECTABLE DRUG	PAR ALLOWANCE	NON-PAR ALLOWANCE	LIMITING CHARGE
J0286	Injection, amphotericin B, any lipid formulation, 50 mg	$95.00	$90.25	$103.79
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units	$6.32	$6.00	$6.90
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1, 200,000 units	$12.65	$12.02	$13.82
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2, 400, 000 units	$25.30	$24.04	$27.64
J0696	Injection, ceftriaxone sodium, 250 mg	$13.50	$12.83	$14.75
J1100	Injection, dexamethasone sodium phosphate, up to 4 mg/ml	$0.59	$0.56	$0.64
J1165	Injection, phenytoin sodium, per 50 mg	$0.68	$0.65	$0.74
J1626	Injection, granisetron hydrochloride, 100 mcg	$18.54	$17.61	$20.25
J1950	Injection, leuprolide acetate (for depot suspension) per 3.75 mg	$454.10	$431.40	$496.10
J2405	Injection, ondansetron HCL, per 1 mg	$6.08	$5.78	$6.64
J3105	Injection, terbutaline sulfate, up to 1 mg	$2.34	$2.22	$2.56
J3305	Injection, trimetrexate glucoronate, per 25 mg	$66.50	$63.18	$72.65
J9015	Aldesleukin, per single use vial	$569.76	$541.27	$622.46
J9209	Mesna, 200 mg	$34.77	$33.03	$37.99
J9310	Rituximab, 100 mg	$420.28	$399.27	$459.16
J9390	Vinorelbine tartrate, per 10 mg	$68.99	$65.54	$75.37

NONPHYSICIAN PRACTITIONERS

Coverage Guidelines for Advanced Registered Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants

The Balanced Budget Act of 1997 (BBA) expanded the eligibility of nonphysician practitioners to provide services to Medicare beneficiaries and file claims for reimbursement. A summary of the changes is as follows:

- Effective January 1, 1998, place of service restrictions were removed
- Covered services are allowed at 85 percent of the Medicare Physician Fee Schedule amount
- Education, certification, and credentialing requirements are more specific

A Medicare Provider Number is Required

Effective January 1, 1999, all clinical nurse specialists, nurse practitioners, and physician assistants were required to obtain a Medicare Provider Identification Number (PIN) in order to receive payment for claims submitted to Medicare. The PIN is essential since modifiers are no longer used to identify the services performed by each of these types of practitioners (effective for claims received on or after July 1, 1999). When initially applying for a Medicare number, completion of a General Enrollment Application Form (HCFA 855) is required. Also required for physician assistants is the Reassignment of Benefits Form (HCFA 855R), as reimbursement must be made payable to the physician assistant's employer.

Types of Services That May be Covered by Medicare

A nonphysician practitioner such as a clinical nurse specialist, nurse practitioner, or physician assistant must meet the general requirements listed below in order to be considered for payment by Medicare:

- The practitioner must be providing services that are within the scope of licensure particular to the provider and the state in which he/she is practicing.
- The services are considered "physician services."
- The services would not be otherwise excluded from Medicare coverage.
- **Clinical nurse specialists** and **nurse practitioners** must work in collaboration with a physician. "Collaboration" is defined as a process by which the practitioner has a professional relationship with one or more physician(s), and the physician agrees to provide medical direction and appropriate supervision regarding issues that are outside the practitioner's scope of practice.
- **Physician assistants** must work under the *general* supervision of a physician. All claims for services rendered to Medicare beneficiaries *must* be filed by the employer on behalf of a physician assistant. Also, any physician assistant who renders services to beneficiaries for which claims will be made *must* have on file a 'Reassignment of Benefits' Form 855R (1/98).
- The services must also meet the general criteria requirements (e.g., medical necessity, reasonableness and appropriateness of service, patient eligibility, etc.).

Requirements for Clinical Nurse Specialists

Coverage is available for services performed by a CNS and direct payment can be made to the CNS or the employer or contractor of the CNS who:

- Is working in collaboration with a physician (i.e., a doctor of medicine or doctor of osteopathy (MD/DO)); and
- Is licensed in the state in which the services are performed; and
- Possesses a masters degree in nursing, with an emphasis in clinical nursing; and
- Possesses a baccalaureate degree in nursing; and
- Has a minimum of two years postgraduate direct patient care in the practice discipline of the private practice for which the nurse has been prepared.

Current Requirements for Nurse Practitioners

For his or her services to be covered, a nurse practitioner must:

- Be a registered professional nurse who is currently licensed to practice in the state in which the services are furnished; and
- Be currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
- Have satisfactorily completed a formal education program of at least one academic year that prepares registered nurses to perform an expanded role in the delivery of primary care and that includes at least four months (in the aggregate) of classroom instruction, and that awards a degree, diploma, or certification for successful completion of the program.

Proposed Requirements for Nurse Practitioners

New educational requirements are in the works for nurse practitioners. According to the Final Rule published in the November 2, 1998, *Federal Register*, Advanced Registered Nurse Practitioners must:

- Satisfy the applicable requirements for qualifications for nurse practitioners of the state in which the services are furnished
- Possess a Master's Degree in Nursing, be currently licensed to practice in the state in which the services are furnished, and be credentialed in the area of practice (specialty-specific)
- Be currently certified as a primary care nurse practitioner (or in another specialty area) by the American Nurses Credentialing Center or agency with recognized standards of nursing practices.

The proposed rule published in the July 22, 1999, *Federal Register* seeks to allow a more liberal time-frame for assuring the requirements are met than was originally proposed, but still ensure that quality services are furnished to Medicare patients. The proposed rule suggests that nurse practitioners must:

- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or
- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law and have been granted a Medicare PIN by December 31, 2000.

  Note: *Nurse practitioners having and maintaining a valid Medicare PIN will not lose these numbers or the ability to bill the Medicare program for covered services solely on the basis of education and credentialing.*
- On or after January 1, 2001, nurse practitioners applying for a Medicare PIN for the first time *must* meet the following standards for nurse practitioners:
  - Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, *and*
  - Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.
  - On or after January 1, 2003, nurse practitioners applying for a Medicare billing number for the first time *must* possess a master's degree in nursing and meet the standards for nurse practitioners that are as follows:
  - Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, *and*
  - Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

These requirements have not been implemented. This information is being provided as an awareness for nurse practitioners. Final implementation dates and requirements will be provided in future *Medicare B Updates!*

Requirements for Physician Assistants

Physician assistants must currently be certified by the National Commission of Certification of Physician Assistants to assist primary care physicians**,** *or* have satisfactorily completed a program for preparing physician assistants that:

- Was at least one academic year in length
- Consisted of supervised clinical practice and at least four months (total) of classroom instruction directed toward preparing students to deliver health care; and
- Was accredited by the American Medical Association's National Commission on Accreditation of Allied Health Education Programs, and has passed a national certification examination that is certified by the National Commission of Certification of Physician Assistants.

An alternative to the accreditation requirements listed above is that the physician assistant has satisfactorily completed a formal educational program for preparing physician assistants that do *not* meet the requirements of supervised clinical practice and at least four months (total) of classroom instruction directed toward preparing students to deliver health care, but has been assisting primary care physicians, under supervision, for a total of 12 months. This information was published in the November 2, 1998, final rule.

Claim Filing Requirements

All services must be submitted on form HCFA-1500 (or electronic equivalent) with the practitioner's PIN in block 33 or 24K. Claims for services rendered by nonphysician practitioners *must* be assigned. Physician assistant services *must* be billed by the physician assistant's employer since direct payment to a physician assistant is not allowed under the Medicare program.

The employer of the nonphysician practitioner may be a physician, hospital, medical group (professional association), or nursing facility. The following are considered valid arrangements:

BILLING OPTIONS	HCFA-1500 REQUIREMENTS
Independent Provider (CNS/NP only)	CNS/NP PIN in block 33 only (e.g., 12345)
Reassignment of Benefits: W-2 *or* 1099 arrangement when group # *has* been assigned	Group's PIN in block 33 (i.e. 99999) CNS/NP PIN in block 24K (e.g., 12345A)
Reassignment of Benefits: 1099 arrangement when group # *not* assigned	CNS/NP PIN in block 33 only (e.g., 12345A) name and address of employer
"Incident To" provision Physician billing	Physician's PIN in block 33 only (e.g., 77777) unless group # assigned

- The nonphysician practitioner is directly **employed** by a physician, physician group, or nursing facility (i.e., the employer files IRS form W-2 and W-4)
- The nonphysician practitioner has a **contractual agreement** or is a **leased** employee of the physician, group, hospital or facility (IRS form 1099). In this instance, the physician, group, hospital or facility is considered the employer.

Unique Provider Identification Number (UPIN) Requirements

Effective for services rendered on or after January 1, 1999, Medicare discontinued the use of the surrogate UPIN "NPP000". All nonphysician practitioners have been issued UPINs that must be used when the nonphysician practitioner is acting as the referring/ordering physician. The UPIN information must appear in block 17 and 17A on form HCFA-1500.

Discontinued Use of Modifiers

Effective for services received on or after July 1, 1999, the following procedure code modifiers for nonphysician practitioners have been eliminated. Because of this change, the practitioner's PIN *must* be reported in block 33 or 24K on the HCFA 1500 form (or electronic equivalent).

The ***deleted modifiers*** are:

AK	Nurse practitioner, rural, team member
AL	Nurse practitioner, non-rural, team member
AN	Physician assistant services for other than assist at surgery, non-team member
AU	Physician assistant for other than assistant at surgery, team member
AV	Nurse practitioner, rural, non-team member
AW	Clinical nurse specialist, non-team member
AY	Clinical nurse specialist, team member

*Note: Modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant-at-surgery) has **not** been discontinued.*

How These Changes Affect Payment

Effective January 1, 1998, the BBA removed the restrictions on the type of areas and settings in which the professional services of nonphysician practitioners are paid by Medicare. Accordingly, payments are allowed for services furnished by these nonphysician practitioners in all areas and settings permitted under applicable state licensure laws. However, the provision maintains the policy that no separate payment be made to a nonphysician practitioner when a facility or other provider payment or charge is also made for such professional services. Reimbursement for nonphysician practitioners is calculated as follows:

- Services rendered by nonphysician practitioners are reimbursed at 85 percent of the Medicare Physician Fee Schedule (MPFS) amount.
- Services for assistant-at-surgery charges are reimbursed at 85 percent of 16 percent of the MPFS amount for the *surgery* (16 percent of the MPFS amount is allowed for a *physician* performing surgical assist).

The "Incident To" Provision

Medicare Part B allows coverage for services and supplies furnished "incident to" a nonphysician practitioner's professional services. There have been no changes to these guidelines since their inception; however, they are often utilized incorrectly (e.g., in an inappropriate setting, such as a hospital). Services and supplies furnished "incident to" a physician's service may be billed as though the physician personally performed the service. To be covered "incident to" the service of a physician or nonphysician practitioner, a service or supply must meet *all* of the following conditions:

- The service must be an *integral*, although incidental, part of the physician's, or nonphysician practitioner's professional service,
- Of a type *commonly* furnished in a physician's office or clinic,
- Furnished under the physician's or nonphysician practitioner's *direct supervision*, and
- Furnished by an individual who qualifies as an employee of the physician or professional association/ group.

Services of Nonphysician Practitioners

Services performed by nonphysician practitioners incident to a physician's professional services include not only services ordinarily furnished by a physician's office staff, but also services ordinarily performed by the physician (e.g., minor surgery, reading X-rays, and other activities that involve evaluation or treatment of a patient's condition). However, the nonphysician practitioner must be licensed or certified to provide such services and the services must meet all the requirements under the "incident to" provision listed above. Payment is made at 85 percent of the MPFS allowed amount.

A nonphysician practitioner such as a physician assistant or nurse practitioner may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without direct physician supervision and have the services covered by Medicare as a nonphysician practitioner's service. However, in order to have that same service covered as incident to a physician's service, it must be performed under the direct personal supervision of the physician as an incidental part of the physician's personal in-office service. This does not mean that each occasion of an incidental service by the nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her active participation in and management of the course of treatment. In addition, the physician must be in the office suite and immediately available to render assistance during the time the nonphysician practitioner is furnishing services which are incident to the physician's services.

Commonly Furnished in Physicians' Offices

Services and supplies commonly furnished in physicians' offices are covered under the "incident to" provision. Where supplies are clearly of a type a physician is not expected to have on hand in the office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the "incident to" provision.

Physician Supervision

General supervision: Services of a nonphysician practitioner must be rendered under the general supervision of a physician (or a physician designated by the supervising physician or other employer as is provided in the state laws governing scope of practice and other regulations). As a general rule, the nonphysician practitioner's physician supervisor is primarily responsible for the overall direction and management of the nonphysician practitioner's professional activities and ensuring that the services provided outside the scope of practice and areas of expertise of the nonphysician practitioner are medically appropriate for the patient. The physician supervisor (or designee) need not be physically present with the nonphysician practitioner when a service is being furnished to a patient, unless state law or regulations specify otherwise. However, if the physician supervisor is not physically present with the nonphysician practitioner, he/she must be immediately available for consultation by telephone or other effective, reliable means of communication.

Direct supervision: Coverage of service/supplies "incident to" the professional services of a physician is limited to situations in which there is direct personal physician supervision. This applies to services of auxiliary personnel employed by the physician and working under his/her supervision

(e.g., nurses, technicians, therapists, other aides, etc.). Thus, where a physician employs auxiliary personnel to assist in rendering services, the services of such personnel are considered "incident to" the physician's services if there is a physician's service rendered to which the services of such personnel are an incidental part, and there is direct personal supervision by the physician. Direct personal supervision in the office setting does not mean that the physician must be present in the same room with the service provider. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing services.

Commonly Asked Questions

Q. Should nurse practitioners receive their own provider number? Under what circumstances?

A. All nurse practitioners who wish to bill services independently under the Medicare program should have their own provider number. Services by nurse practitioners may be reported by any of the following methods:

- Services that meet the requirements as nurse practitioners services may be billed independently by the nurse practitioner or by the employer.
- Services by nurse practitioners that meet the requirements of the "incident to" provision may be billed by the physician or physician group that employs the nurse practitioner as "incident to" services.

Q. Can nurse practitioners render services under their own provider number and/or for a physician working under the "incident to" provision?

A. Services by nurse practitioners may be billed as nurse practitioner's services, or under the "incident to" provision. However, the appropriate requirements must be met for either coverage provision.

Q. Can nurse practitioners be a part of a PA (professional association) group? Can nurse practitioners form a PA group?

A. Yes, a nurse practitioner may be part of a PA group. Additionally, a group of nurse practitioners could form a PA group.

Q. Can nurse practitioners, since they are "performing physician services," have services performed for them by other employees "incident to" their services, and bill them under their nurse practitioner number as a physician would under the "incident to" method of billing?

A. Yes. Services furnished under the supervision of a nurse practitioner may be billed "incident to" the nurse practitioner's services. Therefore, these types of services should be reported as nurse practitioner's services.

Q. What procedures can a nurse practitioner bill?

A. The state license for a nurse practitioner does not specifically detail those services that a nurse practitioner may perform in procedure code terms. Additionally, the competencies of each nurse practitioner are individualized depending on the practice area of their competency and focus. Medicare of Florida has worked with the liaison of the Florida Nurses Association to define those services likely to be performed by nurse practitioners (refer to the *Medicare B Update!* July/August 1998, page 17-19; revised May/June 1999, page 17 and in this issue on page 19). With regard to evaluation and management service, a nurse practitioner should be able to perform and bill any evaluation and management service for which he/she has the competencies to perform.

Q. What happens to the "team concept?"

A. In essence, the "team concept" is obsolete. ❖

Nurse Practitioners: Revised Coverage

The following procedure codes have been added to the services that could potentially be performed by an ARNP:

12031	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032	2.6 cm to 7.5 cm
12034	7.6 cm to 12.5 cm
12035	12.6 cm to 20.0 cm
12036	20.1 cm to 30.0 cm
12037	over 30.0 cm
12041	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042	2.6 cm to 7.5 cm
12044	7.6 cm to 12.5 cm
12045	12.6 cm to 20.0 cm
12046	20.1 cm to 30.0 cm
12047	over 30.0 cm
12051	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052	2.6 cm to 5.0 cm
12053	5.1 cm to 7.5 cm
12054	7.6 cm to 12.5 cm
12055	12.6 cm to 20.0 cm
12056	20.1 cm to 30.0 cm
12057	over 30.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	2.6 cm to 7.5 cm
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	2.6 cm to 7.5 cm
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	2.6 cm to 7.5 cm
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151	1.1 cm to 2.5 cm
13152	2.6 cm to 7.5 cm
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated
13300	Repair, unusual, complicated, over 7.5 cm, any area
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

In the July/August 1998 issue of the *Medicare B Update!* (page 17), a list was provided that outlined procedure codes representing services that could potentially be performed by an ARNP and could potentially be covered by Medicare Part B of Florida. The list was revised in January 1999, based on changes in the 1999 HCPCS update. This revision was published in the May/June 1999 *Update!* (page 17). ❖

GENERAL MEDICINE

LABORATORY/PATHOLOGY

G0102, G0103: Prostate Cancer Screening

Effective for services furnished on or after January 1, 2000, Medicare will cover prostate cancer screening tests and procedures for the early detection of prostate cancer. Guidelines pertaining to this benefit apply to both general medicine and pathology.

Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

G0102 Prostate cancer screening; digital rectal examination

G0103 Prostate cancer screening; prostate specific antigen blood test

Screening Digital Rectal Examinations

Screening digital rectal examinations (G0102) are covered for men who have attained age 50 at a frequency of once every 12 months (at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed). A screening digital rectal examination is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy, or by a qualify physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is authorized under state law to perform the examination, fully knowledgeable about the beneficiary's medical condition, and would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Screening Prostate Specific Antigen Tests

Screening prostate specific antigen tests (G0103) are covered for men who have attained age 50 at a frequency of once every 12 months (at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen blood test was performed). A screening prostate specific antigen (PSA) blood test detects the marker for adenocarcinoma of the prostate. PSA is a reliable immunocytochemical marker for primary and metastatic adenocarcinoma of the prostate. This screening must be **ordered** by the beneficiary's attending physician (doctor of medicine or osteopathy), or by the beneficiary's qualify physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Reimbursement Guidelines

Effective for dates of service on or after January 1, 2000, Medicare will process claims for prostate cancer screening tests and procedures based on age, frequency, sex, and valid HCPCS code.

To determine the 11-month period, counting begins with the month *after* the month in which a previous test/ procedure was performed. For example: the beneficiary receives a screening prostate specific antigen test in January 2000. The counting starts at the beginning of February 2000. The beneficiary is eligible to receive another screening prostate specific antigen test in January 2001 (the month after 11 months have passed).

Fees for these new procedure codes are not yet available. Procedure code G0102 (digital rectal examination) is paid under the physician's fee schedule; the 2000 Medicare Physician Fee Schedule book is scheduled for release in mid-November. This service is subject to the deductible and coinsurance guidelines. Procedure code G0103 (prostate specific antigen blood test) is paid under the clinical diagnostic laboratory fee schedule. The Clinical Laboratory Fee Schedule is included in the annual *HCPCS Special Issue Update!* and will be released in early December. Deductible and coinsurance guidelines do not apply to this service. ❖

RADIOLOGY

Radiologists Ordering X-Rays

Medicare has a long-standing policy designed to prevent the payment of multiple views or multiple radiological procedures when an attending physician orders a single view or single radiological procedure. It states in part that "...diagnostic tests are covered only if ordered by the physician or non-physician [practitioner] who treats the patient." An exception is for a screening mammography; because this is a covered screening test (not a diagnostic one) the patient does not need a medical condition for Medicare to allow payment

In all other instances, **only the attending physician or the physician who will use the test results to treat the patient may order them**. Thus, if a radiologist orders a test, he/she must have records to show that he/she examined the patient and ordered the test based on personal knowledge of the patient's condition. ❖

LOCAL AND FOCUSED MEDICAL REVIEW POLICIES

This section of the Medicare B *Update!* features new and revised medical policies developed as a result of either the Local Medical Review (LMR) or Focused Medical Review (FMR) 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 the accepted standards of medical practice.

Effective Dates

The policies contained in this section are effective for claims processed January 1, 1999 and after, ***unless otherwise stated in the policy*.**

Sources of Information

The sources of information used in the development of these policies may be obtained by accessing the Medicare online Bulletin Board System (BBS). ❖

Table of Contents - Medical Review Policies

Independent Diagnostic Testing Facility—Credentialing for 93325

The credentialing requirements for nonphysician personnel when services are performed by an Independent Diagnostic Testing Facility (IDTF) identified to date were provided in the July/August 1999 *Medicare B Update!* (pages 13-17). Since that time, a revision to the credentialing requirements has been made to procedure code 93325 (doppler echocardiography color flow velocity). The credentials for procedure code 93325 are:

CODE	CERTIFICATION
93325	ARDMS: RDCS, RDMS (Obstetrics & Gynecology) CCI: RCS

This credentialing requirement is effective for services processed on or after October 18, 1999. ❖

J0001: Self-Administered Drugs—Additions to Policy

The local medical review policy for self-administered drugs was published in the March/April 1999 Medicare B Update! *(page 43). The following article provides the complete policy, plus additional drugs now applicable.*

The Health Care Financing Administration (HCFA) receives numerous inquiries about the coverage of self-administered drugs, as well as requests to add more self-administrable drugs to the list of covered benefits.

The Medicare statute does not provide for an overall outpatient drug benefit. As a result, self-administered drugs and biologicals (pill form) or those used for self-injection are generally not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage. Currently, Medicare allows for the coverage of the following self-administered drugs:

- Blood clotting factors;
- Drugs used in immunosuppressive therapy;
- Erythropoietin (EPO);
- Osteoporosis drugs for certain homebound patients;
- Certain oral anti-cancer drugs; and
- Certain oral anti-nausea drugs given in conjunction with oral or IV chemotherapy.

There are times when a drug that is considered to be self-administered may be covered under certain limited circumstances. Coverage for these limited situations is at the discretion of the carrier. Therefore, this policy was developed to clarify when coverage would be extended to allow payment for certain self-administered drugs. Additionally, this policy will be updated as additional self-administered drugs are added or national coverage decisions change.

Indications and Limitations of Coverage and/or Medical Necessity

Based on national coverage guidelines, drugs and biologicals that are self-administered by the patient are not a benefit of Medicare. Additionally, under the "incident to" provision, an FDA approved drug or biological must be a form that cannot be self-administered.

However, certain drugs that are generally self-administered may be covered under the "incident to" provision when administered under one or more of the following circumstances:

- The initiation of the therapy requires dose titration under the supervision of a physician to test the patient's responsiveness and appropriate dosage; and/or
- Prior to self-administration of a drug, the patient/caregiver must be instructed by a medical professional on the administration and proper technique for the drug that is determined to be medically necessary for the patient's condition.

Under these *limited* circumstances, Medicare of Florida will allow payment *only* one time for certain self-administered drugs (See "HCPCS Codes" section).

Note: The individual patient's mental or physical ability to administer any drug may not be a factor in the consideration for this purpose. Decisions regarding coverage are made on an appropriate medical protocol that would apply to any patient with an illness or injury that is being treated by the drug in question.

HCPCS Codes

J1825	Injection, interferon beta-1a, 33 mcg (Avonex)
J1830	Injection, interferon beta-1b, per 0.25 mg (Betaseron)
J3490	Etanercept (ENBREL)
J3490	Somatropin (Genotropin, Humatrope, Norditropin, Nutropin AQ, Saizen, Serostim)
J9218	Leuprolide acetate, per 1 mg
Q0182	Alprostadil, urethral suppository, administered under direct supervision, excludes self-administration

ICD-9-CM Codes that Support Medical Necessity

N/A

Reasons for Denial

Drugs and biologicals that can be self-administered are not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage.

Oral drugs are not covered under the "incident to a physician's service" provision.

Noncovered ICD-9-CM Code(s)

N/A

Coding Guidelines

When billing for the initial drug (listed in this policy), the applicable J or Q code should be billed. For subsequent billing of these drugs, code A9270 should be used.

Documentation Requirements

In the event documentation is required, the provider has the responsibility to ensure that the initial injection/suppository was medically necessary. This information can generally be found in a history and physical and/or office/progress notes.

Effective Date

These changes to this local medical review policy are effective for services rendered on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

J0585: Botulinum Toxin Type A (BOTOX)

Botulinum toxin is a complex protein produced by the anaerobic bacterium *Clostridium botulinum.* Botulinum Toxin Type A injections can be used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, etc.

Botulinum toxin type A blocks neuromuscular conduction by binding to receptor sites on motor nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. When injected intramuscularly or subcutaneously at therapeutic doses, botulinum toxin type A produces a localized chemical denervation muscle paralysis. The resulting chemical denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively. It has the advantage of being a potent neuromuscular blocking agent with good selectivity, duration of action, with the smallest antigenicity, and fewest side effects.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider Botulinum Toxin Type A (Botox) (J0585) to be medically reasonable and necessary for the treatment of blepharospasm, cranial nerve aberrant regeneration, strabismus, hemifacial spasm, facial spasm, achalasia, spasmodic dysphonia, spasmodic torticollis, laryngeal dystonia, and for other dystonias (e.g., writer's cramp, focal task-specific dystonias) and limb spasticity.

Botulinum Toxin Type A can be used to reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and walking; to allow better range of motion, to permit better physical therapy, to reduce severe spasm in order to provide adequate perineal hygiene.

Botox can also be used in the treatment of achalasia. It should not be used for all patients with this disorder, but it can be considered individually in patients who have one or more of the following:

- have failed conventional therapy
- are at high risk of complications of pneumatic dilatation or surgical myotomy
- have failed a prior myotomy or dilation
- have had a previous dilation induced perforation
- have an epiphrenic diverticulum or hiatal hernia both of which increase the risk of dilation-induced perforation

Due to the uncommonness, one would not expect to see the diagnosis of organic writer's cramp (333.84) billed frequently.

There may be patients who require electromyography in order to determine the proper injection site(s). The electromyography procedure codes specified under the HCPCS section of this policy may be covered if the physician has difficulty in determining the proper injection site.

Medicare of Florida will allow payment for one injection per each functional muscle group (e.g., elbow flexors or elbow extensors) regardless of the number of injections made into each group or the muscles that compose it.

Note: It is expected that a patient will not receive continued injections of Botox if treatment failure occurs after 2 consecutive injections, using maximum dose for the size of the muscle.

HCPCS Codes

The following HCPCS codes are to be reported for the injection of Botulinum Toxin A:

J0585 Botulinum Toxin Type A, per unit

The following procedure codes are to be reported with the respective listed covered ICD-9-CM diagnosis codes: (See Coding Guidelines for correct reporting of services)

31513 Laryngoscopy, indirect (separate procedure); with vocal cord injection
31570 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic
31571 with operating microscope
64612 Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
64613 cervical spinal muscles (e.g., for spasmodic torticollis)
64640 Destruction by neurolytic agent; other peripheral nerve or branch
67345 Chemodenervation of extraocular muscle
92265 Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
95860 Needle electromyography, one extremity with or without related paraspinal areas
95861 Needle electromyography, two extremities with or without related paraspinal areas
95863 Needle electromyography, three extremities with or without related paraspinal areas
95864 Needle electromyography, four extremities with or without related paraspinal areas
95869 Needle electromyography; thoracic paraspinal muscles
95870 other than paraspinal (eg, abdomen, thorax)

ICD-9-CM Codes That Support Medical Necessity (J0585 Only)

333.6
333.7
333.81-333.89
351.8
378.00-378.87
478.75
530.0
723.5
728.85

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Botulinum Toxin Type A used for the treatment of anal spasm, irritable colon, biliary dyskinesia or any other spastic conditions not listed as covered in this policy are considered investigational and therefore, noncovered by Medicare of Florida.

Cosmetic for the removal of wrinkles.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

When billing for injections of Botulinum Toxin Type A for covered conditions/diagnoses, the following guidelines should be used. Failure to report this procedure according to these guidelines may result in a denial of a claim.

Procedure Code		ICD-9-CM Code
31513 31570 31571	laryngoscopy, indirect; diagnostic with vocal cord injection therapeutic laryngoscopy with vocal cord injection; with operation microscope	478.75
64612	destruction by neurolytic agent; muscles enervated by facial nerve	333.81 333.82 351.8
64613	destruction by neurolytic agent; cervical spinal muscles	333.83 723.5
64640	Destruction by neurolytic agent; other peripheral nerve or branch	333.6 333.7 333.84 333.89 478.75 530.0 728.85
67345	Chemodenervation of extraocular muscle	378.00-378.87

Botulinum Toxin A is supplied in vials and each contains 100 units. If less than 100 units is given during a single treatment session and the remainder is not used for another patient, bill 100 units in the days/units field (Item 24G) of the 1500 claim form, or electronic equivalent. If more than 100 units are billed during a single treatment session per patient, round up to the nearest 100 units serum only if the remainder was not used. In each case, Botulinum Toxin A is coded as J0585.

Due to the short life of the botulinum toxin, Medicare will reimburse the unused portion of this drug, only when the vial is not split between patients. However, documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

Scheduling of more than one patient is encouraged to prevent wastage of Botulinum Toxin Type A. If a vial is

split between two patients, the billing in these instances must be for the exact amount of Botulinum Toxin Type A used for each individual patient using J0585. If there is any toxin unused after injecting multiple patients, the remainder can be appropriately billed as wastage on the claim of the last patient injected. Medicare would not expect to see billing for the full fee amount for Botulinum Toxin Type A on each beneficiary when the vial is split between two or more patients.

Electromyography guidance (CPT codes 92265, 95860-95864, 95869-95870) may be covered if the physician has difficulty in determining the proper injection site(s). However, electromyography is not required for every patient.

Only one electromyography guidance procedure per injection site should be billed.

The physician should not be reimbursed for an office visit in conjunction with the procedure itself, unless there is a clear indication that the patient was seen for a different reason. The physician should use modifier 25 to indicate that the office visit was for an unrelated condition.

Documentation Requirements

Documentation (e.g., history and physical, office/ progress notes) must be maintained on file and should include the following elements in the event of a postpayment review:

- support for the medical necessity of the Botulinum Toxin A injection
- a covered diagnosis
- a statement that traditional methods of treatment have been tried and proven unsuccessful
- dosage and frequency of the injections
- support for the medical necessity of electromyography procedures
- support of the clinical effectiveness of the injections
- specify the site(s) injected

Effective Date

This local medical review policy is effective for services rendered on or after December 15, 1999.

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 4 for details concerning ABNs. ❖

J1440: G-CSF (Filgrastim, Neupogen®)

A list of diagnosis requirements for Neupogen was published on pages 13 and 14 of the July /August 1996 Medicare B Update! *Since that time, a major revision has been made regarding the "Indications and Limitations of Coverage and/or Medical Necessity" and the "ICD-9-CM Codes that Support Medical Necessity" for Neupogen. Please ensure that these changes are incorporated into your current process to ensure proper reimbursement of this service.*

G-CSF is classified as a recombinant hematopoietic stimulant. This is not a cancer chemotherapy agent. It is a class II hematopoietic growth factor that acts on progenitor cells capable of forming a single differentiated cell type, the neutrophilic granulocyte, and is thus lineage-specific. Because Filgrastim acts only on progenitor cells that are already committed to one pathway, it increases only the neutrophil (e.g., granulocyte) count.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider G-CSF medically reasonable and necessary for the following FDA approved indications when it is not self/caregiver administered:

Cancer patients:

- Bone marrow transplant (BMT) - To reduce the severity of neutropenia in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous BMT.
- Peripheral Blood Progenitor Cell (PBPC) Collection - For use in the mobilization of peripheral stem cells when the bone marrow transplant procedure itself is a covered benefit.
- Progenitor-cell transplantation - As an adjunct to allogeneic and autologous progenitor-cell transplantation, both for mobilization of PBPC and as a means to speed hematopoietic reconstitution following BMT or PBPC transplantation.
- Neutrophil engraftment failure - To assist in the recovery of patients who experience delayed or inadequate neutrophil engraftment following progenitor-cell transplantation.
- Myelosuppressive chemotherapy - 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.
- Acute myelogenous leukemia (AML) - To reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of adults with AML.

Severe chronic neutropenia (SCN) patients:

- Congenital, cyclic, or idiopathic neutropenia - To reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with SCN.

Medicare of Florida will consider G-CSF medically reasonable and necessary for the following off-label indications when it is not self/caregiver administered:

- AIDS leukopenia in children
- Amelioration of leukopenia in AIDS patients on AZT
- Amelioration of leukopenia in AIDS patients with chorioretinitis on Ganciclovir

Limitations

- A physician is not to bill Medicare of Florida for a supply of G-CSF given to the patient for self administration at home.
- The following unlabeled uses of G-CSF have not been shown to be safe and effective and are noncovered by Medicare of Florida: aplastic anemia, hairy cell leukemia, myelodysplastic disorders, myeloid malignancies (other than AML), drug-induced and congenital agranulocytosis, and alloimmune neonatal neutropenia.

- Therapeutic initiation of G-CSF does not add significantly to the antibiotic treatment outcome of established febrile neutropenia. Exceptions to this rule must be documented.
- There is inadequate data to support the use of G-CSF for patients with afebrile neutropenia.
- In general, for previously untreated patients receiving a chemotherapy regimen, primary administration of G-CSF is not considered medically necessary.
- G-CSF should not be given within 24 hours before or after a dose of a chemotherapeutic agent, as rapidly dividing myeloid cells are potentially sensitive to these agents.
- There is no evidence of benefit from the use of G-CSF to increase chemotherapy dose-intensity.
- G-CSF should not be used concurrently with radiation therapy.

Dosage and Frequency

The package insert instructions for dosage and duration of treatment should not be exceeded.

The following is the recommended dosage and frequency when administering this drug:

BMT - Recommended dose following BMT is 10 mcg/kg/day given as an IV infusion of 4 or 24 hours or SC. The first dose should be administered at least 24 hours after chemotherapy and at least 24 hours after bone marrow infusion. The dose should be based on the neutrophil response. When the absolute neutrophil count (ANC) is >1000/mm³ for 3 consecutive days, reduce the G-CSF dosage to 5 mcg/kg/day. If the ANC remains >1000/mm³ for 3 more consecutive days, discontinue use.

PBPC - Recommended dose is 10 mcg/kg/day SC. G-CSF should be given for at least 4 days before the first leukapheresis procedure and continued until the last leukapheresis.

Myelosuppressive chemotherapy - Recommended starting dose is 5 mcg/kg/day SC or short IV infusion (15-30 minutes), or by continuous infusion. Doses may be increased in increments of 5 mcg/kg for each chemotherapy cycle, according to duration and severity of the ANC nadir. Administer no earlier than 24 hours after cytotoxic chemotherapy and not in the 24 hours before administration of chemotherapy. The drug should be discontinued when the absolute neutrophil count (ANC) reaches 10,000/mm³ and/or the patient becomes afebrile, or the patient has received the drug for a maximum of 14 days per treatment regimen.

AML - Recommended starting dose is 5mcg/kg/day SC until: ANC 1,000 cells/mm³ for 3 days or ANC > 10,000 cells/mm³ for 1 day or for a maximum of 35 days.

SCN - Starting dose for congenital neutropenia is 6 mcg/kg twice daily SC every day. Idiopathic or cyclic neutropenia starting dose is 5 mcg/kg as a single injection SC every day. Chronic daily administration is required to maintain clinical benefit. Individually adjust the dose based on the patient's clinical course, as well as the ANC. Reduce the dose if the ANC is persistently > 10,0000/mm³.

** The guidelines recommended for adults are generally applicable to the pediatric age group.

HCPCS Codes

J1440 Injection, filgrastim (G-CSF), 300 mcg
J1441 Injection, filgrastim (G-CSF), 480 mcg

ICD-9-CM Codes that Support Medical Necessity

288.0
V42.9
V58.1
V58.69
V59.8

** Please refer to coding guidelines for specific requirements regarding the billing of each of these ICD-9-CM codes.

Reasons for Denial

The use of G-CSF (Filgrastim, Neupogen®) for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.

Coding Guidelines

Claims for G-CSF should be billed using the following diagnosis codes:

- 288.0 (Agranulocytosis) when G-CSF is used for patients with congenital, cyclic, or idiopathic neutropenia.
- V42.9 (Organ or tissue replaced by unspecified organ or tissue) when G-CSF is given to stem cell recipients e.g., BMT.
- V58.1 (Encounter for other and unspecified procedures and aftercare, chemotherapy) when G-CSF is used for febrile neutropenia resulting from myelosuppressive chemotherapy or following induction or consolidation chemotherapy treatment of adults with AML.
- V58.69 (Long-term (current) use of other medications) when G-CSF is used for a patient with AZT or Ganciclovir neutropenia.
- V59.8 (Donors, other specified organ or tissue) when G-CSF is used in priming for autologous peripheral stem cells (e.g., PBPC), as an adjunct to allogeneic and autologous progenitor-cell transplantation, or for neutrophil engraftment failure.

Documentation Requirements

Medical record documentation maintained by the physician must clearly indicate:

- The patient's current absolute neutrophil count (ANC);
- The patient's weight in kilograms;
- The administration and dosage of the G-CSF;
- The actual indication for which the drug was given and accompanying symptomology (e.g., fever); and
- The patient's response to the treatment.

This information is usually found in the history and physical or the office/progress notes.

Effective Date

This local medical review policy is effective for services rendered on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

J2355 Oprelvekin (Neumega®)

Oprelvekin (Neumega®) is a thrombopoietic growth factor that directly stimulates the proliferation of hematopoietic stem cells and megakaryocyte progenitor cells, and induces megakaryocyte maturation resulting in increased platelet production.

Thrombocytopenia may compromise cancer treatment, causing a reduction in chemotherapy dosaging, alteration in schedule, or the need for platelet transfusions. Thrombopoeitic growth factors may decrease the need for platelet transfusions in patients undergoing dose-intensive chemotherapy.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the administration of Oprelvekin (Neumega®) medically reasonable and necessary for the following indications:

- To prevent severe thrombocytopenia (platelet counts of ≤ 20,000 cells/uL) and to reduce the need for platelet transfusions following myelosuppressive chemotherapy in patients with nonmyeloid malignancies who are at high risk of severe thrombocytopenia.

Medicare of Florida will consider coverage of Oprelvekin ***only*** for patients with nonmyeloid malignancies who have/had a platelet count of ≤ 50,000 cells/uL or patients with nonmyeloid malignancies who required a platelet transfusion after a previous myelosuppressive chemotherapy regimen.

Medicare of Florida will not consider coverage of Oprelvekin medically reasonable and necessary when it is administered simply because the patient has received a chemotherapeutic agent that has a high propensity to cause thrombocytopenia.

Oprelvekin is not indicated following myeloablative chemotherapy (e.g., bone marrow transplant or stem cell support). Oprelvekin is also not indicated as a "rescue" agent.

The recommended daily dosage is 50 ug/kg administered subcutaneously. Dosing should be initiated 6-24 hours following the completion of chemotherapy dosing, and discontinued at least 2 days before starting the next planned cycle of chemotherapy.

A single treatment course should not exceed 21 days. The safety and effectiveness of Oprelvekin immediately prior to or concurrently with cytotoxic chemotherapy has not been established.

Platelet counts should be monitored periodically to assess the optimal duration of therapy. Dosing should be continued until adequate recovery of the platelets has occurred (post-nadir platelet count ≥ 50,000 cells/uL).

Additionally, a patient should be monitored for fluid retention (e.g., weight gain, edema, shortness of breath) during the course of treatment with Oprelvekin.

HCPCS Codes

J2355 Injection, oprelvekin, 5mg

ICD-9-CM Codes That Support Medical Necessity

140.0-149.9	190.0-199.1
150.0-159.9	200.00-200.88
160.0-165.9	201.00-201.98
170.0-176.9	202.00-202.98
179-189.9	287.4

Note: The billing of Oprelvekin requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted. Providers must use ICD-9-CM codes 140.0-202.98 (nonmyeloid malignancy) ***and*** *287.4 (thrombocytopenia due to drugs) to report the approved indication for J2355.*

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

The billing of Oprelvekin requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses must be submitted.

Providers must use ICD-9-CM codes 140.0-202.98 (nonmyeloid malignancy) ***and*** 287.4 (thrombocytopenia due to drugs) to report the approved indication for J2355.

Documentation Requirements

Medical record documentation (e.g., office/progress notes, medication records) maintained by the ordering/referring physician must clearly indicate the reason for the use of this drug, the platelet count, the patient's weight, and the dose administered.

Effective Date

This local medical review policy is effective for services processed on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

J9999: Antineoplastic Drugs - Additions to Policy

The complete local medical review policy for antineoplastic drugs was published in the March/April 1999 *Medicare B Update!*, pages 45-48. Since the publication of that article, the following coverage criteria for the antineoplastic drugs Aldesleukin (Proleukin®, interleukin-2, recombinant, and rIL-2), Carboplatin (Paraplatin®, Paraplatin-AQ®), Paclitaxel (Taxol®), Mitomycin (Mutamycin®, mitamycin-C), and Porfimer (Photofrin®) have been added to the policy:

Aldesleukin (Proleukin®, interleukin-2, recombinant, and rIL-2)

Indications and Limitations of Coverage and/or Medical Necessity

Aldesleukin is classified as a biological response modifier. It increases cellular immunity and inhibits tumor growth. Because of its potential life-threatening toxicities, it is recommended that this medication be given only after careful consideration of the risks and benefits. Aldesleukin is FDA approved for treatment of renal carcinoma and metastatic melanoma.

HCPCS Codes

J9015 Aldesleukin, per single use vial

ICD-9-CM Codes That Support Medical Necessity

172.0-172.9
189.0
189.1

Carboplatin (Paraplatin®, Paraplatin-AQ®)

Indications and Limitations of Coverage and/or Medical Necessity

Carboplatin resembles an alkylating agent. Although the exact mechanism of action is unknown, it is thought to be similar to that of the bifunctional alkylating agents, that is, possible cross-linking and interference with the function of DNA.

Carboplatin is FDA approved for the palliative treatment of epithelial ovarian carcinoma, when refractive to standard chemotherapy that did or did not include Cisplatin and for the initial treatment of advanced epithelial ovarian carcinoma in combination with other approved chemotherapeutic agents.

Clinical trials have also demonstrated the efficacy of Carboplatin in the treatment of additional carcinomas. Medicare of Florida will cover Carboplatin for its FDA approved uses as well as for treatment of the following neoplasms:

- Bladder carcinoma
- Primary brain tumors
- Breast carcinoma
- Endometrial carcinoma
- Head & neck carcinoma
- Small cell and non-small cell lung carcinoma
- Malignant melanoma
- Neuroblastoma
- Retinoblastoma
- Testicular carcinoma
- Wilms' Tumor

HCPCS Codes

J9045 Carboplatin, 50mg

ICD-9-CM Codes That Support Medical Necessity

140.0-149.9
160.0-160.9
161.0-161.9
162.2-162.9
172.0-172.9
174.0-174.9
175.0-175.9
182.0
183.0
186.0-186.9
188.0-188.9
189.0
190.5
191.0-191.9
194.0-194.9
195.0

Paclitaxel (Taxol®)

Indications and Limitations of Coverage and/or Medical Necessity

Paclitaxel is an antimicrotubule agent. It interferes with the normal cellular microtubule function that is required for interphase and mitosis.

Paclitaxel is FDA approved for treatment of the following medical conditions:

Breast carcinoma after failure of combination chemotherapy or at relapse within 6 months of adjuvant chemotherapy; advanced carcinoma of ovary; as a second-line treatment for AIDS-associated Kaposi's sarcoma; and non-small cell lung carcinoma in combination with Cisplatin as a first-line treatment for patients who are not candidates for radiation therapy or potentially curative surgery.

Clinical trials have also demonstrated the efficacy of Paclitaxel in the treatment of additional carcinomas. Medicare of Florida will cover Paclitaxel for its FDA approved uses as well as for treatment of the following neoplasms:

- Bladder carcinoma
- Cervical carcinoma
- Endometrial carcinoma
- Esophageal carcinoma
- Head & neck carcinoma
- Small cell lung carcinoma
- Prostate carcinoma
- Gastric carcinoma

HCPCS Codes

J9265 Paclitaxel, 30mg

ICD-9-CM Codes That Support Medical Necessity

140.0-149.9
150.0-150.9
151.0-151.9
161.0-161.9
162.2-162.9
174.0-174.9
175.0-175.9
176.0-176.9
180.0-180.9
182.0
183.0
185
188.0-188.9

Mitomycin (Mutamycin®, mitamycin-C)

Indications and Limitations of Coverage and/or Medical Necessity

Mitomycin is classified as an antitumor antibiotic. It inhibits DNA synthesis by causing cross-linking. It also inhibits RNA and protein synthesis.

Mitomycin concentrate may be used intravenously or as a topical bladder instillation.

Mitomycin is FDA approved for treatment of gastric and pancreatic carcinoma.

Clinical trials have also demonstrated the efficacy of Mitomycin in the treatment of additional carcinomas. Medicare of Florida will cover Mitomycin for its FDA approved uses as well as for treatment of the following neoplasms:

- Bladder carcinoma
- Cervical carcinoma
- Breast carcinoma
- Esophageal carcinoma
- Head & neck carcinoma
- Non-small cell lung carcinoma
- Prostate carcinoma
- Gallbladder & biliary carcinoma
- Colorectal & anal carcinoma
- Chronic myelocytic & myelomonocytic leukemias

HCPCS Codes

J9280 Mitomycin, 5mg
J9290 Mitomycin, 20mg
J9291 Mitomycin, 40mg

ICD-9-CM Codes That Support Medical Necessity

140.0-149.9
150.0-150.9
151.0-151.9
153.0-154.8
156.0-156.9
157.0-157.9
161.0-161.9
162.2-162.9
174.0-174.9
175.0-175.9
180.0-180.9
185
188.0-188.9
195.0
205.10-205.11

Porfimer (Photofrin®)

Indications and Limitations of Coverage and/or Medical Necessity

Porfimer is a photosynthesizing agent that in combination with light, can cause cellular damage and tumor death. Tumor selectivity occurs as a result of selective distribution and retention of Porfimer on tumor tissue, and by selective delivery of light. Illumination of target tissue with 630 nanometer wavelength laser light induces a photochemical reaction that activates Porfimer. Porfimer photodynamic therapy causes the release of thromboxane A2, which results in vasoconstriction, activation and aggregation of platelets, and increased clotting. These factors contribute to ischemic necrosis which leads to tissue and tumor death.

Porfimer is for intravenous use. It is supplied as a 75 mg. single dose vial. After reconstitution, 2 mg per kg of body weight should be administered slowly over three to five minutes followed by illumination with laser light and debridement of the tumor at appropriate and specific intervals. Photodynamic treatment with Porfimer may be given for a total of three courses of therapy, each separated by at least 30 days.

Porfimer is FDA approved for the palliative treatment of partial or complete obstruction of the esophagus due to esophageal cancer in patients who cannot be satisfactorily treated with Nd:YAG laser therapy alone.

Porfimer is also FDA approved for patients with non-small cell lung cancer (NSCLC) for whom surgery and radiotherapy are not indicated.

HCPCS Codes

J9600 Porfimer sodium, 75 mg

ICD-9-CM Codes That support Medical Necessity

150.0-150.9
162.2-162.9

Reasons for Denial

The use of Proleukin, Paraplatin, Taxol, Mutamycin, or Photofrin, for any clinical indication other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any ICD-9-CM diagnosis code not listed in each of the "ICD-9-CM Codes That Support Medical Necessity" sections of this policy.

Coding Guidelines

When billing for Aldesleukin, use HCPCS code J9015 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Carboplatin 50 mg, use HCPCS code J9045 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Paclitaxel 30 mg, use HCPCS code J9265 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Mitomycin 5mg, 20mg, or 40mg, use HCPCS code J9280, J9290 or J9291, respectively and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

When billing for Porfimer 75 mg, use HCPCS code J9600 and the appropriate ICD-9-CM diagnosis code which indicates the medical condition being treated.

Documentation Requirements

Medical record documentation maintained by the performing physician must substantiate the medical necessity for the use of these chemotherapy drugs by clearly indicating the condition for which these drugs are being used. This documentation is usually found in the history and physical or in the office/progress notes.

Effective Date

The addition of Aldesleukin, Carboplatin, Paclitaxel, Mitomycin, and Porfimer is effective for services processed on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

M0302: Cardiac Output by Electrical Bioimpedance

Electrical bioimpedance, a form of plethysmography, is a noninvasive method of hemodynamic monitoring that works by applying sensors to the neck and chest to transmit and measure the resistance to a small electrical signal. The changes in resistance are used to measure and calculate hemodynamic parameters.

Four dual electrodes are placed on the lateral aspects of the neck and thorax. The inferior neck electrodes are positioned at the base or root of the neck. The superior thoracic electrodes are placed at the mid-axillary line, even with the xyphoid. A low-amplitude, high-frequency electrical signal is emitted from the outer sensors through the thorax.

Because electricity follows the path of least resistance, the electrical signal travels along the most conductive area, the blood-filled aorta. A baseline level of impedance, or resistance to electrical signal, is determined. As the volume and velocity of blood in the aorta change with each heartbeat, the device measures the changes in impedance to the electrical signal. Monitoring these changes permits continuous determination of stroke volume, indices of contractility such as velocity and acceleration of blood flow, systemic vascular resistance (SVR) and index, cardiac output (CO) and index, and thoracic fluid content.

Thoracic fluid content represents conductivity contributions of three compartments of the thorax, namely intravascular, intraalveolar, and interstitial. An excessive thoracic fluid content indicates an excess in thoracic fluids.

Indications and Limitations of Coverage and/or Medical Necessity

Cardiac output monitoring using electrical bioimpedance, a form of plethysmography, is covered by Medicare effective for services furnished on or after July 1, 1999.

These devices utilize electrical bioimpedance to noninvasively produce hemodynamic measurements of cardiac output, specifically stroke volume, contractility, systemic vascular resistance, and thoracic fluid content. These devices are covered for the following indications:

- Noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease;
- Differentiation of cardiogenic from pulmonary causes of ***acute*** dyspnea;
- Optimization of atrioventricular interval for a patient with an atrioventricular sequential cardiac pacemaker;
- Patients with need of determination for intravenous inotropic therapy;
- Post heart transplant myocardial biopsy patients; and/or
- Patients with a need for fluid management.

The following are examples of appropriate clinical indications for which Medicare of Florida will consider the assessment of cardiac output by electrical bioimpedance medically reasonable and necessary:

- For patients with structural heart disease (with an ejection fraction ≤ 40%) associated with the development of congestive heart failure (e.g., valvular and congenital, post myocardial infarction, rheumatic heart disease);
- For patients with inflammatory heart disease (with an ejection fraction ≤ 40%) associated with the development of congestive heart failure (e.g., myocarditis and cardiomyopathy, pericarditis and constrictive pericardial scarring, rheumatic heart disease);
- For patients with ischemic heart disease (with an ejection fraction ≤ 40%) associated with the development of congestive heart failure (e.g., post myocardial infarction, ischemic cardiomyopathy, ischemic mitral valve or left ventricular dysfunction);
- For patients with cardiac disease resulting in congestive heart failure with normal left ventricular function (e.g., diastolic dysfunction, restrictive cardiomyopathy/ infiltrative such as amyloidosis or cancer of the heart);
- For patients with pulmonary disease associated with congestive heart failure (e.g., cor pulmonale and the need to distinguish between pulmonary and cardiac disease as the cause, pulmonary hypertension);
- For acute conditions for which the patient might present to an outpatient setting and in which a decision regarding intervention is necessary (e.g., pericardial effusion with possible tamponade, myocardial infarction, cardiac trauma);
- For patients with recent pacemaker implants who demonstrate clinical manifestations of unexplained fatigue, symptomatic hypotension, or congestive heart failure;
- For the titration of therapeutic agents in the setting of symptomatic congestive heart failure;
- For acute heart rejection during outpatient follow-up of heart transplant patients (as a supplement to invasive endomyocardial biopsy); and/or
- For patients with acute/chronic renal failure or end stage renal disease/dialysis who demonstrate clinical manifestations of unexplained shortness of breath, unexplained reduced access flow, symptomatic hypotension/hypertension.

The frequency of measurements of cardiac output by electrical bioimpedance which Medicare of Florida will consider medically reasonable and necessary will be based on the purpose for which the measurement is obtained. The following are examples of categories of use and the general guidelines regarding measurement frequency:

Diagnostic - Frequency of use for diagnostic purposes will apply to patients in whom congestive heart failure is evident, yet its etiology is unclear. An initial measurement may be sufficient, with infrequent follow-up assessments. Examples include (but are not limited to):

- A patient with respiratory failure and the need to distinguish the presence of a cardiac component of the illness.
- Pericardial effusion of uncertain hemodynamic significance.
- Suspected diastolic dysfunction or the presence of congestive heart failure in the setting of normal left ventricular function.

Titration of Therapeutic Agents - Frequency of use for monitoring therapeutic drug response will require more frequent measurements, and may vary. The frequency at which titration of the therapeutic agents is considered medically reasonable and necessary will be based on whether the drug is approved for use in a regimented fashion. Examples include (but are not limited to):

- Medication adjustments in patients with refractory congestive heart failure due to either systolic or diastolic dysfunction (especially patients with a left ventricular ejection fraction ≤ 40%).

- Medication adjustments for patients receiving a hemodynamically active anti-hypertensive medication for which a regimented or standardized approach exists. Weekly assessments may be considered reasonable in patients undergoing titration of medications for which there is a regimented approach to titration (e.g., carvedilol). Because individual tolerance is quite variable and the side effects make it difficult to ascertain whether the patient is realizing maximal benefit, knowledge of the cardiac output as an objective measure would assist the practitioner in decisions regarding titration. ACE inhibitors may also fall into this category, yet a maximum of 4 to 6 weekly measurements may be sufficient, with subsequent measurements at 1-3 month intervals.

Monitoring - Frequency of use for monitoring of a patient for a period of clinical assessment should be thought of as a single use. Examples include:

- To determine the effect of changes in pacemaker programming where several adjustments might be made during a single visit to optimize pacemaker function.
- Hemodynamic monitoring during a surgical procedure that takes place in the physician's office.

Note: Measurement of cardiac output by electrical bioimpedance is not considered medically reasonable and necessary upon each visit or for each change in the patient's medication regimen.

Limitations of Coverage

Cardiac output by electrical bioimpedance is ***not covered*** for the following indications:

- Monitoring of patients with proven or suspected disease involving severe regurgitation of the aorta;
- Patients with minute ventilation (MV) sensor function pacemakers (since the device may adversely affect the functioning of that type of pacemaker);
- Cardiac bypass patients while on a cardiopulmonary bypass machine (since the device does not render accurate measurements under this circumstance);
- Routine assessment of cardiac output by electrical bioimpedance in an asymptomatic patient (i.e., a patient that presents with no clinical manifestations of illness or injury); and/or
- The use of electrical bioimpedance for the routine assessment of hypertensive patients (those who have demonstrated a blood pressure reading of systolic ≥ 140 or diastolic ≥ 90 on three separate occasions) who have not undergone a course of combination drug therapy that has failed to control the hypertension.

HCPCS Codes

M0302 Assessment of cardiac output by electrical bioimpedance

ICD-9-CM Codes That Support Medical Necessity

391.0-391.9	404.00-404.03	415.0-415.19
394.0-394.9	404.11	420.0-420.99
397.0-397.9	404.12	421.0-421.9
398.90-398.91	404.13	422.0-422.99
401.0	404.91	423.0-423.9
401.9	404.92	424.0
402.00-402.01	404.93	424.2-424.99
402.11	405.01-405.09	425.0-425.8
402.91	405.91-405.99	428.0-428.9
403.00-403.01	410.00-410.92	429.3
403.11	411.0-411.89	429.4
403.91	413.0-413.9	430
	414.00-414.8	518.4

Reasons for Denial

- The use of electrical bioimpedance for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.
- The use of electrical bioimpedance for monitoring of patients with proven or suspected disease involving severe regurgitation of the aorta.
- The use of electrical bioimpedance for patients with minute ventilation (MV) sensor function pacemakers (since the device may adversely affect the functioning of that type of pacemaker).
- The use of electrical bioimpedance for cardiac bypass patients while on a cardiopulmonary bypass machine (since the device does not render accurate measurements under this circumstance).
- The use of electrical bioimpedance for routine assessment of cardiac output in an asymptomatic patient (i.e., a patient that presents with no clinical manifestations of illness or injury).
- The use of electrical bioimpedance for the routine assessment of hypertensive patients (those who have demonstrated a blood pressure reading of systolic ≥ 140 or diastolic ≥ 90 on three separate occasions) who have not undergone a course of combination drug therapy which has failed to control the hypertension.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

The only appropriate HCPCS code to use for the assessment of cardiac output by electrical bioimpedance is M0302. HCPCS codes 93720-93722 must not be used to represent this service.

It is not expected that M0302 (Assessment of cardiac output by electrical bioimpedance) will be utilized simultaneously with 93503 [Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes].

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for assessment of cardiac output by electrical bioimpedance.

Additionally, a copy of the measurements acquired through the use of the electrical bioimpedance device, with the physician's signature, must be maintained in the medical record.

Effective Date

This local medical review policy is effective for services processed on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

48554: Revision to Pancreas Transplantation Coverage

The Health Care Financing Administration (HCFA) has revised the coverage of pancreas transplantation by removing the requirement that the kidney transplant that must take place either simultaneous with or previous to a pancreas transplant has been covered by Medicare. The following revises the "Indications and Limitation of Coverage and/or Medical Necessity" statement of the local medical review policy (LMRP) published in the July/August 1999 *Medicare B Update!* (page 26):

> Effective July 1, 1999, Medicare will consider performance of a whole organ pancreas transplantation medically reasonable and necessary under the following circumstances:
>
> - When it is performed in a licensed facility simultaneously with or after a kidney transplantation (procedure code 50360 or 50365). ❖

53850: Transurethral Microwave Thermotherapy

The Local Medical Review Policy (LMRP) for prostate treatments was published in the November/December 1998 *Medicare B Update!* (pages 24-25). Since that time, a revision has been made to the coverage criteria for Transurethral Microwave Thermotherapy (TUMT). As a result of this change, TUMT is covered for the treatment of symptomatic benign prostatic hyperplasia (BPH) (ICD-9-CM diagnosis code 600) when the treatment is performed using an FDA device approved for this specific indication and the patient meets the following criteria:

- Prostatic lengths between 30-50 mm as determined by ultrasound;
- American Urology Association (AUA) symptom greater than or equal to 9 or Madsen symptom index greater than 8;
- Free peak uroflow rate (PFR) less than 15 cc/sec with a voided volume greater than or equal to 150 cc;
- Post void residual (PVR) less than 350 cc.

Documentation Requirements

Medical records maintained in the patient's file must document his prostatic length and/or size, BPH symptoms, AUA symptoms or Madsen symptom index, the peak flow rate and post void residual. In addition, a description of the thermotherapy procedure must be documented. This information is usually found in the office/progress notes, history and physical, and/or procedure note.

Effective Date

This update to the local medical review policy is effective for services processed on or after December 15, 1999.

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 for 4 for details concerning ABNs. ❖

70450: Computerized Tomography Scans—Correction

The medical policy for computerized tomography scans was published in the March/April 1999 *Medicare B Update!* (pages 57-58). ICD-9-CM diagnosis 784.0 (headache) was inadvertently omitted from the article.

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 4 for details concerning ABNs. ❖

78461, 78465: Billing of Myocardial Perfusion Imaging

An article was published in the January/February 1999 *Medicare B Update!* (pages 29-30) regarding coverage guidelines for myocardial perfusion imaging. The following coding guidelines were provided in that article:

> When performing both the rest and stress portions of the myocardial perfusion imaging for any one of the covered indications, a multiple study procedure code (78461, 78465) should be billed regardless of whether the imaging occurs on the same day or two different days.

Since that article appeared, numerous inquiries have been received requesting billing clarification of myocardial perfusion imaging performed using a two-day protocol. When billing for a myocardial perfusion imaging study (procedure codes 78461, 78465) using a two-day protocol, billing should occur on the day the study is completed. In addition, any add-on procedure codes performed as part of the two-day protocol (e.g.,78478, 78480) should also be billed only once. That is, *procedure code 78461 or 78465 in addition to any add-on codes should only be billed once, regardless of whether the imaging occurred on one day or two days.* ❖

86706, 87349: Hepatitis B Surface Antibody and Surface Antigen

Hepatitis refers to inflammation of the liver. Approximately 50% of all acute viral hepatitis cases in the United States are type B. Hepatitis B is caused by the hepatitis B virus (HBV) which is spread by blood and serum-derived fluids through direct contact with these body fluids (such as transmission through parenteral, sexual and perinatal modes). The incubation period for hepatitis B can be six weeks to six months with a slow onset. The most frequent presenting symptoms of acute viral hepatitis are low-grade fever, anorexia, fatigue, myalgia, and nausea followed one to two weeks later by jaundice. Dark urine and clay colored stools present several days before jaundice. After the onset of jaundice, the liver enlarges and becomes tender. About 5% of patients infected with the hepatitis B virus develop what is coined the "serum-sickness syndrome". The syndrome includes the symptoms of jaundice, fever, rash and arthralgia. Hepatitis B may be quite mild, while a few patients could rapidly progress to death suffering from acute necrosis of the liver. Some patients with hepatitis B (approximately 6%-10%) may progress to a persistent carrier status confirmed by the consistently present hepatitis B surface antigen in their blood. These patients are highly likely to transmit hepatitis B. Each case of hepatitis B is treated symptomatically.

Hepatitis B surface antigen (HBsAg) is the earliest indicator of an acute hepatitis B infection. It can be detected one to seven weeks before liver enzyme elevation or the onset of clinical symptoms. The serology of 50% of affected patients will be positive three weeks after acute onset, while at the seventeen week mark only 10% will remain positive. There is evidence of a "window" stage where the hepatitis B surface antigen has become negative and the patient has not yet developed the hepatitis B surface antibody. The chronic carrier state is indicated by the persistence of hepatitis B surface antigen over six months and longer (possibly years) while never seroconverting to hepatitis B surface antibody. The reference range is negative. The detection of the hepatitis B surface antigen establishes the presence of infection and implies infectivity.

Hepatitis B surface antibody (HbsAb or anti-HBs) is present in the serum of patients who have resolved a previous hepatitis B infection or have been vaccinated against hepatitis B. The disappearance of hepatitis B antigen with the appearance of hepatitis B antibody signals recovery from the hepatitis B infection, the status of noninfectivity and protection from recurrent hepatitis B infection. Hepatitis B surface antibody can be detected several weeks to several years after hepatitis B antigen can no longer be detected. It may persist for life after the acute infection has been resolved. Since there are different serologic subtypes of the hepatitis B virus, it is possible for a patient to have an antibody for one subtype and be infected with another. Transfused individuals or hemophiliacs receiving plasma components may have false positive tests. Individuals vaccinated with HBV vaccine will have antibodies. The appearance of the hepatitis B antibody following vaccination signals successful vaccination against hepatitis B. The detection of hepatitis B surface antibody in the patient's serum can be performed by either the radioimmunoassay (RIA) or enzyme immunoassay (EIA) method. The reference range varies with the clinical circumstance.

Indications and Limitations of Coverage and/or Medical Necessity

Hepatitis B Surface Antibody

Medicare of Florida will consider coverage for the hepatitis B surface antibody (86706) for any of the following indications:

- To confirm the resolution of a recent hepatitis B infection. The HBsAb is drawn one month after the diagnosis of acute hepatitis B is made. This test may be repeated monthly while seeking the disappearance of HBsAg and the appearance of HBsAb indicating immunity and recovery. If the HBsAg is still evident at the end of six months of testing, the patient is considered a persistent hepatitis B carrier. No further HBsAb would be considered reasonable and necessary.
- After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the ***source*** is HBsAg-Positive *and* the previously vaccinated exposed person is either a known responder or the response to vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination. ***Exception***: vaccinated persons who have not been tested within the past 24 months should undergo testing to determine immunity.
- After percutaneous or mucosal exposure to blood and/or serum-derived fluids when the ***source*** is Not Tested or Unknown *and* the previously vaccinated exposed person's response to the vaccination is unknown, in order to determine adequate antibody response. One test would be sufficient to make this determination.
- Following the administration of the hepatitis B vaccine series in order to determine adequate antibody response. Coverage for this indication is limited to two instances.

    1. To determine the antibody response of vaccination due to prophylaxis treatment following percutaneous and/or mucosal exposure, or
    2. To determine the antibody response of vaccination following a Medicare reimbursed vaccination furnished to a beneficiary who is at high or intermediate risk of contracting hepatitis B. See local medical review policy *90744: Hepatitis B Vaccine* for more information regarding this benefit.

    It is recommended this testing occur between one to six months following the completion of the series. If the patient was given Hepatitis B immunoglobulin (HBIg) during this time period, the testing should be delayed until four to six months after the HBIg administration. Those beneficiaries who do not respond to the initial vaccination series, can receive up to three additional doses of vaccine at one to two month intervals. Serologic testing can occur following each dose.

- To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with HCFA National coverage policy. Further testing is dependent upon the initial result and the vaccination status. Please refer to the following table from the Coverage Issues Manual section 50-17.

Vaccination and Serologic Status	**Freq. of HBsAb Surveillance**
Unvaccinated	
Susceptible	Semiannually
HBsAg Carrier	None
HBsAb positive (*)	Annually
Vaccinated	
HBsAb positive (*)	Annually
HBsAb of 9 or less SRUs by RIA	Semiannually

** At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mlU/ml are recognized as conferring protection against hepatitis.*

ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine. Once the response is confirmed as positive, there is no further need to perform semiannual HBsAb tests. If, during future annual HBsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. A booster dose, otherwise known as re-vaccination, requires the complete three-injection-series be repeated. Once again, between one and six months following the final vaccine dose, all patients should be tested for HBsAb response to the vaccine.

HCPCS Codes

86706 Hepatitis B surface antibody (HBsAb)

ICD-9-CM Codes That Support Medical Necessity

070.20-070.23
070.30-070.33
585
V01.7
V05.3
V45.1
V67.59

Note: Billing for hepatitis B surface antibody for ESRD beneficiaries requires dual diagnoses. Please submit codes 585 ***and*** *V45.1 to report the approved indication.*

Hepatitis B Surface Antigen

Medicare of Florida will consider coverage for the hepatitis B surface antigen (87340) for any of the following indications:

- To aid in the differential diagnosis of hepatitis when the patient presents with signs and symptoms of acute viral infection. If the initial HBsAg test is positive with the Anti-HBc-IgM being negative, both of these tests are repeated in two weeks. The results of the repeat tests aid in the differential diagnosis of acute HBV infection vs. chronic HBV carrier status. If the initial HBsAg test is positive with the Anti-HBc-IgM being positive, HBV infection is confirmed. The hepatitis B surface antigen test can be repeated monthly until negative. If, at the end of six months, the hepatitis B surface antigen remains positive, the beneficiary is diagnosed as a chronic HBV carrier and further hepatitis B surface antigen testing would not be reasonable or necessary.
- To evaluate patients with chronic elevations (6 months or longer) of the following serum liver enzyme levels: alanine aminotransferase (ALT) and aspartane aminotransferase (AST) to rule out the diagnosis of hepatitis B. It is expected that only *one* HBsAg test will be required in this clinical situation (ICD-9-CM code 790.4).
- To evaluate patients with polyarteritis nodosa to determine if the illness is associated with replicating hepatitis B. In this instance HBsAg and HBeAg would be evaluated. It is expected that only *one* HBsAg test will be required (ICD-9-CM code 446.0)
- To determine the serological status of a hemodialysis, intermittent peritoneal dialysis, or continuous cycling peritoneal dialysis patient upon entry into a Medicare dialysis facility in accordance with HCFA national coverage policy. Further testing is dependent upon the initial result as well as the vaccination status. Please refer to the following table from the Coverage Issues Manual section 50-17.

Vaccination and Serologic Status	**Freq. of HBsAg Surveillance**
Unvaccinated	
Susceptible	Monthly
HbsAg Carrier	Annually
HbsAb positive (*)	None
Vaccinated	
HbsAb positive (*)	None
HbsAb of 9 or less SRUs by RIA	Monthly

** At least 10 sample ratio units (SRUs) by radioimmunoassay or positive by enzyme immunoassay. Antibody titers 10 mlU/ml are recognized as conferring protection against hepatitis B.*

ESRD patients who are in the process of receiving the hepatitis B vaccine, but have not completed the series, should be followed as susceptible. Between one and six months following the final vaccine dose,

all patients should be tested for HBsAb response to the vaccine. Once the response is confirmed, there is no further need to perform monthly HBsAg tests. If, during future annual HBsAb testing, it is determined that the SRUs drop below 10 or the result by EIA is negative, a booster dose of hepatitis B vaccine should be given. Monthly HBsAg can resume while awaiting the antibody response to this booster. Once the antibody titer confirms protection, no further HBsAg testing would be necessary.

HCPCS Codes

87340 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HBsAg)

ICD-9-CM Codes That Support Medical Necessity

070.20-070.23	780.6
070.30-070.33	780.79
070.6	782.1
070.9	782.4
446.0	783.0
570	787.02
573.1	789.1
573.2	790.4
573.3	791.9
585	792.1
719.40-719.49	V01.7
729.1	V02.61
774.4	V45.1

Note: Billing for hepatitis B surface antigen for ESRD beneficiaries requires dual diagnoses. Please submit codes 585 ***and*** *V45.1 to report the approved indication.*

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" sections of this policy.

Coding Guidelines

Hepatitis B surface antigen and antibody tests are separately billable lab tests for hemodialysis, intermittent peritoneal dialysis and continuous cycling peritoneal dialysis patients. Payment for these tests are not part of the composite rate of reimbursement.

To identify end stage renal dialysis patients, bill *both* 585 and V45.1 on the Medicare claim form. If both ICD-9-CM codes are not on the claim, the services will be denied as lacking medical necessity.

Documentation Requirements

For someone suspected of having been recently exposed to the hepatitis B virus, the medical record documentation must contain information regarding the beneficiary's vaccination status, and the suspected incident including an assessment of current signs and symptoms. It is expected that the initial and, if needed, subsequent hepatitis B lab test results (e.g., HBsAg, HBsAb, and/or Anti-HBc-IgM) will be contained within the medical record. This information is usually found in the history and physical, office notes, test results, and/or progress notes.

Medical record documentation for ESRD beneficiaries receiving services through Medicare dialysis facilities must contain information regarding the method of dialysis, their hepatitis B vaccination status and the results of their initial admission serology testing and all subsequent hepatitis B surface antigen and antibody tests.

If the provider of service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the test(s). The physician must state the beneficiary's vaccination status as well as the clinical indication/medical necessity for the study in his order for the test(s).

Terms Defined

Chronic hepatitis- persistently abnormal liver enzymes for at least six months duration.

End Stage Renal Disease (ESRD)- the term as defined by HCFA in the Medicare Carrier's Manual (MCM 2230.1) reads the "stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life."

Person infected with HBV- the blood of this individual contains the hepatitis B surface antigen.

Person immune to HBV- the blood of this individual contains the hepatitis B antibody.

Person susceptible to HBV- the blood of this individual contains neither hepatitis B surface antigen nor antibody.

Effective Date

This local medical review policy is effective for services processed on or after December 20, 1999.

Advance Notice Requirement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

87086: Urine Bacterial Culture

This policy was last published in the July/August 1997 Medicare B Update. Since that time, the policy has been revised to expand ICD-9-CM coverage and to reflect current policy format. Therefore, it is being published in its entirety.

A culture is the propagation of microorganisms or of living tissue cells in special media that are conducive to their growth. A urine culture is performed to identify the presence of infectious microorganisms in the urinary tract. It is performed when a patient has clinical symptoms indicative of a possible urinary tract infection. These symptoms include pain and/or burning upon urination, urgency, hematuria, urine retention, elevated temperature, and urine incontinence.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider a urine bacterial culture to be medically reasonable and necessary for the following situations:

- An abnormal urinalysis suggestive of a urinary tract infection (e.g., hematuria, pyuria or proteinuria);
- Clinical symptoms indicative of a urinary tract infection (e.g., burning and/or pain on urination);
- Fever of unknown origin or suspected septicemia;
- In follow-up of a previously treated urinary tract infection to confirm effectiveness of therapy.

HCPCS Codes

87086	Culture, bacterial, urine; quantitative colony count
87087	commercial kit
87088	identification, in addition to quantitative or commercial kit

ICD-9-CM Codes That Support Medical Necessity

038.0	592.9	608.86
038.10-038.19	593.0	608.89
038.3	593.1	608.9
038.40	593.2	625.6
038.41	593.3	780.6
038.42	593.4	788.0
038.43	593.5	788.1
038.44	593.6	788.20
038.49	593.70	788.21
038.8	593.71	788.30
038.9	593.72	788.31
580.0	593.73	788.32
580.4	593.81	788.33
580.81	593.82	788.34
580.89	593.9	788.35
580.9	594.0-594.9	788.36
590.00	595.0-595.9	788.37
590.01	596.0-596.9	788.39
590.10	597.0-597.89	788.41
590.11	598.00-598.9	788.42
590.2	599.0-599.9	788.43
590.3	601.0	788.61
590.80	608.0	788.62
590.81	608.2	788.7
590.9	608.4	788.8
591	608.81	790.7
592.0	608.84	791.0
592.1	608.85	791.7

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Documentation Requirement

Documentation maintained in the patient's file must indicate the medical necessity of this procedure. All coverage criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section must be documented in the patient's medical record, as well as a hard copy of the procedure results and made available to Medicare upon request. This information can generally be found in the office/progress notes, history and physical and/or operative notes.

If the provider of the service is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/ referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Effective Date

This local medical review policy is effective for services processed on or after October 26, 1999.

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 4 for details concerning ABNs. ❖

88155: Pap Smears-Revision

Procedure code 88155 was revised in 1999. According to the Current Procedural Terminology (CPT) manual, cervical or vaginal cytopathology slides for definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index) are listed separately in addition to codes for other technical and interpretive pap smear services. The coding guidelines contained in the current local medical review policy for pap smears (88141) have been updated to reflect this change.

For information regarding the indications and limitation of coverage and/ or medical necessity for these services, please refer to the *Medicare B Update!* for January/ February 1999 (page 42), and July/August 1999 (page 10). ❖

93886, 93888: Transcranial Doppler Studies

Transcranial Doppler uses low-frequency Doppler transducers applied across the thin portions of the temporal bone (the temporal acoustic windows) to obtain flow velocity information from the basal intracerebral arteries. The transtemporal acoustic window provides access to hemodynamic data from the middle, anterior, and posterior cerebral arteries. A suboccipital approach, with insonation through the foramen magnum, provides access to the intracranial vertebral and basilar arteries, while a transorbital approach can be used to insonate the ophthalmic artery and the carotid siphon via the optic foramen. This data allows evaluation of the direction, depth, speed, and characteristics of flow in these vessels.

The transcranial Doppler examination is by far the most operator-dependent technique of all the noninvasive studies.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida considers transcranial Doppler evaluation of the intracranial cerebrovascular system (procedure codes 93886 and 93888) to be considered medically necessary in any of the following circumstances (see "ICD-9-CM Codes That Support Medical Necessity"):

- The patient has suspected severe intracranial arterial stenosis based on finite clinical evidence of focal ischemia, and knowledge of this stenosis is necessary in order to properly care for the patient.
- The patient has areas of known severe stenosis or occlusion of arteries supplying the brain and assessment of the pattern and extent of collateral circulation is necessary in order to properly care for the patient.
- The patient has suffered a subarachnoid hemorrhage and transcranial Doppler studies are necessary to assess vasoconstriction of cerebral vessels.
- The patient has suspected or confirmed arteriovenous malformation, and an assessment of the arterial supply and flow pattern is necessary.
- The patient has suspected brain death.

Headaches or dizziness are not indications for transcranial Doppler studies of the intracranial vessels unless associated with other localizing signs and symptoms such as nystagmus, limb ataxia, etc.

Transcranial Doppler studies performed to monitor cerebral vascular resistance and the effects of vasodilators and other drugs in the treatment of stroke and other brain damage, is considered investigational, and therefore not covered by Medicare.

ICD-9-CM Codes That Support Medical Necessity

348.8	433.21	434.90
430	433.30	434.91
433.00	433.31	435.0
433.01	434.00	435.1
433.10	434.01	747.81
433.11	434.10	
433.20	434.11	

Coding Guidelines

Procedure code A9270 (noncovered item or service) should be billed when a transcranial Doppler study is performed to monitor and manage the effects of vasodilators and other drugs in the treatment of strokes and other brain damage.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided.

The use of a simple handheld or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of the bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately billable under procedure codes 93886 or 93888.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of transcranial Doppler studies covered by the Medicare program. Also, the results of transcranial Doppler studies covered by the Medicare program must be included in the patient's medical record. This information is normally found in the office/progress notes, hospital notes, and/or test results.

If the provider of transcranial Doppler studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physican must state the clinical indication/medical necessity for the study in his order for the test. When ordering transcranial Doppler studies from an independent physiological lab or other provider, the ordering/referring physician must state the reason for the transcranial Doppler studies in his order for the tests.

Effective Date

This local medical review policy is effective for services processed on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

93922: Noninvasive Physiologic Studies of Upper/Lower Extremity Arteries

Noninvasive physiologic studies are functional measurement procedures that include Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurements, or plethysmography. These studies are useful to confirm and document arterial insufficiency.

The purpose of this policy is to define the circumstances for which Medicare of Florida will consider noninvasive physiologic studies of upper or lower extremity arteries to be medically necessary and, therefore, covered.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider noninvasive physiologic studies of the upper or lower extremity arteries to be medically necessary under any of the following circumstances (see "ICD-9-CM Codes That Support Medical Necessity"):

- Claudication of less than one block or of such severity that it interferes significantly with the patient's occupation or lifestyle. The diabetic patient with absent or diminished pulses with or without neuropathies may have no symptoms of claudication due to their neuropathy type symptoms. Slowing down of their gait patterns, also, may not cause claudication symptomatology.
- Rest pain (typically including the forefoot), usually associated with absent pulses, which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position.
- Tissue loss defined as gangrene or pregangreneous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses.
- Aneurysmal disease.
- Evidence of thromboembolic events.
- Evidence of compression/occlusion of the vascular structures supplying the upper extremity.
- Blunt or penetrating trauma (including complications of diagnostic and/or therapeutic procedures).
- For evaluation of dialysis access, see procedure code **93990**.
- Transcutaneous oxygen tension measurements (Tp02) are utilized in conditions for which hyperbaric oxygen therapy (HBO) is being considered, as well as for monitoring the course of HBO therapy. Medicare has identified on a national level the medical conditions covered for HBO therapy. The following conditions are considered medically indicated uses for Tp02 testing prior to, and during the course of, HBO therapy: acute traumatic peripheral ischemia, crush injuries and suturing of severed limbs, progressive necrotizing infections, acute peripheral arterial insufficiency, preparation and preservaton of compromised skin grafts, and soft tissue radionecrosis as an adjunct to conventional treatment.
- Transcutaneous oxygen tension measurements (Tp02) used to determine a line of demarcation between viable and non-viable tissue when surgery or amputation is anticipated.

A routine history and physical examination, that includes ankle/brachial indices (ABIs), can readily document the presence or absence of ischemic disease in a majority of cases. It is not medically necessary to proceed beyond the physical examination for minor signs and symptoms such as hair loss, absence of a single pulse, relative coolness of a foot, shiny thin skin, or lack of toe nail growth unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention. Examples of additional signs and symptoms that do not indicate medical necessity include:

- Continuous burning of the feet is considered to be a neurologic symptom.
- "Leg pain, nonspecific" and "Pain in limb" as single diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.
- Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.
- Absence of relatively minor pulses (e.g., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.

While the HBO Society has not published a practice parameter regarding the use of Tp02 to monitor the response to HBO therapy, literature supports repeating the Tp02 value after 20 treatments. Comparison is made with the baseline study to determine the response to therapy.

In general, noninvasive studies of the arterial system are to be utilized when invasive correction is contemplated, but not to follow noninvasive medical treatment regimens (e.g., to evaluate pharmacologic intervention). The latter may be followed with physical findings and/or symptoms.

HCPCS Codes

93922	Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)
93923	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924	Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study

ICD-9-CM Codes That Support Medical Necessity

440.0	444.81-444.89	903.5
440.20-440.24	447.0	903.8
440.30-440.32	447.1	904.0
441.00-441.03	447.2	904.1
442.0	707.1	904.41
442.3	707.8	904.51
443.0	785.4	904.53
443.1	903.00	904.6
443.81	903.02	904.7
443.9	903.1	996.1
444.0	903.2	996.70-996.79
444.1	903.3	998.11-998.13
444.21-444.22	903.4	998.2

Medical conditions covered by Coverage Issues Manual 35-10 for HBO therapy with associated transcutaneous oxygen tension measurements (Tp02):

444.21-444.22	904.41	928.00-928.01
444.81	927.00-	928.10-928.11
686.01-686.09	927.09	928.20-928.21
728.86	927.10-	928.3
733.41-733.49	927.11	928.8-928.9
902.53	927.20-	929.0-929.9
903.01	927.21	990
903.1	927.8	996.52
904.0	927.9	996.90-996.99

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

Duplex scanning (93925, 93926, 93930, and 93931) and physiologic studies (93922, 93923, and 93924) are reimbursed during the same encounter if the physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurysmal disease. Medical record documentation must demonstrate the medical necessity of performing both duplex scanning and physiologic studies on the same date of service.

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must clearly indicate the medical necessity of non-invasive physiologic studies of the upper or lower extremity arteries. Also, the results of arterial studies must be included in the patient's medical record. If performing procedure code 93924, documentation must include results of resting studies *and* after treadmill stress testing studies. This information is normally found in the office/progress notes and test results.

If the provider of the upper or lower extremity arterial studies is other than the ordering/referring physician, the provider of the service must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. When ordering arterial studies from another provider, the ordering/referring physician must state the reason for the studies in his order for the tests.

Vascular testing that is billed excessively may be considered medically necessary when there is a change in the patient's symptoms (acceptable ICD-9-CM code) or there is the presence of a new condition (acceptable ICD-9-CM code).

Effective Date

This local medical review policy is effective for services processed on or after December 20, 1999.

Advance Notice Requirement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 4 for details concerning ABNs. ❖

94664: Diagnostic Aerosol or Vapor Inhalation

Aerosol or vapor inhalation involves the administration of drugs or solution of drugs by the nasal or oral respiratory route for local or systemic effect. The drugs or solution of drugs commonly administered via a nebulizer or aerosol include distilled water, hypertonic saline, and bronchodilators such as anticholinergics and B-Agonists.

Inhalation therapy is used in the therapeutic treatment of patients with known lung disease, as well as for producing bronchodilation, mobilizing sputum, and inducing sputum production for diagnostic purposes.

This policy addresses the use of aerosol or vapor inhalation for sputum mobilization, bronchodilation, and sputum induction for diagnostic purposes.

If a patient is unable to produce sputum, inhalation of a nebulized solution of 3 or 4 ml of distilled water or hypertonic sodium chloride results in the induction of an adequate specimen for examination. Any type of nebulizer may be used; however, ultrasonic nebulizers, which produce a concentrated mist, are preferred. The procedure is terminated when an adequate specimen is obtained, the nebulizer solution is exhausted, or after a maximum of 15-20 minutes. The procedure is most often used for patients suspected of having tuberculosis or a lung malignancy, and to search for *Pneumocystis carinii* infection in patients with the acquired immunodeficiency syndrome (AIDS).

Indications and Limitations of Coverage and/or Medical Necessity

Medicare of Florida will consider the use of an aerosol or vapor inhalation for diagnostic purposes medically reasonable and necessary for the following indications:

- For the induction/mobilization of sputum in a patient who presents with signs and symptoms of a respiratory infection (e.g., fever, dyspnea, chest congestion, cough) or suspected lung malignancy, and who is unable to produce an adequate sputum specimen for examination by conventional methods;
- For the induction/mobilization of sputum in a patient who continues to demonstrate signs and symptoms of a respiratory infection (e.g., fever, dyspnea, chest congestion, cough) despite antibiotic treatment, and who is unable to produce an adequate sputum specimen for follow-up examination by conventional methods; and/or
- To produce bronchodilation prior to a pulmonary function test (PFT), when the patient's functional ability to perform the test is decreased and would otherwise result in an inconclusive finding.

HCPCS Codes

94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation
94665	subsequent

ICD-9-CM Codes That Support Medical Necessity

135	486	515
162.0-162.9	490	517.1-517.8
197.0	491.0-491.9	518.0-518.89
197.3	492.0-492.8	786.02-786.09
212.2	493.00-493.91	786.2
212.3	494	786.3
231.2	495.0-495.9	786.4
446.20	496	793.1
466.0-466.19	508.0	E945.8

Reasons for Denial

When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Noncovered ICD-9-CM Code(s)

Any diagnosis codes not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy.

Coding Guidelines

HCPCS codes 94664 and/or 94665 are not to be used in addition to a bronchospasm evaluation (94060). The bronchodilation is included in the reimbursement for 94060.

HCPCS codes 94664 and/or 94665 are not to be used when performing a therapeutic inhalation treatment for a chronic or acute condition. The appropriate therapeutic HCPCS code (94640-94651) should be used.

HCPCS code 94665 should only be used when a patient continues to demonstrate signs and symptoms of a respiratory infection (e.g., fever, dyspnea, chest congestion, cough) despite antibiotic treatment, and is unable to produce an adequate sputum specimen for follow-up examination by conventional methods.

Documentation Requirements

Medical record documentation (e.g., office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity for performing the service. The documentation must also support that the service was performed for sputum induction/mobilization or bronchodilation for diagnostic purposes, and according to the criteria set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Effective Date

This local medical review policy is effective for services processed on or after December 20, 1999.

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 4 for details concerning ABNs. ❖

ELECTRONIC MEDIA CLAIMS

Adoption of Standard Electronic Health Care Transaction Formats

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 contain a number of requirements designed to improve and simplify the administrative demands on providers of health care. Although use of electronic health care transactions has grown significantly, especially for Medicare, providers have complained that different health plans have different format requirements for transactions. Even when the same format is accepted by multiple plans, those plans usually have different coding or other completion requirements for the formats. This forces providers to be able to respond to each plan's separate requirements if the providers want to be able to interact electronically with those plans for billing, payment, eligibility, claim status query, and a number of other health care transactions. This is inefficient, expensive, and confusing.

HIPAA will remedy those complaints. Providers will begin to experience the benefits of HIPAA on electronic health care transactions within the next few years. As this may have some significant impact on operations and planning for billing/practice management systems, Medicare plans a series of educational efforts to furnish the information that may be needed to make informed choices. In addition, information will also be shared with professional associations, their publications, and national media to publicize the impact of these changes.

HIPAA Administrative Simplification Summary Background

HIPAA requires that the Secretary of the Department of Health and Human Services adopt standards for electronic transactions and data elements for those transactions, standard code sets to be used in the transactions, unique health identifiers, and security standards and safeguards for electronic information systems involved in those transactions. This article is limited to information on the HIPAA transaction standards. **Unique health identifier, standard code set, and security issues will be addressed in future issue of the *Medicare B Update!***

The following health care transaction standards are specified:

- Health claims or equivalent encounter information,
- Enrollment and disenrollment in a health plan,
- Eligibility for a health plan,
- Health care payment and remittance advice,
- Health plan premium payments,
- Health claim status,
- Referral certification and authorization,
- First report of injury,
- Coordination of benefits, and
- Attachments

A proposed rule was published in the *Federal Register* on May 7, 1998, to adopt certain version 4010 electronic formats developed by the American National Standards Institute (ANSI) accredited X12N subcommittee as the national standards for each of the specified electronic health care transactions (except attachments and first report of injury) and National Council for Prescription Drug Programs (NCPDP) electronic formats for retail pharmacy transactions. Those X12N standards are the 837 (claims, encounters, and coordination of benefits), 834 (enrollment and disenrollment), 270/271 (eligibility query and response), 835 (payment and remittance advice), 820 (premium payments), 276/277 (claim status inquiry and response), and 278 (referral certification and authorization). Publication of the final rule for those transactions is expected later this year. The attachments transaction proposed rule is also expected to be published later this year, and a first report of injury transaction proposed rule should be published next year.

HIPAA requires that the adopted standards be implemented by virtually all health plans in the United States (including, but not only, Medicare and Medicaid) who perform the business function related to each standard transaction regardless if that function is performed electronically, in paper form, by telephone or in another mode, and by providers of health care that transmit any of these transactions electronically. Providers that exchange any of these transactions electronically with health plans must either transfer transactions that comply with the implementation guides adopted in the final rule, or contract with a clearinghouse to translate their transactions into or from the standard formats. If a provider chooses to contract with a clearinghouse for these translation services, the provider is responsible for the clearinghouse charges and the accuracy of the translations performed by that clearinghouse.

Moreover, health plans that conduct these transactions electronically must be able to receive and send standard transactions that comply with the requirements in the published implementation guides. Effective with implementation of these standard transaction formats, a plan may not require that electronic transactions of these types be exchanged in any other format. Nor may a provider or a plan use a trading partner agreement to override, substitute or otherwise change any requirement or condition of use of any part of a standard transaction's implementation guide.

A health plan that is unable to directly exchange electronic transactions in a standard format can contract with a clearinghouse to translate incoming and outgoing transactions to comply with the standard format requirements. If a health plan chooses this option, it cannot charge providers or other clearinghouses who choose to use the standards for those translation costs. Nor may a plan delay or disadvantage processing of transactions that are submitted or issued in a standard format.

HIPAA does *not* require that providers submit claims or receive remittance advices electronically. Nor does

HIPAA require that providers submit electronic queries and receive electronic responses for claim status and eligibility. Providers may continue to make mail and telephone inquiries if they prefer. HIPAA does, however, make it easier and more cost-effective to use electronic transactions with the expectation that these improvements will result in greater use of electronic data interchange (EDI). Medicare contractors will continue to issue free billing software for a nominal handling fee that can be used by providers to electronically bill Medicare.

HIPAA requires that the transaction standards be implemented by most health plans and "electronic" providers within 2 years of the effective date of publication of the final rule in the *Federal Register***.** Certain "small" health plans will be allowed three years for implementation. Due to the number of providers involved and the need for system testing with those providers, Medicare expects to have a 12-15 month transition period during which electronic providers will convert to the HIPAA version of the transaction standards.

What This Means for Providers

Once the transaction standards are implemented nationally, a provider will be able to submit the same transaction in the same format to any health plan equipped for the receipt of electronic transactions of these types. Similarly, an "electronic" provider will receive transactions of these types from any plan in the same format. This will make it more cost-effective for most health care providers to use software to automatically produce standard transactions to send to plans, and to automatically post data directly to accounts receivable. HIPAA will reduce the need for manual processing in the day-to-day processing of patient account information.

However, many providers and plans may need to make some significant changes to realize the benefits of HIPAA. Once the HIPAA transaction standards are fully implemented, Medicare will no longer accept flat-file electronic UB-92 or National Standard Format (NSF) transactions for claims. Nor will Medicare issue any electronic remittance advices in the NSF format, or exchange any electronic transactions of the type specified by HIPAA, such as eligibility queries/responses, in any version not adopted as a national standard in the final rules for Administrative Simplification transaction standards.

Where a provider currently uses a clearinghouse to translate outgoing or incoming electronic transactions, he or she can continue to use a clearinghouse capable of HIPAA standard format translation for those services. If a provider does not use a clearinghouse, he or she must choose whether to install software that can send and receive in the HIPAA transaction standard or contract with a clearinghouse for this service.

Providers that do not currently electronically transmit some or any of the transactions affected by HIPAA should re-examine their situation to see if it would be cost-effective for them to begin to use or expand their use of EDI. The Medicare EDI staff can provide information about the advantages of EDI, requirements for EDI, vendors that may be able to help providers to become EDI capable, and on the impact of the HIPAA transaction standards.

Medicare carriers, other than Durable Medical Equipment Regional Carriers (DMERCs), and intermediaries are already able to receive claims in the X12N 837 format and issue remittance advices in the X12N 835 format, although in an earlier version than is expected to be adopted for national use under the final transactions rules for HIPAA. In fact, the X12N 835 is the only electronic remittance advice intermediaries may send. Medicare contractors are also able to accept eligibility inquiries electronically and respond electronically, but not in an X12 format, and will need to convert to use of the X12N 270/271 formats for this. Medicare has not previously required that contractors use any of the other electronic transactions mentioned in HIPAA, but Medicare will implement those that apply to Medicare operations when the Administrative Simplification transactions are effective. DMERCs will also convert to sole use of the HIPAA X12N standards at that time.

What Medicare Providers Can Do Now

Providers and their clearinghouses that would like to get an early start learning about the X12N transactions, or that are otherwise considering changing from their current use of an electronic UB-92 or NSF, may wish to consider upgrading *after January 2000* to the latest X12 claim and/or remittance advice version available from their Medicare carrier or intermediary. While not identical to the HIPAA transaction version that will likely be implemented, they are very similar. Use of a version 3051 claim or 3051.4 remittance advice now should make the subsequent transition to the HIPAA version much easier for those providers, and familiarize those providers with the X12N format rules and syntax, facilitating use of the other HIPAA transactions as they are implemented by Medicare and other payers. This would probably also put those providers into position to transition to the HIPAA transaction standards at the earliest possible time, allowing them to be the first to realize the benefits of Administrative Simplification.

How to Get More Information

Medicare will issue additional information regarding the HIPAA transaction standards as the final rules are published. Providers that would like to obtain more information about EDI under Medicare and HIPAA may also want to consult the following Web sites:

- EDI standards currently used by Medicare—**www.hcfa.gov/medicare/edi/edi.htm**
- X12N version 4010 transaction implementation guides—**www.wpc-edi.com/hipaa**
- Text of Administrative Simplification law and regulations—**http://aspe.os.dhhs.gov/admnsimp**
- X12N meeting and workgroup meeting information and minutes—**www.disa.org** (select the Insurance, X12N, Subcommittee)

Providers who would like to increase their use of EDI, including use of X12N transactions already implemented by Medicare, should contact Provider Electronic Services Marketing at (904) 791-8767.

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.

FRAUD AND ABUSE

Floridians Can Help Fight Medicare Fraud and Abuse

Medicare fraud drains money from the Medicare program. The current national estimate for Medicare fraud, waste, and abuse is *$12.6 billion.* This represents *7.1 percent of all claims processed*. Floridians should care about this fraud, because it drives health care costs higher, and it may affect the quality of patient care. Medicare recipients and providers can protect their Medicare dollars by partnering with Medicare to help fight fraud and abuse.

Fraud means knowingly and willfully attempting to defraud the Medicare program of its benefit dollars for claims that are deceptively filed. Most times, Medicare fraud involves payment in some form, resulting from inappropriately filed claims or other documents. However, other types of fraudulent activities—or "scams"—not specifically affecting Medicare payments *can* directly affect Medicare *beneficiaries* and Medicare *providers*. The following information describes two "scams":

"Refunds from Medicare"

Recently, many Medicare beneficiaries throughout the United States have received notices from a private company (not affiliated with Medicare or the federal government). These notices advise Medicare beneficiaries that they may eligible for a "refund" on their Medicare premiums from the Medicare program. The notices include instructions on how to obtain the so-called "refund."

- The beneficiaries are instructed to call a "900" telephone service (at $4.95 per minute).
- The message on the "900" service again tells beneficiaries that they may be eligible to receive refunds, and it further instructs them to call the Social Security Administration "800" telephone number.
- Further instructions suggest that callers send $20 to a certain address, to receive information concerning "changes" in the Medicare program.

Unfortunately, this entire activity is a scam. There are no refunds of beneficiary premiums.

In limited situations, certain individuals may qualify for a discount; but there are *no refunds.* In addition, the information that a beneficiary may have paid $20 for is nothing more than the *Medicare handbook*—which is *free to all Medicare recipients.*

As mentioned above, this particular scam does not involve *direct* payments from the Medicare program. However, the victims of this fraud are often Medicare beneficiaries. Be alert! Don't get "taken."

"Seminar Attendance is Required"

A private consulting firm (not affiliated with the Medicare program) is advertising to physicians about *its own* Medicare seminars. This is not illegal. No regulations prohibit private organizations from conducting seminars or providing information about the Medicare program.

However, this organization has misrepresented itself as "Medicare" and has advised physicians that attendance at the firm's seminars is *mandatory*. The advertising also suggests that physicians could lose their Medicare participation status if they do not attend the consulting firm's seminars. And, as with most scams, money is involved. Physicians must pay a fee to attend the "mandatory" seminars.

There are no regulations that require attendance at Medicare seminars; nor are there any punitive actions if a provider does not attend one. Attendance at any seminar is *voluntary*, whether the seminar is sponsored by a Medicare contractor or a private company.

How to Help

Health care providers and Medicare beneficiaries should exercise caution when responding to advertising regarding the Medicare program. If there is a question about the information's legitimacy, the Medicare contractor may be contacted for assistance. If false or fraudulent activities are suspected, these should be reported to the Medicare contractor or to the Office of the Inspector General's fraud hot line at 1-800-HHS-TIPS. ❖

Physician and Nonphysician Practitioner Liability for False or Fraudulent Claims

Some physicians and nonphysician practitioners may not be aware that they are liable for any false or fraudulent claims filed on their behalf by staffing and/or billing agencies. Providers should never knowingly or willfully present or cause to be presented false or fraudulent claims for payment by Medicare or other federal health care program(s). ❖

GENERAL INFORMATION

Assignment of Group Provider Numbers And Enrollment of Nonphysician Practitioners

The Medicare Registration Department has received numerous requests for assignment of provider numbers to nonphysician practitioners. In most cases, these nonphysician practitioners are requesting reimbursement under a tax identification number (TIN) belonging to their employer or legal business name under which whom they contract. Whenever a nonphysician practitioner is approved to receive reimbursement under a TIN that is active on the Medicare Part B file, the legal business will be assigned a group provider number for billing. The individual currently being reimbursed under the TIN and the nonphysician practitioner will be assigned a group member provider number (normally a five-digit alphanumeric number with an alpha suffix).

If a request is received from a nonphysician practitioner for reimbursement to be generated under a TIN that is not active in the Medicare system, completion of a general enrollment application (HCFA 855) will be required from the legal business name belonging to that TIN. No group provider number or group member provider number will be assigned until the HCFA 855 (for the entity) *and* HCFA 855R (for each member) are received .

See examples below:

EXAMPLE 1
Information On Medicare File
TIN = 111111111
Legal Business Name: Joseph Magilicutty MD PA
Provider Number = 11111

Applications (HCFA 855 and HCFA 855R) are received for John Brown, PA (physician assistant), to receive reimbursement under TIN 111111111. Since this TIN has already been enrolled, legal business name "Joseph Magilicutty MD PA" will receive a group provider number. Joseph Magilicutty, MD, **and** John Brown, PA, will receive group member provider numbers.

EXAMPLE 2
Information On Medicare File
SSN = 999999999
Name On File: Joseph Magilicutty, MD
Provider Number 11111

Applications (HCFA 855 and HCFA 855R) are received for John Brown, PA (physician assistant), to receive reimbursement under TIN 111111111 and legal business name "Joseph Magilicutty MD PA". Legal business name "Joseph Magilicutty MD PA" must complete a HCFA 855 for assignment of a group provider number since the TIN has not been enrolled. Joseph Magilicutty, MD, must complete a HCFA 855R, for assignment of a group member number. John Brown, PA, may not receive a Medicare Part B provider number until the legal business (Joseph Magilicutty, MD PA) has enrolled.

Nonphysician practitioners enrolling into the Medicare Part B Program that do not have an active Florida Medicare provider number must complete a General Enrollment application (HCFA 855).

Whenever an employee/employer is indicated on a HCFA 855R, a copy of a W2 or W4 must be attached.

Whenever applications request a tax identification number and/or social security number, it must be provided. ❖

Addition to List of Approved Liver Transplant Centers

The following facility has been added to the list of approved liver transplant centers that was published in the March/April 1999 *Medicare B Update!* (page 69):

Name and Address	Effective Date
Tampa General Hospital 409 Bayshore Boulevard Tampa, Florida 33606	August 3, 1999

❖

Crossover Updates

The following updates have been performed to the Medicare Part B of Florida Crossover Insurers list. These changes can be viewed on the Florida Medicare Online Bulletin Board System (BBS) in the Medigap Crossover Listing section.

For additional information concerning Medicare Part B Crossover, please refer to the ***"A Closer Look"*** section of the September/October 1998 edition of the *Medicare B Update!*

Automatic Crossover

New Crossover Insurer

The following private insurer has been added to our list of Automatic Crossover Insurers.

Olympic Health Management

Updates to Crossover Insurers

Health Data Management Corporation (HDM)

HDM added Plans Administer for:

Celtic Life Insurance

USAble Life Insurance Company

Medigap Crossover

Address Change

Number	Insurer Name/Address
45072	Commonwealth Life Ins PO Box 190240 Atlanta GA 31119
42065	Guardian 7 Hanover Square New York NY 10004 ❖

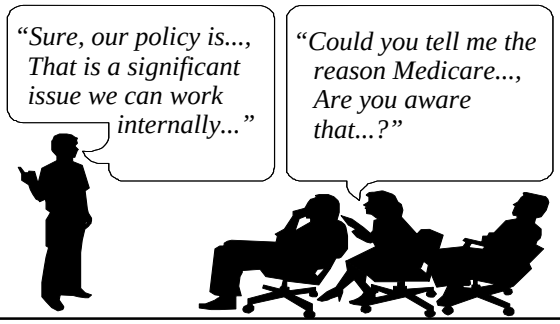
EDUCATIONAL RESOURCES

Medicare Part B "Let's Talk" Session

Do you have questions or issues you want to bring to the attention of the Medicare Carrier's Leadership? Would you welcome an opportunity to discuss your concerns face-to-face with representatives from the many departments within Medicare?

If yes, then come join us for a —

"LET'S TALK" SESSION



WEDNESDAY DECEMBER 8, 1999
JACKSONVILLE, FLORIDA

Reasons You Should Register To Participate:

1. Have an opportunity to effect change in the Carrier's processes
2. Receive focused attention on outstanding or unresolved claims and issues
3. Receive advice on how to improve reimbursement efficiency for your office
4. Establish a communication network with department representatives who can assist in resolving your issue
5. Dialogue face-to-face with representatives from Registration, Medical Policy, Financial Services, Claim Operations, Medicare Secondary Payer, Fraud and Abuse, and others.

Pre-registration and pre-payment are required.

Only $49 per person.

Seating is limited, so secure your reservation today!

Agenda
8:00-8:30 Continental Breakfast in the reception area. Talk to departmental representatives who are specialists in their areas.
9:00-12:00 Panel Discussion. Carrier Leadership introductions and open dialogue on the issues raised by attendees.

See registration form on the following page for more details.

MEDICARE PART B PROVIDERS

Would You Like to Discuss Billing and/or Program Issues With Your Medicare Part B Representatives?

First Coast Service Options, Inc., is offering you the opportunity to discuss your questions or concerns (face-to-face) with representatives from the many departments within Medicare. Help us help you! We are excited about the opportunity to meet you and address/resolve your inquiries. Register for Medicare's first **"LET'S TALK" SESSION**, **December 8, 1999**.

To help us address your questions and/or concerns, please complete this survey and fax it to: **Medicare Education and Outreach at (904) 791-6035 no later than Monday, November 15, 1999**.

Describe specific topics that require further clarification. Include examples and/or any supporting documentation.

Claims Submission *(e.g., claim filing questions, unprocessable claims, denials, etc.)*

_____
_____
_____

Electronic Claim Submissions *(e.g., electronic funds transfer, mailbox questions, PC-ACE™, etc.)*

_____
_____
_____

Inquiries, Appeals, and Overpayments *(e.g., questions about reviews, customer service, returning money to Medicare, etc.)*

_____
_____
_____

Medical Policy/Review *(e.g., medical review process, utilization denials, etc.)*

_____
_____
_____

Specialty *(e.g., chiropractic, radiology, pathology questions, etc.)*

_____
_____
_____

Other

_____
_____
_____

"LET'S TALK" SESSION with the Management/Leaders of First Coast Service Options, Inc.
December 8, 1999 — 532 Riverside Ave., Jacksonville FL

Four Important Steps:

Step 1 Fax this form and the "Lets Talk" questionnaire to: (904) 791-6035

Step 2 Make checks payable to:
First Coast Service Options
Account # 756240
Cost: ***$49 per person.***

Step 3 After you have faxed your forms, please mail them and the payment to:

Seminar Registration
P.O Box 45157
Jacksonville, FL 32231

Step 4 You will receive a confirmation number. Please bring this with you the day of the event.

All cancellations requests must be received seven days prior to the seminar to receive a refund.

Registration Form

Registrant's Name: _____

Registrant's Title/Position: _____

Provider's Name: _____

Medicare Billing Provider/Group Number: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Note: ***Please complete one form per person***.

Medicare Offers FREE National Education Programs

The Health Care Financing Administration (HCFA) has partnered with First Coast Service Options, Inc. (FCSO), the Florida contracted carrier and intermediary, to launch a series of FREE education and training programs designed to give healthcare providers the opportunity to study various topics about Medicare benefits, coverage and billing rules. Leveraging Internet-based training and satellite technology to make Medicare education more readily available to healthcare providers throughout the nation saves on travel, challenging schedules and missed office hours. This approach also helps Medicare providers and beneficiaries avoid potential problems before they occur, further reducing waste, fraud, and abuse.

Medicare Computer Based Training

Computer Based Training Courses via the Internet

Healthcare providers can download FREE Medicare computer based training (CBT) courses that will help them strengthen their understanding of a variety of topics related to Medicare. The current Medicare library has several self-paced courses that are available 24 hours a day, seven days a week. These courses include:

- ICD-9-CM Coding
- Front Office Management
- HCFA-1500 Claims Filing
- HCFA-1450 (UB92) Claims Filing
- Medicare Fraud & Abuse
- Medicare Home Health Benefit
- Medicare Secondary Payer
- Introduction to the World of Medicare

Here's How it Works:

Users visit the Medicare Online Training Web Site at **www.medicaretraining.com** and click on "Computer Based Training'' to download the course(s) of their choice. Once a course is downloaded and set up on their PC, users are then able to take the courses at their leisure. The site provides complete step-by-step instructions on how to download and set up the courses.

CBT System Requirements:

- Windows 95, 98 or NT
- mouse
- VGA color monitor

CBT offers users the flexibility to have control over their learning environment. In every course, users are given the opportunity to practice what they've learned through quizzes and tests. After each test is taken, users are given full access to their results, instantly. Users can take as long as they want to complete each lesson and they can take them as often as they like.

The Medicare Online Training Web Site gives Medicare contractors yet another channel to reach new audiences, build new partnerships, and deliver up-to-date materials and services. To date, the site has recorded more than 20,000 course downloads. HCFA and FCSO welcome your participation in this overwhelmingly successful program. Please visit the Medicare Online Training Web Site at **www.medicaretraining.com**.

Medicare Satellite broadcasts

Courses via Satellite Broadcast

When everyone better understands Medicare guidelines, appropriate services are rendered, claims are filed correctly, providers are paid timely (and accurately) and beneficiaries obtain the care and good service they are entitled to receive. The use of satellite technology gives healthcare providers the opportunity to share a nationwide "virtual" classroom and participate in "live" presentations. Participants retain the interactivity offered in a live seminar, as most programs offer a tollfree hotline for participants to call or to fax questions during the broadcast. The following broadcasts are currently scheduled:

Steps to Promoting Wellness: Adult Immunizations
Available on Videotape from the June 1999 National Satellite Broadcast

Medicare Fraud and Abuse: Proactive Measures to Avoid Becoming a Victim
Available on Videotape from the July 1999 National Satellite Broadcast

Steps to Promoting Wellness: Women's Health
Available on Videotape from the August 1999 National Satellite Broadcast

The Medicare Resident Training Program
Available on Videotape from the September 1999 National Satellite Broadcast

Time and distance have very little meaning in computer-based training and satellite broadcasting education. Additional computer-based training courses and satellite broadcasts are currently being planned. To access the computer-based training courses, a complete list of satellite-based courses, host sites, dates, times, and video availability, please visit the Medicare Online Training Web Site at **www.medicaretraining.com** or the "Learning Resources" section of HCFA's web site at **www.hcfa.gov**.

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. ❖

Using Windows 95/NT/98 To Access "Medicare Online BBS"

What is Medicare Online BBS?

Medicare Online BBS is an electronic Bulletin Board System (BBS) maintained at Medicare of Florida. It enables you to access vast amounts of important Medicare A and B claims processing information. This BBS is available to anyone (with no restrictions), from anywhere even outside Florida, and is available 24 hours a day, 7 days a week. Access can be obtained by using your office and/or home computer, via a TOLLFREE telephone number. All you need is a computer, telephone line, modem, and communications software. The following are instructions for using a communications program included within Windows 95/NT/98 operating systems.

Using HyperTerminal

Windows 95/NT/98 include a communications program called HyperTerminal that will allow you to connect to the Medicare Online BBS. The program includes a simple setup "wizard" used to establish your connection.

Step 1: Accessing HyperTerminal

To access the HyperTerminal program: from the Start menu, click Programs, then Accessories, then HyperTerminal.

Step 2: Setup Wizard

Look for the icon labeled "HyperTerminal", "Hypertrm", "HyperTrm.exe" or "HYPER.TRM". Double-click this icon to start the setup wizard.

Step 3: Connection Description

The setup wizard will ask you to name the connection and select an icon. Name the connection Medicare Online BBS (or any name you like), select the icon you want to use by clicking on it, and click OK. It doesn't matter which icon you use; you can change it later if you like.

Step 4: Phone Number

The setup wizard will ask you for the phone number to dial. Enter the appropriate phone number and then click OK.

All users outside Jacksonville, FL
(800) 838-8859

Users within Jacksonville, FL, area
791-6991

Step 5: Dialing Properties

The setup wizard allows you to revise dialing properties to make your connection. Click on Dialing Properties. Revise settings appropriately under "How I dial from this location": how your location accesses an outside line (e.g., "9" for an outside line), long distance access (e.g., "1" for long distance), and disabling call waiting (click on selections available and choose appropriately: e.g., "*70"). When complete, click OK.

Step 6: Connect

The setup wizard will ask you to make the connection (call). At this time choose Dial to call the Medicare Online BBS.

Step 7: Signing On To Medicare Online BBS

If you are a new user to the Medicare Online BBS, type *NEW* when the system asks for your User ID. You will then complete a brief questionnaire (registration) about your practice/office, along with allowing you to assign your own User ID and password. It's very important that you write your User ID and password down exactly as you entered it (including any special characters), as you will need it for future access to the BBS.

That's it! - When you sign off the Medicare Online BBS and then exit HyperTerminal, be sure to save this new connection when prompted. The next time you open HyperTerminal, you will have an icon in this group titled "Medicare Online BBS." Simply double-click on this icon to connect in the future.

Need Help? - If you have any questions or need assistance with the Medicare Online BBS, contact our BBS Help Line at (904)791-8384. When leaving your message, please speak slowly and clearly when leaving your company name, contact name, telephone number, and detailed description of your inquiry. Existing users should also leave their User ID. Please do not leave your password.

FREE Windows-Based Communications Software

We suggest you try this program; it's more user friendly than the terminal access (which HyperTerminal uses) and makes downloading easier. Once you access the BBS, you can download this program by selecting (M) at the Main Menu. If you are unable to use your existing communication software to access the BBS to download this program, it can be mailed to you. Fax your request to (904)791-6035, or contact the BBS Help Line at (904)791-8384. ❖

HCFA Web Site for Beneficiary Outreach Events

The Health Care Financing Administration (HCFA) has established an Internet-based database of Medicare outreach events. This database will feed into a nationwide calendar of events that can be accessed by beneficiaries on Medicare's beneficiary Web site. The address for that site is:

www.medicare.gov

HCFA is widely promoting the database as a source of information for members of Congress, key members of the Department of Health & Human Services, and other national and corporate partners. In addition, the Customer Service Representatives at 1-800-MEDICARE will tell beneficiaries about local and national events when they call for information.

First Coast Service Options, Inc. (FCSO), the Medicare carrier for Florida, encourages providers to share this information with their Medicare patients. It's a great way for beneficiaries to find answers to their Medicare questions. Additionally, FCSO's Medicare Education and Outreach department (MEO) has a number of *free* educational services available for both beneficiaries and providers. Please refer to the September/October 1999 issue of the *Medicare B Update!* (page 60) for more information regarding these *free* services.

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ORDER FORM - PART B MATERIALS

The following materials are available for purchase by Medicare providers. To order these items, please complete and submit this form along with your check/money order payable to **First Coast Service Options, Inc. with the account number listed by each item.** ***PLEASE NOTE:*** Payment for fee schedules **cannot be** combined with payment for other items; separate payments are **required** for purchases of items from different accounts.

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Update!*** **Subscription** - For non-provider entities or providers who need additional copies at other office locations, an annual subscription is available. This subscription includes all issues published during calendar year 2000 (back issues sent upon receipt of order).	756245	$75.00
_____	**2000 Fee Schedule -** ***Available late November*****.** Available in booklet or diskette format. Contains 2000 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2000. These items include the payment rates for injectable drugs, but *do not* include payment rates for clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* The diskette contains fixed-length ASCII text files of the 2000 physician fee schedule. File layout specifications are included on the disks, and these files can be imported into standard spreadsheet or database programs.	756250	**Booklet** $20.00 **Diskette** $20.00
_____	**Procedure/Diagnosis Relationship File** - This is a printout of the most current file used during claims processing to determine coverage for procedures subject to specific diagnosis criteria. This document is designed to assist providers by outlining coverage criteria in order to limit their financial liability for these procedures.	756245	$15.00

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

Medicare Part B
Medicare Education and Outreach
P.O. Box 2078
Jacksonville, FL 32231-0048

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please make check/money order payable to: BCBSFL- FCSO Account # (fill in from above)

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID -

DO NOT FAX - PLEASE PRINT

ORDER FORM - MEDIFEST AND SPECIALTY SEMINAR BOOKS

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	**1999 Medifest Book** - This is the same manual provided to Medifest attendees and includes information on claim form completion instructions, local medical review policies, home health services and more.	756245	$85.00
_____	**1999 Specialty Seminar Books** - This is the same manual provided to specialty seminar attendees and includes information on coding, coverage and medical policy, ICD-9-CM, primary care, evaluation and management documentation guidelines and more. _____ ASC _____ Ambulance _____ Anesthesia _____ Cardiology _____ Dermatology _____ Home Health _____ IDTF _____ Mental Health _____ Nurse Practitioner/CNS/Physician Assistant _____ Oncology (Medical and Radiation) _____ Orthopaedics _____ Pathology _____ Podiatry _____ Radiology _____ Urology	756245	$25.00 **per book**

NOTE: Please indicate (X) the books you would like to purchase.

Subtotal $ _____

Tax (6.5%) $ _____

Total $ _____

Mail this form with payment to:

Medicare Part B
Medicare Education and Outreach
P.O. Box 2078
Jacksonville, FL 32231-0048

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

Index by Procedure Code

HCPCS Codes

A0000-Z9999

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

Anesthesia/Surgery

00100-69979

Diagnostic Tests

70010-89399

Medicine

90281-99199

Evaluation and Management

99201-99499

Special *Updates!*

*** Signifies a *SPECIAL* or *SPECIALTY UPDATE!* See last page of index for title.**

IMPORTANT ADDRESSES

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

Administrative Law Judge Hearing
Administrative Law Judge Hearing
P. O. Box 45001
Jacksonville, FL 32231-5001

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 32231-0048

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 32231-2537

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 32231-1109

Provider Education: For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Education and Outreach
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32231

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 32231

PHONE NUMBERS

BENEFICIARY

Outside Duval County (in Florida):
(800) 333-7586
Duval County (or outside Florida):
(904) 355-3680
Hearing Impaired:
(800) 754-7820

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

PROVIDERS

Express Line/ARU Status Inquiries:
(904) 353-3205
Specialty Customer Service Reps:
(904) 634-4994

EMC

Format Issues & Testing:
(904) 354-5977
Start-Up & Front-End Edits/Rejects:
(904) 791-8767
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
(904) 791-6895
PC-ACE Support:
(904) 355-0313
Help Desk
(Confirmation/Transmission):
(904) 791-9880

OCR

Printer Specifications/Test Claims:
(904) 791-6912

MEDICARE ONLINE BBS

Access:
(800) 838-8859
(904) 791-6991
Technical Problems:
(904)791-8384

Medicare Part B Publications
P.O. Box 2078
Jacksonville, FL 32231-0048