Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Highlights In This Issue...

Features

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Issues published beginning in 1997 are available at no cost from our provider Web site, **www.floridamedicare.com.**

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

_____

_____

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

TABLE OF CONTENTS

Medicare B Update!

Vol. 15, No. 3
Third Quarter 2002

Publications Staff
Betty Alix
Bill Angel
Shari Bailey
James Griffith
Millie C. Pérez

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

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

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

A PHYSICIAN'S FOCUS

Medicare by the Numbers

It seems as though a sea of numbers increasingly surrounds us on every imaginable subject. I thought it might be interesting to provide some numbers associated with Medicare for your information and consideration. To put the numbers in perspective, consider the following: if your heart beats at one beat per second and you had to buy each beat for one dollar, then one million dollars would buy you 11.57 days, 1 billion dollars would buy you 31.7 years, and 1 trillion dollars would buy you 31,709 years.

With that said, here are some historical and current figures associated with the Medicare program.

19,500,000—Number of persons with Medicare in 1967.
39,600,000—Number of persons with Medicare in 2000.
2,100,000—Number of persons with traditional Medicare in Florida in 2001.
638,513—Number of persons with Medicare enrolled in managed care in Florida in 2001.
68.2—Life expectancy in 1950.
76.7—Life expectancy in 1998.
6,707—Number of inpatient hospital facilities in 1975.
5,985—Number of inpatient hospitals in 1999.
800,000—Number of Medicare certified beds in short-stay hospitals at the beginning of the program.
1,025,000—Number of Medicare certified beds in short-stay hospitals in 1984-86.
875,000—The most recent count of Medicare certified beds in short-stay hospitals.
92,000,000—Number of days of Medicare/short-stay hospitalization in 1985.
$597—Total charges per day of hospital care in 1985.
71,000,000—Number of days of Medicare/short-stay hospitalization in 1999.
$2,495—Total charges per day of hospital care in 1999.
252,000—Number of persons with Medicare served in skilled nursing facilities in 1982.
1,510,000—Number of persons with Medicare served in skilled nursing facilities in 1998.
67,000—Number of enrollees with end-stage renal disease (ESRD) in 1980.
270,000—Number of enrollees with ESRD in 1999.
999—Number of ESRD facilities in 1980.
3,787—Number of ESRD facilities in 1999.
$205—National health expenditures per person in 1965.
$4,358—National health expenditures per person in 1999.
$3,200,000,000—Medicare benefit outlay in 1967.
$215,000,000,000—Medicare benefit outlay in 2000.
$1,211,000,000,000—National health expenditures in 1999, 13 percent of the gross domestic product .
$299,100,000,000—CMS (the Centers for Medicare & Medicaid Services - formerly HCFA) program outlays in 1999, 17.6 percent of the Federal budget.
719,600,000—Number of Medicare Part B claims processed in 1999.
$595,800,000—Cost of processing Medicare Part B claims in 1999.
62,000,000—Number of Medicare claims processed by First Coast Service Options, Inc. (FCSO) in 2001.
122,000—Number of Medicare written inquiries answered by FCSO in 2001.
2,900,000—Number of Medicare telephone inquiries answered by FCSO in 2001.
$5,500,000,000—Medicare payments to Part A Florida providers in 2001.
$4,700,000,000—Medicare payments to Part B Florida providers in 2001.
$530,000,000—Medicare dollars saved or recovered from FCSO's Medicare Integrity Program (MIP) in 2001.
100%—Percentage of MIP savings and recoveries retained by or returned to U. S. Government.

When President Lyndon B. Johnson signed the first Medicare law on July 30, 1965, he stated:

> No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations.

These numbers indicate that the nation has committed significant resources to meet that original promise.

Sincerely,

Sidney R. Sewell, MD
Medical Director

ADMINISTRATIVE

About the *Medicare B Update!*

The *Medicare B Update!* is a comprehensive magazine published quarterly for all Part B providers in the State of Florida. In accordance with notification requirements established by the Centers for Medicare & Medicare Services, approximate delivery dates are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2002	Mid-November 2001	January 1, 2002
Second Quarter 2002	Mid-February 2002	April 1, 2002
Third Quarter 2002	Mid-May 2002	July 1, 2002
Fourth Quarter 2002	Mid-August 2002	October 2002

Important notifications that require communication in between these dates will be posted to the First Coast Service Options, Inc. Florida provider Web site, **www.floridamedicare.com**. In some cases, additional unscheduled special issues will be published.

Who Receives the *Update?*

Distribution of the *Update!* is limited to individual providers and Professional Association (PA) groups who bill at least one Part B claim to Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing copies to *all* practice settings. This primarily affects members of PA groups; one copy of each issue is sent to the group. The group is responsible for dissemination of each copy to its members. For additional copies, providers may purchase a separate annual subscription for $75 (order form on page 75). Issues published since January 1997 may be downloaded from our Web site, free of charge.

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

What is in the *Update?*

The *Update!* is divided into several sections, starting with a letter from the **Carrier Medical Director**. Following is **Administrative** information, then **Claims**, which provides claims submission requirements and tips. Correspondence (appeals and hearings) information is in this section. **Coverage/Reimbursement** discusses *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not Specialties). For example, "Mental Health" presents coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare Physician Fee Schedule, and other pricing issues. **Local and Focused Medical Review Policies** follows, then **Electronic Media Claims**, and **General Information**, which includes **Fraud and Abuse, Medicare Registration,** and **Medicare Secondary Payer** topics, and more. **Educational Resources** provides seminar schedules and reproducible forms. **Important Addresses, Phone Numbers,** and **Web sites** are listed on the inside back cover.

The *Medicare B Update!* Represents Formal Notice of Coverage Policies

Articles included in each *Update!* represent formal notice that specific coverage policies either have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. Florida Medicare maintains copies of the mailing lists for each issue. Inclusion on these mailing lists implies that the issue was received by the provider in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

Advance Beneficiary Notice

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 treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. The Advance Beneficiary Notice (ABN) must meet the following requirements:

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

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA with the service or item. The ABN 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.

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

CLAIMS

Correct Coding Initiative

Version 8.2 of the Correct Coding Initiative (CCI) will be implemented July 1, 2002. Version 8.2 includes all previous versions and updates from January 1996 to the present.

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

The Correct Coding Initiative
AdminaStar Federal
P. O Box 50469
Indianapolis, IN 46250-0469

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

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

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

Source: CMS Transmittal B-02-13, CR 2031

Health Professional Shortage Area (HPSA) Designation Changes

A complete list of HPSA designations was published in the January/February 2000 *Medicare B Update!* (page 7-9). Updates to the HPSA list were subsequently published in the May/June 2000 (page 7), July/August 2000 (page 5), and Second Quarter 2001 (page 6) issues.

Effective for claims processed on or after ***March 1, 2002***, the following locations were changed to low income HPSAs.

1. Wynwood area of Dade County (all Census Tract)
   CT - 0022.02; 0021.00; 0027.01; 0020.01; 0029.00; 0014.01; 0027.02; 0014.02; 0020.03; 0020.04; 0028.00; 0025.00; 0026.00 and 0022.01
2. Everglades and Imokalee of Collier County (all Census Tract)
   Everglades - CT 0111.01 and CT 0111.02
   Imokalee - CT 0112.01; 0113.00; 0112.03; 0114.00 and 0112.02
3. Frostproof/Lake Wales area of Polk County (all Census Tract)
   CT - 0155.00; 0143.00; 0144.00; .0156.00; 0157.00; 0161.98; 0154.00; 0142.00; 0160.00 and 0158.00
4. Dunbar area of Lee County (all Census Tract)
   CT - 0005.01; 0006.00 and 0005.02
5. Hamilton County
6. Taylor County

For more information regarding HPSAs, please refer to the aforementioned articles, all of which are available online at **www.floridamedicare.com**.

Source: CMS

COVERAGE/REIMBURSEMENT

MEDICARE PHYSICIAN FEE SCHEDULE

Correction—First Update to the 2002 Medicare Physician Fee Schedule Database

The first update to the 2002 Medicare Physician Fee Schedule Database was provided in the Centers for Medicare & Medicaid Services (CMS) transmittal AB-02-018, change request 2036. Changes specified in this transmittal were published in the February 2002 *Medicare B Update! Special Issue*. Unfortunately, some of the fees provided in that publication were transposed.

The correct allowances were implemented in our processing system on April 1, 2002, and are listed below. This error *did not* affect the processing of any claims; the correct allowances were used for claims processed on or after April 1. Florida Medicare apologizes for any inconvenience this publication error may have caused.

	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
CODE	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
36533	735.51	790.39	824.48	698.73	750.87	783.26	803.54	863.50	900.74
36533*	330.06	354.08	373.59	313.56	336.38	354.91	360.59	386.83	408.15
92136	89.04	96.08	100.51	84.59	91.28	95.48	97.28	104.97	109.81
92136 26	28.42	29.73	30.66	27.00	28.24	29.13	31.05	32.48	33.50
92136 TC	60.62	66.35	69.85	57.59	63.03	66.36	66.23	72.49	76.31
93025	254.44	274.41	285.53	241.72	260.69	271.25	277.98	299.79	311.94
93025 26	38.34	40.19	41.57	36.42	38.18	39.49	41.89	43.91	45.42
93025 TC	216.09	234.22	243.96	205.29	222.51	231.76	236.08	255.89	266.53
93784**	41.16	44.34	46.16	39.10	42.12	43.85	44.97	48.44	50.43
93786**	32.31	34.95	36.33	30.69	33.20	34.51	35.30	38.18	39.69
93790**	8.86	9.39	9.83	8.42	8.92	9.34	9.68	10.26	10.74
95250	103.88	111.97	115.92	98.69	106.37	110.12	113.49	122.33	126.64
95903	50.75	54.20	56.55	48.21	51.49	53.72	55.44	59.21	61.78
95903 TC	19.41	21.26	22.39	18.44	20.20	21.27	21.21	23.23	24.46
97601	40.37	43.22	45.26	38.35	41.06	43.00	44.10	47.22	49.45

* These amounts apply when service is performed in a facility setting.
** Effective for services performed on or after April 1, 2002.

Add-On Procedures

There are certain procedure codes, which, by definition in the AMA's *Current Procedural Terminology* (*CPT*), are considered add-on procedures (related to another service). Add-on procedures are *always* included in the global period of the primary procedure (i.e., there is no global period for the add-on procedure), and no payment is made for a secondary procedure in the following situations:

- The add-on procedure is billed as a stand-alone service; or
- The primary procedure is denied payment (e.g., the primary procedure was denied payment as not medically necessary).

Example: *CPT* procedure code *11001 (Debridement of extensive eczematous or infected skin; each additional 10% of the body surface)* should not be billed without its primary procedure *(11000 - Debridement of extensive eczematous or infected skin; up to 10% of body surface).* If procedure code 11001 is billed as a stand-alone procedure or if payment was denied for code 11000, then no payment will be made for code 11001.

The patient is not responsible for payment of an add-on procedure if it is billed and denied payment as a stand-alone procedure. In addition, this payment policy not only applies to charges by the surgeon, but to charges by an assistant-at-surgery in those cases where charges for an assistant-at-surgery may be covered.

The following is a list of add-on procedures, as defined in Appendix E of the 2002 edition of *CPT*. Providers should refer to the 2002 *CPT* to determine primary procedures.

0006T	19126	35400	49568	64484	7577426	78480	92984	9592026
01953	19291	35500	49905	64623	75774TC	7848026	92996	95920TC
01968	19295	35681	56606	64627	75946	78480TC	92998	95962
01969	22103	35682	58611	64727	7594626	78496	93320	9596226
11001	22116	35683	59525	64778	75946TC	7849626	9332026	95962TC
11101	22216	35685	60512	64783	75964	78496TC	93320TC	95967
11201	22226	35686	61609	64787	7596426	87187	93321	95973
11732	22328	35700	61610	64832	75964TC	87904	9332126	96412
11922	22522	36218	61611	64837	75968	88141	93321TC	96423
13102	22585	36248	61612	64859	7596826	88155	93325	96570
13122	22614	37206	61795	64872	75968TC	88311	9332526	96571
13133	22632	37208	63035	64874	75993	88312	93325TC	97546
13153	26125	37250	63043	64876	7599326	88313	93571	99100
15001	26861	37251	63044	64901	75993TC	88314	9357126	99116
15101	26863	38102	63048	64902	75996	90472	93571TC	99135
15121	27358	38746	63057	67225	7599626	90474	93572	99140
15201	27692	38747	63066	67320	75996TC	90781	9357226	99290
15221	32501	43635	63076	67331	76085	92547	93572TC	99292
15241	33141	44015	63078	67332	76125	92973	93609	99354
15261	33530	44121	63082	67334	7612526	92974	93613	99355
15343	33572	44128	63086	67335	76125TC	92978	93621	99356
15351	33924	44139	63088	67340	78020	9297826	93622	99357
15401	33961	44203	63091	69990	7802026	92978TC	93623	99358
15787	34808	44955	63308	74301	78020TC	92979	9362326	99359
16036	34813	47001	64472	7430126	78478	9297926	93623TC	99569
17003	34826	47550	64476	74301TC	7847826	92979TC	93662	
19001	35390	48400	64480	75774	78478TC	92981	95920	

Source: Appendix E, *CPT* 2002

"Once-in-a-Lifetime" Procedures

Certain procedures, due to their nature, are payable by Medicare only once in a patient's lifetime. Advance Beneficiary Notice (ABN) is required in the event a service is to be denied or reduced for reasons of medical necessity (see page 5 for details concerning ABNs).

Below is a list of procedure codes considered by Florida Medicare to be once-in-a-lifetime services.

31360	41155	43625	47125	49310	52650	55840	58275	60540
31365	42820	44150	47130	49311	53210	55845	58280	60545
31390	42821	44155	47600	51570	53215	57530	58285	90995
31395	42825	44950	47605	51575	54125	58150	58700	
31400	42826	44955	47610	51580	54130	58200	58720	
38100	42830	44960	47612	51585	54135	58210	60240	
41140	42831	45110	47620	51590	54861	58240	60270	
41145	42835	45112	48155	51595	55810	58260	60500	
41150	42836	45120	48160	51597	55821	58267	60505	
41153	43620	47122	49220	52601	55831	58270	60520	

AMBULATORY SURGICAL CENTER

Modifier SG—Ambulatory Surgical Center (ASC) Facility Service

Information concerning use of modifier SG (Ambulatory Surgical Center facility service) was published on page 3 of the December 2001 *Medicare B Update! Special Issue – Conversion to Medicare's Multi-Carrier System* (MCS). Specifically, in the MCS, **ASC facility charges must be submitted with modifier SG.**

Since conversion to MCS, we have received claims for ASC facility charges without modifier SG. Claims for facility services provided by ASCs submitted without this modifier deny in the MCS. The denial message indicates, "the service is denied when billed by this provider type in this facility type or by a provider of this specialty." This is because, absent the SG modifier, the service is identified as the actual surgery, not the ASC facility fee.

As an interim measure, we added the SG modifier to claims that were pending in the system in an effort to assist ASC providers in obtaining reimbursement for their services. We recycled these claims on April 11 and 12. Some claims, however, had already been denied. The most efficient way to handle these claims is for ASC facilities to resubmit them. Please ensure the SG modifier is used when these claims are resubmitted.

All *future claims* filed by ASCs for facility services *must* be billed with the SG modifier. We will continue to automatically add the SG modifier for 90 days to allow ASCs time for system changes necessary to ensure the SG modifier is on all future claims.

This requirement applies only to services submitted by an ASC for the facility's services. Physicians who provide services in an ASC should *not* use modifier SG on claims for their professional services. Claims with modifier SG submitted by physicians will be denied.

The List of Procedures Approved in an Ambulatory Surgical Center

The following is a current inclusive list of surgical procedures that may be reimbursed when billed by an Ambulatory Surgical Center (ASC). Facility charges for procedures other than those on the list are not covered by Medicare, although the physician's fee may be payable. The beneficiary is liable for such noncovered facility charges; waiver of liability does not apply.

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
10180	2	12018	2	14300	4	15750	2	19100	1	20220	1	20975	2	21310	2
11042	2	12020	1	14350	3	15756	3	19101	2	20225	2	21010	2	21315	2
11043	2	12021	1	15000	2	15757	3	19102	2	20240	2	21025	2	21320	2
11044	2	12034	2	15050	2	15758	3	19103	2	20245	3	21026	2	21325	4
11404	1	12035	2	15100	2	15760	2	19110	2	20250	3	21034	3	21330	5
11406	2	12036	2	15101	3	15770	3	19112	3	20251	3	21040	2	21335	7
11424	2	12037	2	15120	2	15840	4	19120	3	20525	3	21041	2	21337	2
11426	2	12044	2	15121	3	15841	4	19125	3	20650	3	21044	2	21338	4
11444	1	12045	2	15200	3	15842	4	19126	3	20660	2	21050	3	21339	5
11446	2	12046	2	15201	2	15845	4	19140	4	20661	3	21060	2	21340	4
11450	2	12047	2	15220	2	15920	3	19160	3	20662	3	21070	3	21343	5
11451	2	12054	2	15221	2	15922	4	19162	7	20663	3	21100	2	21355	3
11462	2	12055	2	15240	3	15931	3	19180	4	20665	1	21206	5	21360	4
11463	2	12056	2	15241	3	15933	3	19182	4	20670	1	21208	7	21365	5
11470	2	12057	2	15260	2	15934	3	19260	5	20680	3	21209	5	21385	5
11471	2	13100	2	15261	2	15935	4	19290	1	20690	2	21210	7	21386	5
11604	2	13101	3	15350	2	15936	4	19291	1	20694	1	21215	7	21387	5
11606	2	13120	2	15400	2	15937	4	19318	4	20900	3	21230	7	21390	7
11624	2	13121	3	15570	3	15940	3	19328	1	20902	4	21235	7	21395	7
11626	2	13131	2	15572	3	15941	3	19330	1	20910	3	21240	4	21400	2
11644	2	13132	3	15574	3	15944	3	19340	2	20912	3	21242	5	21401	3
11646	2	13150	3	15576	3	15945	4	19342	3	20920	4	21243	5	21406	4
11770	3	13151	3	15600	3	15946	4	19350	4	20922	3	21244	7	21407	5
11771	3	13152	3	15610	3	15950	3	19357	5	20924	4	21245	7	21421	4
11772	3	13160	2	15620	4	15951	4	19364	5	20926	4	21246	7	21422	5
11960	2	14000	2	15625	3	15952	3	19366	5	20955	4	21248	7	21440	3
11970	3	14001	3	15630	3	15953	4	19370	4	20960	4	21249	7	21445	4
11971	1	14020	3	15650	5	15956	3	19371	4	20962	4	21267	7	21450	3
12005	2	14021	3	15732	3	15958	4	19380	5	20969	4	21270	5	21451	4
12006	2	14040	2	15734	3	16015	2	20005	2	20970	4	21275	7	21452	2
12007	2	14041	3	15736	3	16030	1	20200	2	20971	4	21280	5	21453	3
12016	2	14060	3	15738	3	16035	2	20205	3	20972	4	21282	5	21454	5
12017	2	14061	3	15740	2	19020	2	20206	1	20973	4	21300	2	21461	4

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
21462	5	23150	4	23921	3	24530	1	25210	3	25575	3	26261	3	26542	4
21465	4	23155	5	23930	1	24535	1	25215	4	25605	3	26262	2	26545	4
21470	5	23156	5	23931	2	24538	2	25230	4	25611	3	26320	2	26548	4
21480	1	23170	2	23935	2	24545	4	25240	4	25620	5	26350	1	26550	2
21485	2	23172	2	24000	4	24546	5	25248	2	25624	2	26352	4	26551	4
21490	3	23174	2	24065	1	24560	1	25250	1	25628	3	26356	4	26553	2
21493	3	23180	4	24066	2	24565	2	25251	1	25635	1	26357	4	26554	2
21494	4	23182	4	24075	2	24566	2	25260	4	25645	3	26358	4	26555	3
21495	4	23184	4	24076	2	24575	3	25263	2	25660	1	26370	4	26560	2
21497	2	23190	4	24077	3	24576	1	25265	3	25670	3	26372	4	26561	3
21501	2	23195	5	24100	1	24577	1	25270	4	25671	1	26373	3	26562	4
21502	2	23330	1	24101	4	24579	3	25272	3	25675	1	26390	4	26565	5
21510	3	23331	1	24102	4	24582	2	25274	4	25676	2	26392	3	26567	5
21550	1	23395	5	24105	3	24586	4	25275	4	25680	2	26410	3	26568	3
21555	2	23397	7	24110	2	24587	5	25280	4	25685	3	26412	3	26580	5
21556	2	23400	7	24115	3	24600	1	25290	3	25690	1	26415	4	26587	5
21600	2	23405	2	24116	3	24605	2	25295	3	25695	2	26416	3	26590	5
21610	2	23406	2	24120	3	24615	3	25300	3	25800	4	26418	4	26591	3
21620	2	23410	5	24125	3	24620	2	25301	3	25805	5	26420	4	26593	3
21700	2	23412	7	24126	3	24635	3	25310	3	25810	5	26426	3	26596	2
21720	3	23415	5	24130	3	24655	1	25312	4	25820	4	26428	3	26605	2
21725	3	23420	7	24134	2	24665	4	25315	3	25825	5	26432	3	26607	2
21800	1	23430	4	24136	2	24666	4	25316	3	25907	3	26433	3	26615	4
21805	2	23440	4	24138	2	24670	1	25320	3	25922	3	26434	3	26645	1
21810	2	23450	5	24140	3	24675	1	25332	5	25929	3	26437	3	26650	2
21820	1	23455	7	24145	3	24685	3	25335	3	26011	1	26440	3	26665	4
21920	1	23460	5	24147	2	24800	4	25350	3	26020	2	26442	3	26675	2
21925	2	23462	7	24150	3	24802	5	25355	3	26025	1	26445	3	26676	2
21930	2	23465	5	24151	4	24925	3	25360	3	26030	2	26449	3	26685	3
21935	3	23466	7	24152	3	25000	3	25365	3	26034	2	26450	3	26686	3
22100	3	23480	4	24153	4	25020	3	25370	3	26035	4	26455	3	26705	2
22101	3	23485	7	24155	3	25023	3	25375	4	26037	4	26460	3	26706	2
22102	3	23490	3	24160	2	25024	3	25390	3	26040	4	26471	2	26715	4
22103	3	23491	3	24164	3	25025	3	25391	4	26045	3	26474	2	26727	7
22305	1	23500	1	24201	2	25028	1	25392	3	26055	2	26476	1	26735	4
22310	1	23505	1	24301	4	25031	2	25393	4	26060	2	26477	1	26742	2
22315	2	23515	3	24310	3	25035	2	25400	3	26070	2	26478	1	26746	5
22325	3	23520	1	24320	3	25040	5	25405	4	26075	4	26479	1	26756	2
22326	3	23525	1	24330	3	25065	1	25415	3	26080	4	26480	3	26765	4
22327	3	23530	3	24331	3	25066	2	25420	4	26100	2	26483	3	26776	2
22328	3	23532	4	24340	3	25075	2	25425	3	26105	1	26485	2	26785	2
22505	2	23540	1	24342	3	25076	3	25426	4	26110	1	26489	3	26820	5
22900	4	23545	1	24350	3	25077	3	25440	4	26115	2	26490	3	26841	4
23000	2	23550	3	24351	3	25085	3	25441	5	26116	2	26492	3	26842	4
23020	2	23552	4	24352	3	25100	2	25442	5	26117	3	26494	3	26843	3
23030	1	23570	1	24354	3	25101	3	25443	5	26121	4	26496	3	26844	3
23035	3	23575	1	24356	3	25105	4	25444	5	26123	4	26497	3	26850	4
23040	3	23585	3	24360	5	25107	3	25445	5	26125	4	26498	4	26852	4
23044	4	23600	1	24361	5	25110	3	25446	7	26130	3	26499	3	26860	3
23065	1	23605	2	24362	5	25111	3	25447	5	26135	4	26500	4	26861	2
23066	2	23615	4	24363	7	25112	4	25449	5	26140	2	26502	4	26862	4
23075	2	23616	4	24365	5	25115	4	25450	3	26145	3	26504	4	26863	3
23076	2	23620	1	24366	5	25116	4	25455	3	26160	3	26508	3	26910	3
23077	3	23625	2	24400	4	25118	2	25490	3	26170	3	26510	3	26951	2
23100	2	23630	5	24410	4	25119	3	25491	3	26180	3	26516	1	26952	4
23101	7	23650	1	24420	3	25120	3	25492	3	26200	2	26517	3	26990	1
23105	4	23655	1	24430	3	25125	3	25505	1	26205	3	26518	3	26991	1
23106	4	23660	3	24435	4	25126	3	25515	3	26210	2	26520	3	26992	2
23107	4	23665	2	24470	3	25130	3	25520	1	26215	3	26525	3	27000	2
23120	5	23670	3	24495	2	25135	3	25525	4	26230	7	26530	3	27001	3
23125	5	23675	2	24498	3	25136	3	25526	5	26235	3	26531	7	27003	3
23130	5	23680	3	24500	1	25145	2	25535	1	26236	3	26535	5	27030	3
23140	4	23700	1	24505	1	25150	2	25545	3	26250	3	26536	5	27033	3
23145	5	23800	4	24515	4	25151	2	25565	2	26255	3	26540	4	27035	4
23146	5	23802	7	24516	4	25170	3	25574	3	26260	3	26541	7	27040	1

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
27041	2	27396	3	27638	3	27832	2	28260	3	28715	4	30117	3	31320	2
27047	2	27397	3	27640	2	27840	1	28261	3	28725	4	30118	3	31510	2
27048	3	27400	3	27641	2	27842	1	28262	4	28730	4	30120	1	31511	2
27049	3	27403	4	27650	3	27846	3	28264	1	28735	4	30124	1	31512	2
27050	3	27405	4	27652	3	27848	3	28280	2	28737	5	30125	2	31513	2
27052	3	27407	4	27654	3	27860	1	28285	3	28740	4	30130	3	31515	1
27060	5	27409	4	27656	2	27870	4	28286	4	28750	4	30140	2	31525	1
27062	5	27418	3	27658	1	27871	4	28288	3	28755	4	30150	3	31526	2
27065	5	27420	3	27659	2	27884	3	28290	2	28760	4	30160	4	31527	1
27066	5	27422	7	27664	2	28002	3	28292	2	28810	2	30310	1	31528	2
27080	2	27424	3	27665	2	28003	3	28293	3	28820	2	30320	2	31529	2
27086	1	27425	7	27675	2	28005	3	28294	3	28825	2	30400	4	31530	2
27087	3	27427	3	27676	3	28008	3	28296	3	29804	3	30410	5	31531	3
27097	3	27428	4	27680	3	28020	2	28297	3	29805	3	30420	5	31535	2
27098	3	27429	4	27681	2	28030	4	28298	3	29806	3	30430	3	31536	3
27100	4	27430	4	27685	3	28035	4	28299	5	29807	3	30435	5	31540	3
27105	4	27435	4	27686	3	28043	2	28300	2	29819	3	30450	7	31541	4
27110	4	27437	4	27687	3	28045	3	28302	2	29820	3	30520	4	31560	5
27111	4	27438	5	27690	4	28046	3	28304	2	29821	3	30540	5	31561	5
27193	1	27440	5	27691	4	28050	2	28305	3	29822	3	30560	2	31570	2
27194	2	27441	5	27692	3	28054	2	28306	4	29823	3	30580	4	31571	2
27202	2	27442	5	27695	2	28060	2	28307	4	29824	5	30600	4	31576	2
27230	1	27443	5	27696	2	28062	3	28308	2	29825	3	30620	7	31577	2
27238	1	27500	1	27698	2	28070	3	28309	4	29826	3	30630	7	31578	2
27246	1	27501	2	27700	5	28072	3	28310	3	29830	3	30801	1	31580	5
27250	1	27502	2	27704	2	28080	3	28312	3	29834	3	30802	1	31582	5
27252	2	27503	3	27705	2	28086	2	28313	2	29835	3	30903	1	31584	4
27265	1	27507	4	27707	2	28088	2	28315	4	29836	3	30905	1	31585	1
27266	2	27508	1	27709	2	28090	3	28320	4	29837	3	30906	1	31586	2
27275	2	27509	3	27715	4	28092	3	28322	4	29838	3	30915	2	31588	5
27301	3	27510	1	27730	2	28100	2	28340	4	29840	3	30920	3	31590	5
27303	2	27511	4	27732	2	28102	3	28341	4	29843	3	31020	2	31595	2
27305	2	27513	5	27734	2	28103	3	28344	4	29844	3	31030	3	31600	2
27306	3	27516	1	27740	2	28104	2	28345	4	29845	3	31032	4	31611	3
27307	3	27517	1	27742	2	28106	3	28400	1	29846	3	31050	2	31612	1
27310	4	27520	1	27745	3	28107	3	28405	2	29847	3	31051	4	31613	2
27315	2	27524	3	27750	1	28110	3	28406	2	29850	4	31070	2	31614	2
27320	2	27530	1	27752	1	28111	3	28415	3	29851	4	31075	4	31615	1
27323	1	27532	1	27756	3	28112	3	28420	4	29855	4	31080	4	31622	1
27324	1	27535	3	27758	4	28113	3	28435	2	29856	4	31084	4	31625	2
27327	2	27538	1	27759	4	28114	3	28436	2	29870	3	31086	4	31628	2
27328	3	27550	1	27760	1	28116	3	28445	3	29871	3	31090	5	31629	2
27330	4	27552	1	27762	1	28118	4	28456	2	29874	3	31200	2	31630	2
27331	4	27560	1	27766	3	28119	4	28465	3	29875	4	31201	5	31631	2
27332	4	27562	1	27780	1	28120	7	28476	2	29876	4	31205	3	31635	2
27333	4	27566	2	27781	1	28122	3	28485	4	29877	4	31233	2	31640	2
27334	4	27570	1	27784	3	28130	3	28496	2	29879	3	31235	1	31641	2
27335	4	27603	2	27786	1	28140	3	28505	3	29880	4	31237	2	31645	1
27340	3	27604	2	27788	1	28150	3	28525	3	29881	4	31238	1	31646	1
27345	4	27605	1	27792	3	28171	3	28545	1	29882	3	31239	4	31656	1
27350	4	27606	1	27808	1	28173	3	28546	2	29883	3	31240	2	31659	1
27355	3	27607	2	27810	1	28175	3	28555	2	29884	3	31254	3	31700	1
27356	4	27610	2	27814	3	28192	2	28575	1	29885	3	31255	5	31710	1
27360	5	27612	3	27816	1	28193	4	28576	3	29886	3	31256	3	31715	1
27372	7	27613	1	27818	1	28200	3	28585	3	29887	3	31267	3	31717	1
27380	1	27614	2	27822	3	28202	3	28605	1	29888	3	31276	3	31720	1
27381	3	27615	3	27823	3	28208	3	28606	2	29889	3	31280	5	31730	1
27385	3	27618	2	27824	1	28210	3	28615	3	29894	3	31281	5	31750	5
27386	3	27619	3	27825	2	28222	1	28635	1	29895	3	31282	5	31755	2
27390	1	27620	4	27826	3	28225	1	28636	3	29897	3	31283	5	31785	4
27391	2	27625	4	27827	3	28226	1	28645	3	29898	3	31284	5	31800	2
27392	3	27626	4	27828	4	28236	2	28665	1	29900	3	31286	5	31820	1
27393	2	27630	3	27829	2	28238	3	28666	3	29901	3	31287	3	31825	2
27394	3	27635	3	27830	1	28240	2	28675	3	29902	3	31288	3	31830	2
27395	3	27637	3	27831	1	28250	3	28705	4	30115	2	31300	5	32000	1

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
32002	2	40530	2	42260	4	43249	2	45315	1	47530	1	50690	1	52340	3
32005	2	40650	3	42281	3	43250	2	45317	1	47552	2	50951	1	52351	3
32020	2	40652	3	42300	1	43251	2	45320	1	47553	3	50953	1	52352	4
32400	1	40654	3	42305	2	43255	2	45321	1	47554	3	50955	1	52353	4
32405	1	40801	2	42310	1	43258	3	45331	1	47555	3	50957	1	52354	4
32420	1	40805	2	42320	1	43259	3	45332	1	47560	3	50959	1	52400	3
33010	2	40806	1	42325	2	43260	2	45333	1	47561	3	50961	1	52450	3
33011	2	40814	2	42335	3	43261	2	45334	1	47630	3	50970	1	52500	3
34101	3	40816	2	42340	2	43262	2	45337	1	48102	1	50972	1	52601	4
36261	2	40818	1	42405	2	43263	2	45338	1	49000	4	50974	1	52606	1
36262	1	40819	1	42408	3	43264	2	45339	1	49080	2	50976	1	52612	2
36489	1	40820	1	42409	3	43265	2	45355	1	49081	2	50978	1	52614	1
36491	1	40831	1	42410	3	43267	2	45378	2	49085	2	50980	1	52620	1
36530	3	40840	2	42420	7	43268	2	45379	2	49180	1	51005	1	52630	2
36531	2	40842	3	42425	7	43269	2	45380	2	49250	4	51010	1	52640	2
36532	1	40843	3	42440	3	43271	2	45382	2	49300	2	51020	4	52650	2
36533	3	40844	5	42450	2	43272	2	45383	2	49301	3	51030	4	52700	2
36534	2	40845	5	42500	3	43450	1	45384	2	49302	3	51040	4	53000	1
36535	1	41000	1	42505	4	43451	1	45385	2	49303	3	51045	4	53010	1
36640	1	41005	1	42507	3	43453	1	45500	2	49320	3	51500	4	53020	1
36800	3	41006	1	42508	4	43455	2	45505	2	49321	4	51600	1	53040	2
36810	3	41007	1	42509	4	43456	2	45520	1	49322	4	51605	1	53200	1
36815	3	41008	1	42510	4	43458	2	45560	2	49400	1	51610	1	53210	5
36819	3	41009	1	42600	1	43600	1	45900	1	49401	1	51710	1	53215	5
36820	3	41010	1	42700	1	43750	2	45905	1	49420	1	51725	1	53220	2
36821	3	41015	1	42720	1	43760	1	45910	1	49421	1	51726	1	53230	2
36825	4	41016	1	42725	2	43870	1	45915	1	49425	2	51772	1	53235	3
36830	4	41017	1	42802	1	44100	1	46020	3	49426	2	51785	1	53240	2
36832	4	41018	1	42804	1	44312	1	46030	1	49505	4	51865	4	53250	2
36833	4	41105	2	42806	2	44340	3	46040	3	49520	7	51880	1	53260	2
36835	4	41108	1	42808	2	44345	4	46045	2	49525	4	51900	4	53265	2
36840	4	41110	1	42810	3	44346	4	46050	1	49540	2	51920	3	53275	2
36845	4	41112	2	42815	5	44360	2	46060	2	49550	5	52000	1	53400	3
36860	2	41113	2	42821	5	44361	2	46080	3	49555	5	52001	2	53405	2
36861	3	41114	2	42826	4	44363	2	46200	2	49560	4	52005	2	53410	2
37609	2	41115	1	42831	4	44364	2	46210	2	49565	4	52007	2	53420	3
37700	2	41116	1	42836	4	44365	2	46211	2	49570	4	52010	2	53425	2
37720	3	41120	5	42860	3	44366	2	46220	1	49585	4	52204	2	53430	2
37730	3	41250	2	42870	3	44369	2	46250	3	49590	3	52214	2	53431	2
37735	3	41251	2	42880	5	44372	2	46255	3	49650	4	52224	2	53440	2
37760	3	41252	2	42900	1	44373	2	46257	3	49651	7	52234	2	53442	1
37780	3	41500	1	42950	2	44380	1	46258	3	50020	2	52235	3	53444	2
37785	3	41510	1	42955	2	44382	1	46260	3	50040	3	52240	3	53445	1
38300	1	41520	2	42960	1	44385	1	46261	4	50200	1	52250	4	53446	1
38305	2	41800	1	42962	2	44386	1	46262	4	50390	1	52260	2	53447	1
38308	2	41805	1	43200	1	44388	1	46270	3	50392	1	52270	2	53449	1
38500	2	41806	1	43202	1	44389	1	46275	3	50393	1	52275	2	53450	1
38505	1	41827	2	43204	1	44390	1	46280	4	50395	1	52276	3	53460	1
38510	2	42000	2	43215	1	44391	1	46285	1	50396	1	52277	2	53502	2
38520	2	42104	2	43216	1	44392	1	46608	1	50398	1	52281	2	53505	2
38525	2	42106	2	43217	1	44393	1	46610	1	50520	1	52283	2	53510	2
38530	2	42107	2	43219	1	44394	1	46611	1	50551	1	52285	2	53515	2
38542	2	42120	4	43220	1	45000	1	46612	1	50553	1	52290	2	53520	2
38550	3	42140	2	43226	1	45005	2	46700	3	50555	1	52300	2	53605	2
38555	4	42145	5	43227	2	45020	2	46750	3	50557	1	52305	2	53665	1
38700	2	42160	1	43228	2	45100	1	46753	3	50559	1	52310	2	54001	2
38740	2	42180	1	43234	1	45108	2	46754	2	50561	1	52315	2	54015	4
38745	4	42182	2	43235	1	45150	2	46760	2	50570	1	52317	1	54057	1
38760	2	42200	5	43239	2	45170	2	46922	1	50572	1	52318	2	54060	1
38790	1	42205	5	43241	2	45180	3	46924	1	50574	1	52320	5	54065	1
40500	2	42210	5	43243	2	45305	1	46937	2	50576	1	52325	4	54100	1
40510	2	42215	7	43245	2	45307	1	46938	2	50578	1	52330	2	54105	1
40520	2	42220	5	43246	2	45308	1	47000	1	50580	1	52332	2	54110	2
40525	2	42225	5	43247	2	45309	1	47510	2	50684	1	52334	3	54115	1
40527	2	42235	5	43248	2	45310	1	47525	1	50688	1	52337	4	54120	2

PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP	PROC	GROUP
54125	2	56605	1	61020	1	64600	1	64890	2	66180	5	67405	4	69120	2
54152	1	56620	5	61026	1	64605	1	64891	2	66185	2	67412	5	69140	2
54161	2	56625	7	61050	1	64610	1	64892	2	66220	3	67413	5	69145	2
54162	2	56700	1	61055	1	64620	1	64893	2	66225	4	67415	1	69150	3
54163	2	56720	1	61070	1	64622	1	64895	3	66250	2	67420	5	69205	1
54164	2	56740	3	61215	3	64623	1	64896	3	66500	1	67430	5	69310	3
54205	4	56800	3	61790	3	64626	1	64897	3	66505	1	67440	5	69320	7
54220	1	56810	5	61791	3	64627	1	64898	3	66600	3	67450	5	69421	3
54300	3	57000	1	61885	2	64630	2	64901	2	66605	3	67550	4	69424	1
54360	3	57010	2	61888	1	64680	2	64902	2	66625	3	67560	2	69436	3
54420	4	57020	2	62194	1	64702	1	64905	2	66630	3	67715	1	69440	3
54435	4	57065	1	62225	1	64704	1	64907	1	66635	3	67808	2	69450	1
54440	4	57105	2	62230	2	64708	2	65091	3	66680	3	67830	2	69501	7
54450	1	57130	2	62256	2	64712	2	65093	3	66682	2	67835	2	69502	7
54500	1	57135	2	62263	1	64713	2	65101	3	66700	2	67880	3	69505	7
54505	1	57180	1	62268	1	64714	2	65103	3	66710	2	67882	3	69511	7
54512	2	57200	1	62269	1	64716	3	65105	4	66720	2	67901	5	69530	7
54520	3	57210	2	62270	1	64718	2	65110	5	66740	2	67902	5	69550	5
54530	4	57220	3	62272	1	64719	2	65112	7	66821	2	67903	4	69552	7
54550	4	57230	3	62273	1	64721	2	65114	7	66830	4	67904	4	69601	7
54600	4	57240	5	62280	1	64722	1	65130	3	66840	4	67906	5	69602	7
54620	3	57250	5	62282	1	64726	1	65135	2	66850	7	67908	4	69603	7
54640	4	57260	5	62294	3	64727	1	65140	3	66852	4	67909	4	69604	7
54660	2	57265	7	62310	1	64732	2	65150	2	66920	4	67911	3	69605	7
54670	3	57268	3	62311	1	64734	2	65155	3	66930	5	67914	3	69620	2
54680	3	57300	3	62318	1	64736	2	65175	1	66940	5	67916	4	69631	5
54700	2	57310	3	62319	1	64738	2	65235	2	66982	8	67917	4	69632	5
54800	1	57311	4	62350	2	64740	2	65260	3	66983	8	67921	3	69633	5
54820	1	57320	3	62351	2	64742	2	65265	4	66984	8	67923	4	69635	7
54830	3	57400	2	62360	2	64744	2	65270	2	66985	6	67924	4	69636	7
54840	4	57410	2	62361	2	64746	2	65272	2	66986	6	67935	2	69637	7
54860	3	57513	2	62362	2	64771	2	65275	4	67005	4	67950	2	69641	7
54861	4	57520	2	62365	2	64772	2	65280	4	67010	4	67961	3	69642	7
54900	4	57522	2	62367	2	64774	2	65285	4	67015	1	67966	3	69643	7
54901	4	57530	3	62368	2	64776	3	65290	3	67025	1	67971	3	69644	7
55040	3	57550	3	63600	2	64778	2	65400	1	67030	1	67973	3	69645	7
55041	5	57700	1	63610	1	64782	3	65410	2	67031	2	67974	3	69646	7
55060	4	57720	3	63650	2	64783	2	65420	2	67036	4	67975	3	69650	7
55100	1	57800	1	63660	1	64784	3	65426	5	67038	5	68130	2	69660	5
55110	2	57820	3	63685	2	64786	3	65710	7	67039	7	68320	4	69661	5
55120	2	58120	2	63688	1	64787	2	65730	7	67040	7	68325	4	69662	5
55150	1	58145	5	63744	3	64788	3	65750	7	67107	5	68326	4	69666	4
55175	1	58353	8	63746	2	64790	3	65755	7	67108	7	68328	4	69667	4
55180	2	58551	5	63750	4	64792	3	65770	7	67109	5	68330	4	69670	3
55200	2	58555	1	63780	2	64795	2	65800	1	67112	7	68335	4	69676	3
55400	1	58558	3	64410	1	64802	2	65805	1	67115	2	68340	4	69700	3
55500	3	58559	2	64415	1	64831	4	65810	3	67120	2	68360	2	69710	3
55520	4	58561	3	64417	1	64832	1	65815	2	67121	2	68362	2	69711	1
55530	4	58563	4	64420	1	64834	2	65850	4	67141	2	68500	3	69720	5
55535	4	58660	5	64421	1	64835	3	65865	1	67218	5	68505	3	69725	5
55540	5	58661	5	64430	1	64836	3	65870	4	67227	1	68510	1	69740	5
55600	1	58662	5	64470	1	64837	1	65875	4	67250	3	68520	3	69745	5
55605	1	58670	3	64472	1	64840	2	65880	4	67255	3	68525	1	69801	5
55650	1	58671	3	64475	1	64856	2	65900	5	67311	3	68540	3	69802	7
55680	1	58672	5	64476	1	64857	2	65920	7	67312	4	68550	3	69805	7
55700	2	58673	5	64479	1	64858	2	65930	5	67314	4	68700	2	69806	7
55705	2	58800	3	64480	1	64859	1	66020	1	67316	4	68720	4	69820	5
55720	1	58820	3	64483	1	64861	3	66030	1	67318	4	68745	4	69840	5
56360	2	58900	3	64484	1	64862	3	66130	7	67320	4	68750	4	69905	7
56361	3	60000	1	64510	1	64864	3	66150	4	67331	4	68810	1	69910	7
56363	3	60200	2	64520	1	64865	4	66155	4	67332	4	68811	2	69915	7
56405	2	60220	2	64530	1	64870	4	66160	2	67340	4	68815	2	69930	7
56440	2	60225	3	64575	1	64872	2	66165	4	67350	1	68825	2	G0105	2
56441	1	60280	4	64590	2	64874	3	66170	4	67400	3	69110	1	G0121	2
56515	3	60281	4	64595	1	64876	3	66172	4						

ANESTHESIA

Anesthesiologist Billing Services With Student Nurse Anesthetist

Section 15018 of the Medicare Carriers Manual (MCM) provides payment conditions for anesthesiology services. Payment may be made for personally performed services, or services medically directed by an anesthesiologist. An anesthesiologist who is continuously involved in a single case involving a student nurse anesthetist (SNA) service bills under the personally performed rule. An anesthesiologist may bill under the medical direction rule when he or she:

- directs two concurrent cases when either both cases involve an SNA, or
- directs one case involving a student nurse anesthetist and another involving a certified registered nurse anesthetist (CRNA), intern, or resident.

Below are modifiers used for billing anesthesia services (not an inclusive list).

AA Anesthesia services performed personally by anesthesiologist
AD Medical supervision by a physician: more than four concurrent anesthesia procedures
QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX CRNA service: with medical direction by a physician
QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist. (This modifier is effective for anesthesia services furnished by a CRNA (or anesthesia assistant) on or after January 1, 1998.)

The appropriate modifier for an anesthesiologist to bill directing a single-case SNA is AA, not QY or QX, because an SNA is not certified. If the anesthesiologist is directing two or more concurrent cases involving SNAs, modifier QK should be used.

Source: MCM section 15018

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

2002 Jurisdiction List

Below is the updated list of procedure codes for Durable Medical Equipment Regional Carrier (DMERC) and local carrier jurisdictions. The DMERCs and local carriers publish this list to inform providers and suppliers on which contractor they should be billing for these codes.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4210	Needle Free Injection Device	DME REGIONAL Carrier
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4220	Refill Kit for Implantable Pump	Local Carrier

A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4253 - A4259	Diabetic Supplies	DME REGIONAL Carrier
A4260	Levonorgestrel Implant	Local Carrier
A4261	Cervical Cap for Contra -ceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4310 - A4359	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4360	Adult Incontinence Garment/Diaper	DME REGIONAL Carrier
A4361 - A4421	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4454 - A4455	Tape; Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4460	Elastic Bandage	Local Carrier if incident to a physician's service (not separately payable). If secondary surgical dressing, DME REGIONAL Carrier. (See MCM 2079)
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4464	Joint Supportive Device/ Garment	DME REGIONAL Carrier
A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier

A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4572	Rib Belt	DME REGIONAL Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	Local Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4646	Imaging Agent; Contrast Material	Local Carrier
A4647	Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A4651 - A4929	Supplies for ESRD	DME REGIONAL Carrier
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A5500 - A5511	Therapeutic Shoes	DME REGIONAL Carrier
A6000	Non-Contact Wound Warming Cover	DME REGIONAL Carrier

A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier
A6025	Silicone Gel Sheet	DME REGIONAL Carrier
A6154 - A6406	Surgical Dressing	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
A7000 - A7020	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7501-A7509	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier
A9270	Noncovered Items or Services	DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier
A9901	Delivery	DME REGIONAL Carrier
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0116	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier
E0176 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0241 - E0246	Bath and Toliet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0297	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier
E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heel Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0480	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0481	Intra-Pulmonary Percussive Ventilation System	DME REGIONAL Carrier
E0482	Cough Stimulating Device	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier

E0600	Suction Pump	DME REGIONAL Carrier
E0601	CPAP Device	DME REGIONAL Carrier
E0602 - E0604	Breast Pump	DME REGIONAL Carrier
E0605	Vaporizer	DME REGIONAL Carrier
E0606	Drainage Board	DME REGIONAL Carrier
E0607	Home Blood Glucose Monitor	DME REGIONAL Carrier
E0608	Apnea Monitor	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621 - E0635	Patient Lifts	DME REGIONAL Carrier
E0650 - E0673	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0690	Ultraviolet Cabinet	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0752	Implantable Nerve Stimulator Electrodes	Local Carrier
E0754	Patient Programmer for use with IPG	Local Carrier
E0755	Reflex Stimulator	DME REGIONAL Carrier
E0756 - E0759	Implantable Nerve Stimulator	Local Carrier
E0760	Ultrasonic Osteogenic Stimulator	DME REGIONAL Carrier
E0765	Nerve Stimulator	DME REGIONAL Carrier
E0776	IV Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier

E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier
E0830	Ambulatory Traction Device	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0930	Trapeze/Fracture Frame	DME REGIONAL Carrier
E0935	Passive Motion Exercise Device	DME REGIONAL Carrier
E0940	Trapeze Equipment	DME REGIONAL Carrier
E0941	Traction Equipment	DME REGIONAL Carrier
E0942 - E0945	Orthopedic Devices	DME REGIONAL Carrier
E0946 - E0948	Fracture Frame	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier
E1353 - E1390	Additional Oxygen Related Equipment	DME REGIONAL Carrier
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier
E1405 - E1406	Additional Oxygen Equipment	DME REGIONAL Carrier
E1500 - E1699	Artificial Kidney Machines and Accessories	DME REGIONAL Carrier
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1840	Dynamic Flexion Devices	DME REGIONAL Carrier
E1902	Communication Board	DME REGIONAL Carrier
E2000	Gastric Suction Pump	DME REGIONAL Carrier
E2100 - E2101	Blood Glucose Monitors with Special Features	DME REGIONAL Carrier
G0001 - G9016	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7190 - J7192	Factor VIII	Local Carrier
J7193 - J7195	Factor IX	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier

J7300 - J7302	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7316 - J7320	Injection	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7340	Dermal and Epidermal - Tissue of Human Origin	Local Carriers
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7608 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7799	NOC, Other than Inhalation Drugs through DME	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemotherapeutic	DME REGIONAL Carrier
J8510 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0112 - K0116	Spinal Orthotics	DME REGIONAL Carrier
K0183 - K0189	Accessories for Positive Airway Pressure Devices	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0268	Humidifier	DME REGIONAL Carrier
K0415 - K0416	Antiemetic Drugs	DME REGIONAL Carrier
K0452	Wheelchair Bearings	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0460 - K0461	Power Add-on Converters for Wheelchairs	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0531	Accessory for Respiratory Assist Device	DME REGIONAL Carrier
K0532 - K0534	Respiratory Assist Device	DME REGIONAL Carrier
K0538 - K0540	Negative Pressure Wound Therapy Pump	DME REGIONAL Carrier
K0541 - K0547	Speech Generating Device	DME REGIONAL Carrier

K0548	Injection, Insulin Lispro	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
K0549 - K0550	Hospital Bed, Heavy Duty	DME REGIONAL Carrier
K0551	Risidual Limb Support System	DME REGIONAL Carrier
K0561 - K0580	Ostomy Devices and Supplies	DME REGIONAL Carrier
L0100 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME REGIONAL Carrier
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8490	Prosthetics	DME REGIONAL Carrier
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier
L8500 - L8501	Artificial Larynx; Trache-ostomy Speaking Valve	DME REGIONAL Carrier
L8505	Artificial Larynx Accessory	DME REGIONAL Carrier
L8507 - L8510	Voice Prosthesis	DME REGIONAL Carrier
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted prosthetic or device. If other, DME REGIONAL Carrier
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiokymography	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0136	Injection, Epoetin Alpha	Local Carrier
Q0163 - Q0181	Anti-emetic	DME REGIONAL Carrier
Q0183 - Q0184	Artificial Skin	Local Carrier
Q0187	Factor VIIA	Local Carrier
Q1001 - Q1005	New Technology IOL	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3019 - Q3020	ALS Vehicle Used but no ALS Service provided	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q9920 - Q9940	Injection of EPO	DME REGIONAL Carrier when self-administered or for Method II beneficiaries, otherwise Local Carrier

R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME REGIONAL Carrier
V2781	Progressive Lens	DME REGIONAL Carrier
V2785	Processing—Corneal Tissue	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2799	Miscellaneous Vision Service	DME REGIONAL Carrier
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME REGIONAL Carrier
V5362 - V5364	Speech Screening	Local Carrier

Source: CMS Transmittal B-02-15, CR2051

Most DMEPOS claims are processed by the durable medical equipment regional carriers (DMERCs). The DMERC that serves Florida is Palmetto Government Benefits Administrators (www.palmettogba.com). The two articles that follow are intended to provide information to those providers who bill to the DMERC, as well as to local carriers.

KX: New Permanent Modifier for "Specific Required Documentation on File"

The Centers for Medicare & Medicaid Services (CMS) has established a new national modifier for use when a contractor's policies specifically require use of a modifier for "specific required documentation on file." Currently, the Durable Medical Equipment Regional Carriers (DMERCs) use a temporary local modifier ZX in several of their local medical review policies (LMRPs).

Effective for claim submission dates on and after July 1, 2002, DMERCs must discontinue use of modifier ZX, and use the following new level II national modifier: **KX Specific Required Documentation on File**.

This modifier is required only on claims where national policy or LMRPs specifically require its use for a particular item or service. For example, DMERCs currently require the use of modifier ZX for diabetic patients who are being treated with insulin injections. In this case, DMERCs specifically require the presence of the modifier in their LMRP for these types of claims. Medicare Part B requires "documentation" (e.g., medical records, a prescription) for any item or service for which it pays. However, suppliers and providers are not required to use the new modifier on every Healthcare Common Procedure Coding System (HCPCS) code or line item on every claim. Providers and suppliers should use the modifier *only* when the claim is for items or services for which LMRP or national policy requires it.

DMERCs are revising any policies that require use of modifier ZX, and replace references to modifier ZX with modifier KX for dates of service on ort after July 1, 2002.

The usual grace period for new HCPCS codes (i.e., 90 days) will be allowed to give providers and suppliers time to adjust to the new modifier. Therefore, although CMS is discontinuing modifier ZX effective July 1, 2002, claims containing ZX will not be rejected or denied until dates of claim receipt beginning October 1, 2002.

Providers and suppliers should be aware that use of modifier KX constitutes a statement to the effect that they actually have documentation on file required by the policy for the particular item or service.

Source: CMS Transmittal B-02-026, CR 2155

Elimination of CMN Requirement for CPAP Device

The Certificate of Medical Necessity (CMN) requirement for Continuous Positive Airway Pressure (CPAP) devices is eliminated effective for dates of service on or after July 1, 2002. This coincides with the effective date of the revised local medical review policy for CPAP developed by the Durable Medical Equipment Regional Carriers (DMERCs).

Source: CMS Transmittal B-02-022, CR 2076

EVALUATION & MANAGEMENT

Coverage and Billing for the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

Peripheral neuropathy is the most common factor leading to amputation in people with diabetes. In diabetes, peripheral neuropathy is an anatomically diffuse process primarily affecting sensory and autonomic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal, or chemical sources. When foot lesions are present, the reduction in autonomic nerve functions may also inhibit wound healing.

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule (see 42 C.F.R. section 411.15(l)(l)(i)). Foot exams for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 1, 2002, Medicare covers, as a physician service, an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of five tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

HCPCS Codes

G0245 Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), which must include:

1. the diagnosis of LOPS,
2. a patient history,
3. a physical examination that consists of at least the following elements:
   (a) visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) evaluation of a protective sensation,
   (c) evaluation of foot structure and biomechanics,
   (d) evaluation of vascular status and skin integrity,
   (e) evaluation and recommendation of footwear, and
4. patient education

Note: Each provider, or provider group of which that provider is a member, may only receive reimbursement *once* for G0245 for each beneficiary. However, should that beneficiary need to see a new provider, that new provider may also be reimbursed once for G0245 (for that beneficiary).

G0246 Follow-up evaluation of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:

1. a patient history,
2. a physical examination that includes:
   (a) visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) evaluation of protective sensation,
   (c) evaluation of foot structure and biomechanics,
   (d) evaluation of vascular status and skin integrity,
   (e) evaluation and recommendation of footwear, and
3. patient education

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

1. local care of superficial wounds,
2. debridement of corns and calluses, and
3. trimming and debridement of nails

Note: Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.

ICD-9-CM Diagnosis Codes

Providers should report one of the following ICD-9-CM diagnosis codes in conjunction with this benefit: 250.60, 250.61, 250.62, 250.63, or 357.2

Payment Requirements

Codes G0245 – G0247 may be furnished and billed by any Medicare provider licensed to provide such services. Deductible and coinsurance apply.

Claims Editing

Carriers may develop local edits for such claim(s) at their discretion as long as they do not conflict with national policy.

CMS Transmittal AB-02-042 CR 2060

INJECTABLE DRUGS

Medicare Payment Allowance for Injectable Drugs

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

These allowances are effective for services rendered on or after January 1, 2002 that are ***processed on or after April 1, 2002.***

Please remember that assignment must be accepted for these services, as mandated by the Benefits Improvement and Protection Act of 2000.

Code	PAR	NON-PAR	Code	PAR	NON-PAR	Code	PAR	NON-PAR
90740	203.77	203.77	J1885	IC	IC	J8560	45.24	42.98
A9605	1019.99	1019.99	J1980	7.53	7.15	J9017	31.35	29.78
J0150	35.62	33.84	J2010	4.41	4.19	J9160	1099.86	1044.87
J0390	19.93	18.93	J2180	4.59	4.36	J9170	312.72	297.08
J0515	3.90	3.71	J2210	3.87	3.68	J9180	667.08	633.73
J0560	2.83	2.69	J2250	1.63	1.55	J9185	285.42	271.15
J0570	5.66	5.38	J2260	37.76	35.87	J9201	112.05	106.45
J0580	11.32	10.75	J2271	8.16	7.75	J9206	140.70	133.67
J0690	3.08	2.93	J2275	4.02	3.82	J9211	432.83	411.19
J0698	10.90	10.36	J2355	245.81	233.52	J9217	564.92	536.67
J0725	3.33	3.16	J2370	1.82	1.73	J9300	2024.69	1923.46
J0770	57.76	54.87	J2430	265.86	252.57	J9350	695.01	660.26
J0780	4.49	4.27	J2460	0.95	0.90	Q0136	12.69	12.69
J0800	88.84	84.40	J2515	0.71	0.67	Q9920	12.69	12.69
J0895	14.15	13.44	J2540	0.28	0.27	Q9921	12.69	12.69
J0945	0.86	0.82	J2543	5.13	4.87	Q9922	12.69	12.69
J0970	22.60	21.47	J2545	87.02	82.67	Q9923	12.69	12.69
J1030	1.71	1.62	J2560	9.41	8.94	Q9924	12.69	12.69
J1040	2.91	2.76	J2590	1.15	1.09	Q9925	12.69	12.69
J1050	10.48	9.96	J2650	0.52	0.49	Q9926	12.69	12.69
J1060	4.04	3.84	J2700	0.65	0.62	Q9927	12.69	12.69
J1160	2.64	2.51	J2720	1.00	0.95	Q9928	12.69	12.69
J1165	0.66	0.63	J2790	105.45	100.18	Q9929	12.69	12.69
J1380	10.83	10.29	J2792	22.47	21.35	Q9930	12.69	12.69
J1630	7.31	6.94	J2800	3.80	3.61	Q9931	12.69	12.69
J1631	27.02	25.67	J2810	IC	IC	Q9932	12.69	12.69
J1670	114.00	108.30	J2820	29.06	27.61	Q9933	12.69	12.69
J1700	0.34	0.32	J3240	566.67	538.34	Q9934	12.69	12.69
J1710	5.56	5.28	J3260	4.64	4.41	Q9935	12.69	12.69
J1730	122.94	116.79	J3310	7.13	6.77	Q9936	12.69	12.69
J1742	240.64	228.61	J3370	10.42	9.90	Q9937	12.69	12.69
J1810	IC	IC	J3400	IC	IC	Q9938	12.69	12.69
J1820	4.53	4.30	J7316	35.57	33.79	Q9939	12.69	12.69
J1840	3.29	3.13	J7340	13.07	12.42	Q9940	12.69	12.69
J1850	0.48	0.46	J7520	7.19	6.83			

IC = Individual consideration
NC= Noncovered

LABORATORY/PATHOLOGY

Policies Related to Processing Claims for Clinical Diagnostic Laboratory Services

Section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of a negotiated rulemaking committee to develop national coverage and administrative policies for clinical diagnostic laboratory services payable under Part B of Medicare. The BBA requires these national policies be designed to promote program integrity and national uniformity, and simplify administrative requirements.

The Committee for the Negotiated Rulemaking for Laboratory Services recommended several administrative procedures. These administrative policies are discussed herein, and apply to every diagnostic clinical laboratory service payable under Medicare Part B, effective for services processed on or after April 18, 2002. They are applicable regardless of the place where the service was performed or the type of contractor that processes the claim. A service provided in a hospital laboratory, independent laboratory, physician/practitioner office laboratory, or other type of CLIA approved laboratory service is subject to these administrative policies.

The treating physician must be the physician who orders any clinical diagnostic laboratory service.

Limitation on Number of Diagnosis Codes

Until implementation of the Health Insurance Portability and Accountability Act (HIPAA) Florida Medicare does not have the capability to accept eight or more diagnosis codes in the diagnosis section of a claim. Currently, only four diagnosis codes may be referenced. Covered diagnosis codes should be entered in item 21 (1-4) of Form CMS-1500. A one-digit reference to item 21 should be entered in item 24E. Diagnosis codes in excess of four may be provided in item 19, as an attachment, or coded in the narrative field of an electronic claim; however, *do not* refer to narrative diagnoses with a one-digit reference in item 24E. Because claims with more than four diagnoses are manually reviewed, they do take longer to process. Therefore, providers should minimize this practice until HIPAA is fully implemented.

Narrative Diagnosis

When required by local medical review policy (LMRP) or National Coverage Decision (NCD), a laboratory that submits electronic claims *must* use ICD-9-CM codes rather than narrative descriptions. A laboratory that submits paper claims may use narrative descriptions. Be aware, however; paper claims take longer to process than electronic claims.

If a laboratory receives a requisition with a narrative description rather than an ICD-9-CM as the diagnosis, the laboratory may translate that narrative to the appropriate ICD-9-CM diagnosis code. The narrative does not have to exactly match the description of the submitted ICD-9-CM. The laboratory must maintain the requisition with the translated narrative description and submit it upon request.

If the ordering physician submits an ICD-9-CM code on the requisition, the laboratory must use that code unless there is a reason to question the ordering physician to change the code. The laboratory must receive and maintain the documentation to alter the claim. The documentation may be written information from the ordering physician or a written note documenting the telephone call with the ordering physician. A faxed copy of the documentation is acceptable. The laboratory must maintain the documentation and submit it to Medicare upon request.

Noncovered Services

The best way for laboratories to indicate a service is noncovered is to use modifier GY or GZ, as appropriate:

- Modifier GY is used to indicate the item or service is statutorily noncovered (as defined in the Program Integrity Manual (PIM) Chapter 1, section 2.3.3.B) or is not a Medicare benefit (as defined in the PIM, Chapter 1, section 2.3.3.A).
- Modifier GZ is used to indicate it is expected Medicare will deny an item or service as not reasonable and necessary and the provider does not have an Advance Beneficiary Notice (ABN) signed by the beneficiary.

  Note: Modifier GA is used when practitioners want to indicate they expect Medicare will deny a service as not reasonable and necessary and they have an ABN signed by the beneficiary on file. This is generally not the case with laboratories.

Ordering Practitioner

The administrative policies that relate to the individual who orders the service apply to a physician or a nonphysician practitioner qualified to order diagnostic services [42CFR410.32(a)(3)].

Ordering practitioners include nonphysician practitioners such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse midwives, nurse practitioners, and physician assistants who furnish services that would be physician services if furnished by a physician, who work within the scope of their authority under state law and within the scope of the Medicare statutory benefit.

Signature on Requisition Form

Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting the treating physician ordered the service, it is not the only permissible way of documenting the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.

Multiple Services

Two *CPT* modifiers identify multiple services for the same beneficiary on the same day.

- **Modifier 59 indicates distinct procedural services.** Modifier 59 is appropriate to report multiple service submissions by a clinical laboratory for the same beneficiary on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same *CPT* code, and tested the same day.
- **Modifier 91 indicates repeat clinical diagnostic laboratory services.** If an ordering physician requests a laboratory test requiring several of the same services (*CPT* code) be performed for the same beneficiary on the same day, the laboratory should use modifier 91 to indicate that multiple clinical diagnostic laboratory tests were performed.

These modifiers are not interchangeable. It is expected the more frequently used modifier should be 91. Each has a specific use as described above. Using either modifier does not relieve the laboratory of the responsibility to supply medical necessity documentation if requested by the carrier.

Documentation Requirements

The ordering physician must maintain documentation of medical necessity in the beneficiary's medical record.

The laboratory must maintain documentation it receives from the ordering physician, and must ensure the information listed on the claim accurately reflects such documentation.

The laboratory may request additional diagnostic and other medical information from the physician to document the medical necessity and reasonableness of its services. If the laboratory requests additional documentation, it must request material relevant to the medical necessity of the specific service(s), taking into consideration current rules and regulations on patient confidentiality.

If a claim selected for review by Medicare contains additional documentation attached or simultaneously submitted with the claim, Medicare must review the documentation before denying the claim. **Exception**: Medicare may deny without reviewing attached or simultaneously submitted documentation when clear policy serves as the basis for denial. The term "clear policy," means a statute, NCD, coverage provision in an interpretive manual, or LMRP that specifies the circumstances under which a service will always be considered noncovered or incorrectly coded.

Source: CMS Transmittal AB-02-030, CR 1998

Travel Allowance for Collection of Specimens

Information concerning coverage of travel allowance for collection of specimens was published in the September/October 1998 issue of the *Medicare B Update!* (pages 27-28). This information is being republished here as a convenience to our providers. In addition, place of service requirements are defined. Medicare Part B covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient; payment is made based on the clinical laboratory fee schedule.

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee and laboratory procedure(s) for which it is drawn are also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip for both Medicare and non-Medicare patients. The purpose is to exclude payment for non-Medicare patients. The billing laboratory must prorate claims based on the instructions and examples that follow:

Per Mile Travel Allowance (HCPCS code P9603)

Reimbursement is made based on 75 cents per mile. The per mile travel allowance is to be used in situations where the average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician. In examples 1 and 2 that follow, the actual miles traveled is entered in the days or units field (block 24G on the HCFA 1500 claim form).

Example 1: A laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $45.00 (60 miles x $.75 per mile).

Example 2: A laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, travels an additional 10 miles to a non-Medicare patient's home, and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted for the Medicare patient would be for one half of the miles traveled or $30.00 (40 miles x $.75 per mile).

Flat Rate (HCPCS code P9604)

Reimbursement is made based on an allowance of $7.50 one-way. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated

for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The pro-ration is done by the laboratory when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be considered for payment for each patient encounter. In examples 3, 4 & 5, the units billed must equal 2, in order to be reimbursed for the return trip.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate billed would be calculated as follows: 2 x $7.50 for a total amount of $15.00, with a units billed equal 2.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $7.50 =$45.00). Each of the claims submitted would be for $9.00 ($45.00/5 = $9.00). Since one of the patients is non-Medicare, four claims would be submitted with a pro-rated flat rate of $9.00 each, and the units billed equal to 2.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $7.50 = $15.00) and then divided by five (1/5 of $15.00 = $3.00). Since one of the patients is non-Medicare, four claims would be submitted with a pro-rated flat rate of $3.00 each, and the units billed equal to 2.

Place of Service (POS) Requirements

The place of service is determined by the location where the specimen is drawn. In all cases, the patient must be homebound in order for these services to be payable. HCPCS code P9603 is payable *only* for services provided in the beneficiary's home (POS 12). HCPCS code P9604 is payable for services provided in a nursing home (POS 32), intermediate care facility (POS 54), or skilled nursing facility (POS 31). Laboratories providing these services *must* provide the place of service as described above; claims indicating any other place of service will be returned to the provider as unprocessable.

Source: HCFA Transmittal AB-98-33, CR 536

New CLIA Waived Tests

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

- International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Prescription Home Use, effective: July 23, 2001, *CPT* code: 85610QW
- International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Professional Use, effective: July 23, 2001, *CPT* code: 85610QW
- Ostex International Osteomark NTX Point of Care Prescription Home Use, effective: July 30, 2001, *CPT* code: 82523QW
- Embryotech Laboratories FertilMARQ™ Home Diagnostic Screening Test for Male
- Infertility, effective; August 15, 2001, *CPT* code: 89300QW
- Metrika A1c Now™ – Professional Use, effective: August 17, 2001, *CPT* code: 83036QW
- Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick), effective: August 29, 2001, *CPT* code: 82044QW
- FemTek pHEM-ALERT®, effective: October 9, 2001, *CPT* code: 83986QW
- Provalis Diagnostics Glycosal™ HbA1c Test, Effective: November 9, 2001, *CPT* code: 83036QW
- Quidel QuickVue+ Infectious Mononucleosis (Whole Blood), Effective: December 18, 2001, *CPT* code: 86308QW
- Acon® Strep A Rapid Strip Test, effective: December 18, 2001, *CPT* code: 87880QW
- Beckman Coulter Primary Care Diagnostics ICON DS Strep A, effective: December 18, 2001, *CPT* code: 87880QW.

New waived *CPT* codes have been assigned for the following tests:

- 82523QW for the Ostex International Osteomark NTX Point of Care Prescription Home Use test
- 89300QW for the Embryotech Laboratories FertilMARQ™ Home Diagnostic screening Test for Male Infertility.

The additional *CPT* code 83986QW has been added for the Beckman Coulter Primary Care Diagnostics Gastroccult® test since it detects gastric occult blood and determines the pH of gastric aspirates. This test was previously approved for waived status under CLIA and its effective date is August 30, 2001.

TEST NAME	MANUFACTURER	*CPT* CODE	USE
International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Prescription Home Use	International Technidyne Corporation	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency
International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Professional Use	International Technidyne Corporation	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumarin or warfarin effect; screen for Vitamin K deficiency
Ostex International Osteomark NTX Point of Care Prescription Home Use	Ostex International Inc.	82523QW	Measures normalized cross-linked N-telopeptides of type 1 collagen in urine
Embryotech Laboratories FertilMARQ™ Home Diagnostic Screening Test for Male Infertility	Embryotech Laboratories, Inc.	89300QW	Screening test to measure sperm concentration.
Metrika A1c Now™ - Professional Use	Metrika, Inc.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick)	Diagnostic Chemicals Limited (USA)	82044QW	Semi-quantitative measurement of microablumin in urine for the detection of patients at risk for developing kidney damage
FemTek pHEM-ALERT®	FemTek, LLC	83986QW	Vaginal pH detection (acid-base balance)
Provalis Diagnostics Glycosal™ HbA1c Test	Provalis Diagnostics Ltd.	83036QW	Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes
Quidel QuickVue+ Infectious Mononucleosis (Whole Blood)	Quidel Corporation	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis
Acon® Strep A Rapid Strip Test	Acon Laboratories, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever
Beckman Coulter Primary Care Diagnostics ICON DS Strep A	Acon Laboratories, Inc.	87880QW	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis, and scarlet fever

Source: CMS Transmittal AB-02-024, CR 2033

MEDICAL NUTRITION THERAPY

Correct Payment for Medical Nutrition Therapy (MNT) Services Rendered by Registered Dietitians or Nutrition Professionals

Information concerning coverage for MNT services was published in the First Quarter 2002 *Medicare B Update!* (pages 18-19). Since that time, the Centers for Medicare & Medicaid Services (CMS) has provided clarification regarding the payment calculation for these services.

Effective for services rendered on or after January 1, 2002, payment for MNT services is made at the lesser of 80 percent of the actual charge, or 80 percent of 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, the same methodology is used for services provided in the hospital outpatient department.

As with the diabetes self-management training benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

Source: CMS Transmittal B-02-010 CR 2046

NATIONAL COVERAGE DECISION

Non-Contact Normothermic Wound Therapy (NNWT)

Based on a recent National Coverage Decision (NCD) section 60-25 of the Coverage Issues Manual on Non-Contact Normothermic Wound Therapy (NNWT) has been added. The NCD decision is to not cover NNWT.

NNWT is a device reported to promote wound healing by warming a wound to a predetermined temperature. The device consists of a noncontact wound cover into which a flexible, battery powered, infrared heating card is inserted. There is insufficient scientific or clinical evidence to consider this device as reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Social Security Act and will not be covered by Medicare.

New codes were issued for NNWT effective January 1, 2002. The codes are as follows:

E0231	Non-contact wound warming device (temperature control unit, AC adapter, and power cord) for use with warming card and wound cover.
E0232	Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover.
A6000	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card.

Intermediaries and carriers must deny claims for these codes for dates of service on or after July 1, 2002, as not medically necessary. For dates of service prior to July 1, 2002, contractors should use individual consideration.

Source: CMS Transmittal AB-02-025, CR 2027

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 or focused medical review initiatives. Both initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with the accepted standards of medical practice.

LMRP Format

The local medical review policy (LMRP) format is consistent with the manner in which the carrier reports LMRPs to the Centers for Medicare & Medicaid Services.

Effective Dates

The effective dates are provided in each policy. Effective dates are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy).

More Information

Draft LMRPs and previously published final LMRPs may be obtained by accessing the Florida Medicare provider Web site at: **www.floridamedicare.com**

Medical Policy Table of Contents

LOCAL MEDICAL REVIEW POLICIES

Delay in Implementation of Pulmonary Rehabilitation Services Policy

The local medical review policy (LMRP) for Pulmonary Rehabilitation Services in Chronic Respiratory Disease was published in the February 2002 *Medicare B Update! Special Issue* (pages 3-8). Implementation of the policy was to be April 22, 2002; however, due to additional comments received from the provider community, implementation is delayed until further notice. Please continue to refer to our provider Web site – **www.floridamedicare.com** – and future issues of the *Medicare B Update!* for information regarding the Pulmonary Rehabilitation Services LMRP.

Florida Medicare apologizes for any inconvenience this delay may cause.

Billing for Noncovered Investigational/Experimental Services

Information concerning billing of noncovered investigational and/or experimental services was provided in the February 2002 *Medicare B Update! Special Issue* (page 3). Providers billing for services that are noncovered because they are investigational and/or experimental were instructed to use ICD-9-CM diagnosis code 796.4. This policy was scheduled for implementation April 22, 2002, for services performed on or after January 1, 2002; however, it is being re-evaluated and will *not* be implemented at this time.

When a final determination is made, providers will be notified on and our Web site at **www.floridamedicare.com**, and in a future issue of the *Medicare B Update!* In the meantime, providers should continue to bill for noncovered services as instructed in the Second Quarter 2002 issue of the *Update!* (pages 7-8). Florida Medicare apologizes for any inconvenience this may have caused.

NCSVCS: The List of Medicare Noncovered Services

The List of Medicare Noncovered Services was published in the Second Quarter 2002 *Medicare B Update!* (pages 22-27). Since then, the following changes have been made to that local medical review policy.

Local Noncoverage

- The addition of nucleoplasty (64999), PulseMetric DynaPulse© System (93799GY), and transpupillary thermotherapy (G0185, 0016T) to the Local Noncoverage list, effective for dates of service on or after June 24, 2002. For more information regarding the PulseMetric DynaPulse© System, see page 59.
- The addition of the microwave modality (97020) to the Local Noncoverage list based on changes to LMRP 97010: Physical Medicine and Rehabilitation, effective for claims processed on or after March 28, 2002.

National Noncoverage

- Change Request 2036 (Transmittal AB-02-018) changed the procedure code status of *CPT* codes 76390 and 90887 to noncovered, effective for services rendered on or after January 1, 2002, that are processed on or after April 1, 2002. Therefore, 76390 and 90887 have been **added** to the National Noncoverage list.
- Change Request 1985 (Transmittal AB-01-188) and CIM 50-42 provide coverage for ambulatory blood pressure monitoring (*CPT* codes 93784, 93786, and 93790) effective for services performed on or after April 1, 2002. Therefore, 93784, 93786, and 93790 have been **deleted** from the National Noncoverage list.

J0635: Vitamin D Analogs in Chronic Renal Disease

Revision Overview: Based on feedback from CMS, a request was made to revise the oral requirement to a recommendation. Therefore, the policy was revised to indicate that an oral form of vitamin D is recommended prior to initiating parenteral vitamin D therapy.

Policy Number
J0635

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Vitamin D Analogs in Chronic Renal Disease

AMA *CPT* Copyright Statement

CMS National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
06/24/2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Vitamin D is a fat-soluble vitamin derived from natural sources (fish, liver oils) or from conversion of provitamins (7-dehydrocholesterol and ergosterol). In humans, natural supplies of vitamin D depend on ultraviolet light for conversion of 7-dehydrocholesterol to vitamin D_3 or ergosterol to vitamin D_2. Following exposure to ultraviolet light, vitamin D_3 must then be converted to the active form of vitamin D (calcitriol) by the liver and kidneys. Vitamin D is considered a hormone. Although not a natural human hormone, vitamin D_2 can substitute for D_3 in every metabolic step. Biologically active vitamin D metabolites control the intestinal absorption of dietary calcium, the tubular reabsorption of calcium by the kidney, and, in

conjunction with parathyroid hormone (PTH), the mobilization of calcium from the skeleton. They act directly on bone cells to stimulate skeletal growth and on the parathyroid glands to suppress PTH synthesis and secretion. Vitamin D is also involved in magnesium metabolism.

In patients with renal failure, the decreased capacity to synthesize 1, 25-$(OH)_2D$ and to excrete phosphate causes secondary hyperparathyroidism. This results from the lowering of serum calcium by phosphate, the impairment of calcium absorption in the intestine, and the loss of the feedback inhibitory effect of 1, 25-$(OH)_2D$ on PTH production. Hyperparathyroidism is categorized by the severity of disease as determined by the PTH level: mild to moderate (200-600 pg/mL); moderate to severe (>600-1200 pg/mL), and overt severe (> 1200 pg/mL). Management of secondary hyperparathyroidism of chronic renal failure requires both prevention and treatment. The initial preventive focus is directed at maintaining serum calcium and phosphate levels within the normal range. Treatment involves the administration of calcium salts or that of active vitamin D derivatives. Prolonged treatment with active vitamin D derivatives requires regular monitoring to avoid the occurrence of complications such as deterioration of chronic renal failure, adynamic bone disease, and extraskeletal calcifications.

This policy addresses the parenteral forms of vitamin D that include Calcitriol (Calcijex®), Paricalcitol (Zemplar®), and Doxercalciferol (Hectorol®).

Indications and Limitations of Coverage and/or Medical Necessity

Calcitriol (Calcijex®) – J0635

Florida Medicare will consider parenteral Calcitriol medically reasonable and necessary for the following indications:

- Management of hypocalcemia in patients undergoing chronic renal dialysis. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.
- Management of hypocalcemia in patients undergoing chronic renal dialysis who develop hypercalcemia on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.
- Management of secondary hyperparathyroidism and resultant metabolic bone disease in patients with moderate to severe chronic renal failure (Ccr 15 to 55 ml/min) not yet on dialysis. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.
- Management of secondary hyperparathyroidism and resultant metabolic bone disease in patients with moderate to severe chronic renal failure (Ccr 15 to 15 ml/min) not yet on dialysis who develop hypercalcemia on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.

The recommended initial dose of parenteral Calcitriol is 1-2 mcg 3 times weekly approximately every other day. The dose may be increased by 0.5-1 mcg at 2 to 4 week intervals. Calcitriol should be discontinued if hypercalcemia or serum calcium times phosphate (Ca x P) produce totals > 70. Reinitiate at a lower dose. Doses may need to be reduced as the PTH levels decrease in response to therapy (see titration table in Facts and Comparisons).

> **Note**: It is expected that patients taking oral Calcitriol received the recommended dosage as indicated in Facts and Comparisons (i.e., 0.25 mcg/day initially with titration of 0.25 mcg/day at 4-8 week intervals if needed).

Doxercalciferol (Hectorol®) – J1270

Florida Medicare will consider parenteral Doxercalciferol medically reasonable and necessary for the following indication:

- Reduction of elevated iPTH levels in the management of secondary hyperparathyroidism in patients undergoing chronic renal dialysis. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.
- Reduction of elevated iPTH levels in the management of secondary hyperparathyroidism in patients undergoing chronic renal dialysis who develop hypercalcemis on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.

The recommended initial dose of parenteral Doxercalciferol is 4.0 mcg three times a week or every other day for PTH levels >400. Dose titration is based on the following PTH levels:

PTH LEVEL	DOSE
Decreased by <50% & above 300	Increase by 1.0-2.0 mcg at at 8 week intervals
150-300	Maintain current dose
< 100	Suspend times 1 week; resume at least 1.0 mcg lower

> **Note**: It is expected that patients taking oral Doxercalciferol receive the recommended dosage as indicated in Facts and Comparisons (i.e., 10 mcgs three times a week with titration to lower blood iPTH levels into the range of 150-300 pg/ml).

Paricalcitol (Zemplar®) – J2500 and J3490

Florida Medicare will consider parenteral Paricalcitol medically reasonable and necessary for the following indications:

- Prevention and treatment of patients with secondary hyperparathyroidism associated with chronic renal failure. It is recommended that patients receive the oral form of a vitamin D analog prior to initiation of parenteral vitamin D. Reimbursement is not dependent on whether the patient has attempted oral vitamin D therapy.

- Prevention and treatment of patients with secondary hyperparathyroidism associated with chronic renal failure who develop hypercalcemia on the oral form of the drug. Hypercalcemia is defined as a serum calcium level greater than 11.2 mg/dL.

The currently accepted target range for intact parathyroid hormone (pith) levels of CRF patients is 1.5 to 3 times the non-ureic upper limit of normal. The recommended initial dose of potential Paricalcitol is 0.04-0.1 mcg/kg (2.8-7 mcg) administered as a bolus dose no more frequently than every other day at any time during dialysis. If a satisfactory response is not observed, the dose may be increased by 2 to 4 mcgs at 2 to 4 week intervals. If an elevated calcium level or a Ca x P product > 75 is noted, immediately reduce or interrupt the drug dosage until parameters are normalized and reinitiate at a lower dose. Doses may need to be reduced as the PTH levels decrease in response to therapy (see titration table in Facts and Comparisons).

> **Note**: It is expected that patients taking an oral vitamin D analog receive the recommended dosage as indicated in Facts and Comparisons.

All three vitamin D derivatives treat the patient with secondary hyperparathyroidism associated with chronic renal failure by directly suppressing the synthesis and secretion of PTH. Because calcitriol, paricalcitol, and doxercalciferol produce the same clinical effects, reimbursement will be based on the drug that is the least costly when given for patients with secondary hyperparathyroidism (diagnosis code 588.8).

CPT/HCPCS Section & Benefit Category
Drugs Administered Other than Oral Method

CPT/HCPCS Codes
J0635 Injection, calcitriol, 1 mcg ampule
J1270 Injection, doxercalciferol, 1 mcg
J2500 Injection, paricalcitol, 5 mcg

Not Otherwise Classified Codes (NOC)
J3490 Injection, paricalcitol, 2 mcg

ICD-9-CM Codes that Support Medical Necessity
Calcitriol (Calcijex) – J0635
275.41
588.8

Doxercalciferol (Hectorol®) – J1270 and Paricalcitol (Zemplar®) – J2500 and J3490
588.8

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

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

Noncovered Diagnoses
N/A

Coding Guidelines
N/A

Documentation Requirements
Medical record documentation maintained by the performing provider must substantiate the medical necessity for the use of parenteral vitamin D analogs. The documentation must support the criteria as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy. This information is normally found in the office/progress notes, facility/hospital records, and/or laboratory results.

Utilization Guidelines
N/A

Other Comments
The information provided in the Facts and Comparisons identifies titration and administration of the vitamin D analogues based on the patient's calcium, phosphorus, Ca x P product, and PTH levels. The elevated serum phosphorus, calcium/phosphorus product and secondary hyperparathyroidism in patients substantially increase the incidence of cardiac, visceral, and peripheral vascular calcification seen in this population. The current management of the upper limit of Ca x P of 70 or 75 may no longer be acceptable. The following revised treatment goals in dialysis patients have been proposed: Ca x P < 55 mg^2/dL^2, phosphorus 2.5 – 5.5 mg/dL, calcium 9.2 – 9.6 mg/dL, and PTH 100 – 200 pg/mL.

The Facts and Comparisons also indicates that dosing is calculated based on the patient's weight. Newer studies are being conducted to determine whether titration of the analogues demonstrate a more desirable clinical response using a formula (e.g., PTH level/80) rather than the patient's weight.

Sources of Information and Basis for Decision
Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - **www.floridamedicare.com**.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the Florida Society of Nephrologists.

Carrier Advisory Committee Meeting held on May 19, 2001.

Start Date of Comment Period
05/11/2001

End Date of Comment Period
06/25/2001

Start Date of Notice Period
05/01/2002

Revision History

Revision Number	1	PCR B2002-100
Start Date of Comment Period:		05/11/2001
Start Date of Notice Period:		05/01/2002
		3rd QTR 2002 *Update!*
Revised Effective Date		06/24/2002

Advance Notice Statement

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

J1561: Intravenous Immune Globulin

Revision Overview: The requirement for a radiological or CT report as diagnostic evidence to support a diagnosis of CVID that was effective for claims processed on or after 06/18/2001 (previous revision) has been deleted. In addition, language was added allowing treatment of polymyositis and dermatomyositis with IVIG when the patient cannot tolerate corticosteroids or immunosuppressive agents or when these agents are contraindicated for the patient as long as the medical record indicates the reason the patient cannot take the agent(s). These changes are effective for claims processed on or after 06/18/2001.

Policy Number
J1561

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Intravenous Immune Globulin

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Medicare Carriers Manual, Section 2049

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
08/01/1994

Original Policy Ending Date
N/A

Revision Effective Date
06/18/2001

Revision Ending Date
06/17/2001

LMRP Description
Intravenous Immune Globulin (IVIG) is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Indications and Limitations of Coverage and/or Medical Necessity
The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them. Florida Medicare will provide coverage for intravenous immune globulin when it is used in treatment of the following conditions:

1. Immunodeficiency Disorders

a) Primary Humoral Immunodeficiency Syndromes

IVIG is indicated for the treatment of patients with primary immunodeficiency syndromes such as common variable immunodeficiency (CVID), congenital agammaglobulinemia (X-linked agammaglobulinemia), severe combined immunodeficiency (SCID), X-linked immunodeficiency with hyperimmunoglobulin M (IgM), and Wiskott-Aldrich syndrome to replace or boost immunoglobulin G (IgG).

- Common variable immunodeficiency (CVID) (also known as acquired hypogammaglobulinemia, adult-onset hypogammaglobulinemia, and dysgammaglobulinemia) is characterized by reduced serum immunoglobulins, impaired antibody responses, and heterogenous clinical features. It is a rare syndrome, affecting one in 50,000 to one in 200,000 people. In most patients, the onset is in the second or third decade of life. The most common clinical presentation of CVID is an increased susceptibility to infection. Most patients experience severe recurrent and/or chronic sinopulmonary infections such as bronchitis, pneumonia, or bronchiectasis. Patients with CVID can also develop a variety of autoimmune and inflammatory disorders and are also at risk for inflammatory bowel disease.

  Once the diagnosis of CVID is suspected based on clinical presentation, laboratory confirmation should be made. A low serum IgG level is the most consistent laboratory abnormality in CVID, with most patients having concurrent deficiencies of IgA and IgM. However, there are rare instances when a patient will have normal IgG levels. Therefore, the serum immunoglobulin measurement alone does not establish a diagnosis of CVID. A definitive diagnosis of CVID is established when a patient does not demonstrate an antibody response to immunization with protein antigens (e.g., tetanus) or carbohydrate

antigens (e.g., pneumococcal capsular polysaccharides such as pneumovax).

Therefore, Florida Medicare requires the following diagnostic evidence to support a diagnosis of CVID:

- Laboratory reports demonstrating a normal to low IgG level for the assay utilized; and
- Laboratory reports demonstrating a lack of ability to produce an antibody response to protein or carbohydrate antigens (e.g., tetanus, pneumococcal capsular polysaccharides such as pneumovax).

Florida Medicare will not provide reimbursement for the initiation or continuation of intravenous immune globulin therapy based solely on a low IgG value, or for patients with mild sinopulmonary disease, or for those that do not demonstrate a lack of ability to produce an antibody to protein or carbohydrate antigens. IVIG therapy for patients with normal humoral immunity but recurrent infections, particularly upper respiratory infections, has no scientific rationale.

The dosing regimen for patients with CVID is not standardized, but is based primarily on the clinical response. Trough levels of IgG and functional antibody levels should also be taken into consideration in the management of the IVIG therapy. A patient will generally receive initial IVIG doses of 200-400 mg/kg/3 to 4 weeks. IVIG replacement in these patients is usually life-long.

- Congenital agammaglobulinemia (X-linked agammaglobulinemia) is an inherited deficiency that appears in the first 3 years of life and occurs in one out of 10,000 people. Quantitative immunoglobulins show marked deficits or absence of all five immunoglobulin classes. Peripheral blood B-lymphocytes are usually absent.
- Severe combined immunodeficiency (SCID) is a rare and fatal inherited syndrome that has an incidence of approximately one in 1,000,000 people. The typical case involves an infant less than one year of age. The lymphocyte counts are significantly below normal, the levels of B- and T-lymphocytes are absent or below normal, the lymphocyte response to mitogen is absent or below normal, and the quantitative measurements of IgG, IgA, and IgM show marked deficits.
- X-linked immunodeficiency with hyperimmunoglobulin M (IgM) is similar to X-linked agammaglobulinemia, however, these patients sometimes have lymphoid hyperplasia. The concentrations of serum IgG, IgA, and IgE are very low, whereas the serum IgM concentration is either normal or, more frequently, greatly elevated and polyclonal.
- Wiskott-Aldrich syndrome is an X-linked recessive syndrome characterized by eczema, thrombocytopenia purpura with normal-appearing megakaryocytes but small defective platelets, and undue susceptibility to infection. Patients usually present during infancy. Survival beyond the teens is rare.

b) Idiopathic Thrombocytopenic Purpura (ITP)

Idiopathic thrombocytopenic purpura (ITP) is a decrease in the circulating number of platelets in absence of toxic exposure or other disease associated with a low platelet count. It occurs as an effect of peripheral platelet destruction. Acute ITP is a disease of childhood which usually follows an acute infection and has spontaneous resolution within 2 months. Chronic ITP is a disease which persists after 6 months without a specific cause. It is usually seen in adults and persists for months to years.

Patients with platelet counts >50,000 should not be given IVIG. IVIG is also inappropriate for patients with platelet counts >30,000 who are asymptomatic or have only minor purpura.

IVIG is indicated for ITP under the following circumstances:

- When administered preoperatively for patients undergoing elective splenectomy, who have platelet counts <20,000.
- For patients with platelet counts <30,000 who have active bleeding.
- For pregnant women with platelet counts <10,000 in the third trimester.
- For pregnant women with platelet counts 10,000-30,000 who are bleeding.

The duration of treatment is generally a short course of 3 to 5 days.

c) Pediatric Human Immunodeficiency Virus (HIV) Infection

IVIG is indicated for use in HIV-infected children (less than 13 years of age) with a CD-4 lymphocyte count of greater than or equal to 200/mm3 to reduce the risk of serious bacterial infections. Laboratory reports must demonstrate an IgG level that is below the normal age-related ranges for the assay utilized. There must also be evidence of a lack of ability to produce an antibody response to immunization with protein antigens (e.g., tetanus) or carbohydrate antigens (e.g., pneumococcal capsular polysaccharides such as pheumovax). IVIG is *not* indicated for use in adult HIV patients (13 years of age and older).

2. Neurological Disorders

IVIG is indicated for the treatment of patients with neurological disorders such as Guillain-Barre' syndrome, relapsing-remitting multiple sclerosis, chronic inflammatory demyelinating polyneuropathy, myasthenia gravis, refractory polymyositis and refractory dermatomyositis. However, it is noted that not all patients with these diagnoses require treatment with IVIG.

For each of these diseases, the diagnosis of the disorder must be unequivocal. There must be clinical (history, quantitative examination), electrophysiological motor-sensory nerve conductions, electromyography (EMG), cerebrospinal fluid (CSF), and when necessary biopsy (muscle-nerve) data to support the diagnosis.

IVIG therapy will only be considered medically reasonable and necessary for the following neurological diseases when there is evidence of rapid progression of the disease or relapse.

Once treatment is initiated, we expect meticulous documentation of progress. If there is initial improvement, and continued treatment is necessary, then some type of quantitative assessment to monitor the progress is required (e.g., ADL measurements). Changes in these measures must be clearly documented. **Subjective or experiential improvement alone is insufficient to either continue IVIG or to expect coverage.**

There must be an attempt made to wean the dosage when improvement has occurred. There must be an attempt to stop the IVIG infusion if improvement is sustained with dosage reduction. If improvement does not occur with IVIG, then infusion should not continue.

- Guillain-Barre' syndrome is an acute, frequently severe, and fulminant polyneuropathy that occurs at a rate of approximately one case in a million per month. An infection generally precedes the onset of neuropathy by 1 to 3 weeks. A small proportion occur within 1 to 4 weeks of a surgical procedure. The clinical features include ascending paralysis, areflexia (absence of reflexes), possibly ascending sensory loss, and high spinal fluid protein levels. Intravenous administration of high-dose immunoglobulin given over 5 days has been proven effective.
- Multiple Sclerosis that is relapsing-remitting is characterized by unpredictable recurrent attacks of neurological dysfunction. Attacks generally evolve over days to weeks and may be followed by complete, partial, or no recovery. Patients with a relapsing-remitting course experience no progression of neurological impairment between attacks. The age of onset is generally between 15 and 60 years.
- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) includes a group of chronic progressive or relapsing, inflammatory demyelinating peripheral neuropathies that are manifested by physiological abnormalities such as slowed nerve conduction velocities or dispersion of compound muscle action potentials. Clinical features include chronic progressive or relapsing weakness with sensory loss and high spinal fluid protein levels.
- Myasthenia gravis is a disorder of neuromuscular transmission characterized by fluctuating weakness and fatigability. It is attributed to blockage of the acetylcholine receptor at the neuromuscular end-plates by anti-acetylcholine receptor autoantibodies.

  The diagnosis of myasthenia gravis is confirmed by a positive Tensilon test. Anticholinesterase drugs or thymectomy are generally the first treatments for this condition.

  IVIG is indicated in those patients with myasthenia gravis who are either refractory to corticosteroids over a 6 week period; have been unable to successfully taper corticosteroids below moderately high doses; or develop severe side effects due to steroid therapy; and have also failed at least one immunosuppressive agent (e.g., azathiprime, Methotrexate, cyclophosphamide, cyclosperine). Length of treatment with IVIG will vary due to the remittent and recurrent nature of this condition.

- Polymyositis and dermatomyositis are conditions in which the skeletal muscle is damaged by a nonsuppurative inflammatory process dominated by lymphocytic infiltration. Polymyositis begins acutely or insidiously with muscle weakness, tenderness, and discomfort. It affects proximal muscles more often than distal muscles. Dermatomyositis involves characteristic skin changes that may precede or follow the muscle syndrome and include a localized or diffuse erythema, maculopapular eruption, scaling eczematoid dermatitis, or rarely, an exfoliative dermatitis. The classic lilac-colored (heliotrope) rash is on the eyelids, bridge of the nose, cheeks (butterfly distribution), forehead, chest, elbows, knees and knuckles, and around the nailbeds. Periorbital edema is frequent.

  Diagnostic studies to support a diagnosis of polymyositis or dermatomyositis include an elevated creatine phosphokivase (CPK), an abnormal electromyography (EMG), and/or an abnormal muscle biopsy.

  IVIG is indicated in those patients with polymyositis or dermatomyositis who are either refractory to corticosteroids over a 6 week period; have been unable to successfully taper corticosteroids below moderately high doses; or develop severe side effects due to steroid therapy; and have also failed at least one immunosuppressive agent (e.g., azathioprime, Methotrexate, cyclophosphamide, cyclosperine). Length of treatment with IVIG will vary due to the remittent and recurrent nature of these conditions. The need for continuation of IVIG must be documented and would be demonstrated by continued decreased muscle strength, elevated CPKs, and/or EMG abnormalities.

  Note: For patients who are unable to tolerate corticosteroid or immunosuppressive agents, or in the rare instance that these agents are contraindicated for the patient, treatment for polymyositis or dermatomyositis will be covered only if documentation is maintained in the patient's medical record that clearly indicates the reason that the patient cannot take the corticosteroid or immunosuppressive agent.

3. Other Disorders

a) Chronic Lymphocytic Leukemia

Chronic lymphocytic leukemia is a disorder of accumulation of mature-appearing lymphocytes in blood marrow and other organs. The symptoms usually develop gradually and include fatigue, shortness of breath with activity, weight loss, or frequent infections of the skin, lungs, kidneys, or other sites. Recurrent infections are a frequent complication.

IVIG is indicated for the prevention of recurrent bacterial infections in patients with hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia (CLL) in order to help correct the patient's immunity deficiency.

b) Bone Marrow Transplantation (BMT)

IVIG is indicated to prevent the risk of acute graft-versus-host disease, associated interstitial pneumonia (infectious or idiopathic) and infections (e.g., cytomegalovirus infections [CMV], varicella-zoster virus infection, and recurrent bacterial infection) after BMT in patients 20 years of age or older in the first 100 days after transplantation. It is not indicated in BMT patients younger than 20 years of age, nor is it recommended for autologous transplants.

c) Kawasaki Disease (mucocutaneous Lymph Node Syndrome)

Kawasaki disease is an acute childhood vasculitis, the diagnosis of which is made based on clinical criteria. These criteria include fever of at least 5 days duration and at least 4 of the following: (1) polymorphic exanthem, (2) changes in the oropharynx such as fissured lips and strawberry tongue without discrete lesions, (3) changes in the extremities such as edema of the hands and feet and erythema of the palms and soles, (4) bilateral conjunctival infection without exudate, and (5) cervical lymphadenopathy, often singular and unilateral. IVIG is indicated for the treatment of Kawasaki disease when used in conjunction with aspirin.

d) Autoimmune Hemolytic Anemia

Autoimmune hemolytic anemia is an acquired anemia induced by binding of autoantibodies and/or complement to the red cells. Signs and symptoms may include, but are not limited to, weakness, fatigue, exertional dyspnea, pallor, jaundice, tachycardia, splenomegaly, hepatomegaly, and anemia. In the majority of patients, this disease is controlled by steroid therapy alone, by splenectomy, or by a combination.

Intravenous immune globulin is indicated only for those patients who have failed to respond to other forms of therapy and/or require rapid cessation of hemolysis due to severe or life threatening manifestatons of this condition. Duration of treatment is generally a short course of 3-5 weeks.

e) Autoimmune Neutropenia

Autoimune neutropenia is a hematologic disorder in which there is a decreased number of neutrophilic leukocytes in the blood due to an autoimmune mechanism. The disease is usually benign and self-limiting, and does not require treatment with IVIG. Occasionally, however, it is marked by repeated infection. IVIG may be recommended for the treatment of an absolute neutrophil count less than 800mm; with recurrent bacterial infections.

CPT/HCPCS Section & Benefit Category
Drugs and Biologicals

CPT/HCPCS Codes
J1561 J1563

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

042	279.2	357.8
204.10-204.11	283.0	358.0
279.04	287.3	446.1
279.05	288.0	710.3
279.06	340	710.4
279.12	357.0	996.85

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

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

Noncovered Diagnoses
N/A

Coding Guidelines
Evaluation and management services will be reimbursed in addition to payment for intravenous administration (*CPT* 90780-90781).

The number of units of J1561 that can be claimed on a single day of service is limited to the number for which the Medicare allowance is less than or equal to the Medicare allowance for one unit of J1563. Code J1561 should never be reported with a number of units greater than 1.

Documentation Requirements
Medical record documentation maintained by the treating physician must clearly document the medical necessity to initiate intravenous immune globulin therapy and the continued need thereof. Required documentation of medical necessity should include:

- history and physical;
- office/progress note(s);
- applicable test results with written interpretation;
- an accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/ dosage; and
- prior treatment therapies (where appropriate or referenced by this policy).

In addition, medical record documentation maintained by the treating physician for claims billed with a diagnosis of CVID must include the following: the initial presenting IgG levels and evidence that the patient has been vaccinated with pneumovax and has had pre-and post-vaccine pneumococcal antibody titers performed to demonstrate the lack of ability to produce an antibody response to protein or carbohydrate antigens.

Documentation should support the criteria for coverage as set forth in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.

Utilization Guidelines
N/A

Other Comments
N/A

Sources of Information and Basis for Decision
Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - **www.floridamedicare.com**.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2002

Revision History

Revision Number:	9	PCR B2002-095
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2002
		3rd QTR 2002 *Update!*
Revised Effective Date:		06/18/2001

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

J9999: Antineoplastic Drugs–Additions to Policy

The complete local medical review policy (LMRP) for Antineoplastic Drugs was published in the First Quarter 2002 *Medicare B Update!* (pages 31-36). Since that time, Rituximab, J9310 has received an additional indication, chronic lymphoid (lymphocytic) leukemia. Effective for services processed on or after April 22, 2002, ICD-9-CM codes 204.10-204.11 have been added to the LMRP.

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

00001: Independent Diagnostic Testing Facility (IDTF)

Revision Overview:

- ***Effective for services processed on or after 06/24/2002**, credentialing requirements added to the MRI/MRA codes and procedure code 92136; level of physician supervision added for procedure codes 70543-70549, 72195.*
- ***Effective for services rendered on or after 01/01/2002, processed on or after 04/01/2002**, Transmittal AB-02-018 (Change Request 2036) changed the status for procedure code 76390 to noncovered.*
- *The following* CPT *Codes: 76094, 76098, 76100, 76101, 76102, 76120, 76125, 76150, 76350, 76355, 76375, and 76380 were erroneously deleted from the policy and have been added back in.*

Policy Number
00001

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Independent Diagnostic Testing Facility (IDTF)

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Program Memorandum B-01-28
(Change Request 850, 4/19/01)
Transmittal 1725 (9/27/01)

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
04/19/1999

Original Policy Ending Date
N/A

Revision Effective Date
06/24/2002

Revision Ending Date
06/23/2002

LMRP Description

A new regulation (CFR section 410.33) entitled, "Independent Diagnostic Testing Facility (IDTF)," was published in the Federal Register on October 31, 1997. This regulation established that payment for diagnostic procedures would be made only where the service is provided by a physician, a group of physicians, an approved portable X-ray supplier, or an IDTF – except in the case of certain specified exceptions. An IDTF is defined as a fixed location, a mobile entity, or an individual nonphysician practitioner. This entity is independent of a hospital or physician's office. The diagnostic tests in an IDTF must be performed by licensed, certified nonphysician personnel under appropriate physician supervision.

This policy addresses the credentialing requirements and required level of physician supervision for certain diagnostic tests when performed by nonphysician personnel in an IDTF. This policy will be updated as further credentialing requirements are identified and evaluated for other diagnostic tests.

Indications and Limitations of Coverage and/or Medical Necessity

Florida Medicare will cover diagnostic tests performed by an IDTF when the medical necessity set forth in the individual Local Medical Review Policies are met and when furnished in accordance with the criteria listed below:

- Supervising physician
  An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of nonphysician personnel who use the equipment. This level of supervision is the requirement for general supervision.

  The supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. In the case of a procedure requiring the direct or personal supervision of a physician, the IDTF's supervising physician must personally furnish this level of supervision whether the procedure is performed in the IDTF or, in the case of mobile services, at the remote location.
- Nonphysician personnel
  Any nonphysician personnel used by the IDTF to perform tests must demonstrate the basic qualifications to perform the tests in question and have training and proficiency by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician must be certified by an appropriate national credentialing body.
- Ordering of tests
  All procedures performed by the IDTF must be specifically ordered in writing by the physician who is treating the beneficiary, that is, the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. The order must specify the diagnosis or other basis for the testing. The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF's supervising physician is in fact the beneficiary's treating physician. The IDTF may not add any procedures based on internal protocols without a written order from the treating physician.
- Multi-state entities
  An IDTF that operates across State boundaries must maintain documentation that its supervising physicians and technicians are licensed and certified in each of the States in which it is furnishing services.
- Applicability of State law
  An IDTF must comply with applicable laws of any State in which it operates.

The nonphysician personnel credentialing requirements listed below cover the following sections: Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology, Nuclear Medicine, Special Ophthalmological Services, Otorhinolaryngologic Services, Cardiology, Echocardiography, Cardiac Catheterization/ Electrophysiological Procedures/Other Vascular Studies, Noninvasive Vascular Diagnostic Studies, Pulmonary, Allergy and Clinical Immunology and Neurology and Neuromuscular. It is required that the nonphysician personnel performing the diagnostic tests be credentialed, as evidenced by State licensure and/or national board certification. The Carrier requires that all IDTF applicants meet the credentialing criteria as outlined in this policy on the date the applicant enrolls as an IDTF.

In addition, the credentialed and/or licensed nonphysician personnel must maintain an active licensure and/or credential status in order for the diagnostic tests to be covered.

Note: For all credentialed technologists, licensed personnel and personnel for whom no credentialing or licensing board is available, it is a requirement that the individual demonstrate proficiency in the service one is performing. This must be documented and verified by the supervising physician.

The personnel performing the tests identified under the HCPCS Codes section must have the applicable certification/licensing as listed below:

- The American Registry of Radiologic Technologists (ARRT) provides credentialing for 3 primary radiologic sciences: radiography, nuclear medicine technology, and radiation therapy technology. Once credentialing is obtained, then a General license is obtained from the Florida State Board. A person holding a license may have one or more of the following certifications:

  General Radiographer: Certified Radiologic Technologist-Radiographer (CRT-R);
  Basic Machine Operator (BMO): Certified Radiologic Technologist-Radiographer (CRT-R);

Radiation Therapy Technologist: Certified Radiologic Technologist-Radiation Therapy (CRT-T); Nuclear Medicine Technologist: Certified Radiologic Technologist-Nuclear Medicine (CRT-N).

In addition to the primary credentialing sciences mentioned above, there are 5 additional advanced examinations a technologist may take to obtain credentialing for. These are: cardiovascular interventional technology, mammography, computerized tomography, magnetic resonance imaging, and quality management.

- The American Registry of Diagnostic Medical Sonographers (ARDMS) offers the following credentials:

  Registered Diagnostic Medical Sonographer (RDMS);
  Registered Diagnostic Cardiac Sonographer (RDCS);
  Registered Vascular Technologist (RVT);
  Registered Ophthalmic Ultrasound Biometrist (ROUB).

- The RDMS credential is obtained by a combination of physical principles/instrumentation in one or more of the following specialty examinations: Abdomen (AB), Neurosonology (NE), Obstetrics/Gynecology (OB/GYN), and Ophthalmology (OP).

- The Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) offers the following credentials:

  Certified Ophthalmic Assistant (COA);
  Certified Ophthalmic Technician (COT);
  Certified Ophthalmic Medical Technologist (COMT).

- The Medical Dosimetrist Certification Board provides credentialing for radiation oncologists (MDC).
- The Nuclear Medicine Technology Certification Board (NMTCB) offers the following credential:

  Certified Nuclear Medicine Technologist (CNMT).

- The Board of Certification of the Ophthalmic Photographers' Society offers the following credentialing:

  Certified Retinal Angiographer (CRA).

- Cardiovascular Credentialing International (CCI) offers the following credentials:

  Certified Cardiographic Technician (CCT);
  Registered Cardiac Sonographer (RCS);
  Registered Cardiovascular Invasive Specialist (RCIS);
  Registered Vascular Specialist (RVS).

- The State of Florida offers the following certification:

  Emergency Medical Technician (EMT);
  Paramedic.

- The National Board for Respiratory Care (NBRC) offers the following credentials:

  Certified Pulmonary Function Tech (CPFT);
  Registered Pulmonary Function Tech (RPFT);
  Certified Respiratory Therapist (CRT);
  Registered Respiratory Therapist (RRT);
  Perinatal/Pediatric Care Specialist.

Once credentialing is obtained then a State license is obtained from the Florida state board. A person holding a license may have one or more of the above certifications.

- Registered Nurse (RN) with active state licensure and proficiency demonstration.
- Licensed Practical Nurse (LPN) with active state licensure and proficiency demonstration.
- The American Association of Electrodiagnostic Technologists (AAET) offers the following credentials:

  Registered Electrodiagnostic Technologist (R. EDT.).

- The American Board of Registration of Electroencephalographic and Evoked Potential Technologists, Inc. (ABRET) offers the following credentials:

  Registered Electroencephalographic Technologist (R. EEG T.);
  Registered Evoked Potential Technologist (R. EP T.);
  Certified Neurophysiologic Interoperative Monitoring Technologist (CNIM).

- The Board of Registered Polysomnographic Technologists (BRPT) offers the following credentials:

  Registered Polysomnographic Technologist (RPSGT).

- The National Certification of Ultrasound Diagnostic Technologists (NCUDT) offers the following credentialing:

  Abdomen/General (NCUDT);
  Obstetrics & Gynecology (NCUDT/OB/GYN;
  Certified Ultrasound Diagnostic Vascular Technologist (CUDVT);
  Certified Ultrasound Diagnostic Cardiac Technologist (CUDCT).

All credentialing examinations are obtained by a combination of physics and instrumentation and one or more of the following: Obstetrics/Gynecology, abdomen/general, vascular, and echocardiography.

Physician Supervision

Effective for services performed on or after July 1, 2001, the level of physician supervision required for diagnostic tests payable under the Medicare physician fee schedule has been revised. Physician supervision for diagnostic tests is defined under one of three categories: general supervision, direct supervision, or personal supervision (see terms defined in the "Other Comments" Section of the policy).

The levels of physician supervision of diagnostic tests are classified from 1-6. The levels are defined as follows:

1. Procedure must be performed under the general supervision of a physician.
2. Procedure must be performed under the direct supervision of a physician.
3. Procedure must be performed under the personal supervision of a physician.
4. Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

5. Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.
6. Procedure must be personally performed by a physician OR a physical therapist who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the service under State law.

For certain codes within the range of CPT codes 95860-95937, the following additional criteria apply:

Note:

a All level of supervision standards for the lead number ("6" or "7") apply; in addition, the PT with ABPTS certification may personally supervise another PT but only the PT with ABPTS certification may bill.

66 May be performed only by PTs with ABPTS certification and certification in this specific procedure, or performed personally by the physician.

77 PT with ABPTS certification (TC & PC), or direct supervision of physician (TC & PC), or technician with certification and general supervision of physician (TC only; PC physician) procedure.

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

21 Procedure may be performed by technician with certification and under general supervision of a physician; otherwise under direct supervision of physician. (TC only; PC always physician).

***CPT*-4 CODE(S)**	**CERTIFICATION**	**PHYSICIAN SUPERVISION**
54240	ARDMS: RVT; CCI: RVS; NCUDT: Abdomen/General	2
70030-70160	State license: CRT-R (General Radiographer); Medical Physicist	1
70190-70330	State license: CRT-R (General Radiographer); Medical Physicist	1
70336	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
70350-70355	State license: CRT-R (General Radiographer)	1
70360	State license: CRT-R (General Radiographer); Medical Physicist	1
70370-70371	State license: CRT-R (General Radiographer); Medical Physicist	3
70380	State license: CRT-R (General Radiographer); Medical Physicist	1
70450	State license: CRT-R (General Radiographer); Medical Physicist	1
70460-70470	State license: CRT-R (General Radiographer); Medical Physicist	2
70480	State license: CRT-R (General Radiographer); Medical Physicist	1
70481-70482	State license: CRT-R (General Radiographer); Medical Physicist	2
70486	State license: CRT-R (General Radiographer); Medical Physicist	1
70487-70488	State license: CRT-R (General Radiographer); Medical Physicist	2
70490	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
70491-70492	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2

70496-70498	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
70540	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
70542	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
70543	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
70544	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
70545-70546	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
70547	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
70548-70549	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA]	2
70551	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
70552-70553	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
71010-71022	State license: CRT-R (General Radiographer)	1
71023	State license: CRT-R (General Radiographer)	3
71030	State license: CRT-R (General Radiographer)	1
71034	State license: CRT-R (General Radiographer)	3
71035	State license: CRT-R (General Radiographer)	1
71100-71130	State license: CRT-R (General Radiographer)	1
71250	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
71260-71270	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
71275	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
71550	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1

71551-71552	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
71555	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72010-72120	State license: CRT-R (General Radiographer); Medical Physicist	1
72125	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
72126-72127	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
72128	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
72129-72130	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
72131	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
72132-72133	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
72141	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
72142	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72146	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
72147	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72148	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
72149-72158	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72159	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72170-72190	State license: CRT-R (General Radiographer); Medical Physicist	1
72191	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
72192	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1

72193-72194	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
72195	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
72196	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
72197	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72198	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
72200-72220	State license: CRT-R (General Radiographer); Medical Physicist	1
73000-73030	State license: CRT-R (General Radiographer); Medical Physicist	1
73050-73080	State license: CRT-R (General Radiographer); Medical Physicist	1
73090-73092	State license: CRT-R (General Radiographer); Medical Physicist	1
73100-73110	State license: CRT-R (General Radiographer); Medical Physicist	1
73120-73140	State license: CRT-R (General Radiographer); Medical Physicist	1
73200	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
73201-73202	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
73206	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
73218	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
73219	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
73220-73221	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
73222-73223	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
73225	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
73500-73520	State license: CRT-R (General Radiographer); Medical Physicist	1
73540-73565	State license: CRT-R (General Radiographer); Medical Physicist	1

73590-73610	State license: CRT-R (General Radiographer); Medical Physicist	1
73620-73660	State license: CRT-R (General Radiographer); Medical Physicist	1
73700	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
73701-73702	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
73706	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
73718	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
73719	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
73720-73721	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
73722-73723	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
73725	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
74000-74022	State license: CRT-R (General Radiographer); Medical Physicist	1
74150	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
74160-74170	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
74175	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	2
74181	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
74182-74183	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
74185	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
74210-74249	State license: CRT-R (General Radiographer)	3
74250	State license: CRT-R (General Radiographer)	2
74251	State license: CRT-R (General Radiographer)	3
74260-74283	State license: CRT-R (General Radiographer)	3

74290-74291	State license: CRT-R (General Radiographer)	1
74400-74415	State license: CRT-R (General Radiographer)	2
74420	State license: CRT-R (General Radiographer)	3
74710	State license: CRT-R (General Radiographer); Medical Physicist	1
74775	State license: CRT-R (General Radiographer)	3
75552	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
75553	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	2
75554-75555	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
75556	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
76003	State license: CRT-R (General Radiographer)	3
76005	State license: CRT-R (General Radiographer)	3
76010-76066	State license: CRT-R (General Radiographer); Medical Physicist	1
76070-76076	State license: CRT-R (BMO)	1
76078	State license: CRT-R (General Radiographer)	1
76090-76092	ARRT: CRT-R with advanced credentialing in mammography	1
76093-76094	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
76098	State license: CRT-R (General Radiographer)	1
76100-76125	State license: CRT-R (General Radiographer)	2
76150	State license: CRT-R (General Radiographer)	1
76350	State license: CRT-R (General Radiographer)	2
76355	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	3
76375-76380	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
76400	ARRT: Magnetic Resonance Imaging Technologist State license with documented training and experience in MRI/MRA	1
76499	Dependent on diagnostic procedure performed	
76506	ARDMS: RDMS-Neurosonology	1

76511-76513	ARDMS: RDMS-Ophthalmology; JCAHPO: COA, COT, COMT	2
76516-76519	ARDMS: ROUB, RDMS-Ophthalmology; JCAHPO: COA, COT, COMT	1
76529	ARDMS: RDMS-Ophthalmology; JCAHPO: COA, COT, COMT	1
76536	ARDMS: RDMS-Abdomen; NCUDT: Abdomen/General	1
76604	ARDMS: RDMS-Abdomen	1
76645-76778	ARDMS: RDMS-Abdomen; NCUDT: Abdomen/General	1
76800	ARDMS: RDMS-Neurosonology	1
76805-76815	ARDMS: RDMS-Obstetrics & Gynecology; NCUDT:NCUDT/OB/GYN	1
76816-76818	ARDMS: RDMS-Obstetrics & Gynecology; NCUDT:NCUDT/OB/GYN	1
76819	ARDMS: RDMS-Obstetrics & Gynecology; NCUDT:NCUDT/OB/GYN	2
76825	ARDMS: RDMS-Obstetrics & Gynecology; ARDMS: RDCS; NCUDT:NCUDT/OB/GYN	1
76826-76828	ARDMS: RDMS-Obstetrics & Gynecology; ARDMS: RDCS; NCUDT:NCUDT/OB/GYN	1
76830-76831	ARDMS: RDMS-Obstetrics & Gynecology; NCUDT:NCUDT/OB/GYN	1
76856-76857	ARDMS: RDMS-Obstetrics & Gynecology; NCUDT:NCUDT/OB/GYN	1
76870	ARDMS: RDMS-Abdomen; NCUDT: Abdomen/General	1
76872	ARDMS: RDMS-Abdomen; NCUDT: Abdomen/General	1
76873	ARDMS: RDMS-Abdomen; NCUDT: Abdomen/General	2
76880	ARDMS: RDMS-Abdomen	1
76885	ARDMS-RDMS	1
76886	ARDMS-RDMS	1
76977	Demonstrates proficiency	1
76999	ARDMS: RDMS-Appropriate credentialing based on body area examining; NCUDT: Appropriate credentialing based on body area examining	
77417	State license; MDC	1
78000-78018	State license: CRT-N, CNMT	1
78020	State license: CRT-N, CNMT	1
78070-78075	State license: CRT-N, CNMT	1
78099	State license: CRT-N, CNMT	
78102-78195	State license: CRT-N, CNMT	1
78199	State license: CRT-N, CNMT	

78201-78291	State license: CRT-N, CNMT	1
78299	State license: CRT-N, CNMT	
78300-78350	State license: CRT-N, CNMT	1
78399	State license: CRT-N, CNMT	
78414-78455	State license: CRT-N, CNMT	1
78456	State license: CRT-N, CNMT	1
78457-78458	State license: CRT-N, CNMT	1
78460-78483	State license: CRT-N, CNMT	1
78494-78496	State license: CRT-N, CNMT	1
78499	State license: CRT-N, CNMT	
78580-78596	State license: CRT-N, CNMT	1
78599	State license: CRT-N, CNMT	
78600-78607	State license: CRT-N, CNMT	1
78610-78660	State license: CRT-N, CNMT	1
78699	State license: CRT-N, CNMT	
78700-78761	State license: CRT-N, CNMT	1
78799	State license: CRT-N, CNMT	
78800-78807	State license: CRT-N, CNMT	1
78999	State license: CRT-N, CNMT	
92081-92083	JCAHPO: COT, COMT	1
92100-92130	JCAHPO: COA	1
92135-92136	JCAHPO: COA	1
92235-92240	JCAHPO: COT, COMT; Registered Nurse; CRA	2
92250	JCAHPO: COT, COMT; CRA	1
92265-92275	JCAHPO: COT, COMT; Registered Nurse	3
92283-92284	JCAHPO: COA, COT, COMT	2
92285	JCAHPO: COT, COMT; CRA	2
92286	JCAHPO: COT, COMT; Registered Nurse; CRA	3
92287	JCAHPO: COT, COMT; Registered Nurse; CRA	3
92516	Certified Audiologist	5
92520	Speech Pathologist	5
92541-92548	Certified Audiologist	5
92552-92557	Licensed Audiologist	5
92561-92584	Licensed Audiologist	5
92585-92586	ABRET: R. EP T., R. EEG T.; Audiologist	5
92587-92589	Licensed Audiologist	5

93000-93005	CCI: CCT, RCS; Registered Nurse (RN); Paramedic; Licensed Practical Nurse (LPN)	1
93012	CCI: CCT, RCS; Registered Nurse (RN); Paramedic	1
93015-93017	CCI: CCT, RCS; Registered Nurse (RN); Paramedic	2
93024	CCI: CCT, RCS; Registered Nurse (RN); Paramedic	3
93040-93278	CCI: CCT, RCS; Registered Nurse (RN); Paramedic	1
93303-93308	ARDMS: RDCS; CCI: RCS; NCUDT: CUDCT	1
93312	ARDMS: RDCS; CCI: RCS; NCUDT: CUDCT	3
93315	ARDMS: RDCS; CCI: RCS; NCUDT: CUDCT	3
93320	ARDMS: RDCS; CCI: RCS; NCUDT: Abdomen/General, OB/GYN, CUDVT, CUDCT	1
93321-93325	ARDMS: RDCS, RDMS (Obstetrics & Gynecology); CCI: RCS; NCUDT: Abdomen/General, OB/GYN, CUDVT, CUDCT	1
93350	ARDMS: RDCS; CCI: RCS, CCT for stress portion; Registered Nurse; Paramedic; NCUDT: CUDCT	1
93501	State license: CRT-R (General Radiographer); CCI: RCIS, RCS; Registered Nurse	3
93505	State license: CRT-R (General Radiographer); CCI: RCIS, RCS; Registered Nurse	3
93510-93533	State license: CRT-R (General Radiographer); CCI: RCIS, RCS; Registered Nurse	3
93555-93572	State license: CRT-R (General Radiographer); CCI: RCIS, RCS; Registered Nurse	3
93600-93642	CCI: CCT, RCIS, RCS; ARDMS: RDCS; Registered Nurse	3
93613	CCI: CCT, RCIS, RCS; ARDMS: RDCS; Registered Nurse	3
93660	CCI: CCT, RCIS, RCS; ARDMS: RDCS; Registered Nurse	3

93701	Demonstrates Proficiency	1
93720-93721	ARDMS: RVT; CCI: RVS	1
93724	CCI: CCT; Registered Nurse; Paramedic	3
93727	CCI: CCT; Registered Nurse; Paramedic	2
93731-93732	CCI: CCT; Registered Nurse; Paramedic	2
93733	CCI: CCT; Registered Nurse; Paramedic	1
93734-93735	CCI: CCT; Registered Nurse; Paramedic	2
93736	CCI: CCT; Registered Nurse; Paramedic	1
93741-93744	CCI: CCT; Registered Nurse; Paramedic	2
93770	CCI: CCT; Registered Nurse; Paramedic	1
93799	CCI: CCT; Registered Nurse; Paramedic	
93875-93882	ARDMS: RVT; CCI: RVS; NCUDT:CUDVT	1
93886-93888	ARDMS: RVT; CCI: RVS	1
93922-93990	ARDMS: RVT; CCI: RVS; NCUDT:CUDVT	1
94010	State license: CPFT, RPFT, CRT, RRT; Registered Nurse (RN)	1
94060-94070	State license: CPFT, RPFT, CRT, RRT; Registered Nurse (RN)	2
94200-94375	State license: RPFT, RRT, CPFT, CRT	1
94400-94450	State license: RPFT, RRT, CPFT, CRT	2
94620	State license: RPFT, RRT; Registered Nurse (RN)	1
94621	State license: RPFT, RRT; Registered Nurse (RN)	2
94664-94665	State license: CPFT, RPFT, CRT, RRT; Registered Nurse (RN)	2
94680-94690	State license: RPFT, RRT	2
94720-94750	State license: RPFT, RRT	1
94760-94762	Demonstrates proficiency	1

94770	State license: RPFT, RRT	1
94799	State license: Appropriate credentialing based on service performing	
95004	RN with active state license	2
95024-95056	RN with active state license	2
95805, 95807-95811	ABRET: R. EEG T; BRPT: RPSGT; State license: CPFT, RPFT, CRTT, RRT	1
95812-95822, 95827	ABRET: R. EEG T.	1
95900-95904	AAET: R. EDT; ABRET: R. EP T; Qualified Physical Therapist who is permitted to perform service under state law	77a
95921	AAET: R. EDT	2
95922-95923	AAET: R. EDT	3
95925-95930	ABRET: R. EP T., R. EEG T.	21
95933-95937	AAET: R. EDT; Qualified Physical Therapist who is permitted to perform service under state law	77a
95950-95953	ABRET: R. EEG T.	1
95954	ABRET: R. EEG T.	3
95956-95957	ABRET: R. EEG T.	1
95958	ABRET: R. EEG T.	3
95999	Appropriate credentialing based on service performing	
G0004-G0015	CCI: CCT; Registered Nurse (RN); Paramedic	1
G0050	ARDMS: RDMS-Abdomen; NCUDT: Abdomen/General	1
G0030-G0047, G0125	ARRT: CRT-N; NMTCB: CNMT	1
G0130	State license: CRT-N, CNMT	1
G0131-G0132	ARRT: Computerized Tomography Technologist State license with documented training and experience in CT; Medical Physicist	1
G0195-G0196	Speech Pathologist	
G0202-G0206, G0236	ARRT: CRT-R with advanced credentialing in mammography	1
G0210-G0234	ARRT: CRT-N; NMTCB: CNMT	1
Q0035	CCI: CCT; Registered Nurse (RN); Paramedic	1

CPT/HCPCS Section & Benefit Category

Diagnostic Ultrasound/Radiology
Noninvasive Vascular Diagnostic Studies/Medicine
Male Genital System
Pulmonary/Medicine
Cardiovascular/Medicine
Diagnostic Radiology
Radiation Oncology/Radiology
Nuclear Medicine/Radiology
Ophthalmology/Medicine
Special Otorhinolaryngologic Services/Medicine
Allergy and Clinical Immunology/Medicine
Neurology and Neuromuscular Procedures/Medicine

CPT/HCPCS Codes

G0004	70140	71270	73120	74260	76810	78231	78647	92568	93572	94240
G0005	70150	71275	73130	74270	76815	78232	78650	92569	93600	94250
G0006	70160	71550	73140	74280	76816	78258	78660	92571	93602	94260
G0015	70190	71551	73200	74283	76818	78261	78699	92572	93603	94350
G0030	70200	71552	73201	74290	76819	78262	78700	92573	93609	94360
G0031	70210	71555	73202	74291	76825	78264	78701	92575	93610	94370
G0032	70220	72010	73206	74400	76826	78270	78704	92576	93612	94375
G0033	70240	72020	73218	74410	76827	78271	78707	92577	93613	94400
G0034	70250	72040	73219	74415	76828	78272	78708	92579	93615	94450
G0035	70260	72050	73220	74420	76830	78278	78709	92582	93616	94620
G0036	70300	72052	73221	74710	76831	78282	78710	92583	93618	94621
G0037	70310	72069	73222	74775	76856	78290	78715	92584	93619	94664
G0038	70320	72070	73223	75552	76857	78291	78725	92585	93620	94665
G0039	70328	72072	73225	75553	76870	78299	78730	92586	93621	94680
G0040	70330	72074	73500	75554	76872	78300	78740	92587	93622	94681
G0041	70336	72080	73510	75555	76873	78305	78760	92588	93623	94690
G0042	70350	72090	73520	75556	76880	78306	78761	92589	93624	94720
G0043	70355	72100	73540	76003	76885	78315	78799	93000	93631	94725
G0044	70360	72110	73550	76005	76886	78320	78800	93005	93640	94750
G0045	70370	72114	73560	76010	76977	78350	78801	93012	93641	94760
G0046	70371	72120	73562	76020	76999	78399	78802	93015	93642	94761
G0047	70380	72125	73564	76040	77417	78414	78803	93017	93660	94762
G0050	70450	72126	73565	76061	78000	78428	78805	93024	93701	94770
G0125	70460	72127	73590	76062	78001	78445	78806	93040	93720	94799
G0130	70470	72128	73592	76065	78003	78455	78807	93041	93721	95004
G0131	70480	72129	73600	76066	78006	78456	78999	93224	93724	95024
G0132	70481	72130	73610	76070	78007	78457	92081	93225	93727	95027
G0195	70482	72131	73620	76075	78010	78458	92082	93226	93731	95028
G0196	70486	72132	73630	76076	78011	78460	92083	93230	93732	95044
G0202	70487	72133	73650	76078	78015	78461	92100	93231	93733	95052
G0204	70488	72141	73660	76090	78016	78464	92130	93232	93734	95056
G0206	70490	72142	73700	76091	78018	78465	92135	93235	93735	95805
G0210	70491	72146	73701	76092	78020	78466	92136	93236	93736	95807
G0211	70492	72147	73702	76093	78070	78468	92235	93268	93741	95808
G0212	70496	72148	73706	76094	78075	78469	92240	93270	93742	95810
G0213	70498	72149	73718	76098	78099	78472	92250	93271	93743	95811
G0214	70540	72156	73719	76100	78102	78473	92265	93278	93744	95812
G0215	70542	72157	73720	76101	78103	78478	92270	93303	93770	95813
G0216	70543	72158	73721	76102	78104	78480	92275	93304	93799	95816
G0217	70544	72159	73722	76120	78110	78481	92283	93307	93875	95819
G0218	70545	72170	73723	76125	78111	78483	92284	93308	93880	95822
G0220	70546	72190	73725	76150	78120	78494	92285	93312	93882	95827
G0221	70547	72191	74000	76350	78121	78496	92286	93315	93886	95900
G0222	70548	72192	74010	76355	78122	78499	92287	93320	93888	95903
G0223	70549	72193	74020	76375	78130	78580	92516	93321	93922	95904
G0224	70551	72194	74022	76380	78135	78584	92520	93325	93923	95921
G0225	70552	72195	74150	76400	78140	78585	92541	93350	93924	95922
G0226	70553	72196	74160	76499	78160	78586	92542	93501	93925	95923
G0227	71010	72197	74170	76506	78162	78587	92543	93505	93926	95925
G0228	71015	72198	74175	76511	78170	78588	92544	93510	93930	95926
G0229	71020	72200	74181	76512	78172	78591	92545	93511	93931	95927
G0230	71021	72202	74182	76513	78185	78593	92546	93514	93965	95930
G0231	71022	72220	74183	76516	78190	78594	92547	93524	93970	95933
G0232	71023	73000	74185	76519	78191	78596	92548	93526	93971	95934
G0233	71030	73010	74210	76529	78195	78599	92552	93527	93975	95936
G0234	71034	73020	74220	76536	78199	78600	92553	93528	93976	95937
G0236	71035	73030	74230	76604	78201	78601	92555	93529	93978	95950
Q0035	71100	73050	74240	76645	78202	78605	92556	93530	93979	95951
54240	71101	73060	74241	76700	78205	78606	92557	93531	93980	95953
70030	71110	73070	74245	76705	78206	78607	92561	93532	93981	95954
70100	71111	73080	74246	76770	78215	78610	92562	93533	93990	95956
70110	71120	73090	74247	76775	78216	78615	92563	93555	94010	95957
70120	71130	73092	74249	76778	78220	78630	92564	93556	94060	95958
70130	71250	73100	74250	76800	78223	78635	92565	93561	94070	95999
70134	71260	73110	74251	76805	78230	78645	92567	93571	94200	

Not Otherwise Classified Codes (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
N/A

Diagnoses that Support Medical Necessity
N/A

ICD-9 Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for Denials
When performed for indications other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the separate individual local medical review policies.

When the medical record does not verify that the service described by the HCPCS code was provided.

Noncovered ICD-9 Codes
N/A

Noncovered Diagnoses
N/A

Coding Guidelines
The performing provider must have on-site 24 hour availability when the *CPT*/HCPCS code(s) identifies the services as one performed for 24 hours. The use of an answering service or machine for review at a later time to meet the 24 hour requirement, is not appropriate.

Effective 1/1/2000, procedure code 93770 is considered a bundled service and therefore, is not separately reimbursable.

Effective 1/1/2000, procedure codes 94760 and 94761 are considered bundled services and therefore, are not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day.

Documentation Requirements
Medical record documentation maintained by the Independent Diagnostic Testing Facility must include the information listed below:

- hard copy documentation of the test results and interpretation; and
- the medical necessity (reason) for performing the diagnostic test(s).

In addition, documentation must be available upon request verifying that the technician performing the service(s) meet(s) the credentialing requirements as outlined in this policy.

Also, the IDTF must maintain documentation of sufficient physician resources during all hours of operations to assure that the required physician supervision is furnished. Documentation must be maintained in the IDTF that the personnel performing the diagnostic test(s) have been adequately trained and demonstrates proficiency in the performance of the service(s). This documentation must contain verification by the supervising physician(s).

Utilization Guidelines
N/A

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

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

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

Sources of Information and Basis for Decision
Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - **www.floridamedicare.com**.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Phase I presented at the 11/14/1998 Carrier Advisory Committee Meeting. Phase II presented at the 02/20/1999 Carrier Advisory Committee Meeting.

Phase III presented at the 08/25/2001 Carrier Advisory Committee Meeting.

Phase IV presented at the 01/19/2002 Carrier Advisory Committee Meeting.

Start Date of Comment Period
01/11/2002

End Date of Comment Period
02/25/2002

Start Date of Notice Period
05/01/2002

Revision History

Revision Number:	12	PCR B2002-084
Start Date of Comment Period		01/11/2002
Start Date of Notice Period		05/01/2002
		3rd QTR 2002 *Update!*
Revised Effective Date:		06/24/2002

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

31231: Diagnostic Nasal Endoscopy

The local medical review policy (LMRP) for diagnostic nasal endoscopy was published in the Fourth Quarter 2001 *Medicare B Update!* (pages 57-59). **Effective for services processed on or after March 25, 2002**, the diagnosis code range for malignant neoplasm of nasal cavities, middle ear, and accessory sinuses (**160.0-160.9**) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP for procedure codes **31231-31235** and **92511**.

66821: Yag Laser Capsulotomy

Revision Overview: To further define the medical necessity and reasonableness of performing a Yag laser capsulotomy within four months following cataract surgery.

Policy Number
66821

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Yag Laser Capsulotomy

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 35-52

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
08/17/1998

Original Policy Ending Date
N/A

Revision Effective Date
06/24/2002

Revision Ending Date
06/23/2002

LMRP Description
The neodymium:YAG (Nd:Yag) laser is used to create posterior capsulotomies for posterior capsule opacification. Posterior capsule opacification generally occurs following cataract surgery. Desired outcomes of use of the Nd:Yag laser are an increase in visual acuity and/or improvement in glare and contrast sensitivity.

Indications and Limitations of Coverage and/or Medical Necessity
Florida Medicare will consider the Nd:Yag laser capsulotomy medically necessary and reasonable if the following criteria are met:

- The patient complains of symptoms such as blurred vision, visual distortion and/or glare resulting in reduced ability or inability to carry out activities of daily living due to decreased visual acuity or an increase in glare, particularly under bright light conditions, and/or conditions of night driving.
- The eye examination confirms the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods:
    - The eye examination should demonstrate decreased light transmission (visual acuity < 20/30 or < 20/25 if the procedure is performed to assist in the diagnosis and treatment of retinal detachment) after other causes of loss of acuity have been ruled out, or
    - Additional testing must demonstrate 1) contrast sensitivity testing resulting in a decreased visual acuity by two (2) lines or 2) a decrease of two (2) lines of visual acuity in the glare tester.
- This procedure should not be routinely scheduled after cataract surgery and rarely would it be expected to see this procedure performed within four months following cataract surgery. However, if a patient develops a posterior capsular opacification within four months following cataract surgery, Yag laser capsulotomy will be considered medically reasonable and necessary when the documentation demonstrates the following: the patient is experiencing symptoms of blurred vision, visual distortion, and/or glare with associated functional impairments; decreased light transmission (visual acuity < 20/30; and/or contrast sensitivity testing or glare testing resulting in a decreased visual acuity by two (2) lines.
- Occasionally, a Yag laser capsulotomy may also be performed to assist in the diagnosis and treatment of retinal detachment; to assist in the diagnosis and treatment of macular disease; to assist in the diagnosis and treatment of diabetic retinopathy; to evaluate the optic nerve head; or to diagnose posterior pole tumors.
- Generally, the Yag laser capsulotomy is expected to be performed only once per eye per lifetime of a beneficiary.

CPT/HCPCS Section & Benefit Category
Surgery/Eye and Ocular Adnexa

CPT/HCPCS Codes
66821

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
366.50
366.51
366.53

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

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

Noncovered Diagnoses
N/A

Coding Guidelines
Report procedure code 66821 with the -50 modifier if the procedure is done bilaterally.

Report procedure code 66821 with a -LT or -RT modifier if performed on one eye only.

Report procedure code 66821 with a -78 modifier if performed within 90 days of cataract surgery.

When a series of procedures is planned for the removal of a posterior dense fibrotic capsule, it will be covered as a single procedure.

If the procedure is performed on the same patient, on the same eye and is not part of a series of posterior capsule removal, documentation must be submitted to determine the medical necessity of the subsequent procedure(s).

Documentation Requirements
Documentation such as the patient's medical record should demonstrate very clearly why Yag laser capsulotomy was performed. This should include the results of a visual acuity test and/or a glare test

If procedure code 66821 is billed within four months of cataract surgery, documentation must be submitted with the claim to determine medical necessity.

Utilization Guidelines
It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Other Comments
N/A

Sources of Information and Basis for Decision
Sources of information may be found online under "Medical Policy" in the Part B section on our provider Web site - **www.floridamedicare.com**.

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the Florida Society of Ophthalmology.

Carrier Advisory Committee Meeting held on January 19, 2002.

Start Date of Comment Period
01/11/2002

End Date of Comment Period
02/25/2002

Start Date of Notice Period
05/01/2002

Revision History

Revision Number	2	PCR B2002-091
Start Date of Comment Period:		01/11/2002
Start Date of Notice Period:		05/01/2002
		3rd QTR 2002 *Update!*
Revised Effective Date		06/24/2002

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

84100: Serum Phosphorus

The local medical review policy (LMRP) for serum phosphorus (**84100**) was published in the First Quarter 2001 *Medicare B Update!* (pages 72-74). Since that time, the following changes have been made to "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP:

- Diagnosis code **275.3** was added, **effective for claims processed on or after March 25, 2002.**
- Diagnosis codes **403.01, 403.11, 404.02, 404.03, 404.12,** and **404.13** were added, **effective for claims processed on or after April 29, 2002.**

84436: Thyroid Function Tests

The local medical review policy for thyroid function tests was published in the First Quarter 2002 *Medicare B Update!* (pages 61-63). Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy: ICD-9-CM code 354.0 (Carpal tunnel syndrome) and E942.0 (agents primarily affecting the cardiovascular system, cardiac rhythm regulators). In addition, ICD-9-CM code 783.4 (Lack of expected normal physiological development in childhood) was expanded to specificity 783.40- 783.43. These revisions are effective for claims processed on or after March 25, 2002.

85651: Sedimentation Rate, Erythrocyte

Revision Overview: Policy was revised to add ICD-9-CM code 783.21 to the list of covered diagnoses.

Policy Number
85651

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Sedimentation Rate, Erythrocyte

AMA *CPT* Copyright Statement

CMS National Coverage Policy
N/A

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
12/01/1993

Original Policy Ending Date
N/A

Revision Effective Date
04/22/2002

Revision Ending Date
04/21/2002

LMRP Description
The erythrocyte sedimentation rate (ESR) is a sensitive but nonspecific test that is frequently the earliest indicator of disease when other chemical or physical signs are normal. It is most often used as a gauge for determining the progress and detection of an inflammatory disorder caused by infection, autoimmune mechanisms, or connective tissue disease.

Indications and Limitations of Coverage and/or Medical Necessity
Erythrocyte sedimentation rate is a covered service under the Medicare program when deemed medically necessary.

An ESR should be performed by or under the direct supervision of a physician within the accepted standards of medical practice.

The ESR is a covered service for:

- aiding in the diagnosis of temporal arteritis (giant cell arteritis) and polymyalgia rheumatica;
- monitoring disease activity in temporal arteritis and polymyalgia rheumatica for the principal indication of adjusting the dosage of corticosteroids;
- monitoring patients with treated Hodgkin's disease; and
- monitoring patients with autoimmune diseases, including rheumatoid arthritis.

CPT/HCPCS Section & Benefit Category
Pathology and Laboratory/Hematology and Coagulation

CPT/HCPCS Codes
85651
85652

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity

200.20	201.74	391.2
200.21	201.75	391.8
200.22	201.76	410.00-410.02
200.23	201.77	410.10-410.12
200.24	201.78	410.20-410.22
200.25	201.90	410.30-410.32
200.26	201.91	410.40-410.42
200.27	201.92	410.50-410.52
200.28	201.93	410.60-410.62
201.40	201.94	410.70-410.72
201.41	201.95	446.0
201.42	201.96	446.5
201.43	201.97	447.6
201.44	201.98	556.0-556.9
201.45	202.00	696.0
201.46	202.01	710.0
201.47	202.02	710.1
201.48	202.03	710.2
201.50	202.04	710.4
201.51	202.05	710.9
201.52	202.06	714.0
201.53	202.07	714.1
201.54	202.08	714.2
201.55	202.80	714.30
201.56	202.81	714.81
201.57	202.82	714.9
201.58	202.83	716.59
201.60	202.84	719.49
201.61	202.85	720.0
201.62	202.86	725
201.63	202.87	729.1
201.64	202.88	733.99
201.65	240.0- 240.9	783.21
201.66	241.0- 241.9	E933.1
201.67	242.00-242.91	E933.8
201.68	245.0 - 245.9	E935.6
201.70	246.8	E947.2
201.71	279.4	V10.72
201.72	391.0	
201.73	391.1	

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

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

The ESR is not indicated in asymptomatic persons. (This service is not covered when performed for screening purposes.)

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

Noncovered Diagnoses
N/A

Coding Guidelines
When billing for either 85651 or 85652 include the ICD-9-CM diagnosis code indicating the condition for which the test is being performed.

Erythrocyte sedimentation rates performed on rheumatoid arthritis patients to assess for medication adjustments should be billed with the E diagnosis code which reflects the medication the patient is receiving. These diagnosis codes are to be billed only for rheumatoid arthritis medication evaluation:

E933.1 for patients receiving antineoplastic and immunosuppressive drugs such as methotrexate.
E935.6 for patients receiving antirheumatics such as gold salts.
E947.2 for patients receiving antidoes and chelating agents, such as penicillamine.

Documentation Requirements
Documentation in support of medical necessity would include a history and physical, progress notes, and lab reports indicating the following information:

An ESR should be used selectively in patients with symptoms that are not explained by results of a careful history and physical examination.

Rapid screen for elevated protein or globulin level in serum ESR may be used with or replaced by C-Reactive protein in evaluation of unexplained inflammatory states.

Electronic Media Claims can be submitted for these services.

Utilization Guidelines
It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Other Comments
Terms Defined:
Sedimentation rate: a nonspecific laboratory test of speed at which erythrocytes settle. In this test, blood to which an anticoagulant has been added is placed in a long, narrow tube, and the distance of the red cells fall in one hour is the rate, ESR. The speed at which the cells settle depends upon the size of the clumps into which the red cells aggregate, and the size of the clumps appears to depend upon the amount of fibrinogen and beta globulin in the blood.

Sources of Information and Basis for Decision
Clinical Laboratory Tests, Values and Implications; Springhouse Corporation
Taber's Cyclopedic Medical Dictionary

Advisory Committee Notes
This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on October 23, 1993.

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2002

Revision History

Revision Number:	10	PCR B2002-089
Start Date of Comment Period		N/A/01/2002
Start Date of Notice Period		05/01/2002
		3rd QTR 2002 *Update!*
Revised Effective Date:		04/22/2002

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

90800: Psychiatric Services

Revision Overview: Transmittal AB-02-018 (Change Request 2036) changed the status for procedure code 90887 to noncovered. This change is effective for services performed 01/01/2002 processed on or after 04/01/2002.

Policy Number
90800

Contractor Name
First Coast Service Options, Inc.

Contractor Number
00590

Contractor Type
Carrier

LMRP Title
Psychiatric Services

AMA *CPT* Copyright Statement

CMS National Coverage Policy
Coverage Issues Manual, Section 35-14
Medicare Carriers Manual, Sections 2476.2-2476.5 and 4900.6

Primary Geographic Jurisdiction
Florida

Secondary Geographic Jurisdiction
N/A

CMS Region
Region IV

CMS Consortium
Southern

Original Policy Effective Date
04/11/1994

Original Policy Ending Date
N/A

Revision Effective Date
01/01/2002

Revision Ending Date
12/31/2001

LMRP Description
Psychology is the study of human behavior. The study of human behavior can be accomplished at four levels:

- Observation
- Understanding
- Prediction
- Control

To control behavior it is necessary to understand it. To understand it is to appreciate the nature of the variables that cause behavior. There are two broad sets of variables; individual and environmental.

The goal of therapy is to change the patient's faulty evaluation of future outcomes, either by changing the way environmental information is processed or by training the patient in skills that will allow him or her to expect desired behavioral outcomes, or by doing both.

Indications and Limitations of Coverage and/or Medical Necessity
Family counseling services (90846, 90847, 90849) are covered only where the primary purpose of counseling is for the treatment of the patient's condition.

Two situations where family counseling services would be appropriate are:

- there is a need to observe the patient's interaction with family members, or
- there is a need to assess capability of and assist the family members in aiding in the management of the patient.

Documentation for family counseling services should be maintained on file in the event of a postpayment audit.

Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders (M0064) are not subject to the benefit limitation. However, where a particular treatment rendered to a patient is primarily psychotherapy, it will be subject to the limitation and 908xx series of codes should be used.

Psychological testing (96100) with interpretation and report per hour is a covered service. The hours reported should include administration, scoring, and reporting.

Reimbursement for hypnotherapy (90880) will be limited to the session having the greatest length of time when performed on the same day by the same physician.

CPT/HCPCS Section & Benefit Category
Medicine/Psychiatry

CPT/HCPCS Codes
90845 90846 90847 90849 90862 90880
90882 90885 90887 90889 96100

Not Otherwise Classified Codes (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
N/A

Diagnoses that Support Medical Necessity
N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity
N/A

Diagnoses that DO NOT Support Medical Necessity
N/A

Reasons for Denials
Psychological testing 96100 is not covered for Licensed Clinical Social Workers.

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

Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (90887) is a noncovered service.

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

Procedure codes 90885, and 90889 are bundled services, and, therefore, not separately reimbursable.

Noncovered ICD-9-CM Codes
N/A

Noncovered Diagnoses
N/A

Coding Guidelines
Reimbursement for other psychotherapeutic services (90842-90844, 90849) on the same day of service as insulin shock therapy (90899) or convulsive therapy (90870-90871) is made only if it is documented that psychotherapy was rendered prior to insulin shock or convulsive therapy.

Conjoint marital therapy and supervision of treatment team are noncovered services. For services not covered under the psychology or social worker benefit, modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) should be added to the applicable procedure code.

The outpatient psychiatric limitation applies to the physician's therapeutic services, but not to his diagnostic services (except those administered to follow the progress of a course of psychiatric treatment for a diagnosed condition).

Three types of diagnostic services that are exempt from the limitation:

- Psychiatric testing - Use of actual testing instruments.
- Psychiatric consultations - Evaluation made by a physician for the purpose of preparing a report for the attending physician.
- Initial psychiatric visits - Evaluation made by the physician who treats the patient.

Clinical psychologists should use the AH modifier with covered services. Licensed Clinical Social Worker should apply the AJ modifier when filing for covered services.

The approved charges are the lower of the billed amount or the fee schedule amount and are based on an assigned basis.

Documentation Requirements
Psychological Testing (96100) should only be performed in the following situations:

- Diagnostic puzzle, which cannot be answered by other means or a re-examination of patient status in regards to significant aspects of daily living (such as driving). The result of testing will change the treatment plan.
- Documentation should clearly state the questions to be answered, and why they cannot be answered on the basis of clinical interview alone. If the patient has a diagnosis of senile dementia and is incapable of a physical/verbal response or cannot actively participate in the testing, then testing would not be appropriate.

The provider has a responsibility to maintain a record for prepayment audit.

The required documentation for medical necessity should include:

Interpretation and report per hour of psychological testing, including, but not limited to: MMPI, Wechsler Index, Beck Depression Inventory, Bender-Gestalt Test, and Projective Drawings in patients with severe conditions as major depression or schizophrenia.

Utilization Guidelines
N/A

Other Comments
Terms defined:

Alzheimer's Disease: a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration.

Hypnotherapy: psychotherapy that facilitates suggestion, re-education or analysis by means of hypnosis.

Narcosynthesis (Narcoanalysis): psychotherapy performed under sedation for the recovery of repressed memories together with the emotion accompanying the experience. The goal is toward reintegration of the patient's personality.

Psychotherapy: treatment of mental or emotional disorder or maladjustment by psychological means especially involving verbal communication (as in psychoanalysis, nondirective psychotherapy, re-education, or hypnosis).

Sources of Information and Basis for Decision
Contemporary Psychology
Innovative Psychotherapies
PQAB/JC 08/92

Advisory Committee Notes
N/A

Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
05/01/2002

Revision History

Revision Number:	5	PCR B2002-093
Start Date of Comment Period		N/A
Start Date of Notice Period		05/01/2002
		3rd QTR 2002 *Update!*
Revised Effective Date:		01/01/2002

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

92502: Special Otorhinolaryngologic Services—Correction to Policy

The local medical review policy for special otorhinolaryngologic services was published in the Second Quarter 2002 *Medicare B Update!* (pages 67-68). Since that time, the following correction has been made to the list of *CPT* codes in the "Indications and Limitations of Coverage and/or medical Necessity" section of the policy: *CPT* code range 92531-9***3***534 has been changed to range 92531-9***2***534. This change is effective for claims processed on or after April 15, 2002.

94010: Spirometry;
94240: Functional Residual Capacity or Residual Volume

The local medical review policies for Spirometry (94010) and Functional Residual Capacity or Residual Volume (94240) were published in the First Quarter 2002 *Medicare B Update!* (pages 70-75). Since that time, additional diagnoses have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of **both** policies. The additions include the following ICD-9-CM codes: 500, 501, 502, 503, 504, 505, 506.4, and 506.9. These changes are effective for services processed on or after April 29, 2002.

97399: Noncoverage of PulseMetric DynaPulse© System for use as an Electrical Thoracic Bioimpedance Device)

The PulseMetric DynaPulse© system measures cardiac output using a pulse-waveform analysis of blood flow through a special brachial artery blood pressure cuff. Its patented algorithm allows the physician to determine a patient's cardiac output as an aid in the treatment and management of cardiovascular disease. The data is then transmitted to the Pulse Dynamic Analysis Center, run by PulseMetric. The result of the Center's analysis is then transmitted to the patient's physician, where the analysis is displayed for his/her use in diagnosing and treating the patient.

The current devices on the market that meet the definition of HCPCS code M0302 Cardiac output monitoring by electrical bioimpedance (which was replaced with *CPT* code 93701 after January 1, 2002) derive the cardiac output from analysis of the impedance waveforms vs. blood flow. However, the DynaPulse© device analyzes the arterial blood pressure waveforms vs. blood flow to derive the cardiac output. The DynaPulse© device does not meet the definition of the devices that utilize electrical bioimpedance to noninvasively produce hemodynamic measurements of cardiac output as defined in section 50-54 of the Medicare Coverage Issues Manual, as the DynaPulse© device utilizes blood pressure wave forms rather than electrical bioimpedance. Therefore, it is not appropriate to bill for HCPCS code M0302 (or *CPT* code 93701 after January 1, 2002) for the performance of cardiac output monitoring by electrical bioimpedance. When the DynaPulse© device is utilized, unlisted procedure code **93799GY should be billed instead.**

FOCUSED MEDICAL REVIEW

Comprehensive Data Analysis Findings

The Comprehensive Data Analysis Department (formerly known as the Focused Medical Review Department) recently reviewed several *CPT* codes used for billing surgical pathology staining services, codes associated with cerumen removal and binocular microscopy, and codes used for billing anesthesia services.

Pathology Codes

The following *CPT* codes were included in the analyses of surgical pathology staining services:

Code	Descriptors
88311	*Decalcification procedure (List separately in addition to the code for surgical pathology examination)*
88312	*Special stains (List separately in addition to code for surgical pathology examination); Group I for microorganisms (e.g., Gridley, acid fast, methenamine silver), each*
88313	*Group II, all other, (e.g., iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each*

Several items of interest were noted during the analysis of this code grouping, which clearly indicates a number of billing and coding errors occurring frequently in Florida. A number of coding articles are available in national coding journals that indicate these services are frequently mis-coded by providers.

- These three codes are a part of the general surgical pathology subsection.
- Guidelines indicate these services are to be coded in addition to the primary pathology code.
- Medicare defines "a unit of service" as *each individual staining method and single specimen*. Specimen is further defined as the entire mass, growth, etc. no matter how many times the specimen is sliced/cut.
- Please note that special stains are billed per stain, per specimen regardless of the number of slides. For example, if one specimen with one stain were used on multiple slides, the stain would be reported once. If one specimen received three different stains, the correct staining code would be reported with three units.

Cerumen Removal Services

Florida Medicare developed and implemented local medical review policy (LMRP) on cerumen removal (*CPT* 69210) in March 2001. Providers were notified in the policy that "cerumenectomy/*CPT* 69210" is only covered when performed using a binocular microscope (*CPT* 92504), or some other form of operating microscope. Based on the recent analysis of binocular microscopy by the comprehensive data analysis team, it appears that Florida providers are billing the cerumenectomy and binocular microscopy services on the same day for the same patient. It was not the intent of the LMRP to allow providers payment for both services when rendered on the same day; rather the intent is to allow reimbursement for the cerumenectomy service when performed using some form of binocular microscopy. Please make note of this policy and bill for the cerumenectomy procedure *only* (*CPT* 69210) when performed by a physician utilizing the binocular microscope.

Inappropriate Anesthesia Billing

The following codes for anesthesia services were included in the analyses:

Code	Descriptor
00100	*Anesthesia for procedures on salivary glands, including biopsy*
00103	*Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)*
00140	*Anesthesia for procedures on eye; not otherwise specified*
00142	*lens surgery*
00530	*Anesthesia for permanent transvenous pacemaker insertion*
00910	*Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified*
01922	*Anesthesia for non-invasive imaging or radiation therapy*

The following bullets highlight the key issues identified through these analyses:

- The majority of diagnosis codes billed with *CPT* code 00140 were inappropriate. Providers *should not* bill this procedure with ICD-9-CM diagnosis codes 366.0 through 366.9, which represent diagnoses related to the lens. *CPT* code 00140 describes procedures on the eye *not* related to lens surgery.
- The most frequent ICD-9-CM code billed with 00140 was 366.16 (senile nuclear cataract), which comprised more than 12 percent of the total number of diagnoses billed with this procedure for the six month period analyzed. When billing for lens-related surgical procedures, *CPT* 00142 should be utilized.
- The majority of claims for *CPT* code 01922 appeared to be for monitored anesthesia care related to conscious sedation administered during MRI and other procedures such as CT scans, indicating a widespread *routine* usage of conscious sedation with these procedures. Billing for Monitored Anesthesia Care requires one-on-one monitoring by the provider throughout the *duration* of the procedure. Providers need to ensure documentation provides evidence of medical necessity for sedation, and consequently, MAC, as well as evidence of continuous monitoring activity. Modifier QS must be included on the claim to indicate MAC.
- It was also noted that several providers routinely billed for MAC while concurrently billing for the direction of two or more CRNAs. Because of the one-to-one coverage expected, MAC cannot be billed as performed during other activities.

ELECTRONIC MEDIA CLAIMS

CMS Issues Model Plan to Extend Deadline for Compliance with Electronic Transactions Rule

The following is a release from the CMS Public Affairs Office dated March 29, 2002

The Centers for Medicare & Medicaid Services (CMS) today issued a model compliance plan that will allow health plans, health care clearinghouses and health care providers to receive a one-year extension to comply with the new rule governing electronic health care transactions.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the Department of Health and Human Services (HHS) to adopt national standards for conducting health care transactions electronically. By ensuring consistency throughout the industry, these national standards will make it easier for health plans and for doctors, hospitals and other health care providers to process claims electronically.

The original deadline for compliance with the electronic transactions rule was Oct. 16, 2002 for all covered entities except small health plans, which by law had an additional year. Last year, in the Administrative Simplification Compliance Act, Congress authorized a one-year extension – to Oct. 16, 2003 – for those covered entities required to comply in 2002. To obtain the extension, a covered entity must submit a compliance plan on or before Oct. 15, 2002. Covered entities can use the model plan for this purpose.

"This model plan will help healthcare businesses prepare to meet these transaction standards while giving them until October 2003 to finish the job," HHS Tommy G. Thompson said. "Once adopted, these national standards will make it less costly to process claims, reducing administrative costs nationwide."

Today, different insurers require a wide variety of electronic and paper forms from health care providers filing claims. With the national standards, all health care providers—including physicians and other practitioners, hospitals and nursing facilities—will be able to use the new standards, and all health plans will be required to accept these standard electronic transactions.

"Implementing the electronic health care transactions standard is critical," CMS Administrator Tom Scully said. "This extension will allow providers time to assess their compliance needs, thoroughly test their systems and be ready under the new standards."

A covered entity will be able to submit its extension plan electronically through the CMS Web site, **www.cms.hhs.gov/hipaa**, and CMS will provide an electronic confirmation of receipt of the plan. Covered entities also have the option of submitting its own version of an extension plan that provides equivalent information and can submit a plan on paper. Instructions for filing a plan are available on the Web site.

Covered entities (except for small health plans) that do not submit a compliance plan must comply with the HIPAA electronic transactions rule by Oct. 16, 2002. Small health plans with less than $5 million in receipts already have until October 2003 to comply and do not need to submit a compliance plan.

Under the Administrative Simplification Compliance Act, health care plans and providers must submit information on their compliance activities, including budget, assessment of compliance concerns, whether a contractor or vendor might be used to help achieve compliance, and a schedule for testing to begin no later than April 16, 2003.

The model compliance plan, and instructions on how to complete it, is available at **www.cms.hhs.gov/hipaa**. Electronic submission capability will be available soon on the Web site. The model compliance plan and instructions also will be published in the Federal Register in the near future.

The electronic transactions standards are one of a series of national "administrative simplification" provisions included in HIPAA. More information on other standards, including health information privacy standards, is available at **http://aspe.hhs.gov/admnsimp**.

Source: CMS Press Release, March 29, 2002

Administration Simplification Compliance Act (ASCA)—Questions and Answers

On December 27, 2001, President Bush signed the *Administrative Simplification Compliance Act* (Public Law 107-105). This law provides for a one-year extension of the date for complying with the Health Insurance Portability and Accountability Act–Administration Simplification (HIPAA-AS) standard transactions and code set requirements (until October 16, 2003) for any covered entity that submits to the Secretary of Health and Human Services, prior to October 16, 2002, a plan of how the entity will come

into compliance with the HIPAA-AS requirements by October 16, 2003. This law can be viewed at the following Web site at **www.access.gpo.gov/nara/publaw/107publ.html**. Below are questions and answers regarding the ASCA from the Centers for Medicare & Medicaid Services (CMS) Web site: **www.cms.hhs.gov**. The "we" referenced in this article refers to CMS.

Q1: What will be the impact of the one-year extension?

A1: The delay will give covered entities more time to build, test, and successfully implement the new Final Electronic Transactions and Code Sets required by HIPAA.

Q2: Does the extension affect the compliance date for the HIPAA privacy standards?

A2: No, the compliance date for the privacy standards is still April 2003 or, for small health plans, April 2004.

Q3: Can small health plans get an extension to their current compliance date of October 2003?

A3: No, the compliance date for small plans does not change.

Q4: Do all covered entities automatically get an extension?

A4: No. Covered entities must submit a compliance extension plan to the Department of Health and Human Services (HHS) before October 16, 2002 to get an extension.

Q5: Why didn't Congress just give everyone an extension?

A5: The requirement to submit a compliance extension plan provides assurance that covered entities have plans in place that will allow them to be compliant by the new deadline of October 16, 2003.

Q6: Is HHS going to actually review and approve all these compliance extension plans? Will some be denied?

A6: The law does not require approval or disapproval of plans. Submission of an extension plan is sufficient to secure the one-year extension.

Q7: When will the model compliance extension form be available?

A7: The form will be available by March 31, 2002.

Q8: Where can I get a copy of the form? Do I have to use the form, or can I submit a compliance plan in another format?

A8: We will publish the form in the **Federal Register** and will also make it available on several Web sites. The compliance extension form we are developing is a model. While we strongly recommend its use, covered entities may submit plans using other formats.

Q9: How extensive will the model compliance extension form be?

A9: We are still working on the form, but we intend to make it as simple and easy to complete as possible. The ASCA requires the plans to contain summary information regarding compliance activities, including: 1) budget, schedule, work plan and implementation strategy for achieving compliance; 2) planned use of contractors or vendors; 3) assessment of compliance problems; and 4) a timeframe for testing to begin no later than April 16, 2003.

Q10: My organization has a very detailed, voluminous compliance plan – are we supposed to submit the whole thing?

A10: No. The compliance extension form will ask only for summary information from your detailed plan. You do not need to send other information.

Q11: Can I file the compliance extension form electronically?

A11: Yes, we will encourage electronic filing of compliance extension plans, although we will also accept plans submitted on paper.

Q12: What will be the application deadline for a delay?

A12: Covered entities must submit their compliance extension plans by October15, 2002.

Q13: Where should I send my completed compliance extension form?

A13: Please do not submit requests at this time. Instructions will be issued that will explain how to submit compliance extension plans.

Q14: How will one covered entity know whether another covered entity with which it does business has submitted a plan?

A14: Each covered entity should communicate directly with its own trading partners to determine which ones have submitted plans. This information could be included in establishing schedules for the testing activities that are to begin by April 16, 2003, culminating in a migration to the new standards that meets the needs of all trading partners.

Q15: I believe I will be fully compliant by October 2002. However, I know that some of my trading partners are requesting extensions and will continue to use nonstandard formats after that date. Do I need to submit a compliance extension plan so that I can continue to communicate with these partners using nonstandard transactions?

A15: No. A covered entity will be considered compliant if it can send and receive compliant transactions, and therefore would not need to submit an extension plan.

Q16: Can a plan require its network providers to move to standard transactions before October 16, 2003?

A16: This is a business decision between the plan and its provider network. Neither HIPAA nor ASCA preclude plans from requiring that their providers use standard transactions in advance of the compliance deadline, but HIPAA noncompliance penalties would not apply to a provider that has submitted a plan until 2003.

Q17: What will be done with the information I provide?

A17: ASCA requires that a sample of the plans will be provided to the National Committee on Vital and Health Statistics (NCVHS), an advisory committee to the Secretary of Health and Human Services. The NCVHS will review the sample to identify common problems that are complicating compliance activities, and will periodically publish recommendations for solving the problems.

Q18: Will the information I provide be made public?

A18: Under the Freedom of Information Act (FOIA), information held by the federal government is available to the public on request, unless it falls within one of several exemptions. The model form will be designed to avoid collection of any information that would be subject to exemption, such as confidential personal or proprietary information. If such information is submitted, both the FOIA and the ASCA require that it be redacted before the files are released either to the NCVHS or to the public.

Q19: How does the delay affect Medicare implementation activities?

A19: Medicare will continue to implement the HIPAA transaction standards on a sequenced basis, and that schedule will not change significantly. We expect to be ready to test the claim and several other transactions by Spring 2002, but implementation of several transactions (such as the referral/authorization transaction) will be in early FY 2003. Once a provider has successfully tested a transaction with us, it will be able to use the standard in our production environment.

Q20: When will Medicaid Agencies begin testing compliant transactions with their trading partners?

A20: Each Medicaid State Agency has its own project plan for achieving HIPAA compliance, and will decide whether to submit a compliance extension plan. If you are a trading partner, you will receive notice of testing directly from the Medicaid State Agency(s) with whom you do business.

Q21: Do software vendors need to file for an extension?

A21: No. Only covered entities – plans, clearinghouses and providers – must file. In fact, vendors will need to maintain their current delivery schedules for compliant software in order for covered entities to make use of the additional implementation time.

Q22: Should covered entities discontinue testing until 2003?

A22: ASCA requires that compliance plans include a testing phase that would begin no later than April 16, 2003. We recommend that all covered entities begin to test as soon as they are ready in order to allow adequate time to address and correct problems. CMS will soon send out an instruction with dates by which Medicare contractors must begin testing with providers.

Q23: ASCA allows the Secretary of HHS to exclude covered entities from the Medicare program if they do not submit a compliance extension plan or achieve compliance by October 2002. Will every such covered entity be excluded?

A23: HHS will be publishing proposed regulations to address this new exclusion authority.

Q24: Doesn't the law also require Medicare claims to be submitted electronically after October 2003?

A24: ASCA prohibits HHS from paying Medicare claims that are not submitted electronically after October 16, 2003, unless the Secretary grants a waiver from this requirement. It further provides that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances. We will publish proposed regulations to implement this new authority.

Source: http://www.hcfa.gov/medicaid/hipaa/adminsim/hascaq&a.htm

Health Insurance Portability and Accountability Act (HIPAA)—New Testing Timeline

Based on transmittal AB-02-020 received from the Centers for Medicare & Medicaid Services (CMS) and effective February 8, 2002, testing dates have changed for the ASC X12N version 4010 electronic transactions listed below. The testing dates provided in this instruction replace those that have been previously communicated.

Transaction Number	Transaction Description	Available for Trading Partner Testing
837	Health Care Claim	May 1, 2002
835	Health Care Claim Payment (Remittance) Advice	May 16, 2002
276/277	Health Care Claim Status Request & Response	July 16, 2002

Note: The 2003 dates indicated below are only applicable if you have filed for an extension as provided by the Administrative Simplification Compliance Act (for information on this law, refer to the article on pages 61-63). In the absence of filing an extension, compliance must be obtained by October 16, 2002, as specified by the Transaction and Code Set Final Rule.

837-Electronic Claim Submission

As of October 2003, Medicare will switch to exclusive use of the ANSI X12N 837 Version 4010 for submission of inbound claims. Beginning on or about May 1, 2002, Medicare will be able to receive test files in the ANSI X12N 837 Version 4010 format. EDI (Electronic Data Interchange) submitters are required to pass specified levels of testing on this transaction prior to acceptance of production files.

835-Electronic Remittance Advice

General testing, while not required but recommended, will begin on or around May 16, 2002, and is scheduled to continue through October 2003. Testing will occur on a first-come, first-serve basis. Due to the large number of senders who will be testing, Medicare EDI encourages senders to begin their testing early. Senders who wait until the last few months of testing may not have enough time to prepare for the 4010 migration. Medicare will switch to exclusive use of the ANSI X12N 835 Version 4010 as of October 2003.

276/277-Electronic Claim Status Request/ Response

Providers, agents, and clearinghouses are not required, in most cases, to test the 276/277 transactions prior to production submission of a 276 claim status request or for receipt of a 277 claim status response. You are required to notify Medicare when you plan to begin submitting 276 version 4010 queries. The X12N 276/ 277 Version 004010X093 transaction will become available for testing on or about July 16, 2002. Medicare will switch to exclusive use of the ANSI X12N 276/277 Version 4010 as of October 2003.

First Coast Service Options, Inc. (FCSO), the Medicare carrier for Florida, strongly encourages new EDI submitters to begin with HIPAA formats, rather than test and submit production transactions in pre-HIPAA formats. FCSO will not enroll any new EDI submitters on pre-HIPAA formats after October 1, 2002.

PC-ACE Pro32® software users are not required to test the software. PC-ACE Pro32® software in the ANSI ASC X12N Version 4010 format required for Medicare claims will become available on or near July 15, 2002.

Source: CMS Transmittal AB-02-20, CR2039

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

GENERAL INFORMATION

FRAUD AND ABUSE

Payment to Supplier of Diagnostic Tests for Purchased Interpretations

It has come to the attention of this carrier that some providers may not be aware of the rules governing purchased interpretations for diagnostic tests. From the Medicare Carriers Manual, section 3060.5:

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

- The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;
- The person or entity providing the tests and purchasing the interpretations submits either an assigned or unassigned claim for both the tests and the interpretations thereof; and
- The physician or medical group providing the interpretations does not see the patient.
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

The purchaser must keep on file the name, the provider identification number and address of the interpreting physician."

Source: MCM section 3060.5

Four "Rights" Can't Go Wrong

As a contractor for the Federal government, First Coast Service Options, Inc. (FCSO) is responsible for ensuring the integrity of the Medicare program. Our objective is clear: "Pay the **right** amounts to the **right** providers for the **right** services on behalf of the **right** beneficiaries."

FCSO believes the majority of our customers, that is, health care providers and people with Medicare, are honest and try not to abuse the Medicare program. Therefore, the actions we take as a Medicare contractor when improper payments are identified must be fair and appropriate. We employ a number of processes, both proactive and reactive, to help identify and address improper payments. For example:

- There are numerous medical policies and "edits" within our claims processing system that help identify and prevent inappropriate payments. Some edits are designed to automatically deny payment based on the information on the claim; others prompt us to manually review the claim to ensure services are appropriate for the patient.
- We receive complaints of alleged fraudulent activities on a regular basis. Before any punitive measures are considered, we rule out the obvious—billing errors, payment errors, or misunderstandings of information. The findings of our research determine the course of action to take: correcting claims information, collecting monies paid in error, and/or providing clarification to our customers. If fraud is suspected, further research is conducted to substantiate or negate the allegations.
- We analyze claims submissions for aberrancies or unusual billing patterns. Identification of such occurrences does not automatically indicate potential fraud. Rather, it provides a basis for researching why a particular aberrancy or billing pattern is occurring. Again, the results of our research determine the course of action, whether it's education, review of claims for medical necessity, collection of overpaid funds, investigation of suspected fraudulent activities, or nothing at all.

The work we do to protect the Medicare program is important work. Efforts during fiscal year 2001 resulted in $523.2 million in savings to the Medicare program. In terms of efficiency: for every tax dollar we spent on safeguards activities, $18 was returned to the Medicare program. In addition, the work we contributed toward prosecution of healthcare fraud cases in 2001 resulted in more than $165 million in fines, restitution, penalties, and settlements.

We at FCSO are proud of our contributions to protecting the Medicare program, and we are committed to ensuring that taxpayer dollars are used as they should be—to care for those who need it.

Inappropriate Billing of Diagnostic Tests

Medicare guidelines impose no special charge or payment constraints on diagnostic tests performed by a physician or a physician's employees under his or her supervision. However, attempts may be made by the medical diagnostic community to adjust or establish arrangements that allow physicians to profit from others' work or by creating the appearance a physician performed or supervised his or her employees' performance of diagnostic services. Some of these arrangements may involve cardiac scanning services, pacemaker monitoring, or mobile ultrasound companies leasing their equipment to physicians and hiring out their staff to the physician to meet supervision requirements.

These arrangements appear to be suspect. They are viewed as a transparent attempt to circumvent the prohibition against marking-up purchased diagnostic tests. The mere issuance of a W-2 from the physician does not automatically make the leasing company's technician the physician's employee for purposes of the employer-employee tests. Rather, the determination of a valid employer-employee relationship is dependent upon factors such as: who has the right to hire and fire, who trains the employee, who is paying health and retirement benefits, who schedules work, who approves sick and vacation time, and so forth.

Another arrangement used to circumvent the purchased diagnostic service provision is when the ordering physician reassigns his or her payment for interpretation of the test to the supplier. The supplier, in turn, bills for both the test and interpretation, and pays the ordering physician a fee for the interpretation. This arrangement violates provisions that prohibit Medicare from paying benefits due the person who furnished the service to any other person, subject to limited exceptions (such as payment to a group that employs the physician). This arrangement may constitute a violation of anti-kickback statutes, which prohibit remuneration for referrals.

As a final example, there are medical equipment supply companies that furnish equipment and technicians at no charge to physicians (e.g., for pacemaker analysis) in hopes the physician will either recommend or endorse their products to a hospital or other facility. At face value, there are no provisions of law that prohibit this activity. However, if the physician then bills the services as a global charge (as if the services were personally furnished by him or her or by an employee under his or her supervision), it may constitute a violation of the False Claims Act, because the physician is claiming payment for services where no expense is incurred. Therefore, billing such services as a global charge is inappropriate. Rather, the physician should bill for only the interpretation. This arrangement may also constitute a violation of anti-kickback statutes, as the equipment supply company is providing free services in return for the purchase of their equipment.

Medicare Fraud Alert: Inappropriate Billing of Free Samples or Items

Federal regulations do not prohibit sales representatives from a pharmaceutical company or durable medical equipment supply company, to furnish free samples or items to physician practices, hospitals, or other health care providers and suppliers for their use. Regulations also do not prohibit health care providers from furnishing these free samples or items to their patients as part of their care. However, it is *not* appropriate for the health care provider to submit claims for payment to Medicare for furnishing such free samples or items. Such an activity may constitute a violation of the False Claims Act, as the provider is claiming payment for items for which no expenses are incurred. In addition, this activity may be considered a violation of the Anti-Kickback Statutes, as the sales representatives' intent for furnishing free samples or items appears questionable. That is, it gives the appearance sales representatives are expecting the provider to purchase or endorse their products, in return for billing for the free samples or items.

It is understood that receiving free samples and items from sales representatives is a common business practice. However, regardless of the circumstances, health care providers may not request payment for these free samples and items from the Medicare program.

FINANCIAL SERVICES

Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR), or the current value of funds rate (5 percent for calendar year 2001). The Secretary of the Treasury has notified the Department of Health and Human Services that the PCR has been changed to 12.625 percent, effective February 1, 2002. The PCR notice was published in the *Federal Register* (See Vol. 67, No. 22 dated 02/01/02).

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

INTEREST RATE TABLE

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

Source: CMS Transmittal AB-02-011, CR 1897

MEDICARE REGISTRATION

Electronic Medicare Provider/Supplier Enrollment Forms

The Centers for Medicare & Medicaid Services (CMS) recently announced the availability of five electronic Medicare Provider/Supplier Enrollment forms that may be accessed on the CMS Web site at **http://www.hcfa.gov/medicare/enrollment/forms/**. These forms include the CMS 855A, CMS 855B, CMS 855I, CMS 855R and CMS 855S. A comprehensive user guide providing detailed instructions on how to download these applications is also available on the Web site. Providers/suppliers can complete a form on their computer, save it as a file, and print the completed form for final signature and submission. Providers/suppliers *cannot* submit these forms electronically at this time.

Physicians, nonphysician practitioners, and other healthcare providers who have additional questions should contact customer service at (866) 454-9007. Suppliers with questions should contact the National Supplier Clearinghouse.

Source: CMS Transmittal AB-02-029 CR 2045

HOME HEALTH CONSOLIDATED BILLING

Payment for Therapy Services Wrongfully Denied

In October 2000, edits were installed in the Common Working File (CWF) to enforce the consolidated billing of home health services for dates of services falling within an open home health (HH) Prospective Payment System (PPS) episode of care. The edits applied to certain outpatient therapy services and nonroutine medical supplies that were defined in the HH PPS final rule (65 FR 41128), published in the *Federal Register* on July 3, 2000. An updated list of procedure codes corresponding to those services was published in the First Quarter 2002 *Medicare B Update!* (pages 80-81). Before October 2001, these edits applied only if an HHA had submitted a request for anticipated payment (RAP) for the episode.

These denials occurred even when the beneficiary received therapy services after he or she was no longer under the home health plan of care, but the home health agency had not yet filed a claim to end the episode. Under CWF edits in place October 2000 through September 2001, some claims for therapy services that should have been paid were improperly denied. These denials occurred when the beneficiary received therapy services prior to the end of the 60-day period that was established based on the RAP, but before the home health agency filed the claim to end the episode in CWF. CWF edits were revised to correct this problem in October 2001. Therefore, claims that are submitted for therapy services and supplies under these conditions will not be rejected by CWF as bundled into HH PPS if processed on or after October 1, 2001.

Therapists may resubmit improperly denied claims where each of the following criteria are met:

- Claims were submitted on or after October 1, 2000 but before October 1, 2001.
- Claims were for therapy services bundled into home health consolidated billing.

For the improperly denied claims, therapists received remittance advice notice: B15: "Claim denied/reduced because this procedure/service is not paid separately."

The resubmitted claims will pay if they do not overlap with the period between the first and last service date in a home health episode; however, if they do overlap with such periods, they will again be denied because they are correctly being edited for home health consolidated billing.

Source: CMS Transmittal B-02-009 CR 1991

Correction of Remark Code Message

Remittance advice remark codes were provided in the Second Quarter 2002 *Medicare B Update!* (pages 89-97). Since that publication was released, CMS has issued a revision to remark code N70 is being revised. The correct message will now read: "Home health consolidated billing and payment applies." This change is effective for services processed on or after March 29, 2002.

Source: CMS Transmittal AB-02-041 CR 2080

SNF CONSOLIDATED BILLING

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

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

Update to Coding Files

Add to file: Part A stay, always submit to carrier/DMERC (PCTC=0)

A4651	A4707	A4721	A4726	A4802	E1637	G0245
A4652	A4708	A4722	A4736	A4911	E1638	G0246
A4656	A4709	A4723	A4737	A4928	E1639	G0247
A4657	A4719	A4724	A4766	A4929	G0124	P3001
A4706	A4720	A4725	A4801	E1500	G0141	V5299

Remove from file: Part A stay, always submit to carrier/DMERC (PCTC= 0)

83020	84182	86256	86334	88372	96002	G0118	G0195	G0199	L5669
83912	85390	86320	87164	89060	96003	G0121	G0196	G0200	
84165	85576	86325	87207	95833	97601	G0193	G0197	G0201	
84181	86255	86327	88371	95834	G0117	G0194	G0198	J3370	

Add to file: Part A stay, only submit to carrier with modifier 26 (PCTC=1)

76075	83020	84182	86256	86334	88372	G0131
76977	83912	85390	86320	87164	89060	G0132
78890	84165	85576	86325	87207	93770	
78891	84181	86255	86327	88371	94150	

Add to file: Part B stay only, always consolidated - Rehab B

95833	96000	96002	97601	G0194	G0196	G0198	G0200
95834	96001	96003	G0193	G0195	G0197	G0199	G0201

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

GENERAL INFORMATION

Payment to Hospice Members Enrolled in Managed Care Organizations (MCOs)

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42CFR Part 417, Subpart P, 42 CFR 417.585 Special Rules: Hospice Care (b), and 42 CFR 417.531 Hospice Care Services (b).

Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an MCO to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician, if the physician is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

Billing of Covered Services

The MCO may directly bill for attending physician services, as listed above, to Medicare carriers in keeping with existing processes.

Medicare physicians may also bill such services directly to carriers as long as all current requirements for billing hospice beneficiary services are met. Revised requirements for such billing were recently set forth in Transmittal 1728,

Change Request (CR) 1910 of the Medicare Carriers Manual (MCM), Part 3, effective April 1, 2002. This CR specifies use of modifiers GW (service not related to the hospice patient's terminal condition) and GV (attending physician not employed by or paid under agreement by the patient's hospice provider). Please refer to the February 2002 *Medicare B Update! Special Issue*, page 8) for more information.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Timely Filing

The above instructions apply to all contractors for claims filed in the timely filing period for managed care enrollees who have elected hospice. The timely filing period extends from the date of service to the end of the calendar year after the year service was rendered. However, if a service was provided in the fourth quarter of a calendar year, the claim will be timely to the end of the second year after the year in which the service was rendered.

Source: CMS Transmittal AB-02-015 CR 2013

Beneficiaries Previously Enrolled in Managed Care Who Transition to Traditional Fee for Service (FFS)

When a beneficiary who was previously enrolled in a Medicare Health Maintenance Organization (HMO)/managed care program transitions to traditional FFS, he or she is subject to all benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS. It is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may continue to receive such items and services only if they would be entitled to them under Medicare FFS coverage criteria and documentation requirements.

For example, if a beneficiary received a manual wheelchair under their HMO/managed care plan, he or she would need to meet Medicare coverage criteria and documentation requirements for manual wheelchairs. He or she would have to obtain a Certificate of Medical Necessity (CMN), and would begin an entirely new rental period, just as a beneficiary enrolled in FFS is required to do when obtaining a manual wheelchair for the first time.

There is an exception to this rule if a beneficiary was previously enrolled in FFS and received a capped rental item, then enrolled in an HMO, stayed with the HMO for 60 or fewer days, then returned to FFS. CMS has interpreted an end to medical necessity to include enrollment in an HMO for 60 or more days.

Another partial exception to this rule involves home oxygen claims. If a beneficiary has been receiving oxygen while under a Medicare HMO, the supplier must obtain an initial CMN and submit it to the Durable Medical Equipment Regional Carrier (DMERC) at the time that FFS coverage begins. However, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the Initial Certification date on the CMN, but the test must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare HMO, it does not necessarily follow that he/she will qualify for oxygen under FFS.

These instructions apply whether a beneficiary voluntarily returns to FFS, or if he or she involuntarily returns to FFS because their HMO or managed care plan no longer participates in the Medicare+Choice program.

Source: CMS Transmittal 1740, CR 1966

Changes to the Standard Paper Remittance (SPR) Advice Notice

In an effort to reprogram SPRs to correspond to the X12 835 changes for HIPAA, a number of improvements have been made in the SPR format. This article, based on the Centers for Medicare & Medicaid Services (CMS) Program Memorandum (PM) 1953, provides details of revisions to the SPR format to incorporate those improvements and information on balancing financial amounts in an SPR. These changes are effective with SPRs created on or after April 20, 2002.

Sample SPR Format

The sample SPR found on pages (71-72) provides an example of the general format, but an actual SPR may contain additional (or fewer) lines (e.g., a line for additional reason code(s) may be added after first reason code line). The following format changes are included in this revision:

1. "AMOUNT PAID TO BENEFICIARY," and "MSP AMOUNT" fields used to compute provider payment will now be reported as reason code adjustments, rather than in separate fields.
2. There is a new claim level field for the informational reporting of late filing reductions.
3. There is also space to provide the submitted HCPCS code and the paid HCPCS code at each service line.
4. The "TOTAL OFFSET" field has been renamed as "PROVIDER ADJ."
5. The " TOTAL PAID TO BENEFICIARY," and "TOTAL OTHER ADJUSTMENTS" fields have been deleted at the provider level.

SPR Balancing

As with an electronic remittance advice (835), the amounts reported in a paper remittance advice must balance at the transaction, the claim and the service line levels, following these formulas:

- **Service line balancing:**
  Submitted line charge – Sum of service level RC amounts = Prov Pd (Calculated pmt to provider)
- **Claim level balancing:**
  Billed (submitted claim level charge) – Sum of all service level RC amounts = Prov Pd (calculated pmt to provider at the claim level)
- **Transaction level balancing:**
  Sum of all Prov. Pd amounts in the claim segments – Total provider adj. = Amount of check

General SPR Information

- The computed field "NET" includes "PROV PD" (Calculated Pmt to Provider, CLP04 in the 835), INTEREST, LATE FILING CHARGES and PREV PAID.
- Only the name of the first supplemental crossover insurer on Florida Medicare's files will appear on the SPR, even if the beneficiary has more than one supplemental insurer.
- The amount of check is the sum of all claim level payments less any provider level adjustments.
- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.
- On an SPR for the adjusted claim, the "PREV PAID" field shows the amount paid for the original voided claim.

SPR Changes

OLD	NEW
Account Number (18) bytes	Account Number expanded to (20) bytes
Provider Offsets using 4010	Now reporting in the Glossary Section
Glossary Section Title has removed the word "Offset Codes"	Replaced with the words "Adjustment Codes"
ADJS Line: Total Prev Pd, Total Pd To Bene, Total MSP, Total Offset, Total Other Adj, Amount of Check	Completely removed from footer of SPR. Two fields Total Int, 'PD to Bene' and 'Total MSP' are now combined and displaying under Prov PD Amt
ADJS Line: at claim level has changed From PREV PD, PD TO Bene, INT, MSP	ADJS line: at claim level now reflects PREV PD, INT, Late Filing Charge: The Pd to Bene and MSP are now combined and displays in the detail Prov PD.
Offset Details Lines	Renamed as Provider ADJ Details:
Offset Detail Lines: had field 'ACNT/ Name'	This field has been removed and a new field has been added "PLB Reason Code."

Glossary Changes

Old ADJ/Offset Reason Codes	New	Description
BF	**FB**	Forwarding Balance
1. This can represent an amount under $1.00 that will be paid in the future, (accounts payable). The value will be a positive number. 2. This can represent an amount under $1.00 that is being released from situation number 1. This value will be a positive amount. 3. For full claim adjustments that are overpayments, this amount represents an amount that was overpaid on a previous claim. The adjustment detail amount will be a negative amount, and the FCN (Financial Control Number) will contain the original HIC (Health Insurance Claim number) for the overpayment.		
OF	**WO**	Withholding
Offset as a result of a previous overpayment. (A/R)		
IN	**L6**	Interest
Interest applied on the claim. If the net interest is added to the TOTAL PROV PD amount, then the offset detail will be a negative number. If it is subtracted from the TOTAL PROV PD amount, then the offset will be a positive number.		
RI	**CS**	Adjustment
Amount paid on original claim for full claim adjustments		
AJ	**JI**	Nonreimbursable
Used to zero balance provider payment for Centers of Excellence and Medicare+Choice Remittance		
RF	**B2**	Rebate
Refund (RF & PA Financial Transactions)		
LF	**50**	Late Filing
Late File applied on the claim.		

SAMPLE SPR FORMAT

CARRIER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP
(9099) 111-2222

MEDICARE REMITTANCE NOTICE

PROVIDER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP

PROVIDER #: 1234567890
PAGE #: 1 OF 999
CHECK/EFT #: 12345678901234567890
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

*LINE 1 *
*LINE 2 *
*LINE 3 *
*LINE 4 *
*LINE 5 *
*LINE 6 *
*LINE 7 *
*LINE 8 *
*LINE 9 *
*LINE 10 *
*LINE 11 *
*LINE 12 *
*LINE 13 *
*LINE 14 *
*LINE 15 *

PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/ RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

CARRIER NAME YYYY/MM/DD (999) 111-2222 **MEDICARE**
PROVIDER #: 1234567890 PROVIDER NAME **REMITTANCE**
CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999 **NOTICE**
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12

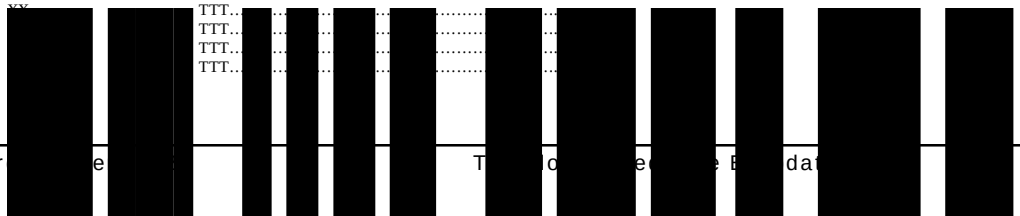
CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	99999	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12

PROVIDER ADJ DETAILS:	PLB REASON CODE	FCN	HIC	AMOUNT
	1111	12345678901234567	123456789012	1234567.12
	2222	12345678901234567	123456789012	1234567.12
	3333	12345678901234567	123456789012	1234567.12
	4444	12345678901234567	123456789012	1234567.12
	5555	12345678901234567	123456789012	1234567.12

GLOSSARY: GROUP, REASON, MOA, REMARK AND REASON CODES

XX TTT...
TTT...
TTT...
TTT...



```
CARRIER NAME                YYYY/MM/DD                (999) 111-2222              MEDICARE
PROVIDER #: 1234567890                                PROVIDER NAME               REMITTANCE
CHECK/EFT #:12345678901234567890                      PAGE #: 999 OF 999          NOTICE
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

                              SUMMARY OF NON-ASSIGNED CLAIMS

PERF PROV  SERV DATE    POS  NOS  PROC  MODS       BILLED     ALLOWED    DEDUCT     COINS      RC-AMT     PROV PD
---------------------------------------------------------------------------------------------------------------------
NAME LLLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X     MOA   11111   22222
                                                                                                33333 44444 55555
1234567890 MMDD MMDDYY 12 123 PPPPP     aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
                              (PPPPP)        REM:   RRRRR     RRRRR     RRRRR     RRRRR     RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP     aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
                              (PPPPP)        REM:   RRRRR     RRRRR     RRRRR     RRRRR     RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP     aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
                              (PPPPP)        REM:   RRRRR     RRRRR     RRRRR     RRRRR     RRRRR

PT RESP  1234567.12                CLAIM TOTAL    1234567.12   1234567.12   1234567.12   1234567.12   1234567.12   1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXX
---------------------------------------------------------------------------------------------------------------------
```

Source: CMS Transmittal B-01-76 CR 1953

[redacted]

THE PATIENT FRIENDLY ADVISORY

Easy-to-Access Help Available at Medicare.gov

More and more, people with Medicare and those who will soon be eligible for Medicare, including your patients, use the Internet. Research shows that Internet use is growing among people age 50 and older. Findings from the Medicare Current Beneficiary Survey, sponsored by the Centers for Medicare & Medicaid Services (CMS), indicate that the percentage of People with Medicare reporting access to the Internet climbed from 6.8 percent in 1997 to 31 percent in 2001.

Established by CMS, Medicare.gov (officially, **http://www.medicare.gov**), the official U.S. government Web site for People with Medicare, has useful information for your patients and those who help them make health care decisions. By accessing this site, your patients can:

- Search for information on health plans, nursing homes, dialysis facilities, Medigap policies, participating physicians and suppliers, telephone contacts, and Medicare activities in their area.
- Get information on coverage, eligibility, enrollment, their Medicare card, address changes, and help with health care costs.
- Learn about the Original Medicare Plan, Medicare+Choice Plans (managed care plans and Private Fee-for-Service plans), and Medigap policies, and compare health plans available in their area.
- Get information on payment, patient rights, and alternatives to nursing homes, and compare nursing homes in their area.
- Find telephone numbers and Web sites to help answer their questions.
- Look at, order, or download Medicare and health-related publications.
- Learn how to recognize and prevent fraud and abuse.
- Get important information and links to health Web sites to help them stay healthy.

Medicare.gov is designed with the needs of the diverse Medicare population in mind. First, the Medicare information is available in Spanish and Chinese. Second, “Screen Reader” technology allows people with low vision or blindness to have quick, reliable access to the information they need. Third, easy print format allows visitors to print all pages within each section without links and extra text. Last, the “Frequently Asked Questions” section allows visitors to search by category or phrase to quickly find answers to their questions. If visitors are unable to find answers, they can submit questions. This section also includes a subscription service that notifies users when questions are updated.

You may find this Web site useful for you and your staff, as well as for your patients. For example, you can order free publications on a variety of topics for display and distribution in your waiting room. To order Medicare publications in quantities of greater than 25, please use the order form on Medicare.gov and fax your order to (410) 786-1905. You can also call 1-800-MEDICARE to order publications. A list of Medicare publications for People with Medicare can be found in the Publications Catalog on Medicare.gov. In addition, you can use the Web site to help identify prescription drug assistance programs for your low-income patients. You can also find out about local educational events for your patients. Medicare.gov has answers you may need for you and your patients. Check it out!

EDUCATIONAL RESOURCES

Medicare Education and Outreach—Calendar of Upcoming Events

Below and on the following page are three months of calendars for upcoming Medicare Education and Outreach events. This will become a regular feature in the *Medicare B Update!* enabling you to plan your attendance at least a quarter at a time. Please refer to the symbol legend below to determine the type of event listed. Please note; the events with the legend (T) will not have a city listed because it is a teleconference and you are required to call in. When you find a listing you are interested in, please refer to our Web site or fax a request for more information to (904) 791-6035.

Legend:

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

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

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

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

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

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

July 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	**12 (SS)** Part A: Ambulance/ABN Part B: Ambulance/ MSP/Cardiology West Palm Beach	13
14	15	**16 (W)** Part A: UB92/DDE Jacksonville	17	18	19	20
21	22	23	**24 (BB)** Part B:E/M Coding/ E/M Doc Pensacola	25	26	27
28	29	30	31			

August 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	**6 (SS)** Part A:HOPPS Part B: Mental Health/ Chiropractic Miami	7	8	**9 (B)** Part B: CMS-1500 Jacksonville	10
11	12	**13 (W)** Part A: Modifiers Jacksonville	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	**10 (E)** Ultimate Medicare Expo for A & B: Miami	**11 (E)** Ultimate Medicare Expo for A & B: Miami	12	13	14
15	16	17	18	**19 (SS)** Part A: Rehab Jacksonville	**20 (T)** Part B: ARNP/PA	21
22	23	**24 (SS)** Part A: Hospital Swing Bed/PPS Part B: Radiology/ Med Oncology Ft. Lauderdale	25	26	**27 (T)** Part A Critical Access Hosp	28
29	30					

FLORIDA MEDICARE EDUCATION AND OUTREACH
MEDICARE PART B
RESOURCE MANUAL ORDER FORM

INSTRUCTIONS: Complete all portions of this form and follow the payment instructions outlined in #3 below.

1. TELL US ABOUT YOURSELF. *PLEASE PRINT*	
Name	
Title/Position	
Company/Organization	
Address	
City, State, Zip Code	
Phone Number	( ) - **Extension:**
Fax Number	( ) -
E-Mail Address	

2. PLEASE INDICATE THE MATERIALS YOU WOULD LIKE TO PURCHASE.

QUANTITY	TITLE	PRICE (EA.)	TOTAL
	Medicare Part B Resource Manual **Includes our most popular subjects:** Advanced Beneficiary Notice; ARNP/PA Guidelines; CPT Coding; Electronic Media Claims; Evaluation and Management Documentation and Coding; Focused Medical Review; Fraud and Abuse; Global Surgery; HCFA-1500 Claims Filing; HIPAA-AS; How to Help Patients Understand Medicare; ICD-9-CM Coding; Inquiries, Appeals, and Overpayments; Medical Review; Medicare Part C; Medicare Secondary Payer; Primary Care; Provider Enrollment; and Reimbursement Efficiency	$80.00	$
		Sub-Total	$
		Add 7% Tax	$
		Total	$

3. PLEASE SUBMIT YOUR PAYMENT

☞ **SEND YOUR PAYMENT**	Submit the completed form with your check or money order: ▪ *Payable to* **First Coast Service Options, Inc. #756240** ▪ *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 11 Tower, P.O. Box 2078, Jacksonville, FL 32231** Your order will be shipped within four to six weeks.

FLORIDA MEDICARE EDUCATION AND OUTREACH
MEDICARE PART B
INDIVIDUAL MODULE ORDER FORM

INSTRUCTIONS: Complete all portions of this form and follow the payment instructions outlined in #3 below.

1. TELL US ABOUT YOURSELF. *PLEASE PRINT*	
Name	
Title/Position	
Company/Organization	
Address	
City, State, Zip Code	
Phone Number	( ) - **Extension:**
Fax Number	( ) -
E-Mail Address	

2. PLEASE INDICATE WHICH INDIVIDUAL MODULES YOU WANT BY CLEARLY PRINTING THEIR NAMES IN THE LINES PROVIDED BELOW THE LIST. EACH MODULE COSTS $35.00. ***(Modules followed by * are included in a resource manual)***

Advanced Beneficiary Notice*	**Fraud and Abuse***	**Oncology**
Ambulance Regulations	**Global Surgery***	**Orthopedics**
Anesthesia	**HCFA-1500 Claims Filing***	**Pathology**
ARNP/PA Guidelines*	**HIPAA-AS***	**Podiatry**
Cardiology	**How to Help Patients Understand Medicare***	**Primary Care***
Chiropractic	**ICD-9-CM Coding***	**Provider Enrollment***
CPT Coding*	**Inquiries, Appeals, & Overpayments***	**Radiology**
Dermatology	**Medical Review***	**Rehabilitation Services**
Electronic Media Claims (EMC)*	**Medicare Part C***	**Reimbursement Efficiency: Part B***
E/M Coding*	**Medicare Secondary Payer***	**Vision**
E/M Documentation*	**Mental Health Services**	
Focused Medical Review*	**Nephrology**	

QUANTITY	**TITLE**	**PRICE (EA.)**	**TOTAL**
		$35.00	
		Sub-Total	$
		Add 7% Tax	
		Total	$

3. PLEASE SUBMIT YOUR PAYMENT

☛ **SEND YOUR PAYMENT**	Submit the completed form with your check or money order: ▪ *Payable to* **First Coast Service Options, Inc. Account #756240** ▪ *Mail to* **Medicare Education and Outreach, Attn: Phyllis Brooks, 11 Tower, P.O. Box 2078, Jacksonville, FL 32231** Your order will be shipped within four to six weeks.

ORDER FORM – 2002 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to BCBSFL - FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
❑	***Medicare B Update!*** **Subscription –** One copy of the *Update!* is sent free of charge to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the twelve months prior to the release of each issue. Nonprovider entities or providers who need additional copies at other office locations may purchase an annual subscription. This subscription includes all issues published during calendar year 2002 (back issues sent upon receipt of order).	756245	$75.00
❑	**2002 Fee Schedule –** One copy of the *Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* is sent free of charge in mid-November to individual providers and Professional Association (PA) groups who bill at least one claim to Medicare Part B of Florida for processing during the preceding six months. The Fee Schedule contains calendar year 2002 payment rates for all Florida localities. These fees apply to services performed between January 1 and December 31, 2002. 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!* Non provider entities or providers who need additional copies at other office locations may purchase additional copies.	756250	$20.00

Subtotal $ _____

Tax (7%) $ _____

Total $ _____

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 45280
Jacksonville, FL 32232-5280

Contact Name: _____

Provider/Office Name: _____

Phone : _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please make check/money order payable to: BCBSFL- FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID - DO NOT FAX - PLEASE PRINT

Note: The *Medicare B Update!* and *2002 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* are available **free of charge** online at **www.floridamedicare.com**.

Procedure-to-Diagnosis Relationship Booklet No Longer Available

For several years, Florida Medicare has made a procedure-to-diagnosis relationship booklet available for purchase. We are no longer able to produce this booklet; however, specific procedure-to-diagnosis relationships may be easily found by using the search function on our provider Web site, **www.floridamedicare.com**, or in the Part B Medical Policy section of the Web site.

The default is to search the entire site; however, this can be limited to specific sections. For procedure-to-diagnosis relationships, limit your search to the "Part B Final LMRP" (local medical review policy) section. The search results window will indicate all LMRPs that contain the requested procedure code. Once you have opened the appropriate policy, page down to the "*CPT*/HCPCS Codes" section of the policy and find your procedure code (note that some LMRPs have more than one *CPT*/HCPCS Codes section). Continue down to the "ICD-9-CM Codes That Support Medical Necessity" section; all covered diagnoses for the procedure are found there. In addition, because the complete LMRP is now at your fingertips, you have access to any coverage criteria, coding guidelines, and documentation requirements that may apply, as well as the procedure-to-diagnosis relationships.

This index covers quarterly and special issues of the *Medicare B Update!* produced since the beginning of fiscal year (FY) 2002, October 1, 2001. An index to FY2001 publications was published in the November 2001 Special Issue *Update!* In addition, a comprehensive index to all publications issued since January 1997 is available in the Part B Publications section of our provider Web site **www.floridamedicare.com**.

*** Signifies a SPECIAL ISSUE *UPDATE!***

*** Signifies a SPECIAL ISSUE *UPDATE!***

R

S

T

U

V

Local Medical Review Policies

*** Signifies a SPECIAL ISSUE *UPDATE!***

* Special Issue *Updates!*

*** Signifies a SPECIAL ISSUE *UPDATE!***

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 Communication and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

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

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

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

PROVIDERS

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

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

EMC

Format Issues & Testing:
(904) 354-5977
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) 905-8880

OCR

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

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
(803) 735-1034

MEDICARE PART A

Toll-Free:
(877) 602-8816

WEB SITES

PROVIDER

Florida
www.floridamedicare.com

Centers for Medicare & Medicaid Services
www.hcfa.gov or **www.cms.hhs.gov**

BENEFICIARY

Florida
www.medicarefla.com

Centers for Medicare & Medicaid Services
www.medicare.gov

MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC. P.O. BOX 2078 JACKSONVILLE, FL 32231-0048

PRSRT STD
U.S. POSTAGE
PAID
JACKSONVILLE, FL
PERMIT NO. 3996

*** ATTENTION BILLING MANAGER***