

# Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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



**The Medicare B Update!** should be shared with all healthcare practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education Web sites: [www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com).

#### Routing Suggestions:

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other \_\_\_\_\_



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## Medicare B Update!

Vol. 1, No. 2  
 Third Quarter 2003

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

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

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## A PHYSICIAN'S FOCUS

### ***“Helpful Hints for Working with Medicare”***

Medicare is a large and complex organization. However, it remains the foundation for most healthcare in the United States. True, it lacks a pharmacy benefit, but I am confident that Congress will soon remedy that shortcoming. Here are some suggestions to help you work with Medicare:



- Whatever the circumstances of your practice setting, you must become knowledgeable about basic Medicare rules and how they affect your practice. To drive a car in this country, you must pass a written test and demonstrate safe driving procedures. Yet few medical schools or residencies prepare physicians for the challenges of Medicare and other insurance programs they will face upon completion of their training. So, how or where can the physician learn about Medicare?

Under our current system, your best bet is your local Medicare carrier. For readers of this publication, that would be First Coast Service Options, Inc. (FCSO). We have seminars and publications to assist you and your staff in determining which services are covered, and how to bill appropriately. All of our local medical review policies (LMRP), fee schedules, single drug pricer, self-administered drug list, etc., can be downloaded from our provider education Web sites. If in doubt, our customer service representatives are available to answer your questions via a toll-free line. Computer based training programs are also available, via a link to the CMS Web site.

- Don't have claims needlessly denied for minor coding or billing errors. Ensure your staff is aware of Medicare coverage and/or guidelines, and stays abreast of changes. Provide your staff with the latest editions of the coding books (e.g., *CPT*, *ICD-9-CM*). Medicare updates our policies and systems annually to use only the newest codes to the highest specificity.
- Don't guess at a *CPT* (*Current Procedural Terminology*) code when performing a new or novel procedure. If there is no appropriate code in the book, use an unlisted procedure code and include the appropriate documentation with the claim. If it is a service that will become widespread, ask your professional association to apply to the AMA (American Medical Association) for a new *CPT* code. Using an inappropriate code can result in overpayments and later requests for repayments.
- Understand the proper use of the Advance Beneficiary Notice (ABN). When you perform a service for which you expect Medicare to deny payment, ask the patient to sign an ABN. Doing so will notify the patient that they are responsible for payment if Medicare denies the claim.
- When Medicare denies payment for a claim for a service, which you believe is covered, have your office billing “expert” review the claim before asking for a review. Many times it may simply be a problem such as not using the latest edition of the *ICD-9-CM*. If that is not corrected, the claim will also be denied when reviewed.
- Have a compliance plan, and appoint someone with the primary responsibility for monitoring your plan. The document should state your values and how you are going to ensure correct documentation and billing practices. Refer to or attach the appropriate Medicare national and local policies for services rendered by your office. Have copies of those policies readily available for your staff to review.
- Your compliance plan should be robust enough to occasionally uncover an overpayment issue. Don't panic! Do a reasonable evaluation of the extent of the problem, implement procedures to avoid continuing the error, and make an appropriate repayment to the carrier. This can avoid many problems in the future.
- There are many reasons for Medicare to request copies of your records. Some are only for collecting data and others may be for medical audits, which involve repayment issues. The best thing to do is to comply with the request. Failure to do so can result in questions about whether the service was actually performed or was medically necessary.

It would be prudent to review the records to insure legibility, but they should never be altered. If the records are not legible, you may submit a word-for-word transcript *with the original record*. If the records do not completely document your services, you may explain what additional issues were addressed. Supporting information would be helpful.

There are two basic types of Medicare medical audits under our Progressive Corrective Action program. One is the probe, or small sample, and the other is the statistically valid random sample (SVRS), or large sample. A probe must precede an SVRS, and is done to see if the error rate is great enough to warrant a full scale SVRS. You are liable only for actual charges on the probe. Errors found on an SVRS will be extrapolated to all of your claims for that service during that period of time, and could result in a large repayment request.

You have the right to appeal the findings of a probe and/or SVRS. As with denied claims, it is important to appeal in a timely manner. FCSO cannot process any appeal requested beyond the time limits stated in the denial. If you need help, hire an expert. Don't rely upon the advice of colleagues.

- Call your representative on the Carrier Advisory Committee (CAC). Offer your expertise to help him/her review any draft LMRPs presented to the CAC, which might affect your practice.
- Visit the Medicare Web sites regularly or have someone in your office do so. Issues often surface on the Web sites long before they become official and affect your practice. Exercise your right to comment on proposed rules, national coverage decisions and draft LMRPs.
- Beware of the marketing techniques of the medical industrial complex. The newest and most expensive products may not always be the best for your patient. Someone is going to be paying for the service. Help them get the biggest bang for their buck.
- Be active in your profession and government. There is strength in numbers. Join and support the organizations that champion your causes. This will not change how your claims are processed today, but can influence how they are done in the future.

In closing, this is my last editorial for the *Medicare B Update!* I am retiring, and Dr. James J. Corcoran, Jr. will be taking my position. Dr. Frank A. Delli Carpini will continue in his role as Carrier Medical Director for Connecticut. I thank all of my CAC members and other contacts who have helped me during my time with FCSO. Your support has been invaluable. I am sure you will do no less for Jim.

Sincerely,

Sidney R. Sewell, M.D.  
Medical Director

# THE FCSO MEDICARE B UPDATE!

## Distribution and Format of the FCSO Medicare B Update!

The *FCSO Medicare B Update!* is a comprehensive magazine published quarterly by First Coast Service Options, Inc. (FCSO) for Part B providers in Connecticut and Florida. In accordance with notification requirements established by the Centers for Medicare & Medicaid Services (CMS), approximate delivery dates for fiscal year 2003 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2003	November 2002	January 1, 2003
Second Quarter 2003	February 2003	April 1, 2003
<b>Third Quarter 2003</b>	<b>May 2003</b>	<b>July 1, 2003</b>
Fourth Quarter 2003	August 2003	October 1, 2003

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

### Who Receives the Update?

*Note: the following two paragraphs describe current processes that will be changing beginning with the Fourth Quarter 2003 issue. Please see page 7 for information regarding our new distribution process.*

Distribution of the *Update!* is limited to individual providers and professional association (PA) groups who bill at least one Part B claim to either Connecticut or Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are sent one complimentary copy of that issue. Production, distribution, and postage costs prohibit us from distributing copies to *all* practice settings. This primarily affects members of professional association 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 (see order form in the back of this issue). Issues published since 1997 may be downloaded from the Web sites, free of charge.

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

### Clear Identification of State-Specific Content

Each article clearly indicates whether the topic is applicable to both Connecticut and Florida, Connecticut only, or Florida only. Articles common to both states appear at the beginning of the publication. Within common articles, references to phone numbers,

addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate. Connecticut and Florida medical review and education/outreach content is maintained in separate sections.

### Publication Format

Following the table of contents, a letter from the Carrier Medical Director, and this informational section, the *Update!* begins with content applicable to both states. Articles are categorized as follows: The **claims** section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information. The **coverage/reimbursement** section discusses specific *CPT* and *HCPCS* procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues. The section pertaining to **EMC** (electronic media claim) submission also includes information pertaining to **HIPAA** (the Health Insurance Portability and Accountability Act). The **general information** section includes fraud and abuse, provider registration, and Medicare Secondary Payer topics, plus additional topics not included elsewhere. Within each section, information pertinent to both Connecticut and Florida is presented first, followed by articles specific to Connecticut or Florida.

**Medical review**, including **LMRPs** (local medical review policies) and **comprehensive data analysis** initiatives, will *always* be state-specific, as will the **educational resources** sections.

**Indexes** to the year's previous issues of the *Update!* plus important **addresses, phone numbers, and Web sites** are listed for each state in the back of the publication.

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

Articles included in each *Update!* represent formal notice that specific coverage policies either have or will

take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. **The date the Update! is posted to the Web site is considered the notice date**, in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

## Advance Beneficiary Notices (ABNs)

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

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

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. ABNs advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket, and to be more active participants in their own healthcare treatment decisions. An ABN must meet the following requirements:

- The ABN must be on an approved Form CMS-R-131 (see the following section, "New Patient Liability Notice").
- The ABN must be given in writing, in advance of furnishing the service or item.
- The ABN must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., the service is not covered based on the patient's diagnosis, the frequency of the service was in excess of accepted standards of medical practice, etc.).

- The notice must be signed and dated by the patient, indicating the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for reason(s) indicated on the ABN. The signature of the provider of service is not required.
- The ABN should be maintained with the patient's medical record.

### New Patient Liability Notice

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

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

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

### ABN Modifiers

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

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

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

*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.

## Providers Must Qualify and Register to Continue Receiving the *Medicare B Update!* in Hardcopy Format

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Connecticut Medicare Part B and Florida Part A and B customers are available on our provider education Web sites ([www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com)). Our Medicare publications are posted to the Web sites in PDF (portable document format) and may be viewed, printed, or downloaded free of charge. Hardcopy publications, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

Hardcopy distribution of the *Medicare B Update!* has previously been limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003, Medicare providers who meet these criteria will have to register with us to continue to receive the *Update!* in hardcopy format.** Qualifying providers will be eligible to receive one hardcopy of that issue, *if* you can show a valid reason why you cannot utilize the electronic publication available on the Internet. “I just prefer hardcopy” is an invalid reason – a valid reason might be lack of a personal computer with Internet access, or other technical barrier.

If you believe you meet these criteria and wish to continue receiving hardcopies, you must complete and return the registration form on the following page. If you include your email address or fax number, we will use one of those methods to notify you that you will continue to receive hardcopy publications. You will be required to re-register annually.

If you are willing and able to receive the *Update!* electronically, you do not need to reply to us. Providers and other entities that do not meet the criteria and desire a hardcopy may purchase an annual subscription to the *Update!* (please see the “2003 Part B Materials” order form in this issue).

**Note:** If you have a paid subscription, you will continue receiving a hardcopy of the *Medicare B Update!* through your subscription period.

### Features of the Electronic Publication

There are already advantages to accessing the *Update!* online: the electronic version is posted to the Web before print copies are distributed, and you can view, print, or download only those articles important to your practice.

In addition, we will be enhancing the format of electronic newsletters to provide helpful features that do not appear in the current hardcopy format, including hyperlinks. A hyperlink is an element in an electronic document that links the user to another place in the same document, to an entirely different document, or to a Web site. This feature will provide users instant access to the following items:

- *Articles of Interest* – The newsletters’ table of contents will include hyperlinks to each article, therefore a provider can choose an article(s) of particular interest to his/her medical practice.
- *Third-Party Web sites* – All third-party Web sites referenced within articles will include hyperlinks to the applicable information on that Web site.
- *References within the Contractor Web sites* – All additional resources or reference materials mentioned in the newsletter will include hyperlinks to that information within the FCSO Medicare Web sites (e.g., full-text versions of local medical review policies, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages will allow access to information applicable to the user’s specialty classification.

The enhanced electronic publications will be available at no charge through the FCSO Medicare Web sites and on CD-ROM at a minimal cost. In addition, you may sign up for the *FCSO eNews*, our free electronic mailing list. Subscribers receive an email notice when new publications are posted to our Web sites, plus frequent notification of other items of interest. Anyone with an email address may sign up for *eNews*; you don’t have to be at the office.

## *Medicare B Update!* Hardcopy Registration Form

To continue receiving the *Medicare B Update!* in hardcopy format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy of the Fourth Quarter 2003 *Update!* your form must be faxed or postmarked on or before June 30, 2003.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare B Update!* – issues published beginning in 1997 are available free of charge on our provider education Web sites [www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com).

**Provider/Professional Association Name:**

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**Provider Number:**

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**Address:**

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**City, State, ZIP Code:**

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**Contact Person/Title:**

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**Telephone Number:**

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**Rationale for needing a hardcopy:**

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**Mail your completed form to:**

Medicare Communication and Education - Publications  
P.O. Box 45270  
Jacksonville, FL 32232-5270

**or fax to:** 1-904-791-6292

Please let us know your concerns or questions regarding this initiative:

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Please do not contact our customer service call center regarding this initiative. Additional questions or concerns may be submitted via the Web site in the “contact us” section.

## Medicare B Update! Reader Survey Results

A customer satisfaction survey was included in the Second Quarter 2003 issue of the *Update!* We would like to take this opportunity to thank all of you who responded. We have noted several trends we would like to share with you. Respondents would like:

- articles to be less technical with greater clarity
- information provided or grouped by specialty
- fewer changes and corrections
- answers to specific inquiries

One reader indicated, “the talk is so legal sounding,” another said, “language is always way too technical.” Admittedly, that’s often true. Keep in mind that much of the information we publish is intended to furnish the provider with his or her legal obligations. However, we will begin making changes to address this feedback. In addition, we will make a greater effort to present information in a manner that’s less formal and easier to read.

When we conduct a reader survey, we frequently receive replies indicating a desire for more specialty-driven publications. We attempt to do this when possible, but we still must ensure information is provided to everyone to whom it may apply. For example, services that may be billed by a psychologist may also be billed by an M.D. In this case, we would list an article under the general heading of “Mental Health.” A recent publication provided to oncologists actually involved six specialties; technically, any M.D. could bill for the services referenced.

We would all like to see fewer changes; however, given the nature of Medicare that’s not likely to occur. Sometimes, changes take place too rapidly for inclusion in our quarterly publications. We are committed to providing timely, accurate information. To stay abreast of the latest and most up-to-date information, visit our provider education Web sites often. Special release articles and links to CMS publications are posted frequently. Subscribing to our free *eNews* electronic mailing list is a good way to stay informed of changes and additions to the Web sites.

We regret that we are unable to reply to specific inquiries in the *Update!* These can generally be handled by our provider call center. For those of you who returned surveys with an address, fax, or phone number, your inquiries have been forwarded to the appropriate area(s) for handling.

We’re always open to your suggestions and ideas! We will continue to seek your feedback by repeating the survey in the Fourth Quarter 2003 issue. In addition, we will provide an enhanced online survey to make responding as easy as possible. You can provide feedback concerning the publication at any time by writing to the Medicare Communication and Education department at the address on page 2 of this issue.

Keep providing us with your valuable thoughts and opinions, and please understand that improvements do not always occur overnight. We appreciate your time and support in helping us make your *Medicare B Update!* better!

# CLAIMS

## Claims Mistakenly Submitted to the Local Carrier Will Be Returned as Unprocessable

When we receive a request for Medicare payment for services furnished in another local carrier's payment jurisdiction, or for a Railroad Retirement Board (RRB) beneficiary, we return assigned services as unprocessable, and deny nonassigned services. Effective for claims processed on or after July 7, 2003, this process will be applied to misdirected claims for United Mine Workers of America (UMWA) beneficiaries.

Providers should resubmit such misdirected claims as follows:

- **Claim with some or all services in another local carrier's payment jurisdiction**  
FCSO processes Part B claims for services provided in Connecticut and Florida. You can identify the correct Medicare contractor for services performed in other states through the CMS Web site at [www.cms.hhs.gov](http://www.cms.hhs.gov).
- **Claim for an RRB beneficiary**  
Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 1-866-749-4301 for RRB EDI information for electronic claims processing.
- **Claim for a UMWA beneficiary**  
Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.

Source: CMS Transmittal 1789, CR 2502

## Correct Coding Initiative—Update

Version 9.2 of the Correct Coding Initiative (CCI) will be implemented July 1, 2003. Version 9.2 will include all previous versions and updates from January 1, 1996, to the present, and will be organized in two tables: Comprehensive/Component Edits and Mutually Exclusive Code (MEC) Edits.

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

- Single issues of the national correct coding policy manual may be requested by calling 1-703-605-6000.
- Subscriptions to the national correct coding policy may be requested by calling 1-703-605-6060 or 1-800-363-2068.
- To receive information from NTIS by mail, call 1-800-553-6847.
- Ordering and product information is also available online at <http://www.ntis.gov/products/families/cci/index.asp>.

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

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

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

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

Source: CMS Transmittal B-03-018 CR 2565

*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.

## Invalid or Inappropriate Modifiers

### IMPORTANT NOTICE:

The article that originally appeared here has been removed, pending additional information and/or a change in effective date. More information will be posted to our provider education Web sites ([www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com)) as it becomes available.

Be sure to check the Web sites frequently for updated information.

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

Medicare sometimes receives claims when the beneficiary is a member of a Health Maintenance Organization (HMO) that include services furnished when the beneficiary *was* a member, and services furnished when the beneficiary *was not* a member of an HMO. Medicare will process the non-member portion of the claim and deny the HMO portion along with instructions for the service provider to submit a claim to the beneficiary's HMO for the denied services. If the beneficiary was an HMO member for *all* the services on the claim, Medicare will deny the entire claim.

Source: CMS Transmittal 1792, CR 2473; MCM 4267.1

## Time Limit for Filing a Request for Appeal

Effective October 1, 2002, section 1869(a)(3)(C) of the Social Security Act (the Act) as amended by section 521 of EBIPA (the Benefits Improvement and Protection Act of 2000) eliminated the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of *all* initial determinations. Additional system changes were made, effective January 1, 2003, so the date by which an appeal must be filed with a contractor is automatically calculated and listed on the MSN (Medicare Summary Notice). This information was published in the August 2002 special issue *Medicare B Update!* (per CMS transmittal AB-02-111).

CMS recognizes that making the transition to the shorter filing timeframe may prove difficult in situations where appellants need to obtain documentation from other sources to file an appeal. In order to alleviate any hardship associated with the possible need to gather documentation faster than in the past, extensions of up to 60 days to the 120-day filing deadline for appeals of Part B claims may be granted, provided the appeal request includes a *credible explanation* from the beneficiary, physician, or supplier that the time was needed to gather the necessary supporting records (e.g., information not provided to them timely). Such extensions may be granted for appeals of initial determinations made on or after October 1, 2002.

**Note:** the initial determination date is the date the *original claim* (not resubmitted claims or subsequent appeals) was processed by Medicare.

Source: CMS Transmittal AB-03-039, CR 2492

## Help Us Reduce Duplicate Claim Receipts

We are concerned with the volume of duplicate claims received since the recent conversion to the Multi-Carrier System (MCS). Every claim incurs processing costs, whether an original submission or a duplicate. Currently, approximately **8%** of all claims filed to Connecticut Medicare are being denied as duplicates. A duplicate claim occurs when you re-file an entire or partial claim containing a service or services previously processed, or a service or services currently being processed.

In order to minimize the submission of duplicate claims we are providing you with three duplicate prevention tips:

- Always check the status of your claim prior to resubmitting by calling the status line at 1-866-419-9455 (toll-free).
- If you receive a denial you believe was in error, check the MCS Part B System Issues Log located on our provider education Web site at [www.connecticutmedicare.com](http://www.connecticutmedicare.com) for instructions prior to contacting our office or resubmitting the claim.
- In the event you are instructed to re-file the denied service you should resubmit *only* those denied services. If your claim includes paid and denied services, do not resubmit the entire claim, as this would further create duplicate denials.

## COVERAGE/REIMBURSEMENT

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

#### Announcement About Medicare Participation for 2003

*Note: the following information was posted to our provider education Web sites (www.connecticutmedicare.com and www.floridamedicare.com) on February 28, 2003.*

We have great news to share with physicians and other practitioners throughout the country. As you know, CMS was scheduled to implement a negative 4.4 percent update effective March 1, 2003. CMS worked with Congress for many months in an effort to correct a defect in the formula generated in part by unanticipated changes in economic conditions. We are pleased to announce that Congress acted—this flaw has been corrected and, instead of a negative 4.4 percent update, we implemented a positive 1.6 percent update effective March 1, 2003. The new fee schedules, effective for services rendered March 1, 2003, through December 31, 2003, are available on our provider education Web sites, and may be downloaded or printed free of charge.

Medicare remains a lifeline to millions of seniors and disabled Americans, and your commitment and participation in the Medicare program make this lifeline possible. We hope that you kept this in mind as you made your decision regarding your participation in 2003. All physicians and practitioners were given until April 14, 2003, to make their 2003 Medicare participation decisions.

As stated above, the 2003 Participation Enrollment Period was extended an additional 45 days from March 1, 2003 to April 14, 2003, to allow physicians/practitioners an opportunity to make changes to their participation status. The participation period is the period of time in which providers can elect to participate in Medicare or to change their enrollment status. Any change in the participation status made during this period is effective March 1, 2003. Any change to the participation status made before March 1, is effective back to January 1, 2003.

Source: CMS Transmittal AB-03-027, CR 2601

#### Correct Payment of January and February 2003 Physician Services

Since the 2003 Medicare Physician Fee Schedule rates were effective March 1, 2003, any January 1 through February 28, 2003 dates of service containing 2002 HCPCS processed from **March 1 through March 11 for Connecticut** and **March 1 through March 10 for Florida** were paid at the 2003 rates. FCSO will automatically adjust these claims after July 1, 2003 to be correctly paid at the 2002 rates. Physicians/practitioners do not need to take any action to receive the adjustments. Please note that some overpayments may result due to these adjustments and they will be recouped using normal procedures.

Source: CMS Transmittal B-03-011, CR 2549

#### MPFS Calculation Method

The information that follows is designed to assist you in understanding how the MPFS is calculated. Calculations are based on guidelines in section 15000 of the Medicare Carriers Manual (MCM). For the majority of physician services, this calculation is performed by and provided to carriers by CMS. The elements used to calculate the fee schedule amounts are as follows:

**Resource Based Relative Value Units (RBRVU):** This factor takes into consideration the physician work required for the service, practice expenses, and the malpractice insurance premium. RBRVUs are established at a national level and do not vary among Medicare carriers. The RBRVUs for 2003 remain as published in the December 31, 2002, *Federal Register*.

**Geographic Practice Cost Index (GPCI):** This factor represents the variations in practice costs, which exist in different geographic areas. For MPFS purposes, Connecticut comprises a single geographical area (locality); Florida is comprised of three geographical areas. The GPCI is established for each RBRVU component (work, overhead, and malpractice) in each pricing locality for a given state.

**Conversion Factor (CF):** This factor is a single number set at a national level and is used by all carriers in calculating the final fee schedule amounts. *This is the factor to which the 1.6 percent increase effective March 1, 2003, is applied.*

For each fee schedule service, there are three RBRVUs:

- A relative value for physician work (RVUw),
- A relative value for practice expense (RVUpe),  
*Note: for certain services, there are different practice expense RVUs depending on the place of service—facility or non-facility.*
- A relative value for malpractice (RVUm).

For each payment locality, there are three GPCIs:

- A GPCI for physician work (GPCIw),
- A GPCI for practice expense (GPCIpe), and
- A GPCI for malpractice (GPCI<sub>m</sub>).

The formula for calculating the payment allowance for a given service under the fee schedule is:

$$\text{Fee Schedule Amount} = [(RVUw \times GPCIw) + (RVUpe \times GPCIpe) + (RVUm \times GPCI_m)] \times CF$$

The RBRVUs, GPCIs, and the conversion factor are published in a Final Rule in the *Federal Register*, generally on or near November 1 of each year (the revised Final Rule for 2003 was published on February 28, 2003). These calculations *do not* take into account any reductions based on fee schedule payment policies (e.g., pre- post- and intraoperative percentages, professional and technical components, multiple surgery, bilateral surgery, assistant-at-surgery, co-surgery, team surgery, or facility pricing rules). Information regarding fee schedule payment policies may be found at <http://cms.hhs.gov/physicians/mpfsapp/step0.asp>.

## ANESTHESIA

### Add-On Codes for Anesthesia

Payment for anesthesia services is based on the sum of an anesthesia code-specific base unit value plus anesthesia time units multiplied by the locality-specific anesthesia conversion factor. Under current policy, if the physician is involved in multiple anesthesia services for the same patient during the same operative session, payment is based on the base unit assigned to the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services.

The physician reports the anesthesia procedure with the highest base unit value with the multiple procedures modifier (51), and total time across all surgical procedures.

#### New Procedure Codes

The 2003 *Current Procedural Terminology (CPT)* includes new add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia. The add-on code is billed *in addition to* the primary anesthesia code.

- In the burn area,  
code **01953** (1 base unit) is used in conjunction with code **01952** (5 base units)
- In the obstetrical area,  
code **01968** (2 base units) is used in conjunction with code **01967** (5 base units)  
code **01969** (5 base units) is used in conjunction with code **01967** (5 base units)

The physician reports the add-on code with the primary anesthesia code.

#### Pricing Methodology for Obstetrical Anesthesia

Anesthesia add-on codes are priced differently than multiple anesthesia codes. Generally, for an add-on code, Medicare allows only the base unit of the add-on code. All anesthesia time should be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia.

The Centers for Medicare & Medicaid Services (CMS) has learned that third party payers may have different policies for payment of time units for obstetrical anesthesia than for other anesthesia codes. If the time of the add-on obstetrical codes, such as 01968 or 01969, were reported with the primary code, the time units of the add-on code might be undervalued. To prevent this result, **effective for services processed on or after July 1, 2003**, for the obstetrical add-on codes, anesthesia time must be separately reported for the primary and the add-on code based on the amount of time appropriately associated with each code. Therefore, Medicare will recognize both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes.

Source: CMS Transmittal B-03-017, CR 2539

## AMBULATORY SURGICAL CENTER (ASC)

### Procedures Approved in an ASC for 2002—Correction

The list of procedures approved in an ASC for 2002 was published in the Third Quarter 2002 *Medicare B Update!* (page 11). Since then, we have discovered that although procedure code 41108 was included, an ASC facility fee is *not* payable for this procedure. In addition, code 58353 was identified under ASC payment group 8; in fact, it is payable under ASC group 4.

We apologize for any inconvenience this may have caused.

## DIABETES

### Billing on Behalf of a Diabetes Outpatient Self-Management Training Services (DSMT) Program—Clarification

Information confirming that Medicare nonphysician practitioners, such as nurse practitioners or registered dietitians who are eligible to render other Medicare services, may bill on behalf of a DSMT program was published in the Second Quarter 2003 *Medicare B Update!* (pages 14-15). These practitioners, indeed, *all* billers for DSMT services, should note that any income from codes G0108 or G0109 will be accrued under their provider number and reported to the Internal Revenue Service.

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

## DRUGS AND BIOLOGICALS

### Medicare Covered Drugs—Quarterly Pricing Update

On January 1, 2003, CMS implemented a single drug pricer (SDP) for most drugs and biologicals (hereinafter “drugs”). More information concerning the SDP may be found in the special issue *Medicare B Update!* entitled “2003 Healthcare Common Procedure Coding System and Medicare Physician Fee Schedule Database Update” (pages 9-12).

The quarterly revisions to the SDP file are provided below. These changes are effective for services rendered on or after January 31, 2003, processed on or after April 1, 2003.

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

CODE	PAR	NON-PAR	CODE	PAR	NON-PAR	CODE	PAR	NON-PAR
90675	\$142.15	\$135.04	J1436	\$76.95	\$73.10	J7197	\$1.25	\$1.25
90743	\$27.05	\$27.05	J1563	\$76.00	\$72.20	J7320	\$233.14	\$221.48
90744	\$27.05	\$27.05	J1610	\$45.60	\$43.32	J7342	\$15.40	\$14.63
J0150	\$38.89	\$36.95	J1631	\$25.08	\$23.83	J7507	\$2.97	\$2.82
J0170	\$2.35	\$2.23	J1650	\$5.81	\$5.52	J7508	\$14.85	\$14.11
J0207	\$452.97	\$430.32	J1670	\$118.75	\$112.81	J7510	\$0.08	\$0.08
J0256	\$2.66	\$2.53	J2300	\$1.49	\$1.42	J7515	\$1.31	\$1.24
J0280	\$1.19	\$1.13	J2310	\$2.37	\$2.25	J7516	\$25.08	\$23.83
J0360	\$16.04	\$15.24	J2320	\$5.46	\$5.19	J8510	\$2.08	\$1.98
J0530	\$11.92	\$11.32	J2321	\$10.73	\$10.19	J8600	\$2.50	\$2.38
J0550	\$50.12	\$47.61	J2322	\$21.28	\$20.22	J8610	\$3.56	\$3.38
J0610	\$1.18	\$1.12	J2410	\$2.95	\$2.80	J9000	\$42.82	\$40.68
J0670	NC	NC	J2675	\$3.69	\$3.51	J9010	\$536.27	\$509.46
J0740	\$843.60	\$801.42	J2690	\$1.52	\$1.44	J9017	\$37.05	\$35.20
J0780	\$4.90	\$4.66	J2995	\$89.06	\$84.61	J9093	\$5.82	\$5.53
J0835	\$18.24	\$17.33	J3120	\$8.12	\$7.71	J9215	\$8.17	\$7.76
J1030	\$4.30	\$4.09	J3230	\$4.40	\$4.18	J9245	\$420.10	\$399.10
J1040	\$5.18	\$4.92	J3260	\$5.84	\$5.55	J9390	\$104.31	\$99.09
J1060	\$4.65	\$4.42	J3280	\$5.52	\$5.24	Q2008	\$11.50	\$10.93
J1110	\$33.01	\$31.36	J3302	\$0.34	\$0.32	Q2009	\$10.13	\$9.62
J1212	\$44.60	\$42.37	J3420	\$1.19	\$1.13	Q2017	\$257.46	\$244.59
J1250	\$4.74	\$4.50	J3475	\$0.14	\$0.13	Q3025	\$85.21	\$80.95
J1260	\$16.45	\$15.63	J7051	\$0.75	\$0.71			

NC = noncovered

Source: CMS Transmittal AB-02-174, CR 2381; April 2003 SDP files

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

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

### 2003 Jurisdiction List

Below is the updated list of procedure codes for Durable Medical Equipment Regional Carrier (DMERC) and local carrier jurisdictions. The DMERC that serves Connecticut (Region A) is HealthNow ([www.umd.nycpic.com](http://www.umd.nycpic.com)); for Florida (Region D) it is Palmetto Government Benefits Administrators ([www.palmettoeba.com](http://www.palmettoeba.com)).

The DMERCs and local carriers publish this list to inform providers and suppliers which contractor they should be billing for these codes.

HCPCS CODE	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 Contraceptive 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.
A4266-A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4281-A4286	Accessory for Breast Pump	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.

A4361-A4422	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.
A4450-A4455	Tape; Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other, DME REGIONAL Carrier.
A4458	Enema Bag	DME REGIONAL Carrier
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other, 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
A4521-A4538	Diapers	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
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME REGIONAL 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.
A4606	Oxygen Probe for Oximeter	DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4609-A4610	Tracheal Suction 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-A4932	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) or if supply for implanted prosthetic device or implanted DME. If other, DME REGIONAL Carrier.
A6025	Silicone Gel Sheet	DME REGIONAL Carrier
A6154-A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME REGIONAL Carrier.
A6412	Eye Patch	DME REGIONAL Carrier
A6421-A6512	Surgical Dressings	DME REGIONAL Carrier
A7000-A7039	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7042-A7043	Pleural Catheter	Local Carrier
A7044	Respiratory Accessory	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-E0117	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 Toilet 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-E0484	Oxygen and Related Respiratory Equipment	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
E0610-E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0618-E0619	Apnea Monitor	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621-E0636	Patient Lifts	DME REGIONAL Carrier
E0650-E0673	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0691-E0694	Ultraviolet Light Therapy Systems	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0701	Helmet	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
E0761	Electromagnetic Treatment Device	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.
J3590	Unclassified Biologics	Local 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.
J7317-J7320	Injection	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7340-J7350	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	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
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

K0556-K0559	Socket Inserts	DME REGIONAL Carrier
K0581-K0597	Ostomy Devices and Supplies	DME REGIONAL Carrier
L0100-L2090	Orthotics	DME REGIONAL Carrier
L2102-L2104	Casts	Local Carrier
L2106-L2116	Orthotics	DME REGIONAL Carrier
L2122-L2124	Casts	Local Carrier
L2126-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; Tracheostomy 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 device. If other, DME REGIONAL Carrier.
M0064-M0301	Medical Services	Local Carrier
P2028-P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiolymography	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
Q0144	Azithromycin dihydrate	Local Carrier
Q0163-Q0181	Anti-emetic	DME REGIONAL Carrier
Q0183	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 Transport	Local Carrier
Q3021-Q3026	Vaccines	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-03-020, CR 2567

## April Quarterly Update for 2003 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Most procedures on the DMEPOS fee schedules are processed by the durable medical equipment regional carriers (DMERCs), however, some are processed by the local carriers and others are considered "joint jurisdiction" codes. Joint jurisdiction codes are generally processed locally if provided incident to a physician's service and by the DMERCs if other. (See the related article "2003 Jurisdiction List" in this issue.) The DMERC that serves Connecticut (Region A) is HealthNow ([www.umd.nycpic.com](http://www.umd.nycpic.com)); for Florida (Region D), it is Palmetto Government Benefits Administrators ([www.palmettogba.com](http://www.palmettogba.com)).

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Listed below are the revisions effective for local carrier and joint jurisdiction services processed on or after April 1, 2003.

### CONNECTICUT ONLY

### COVERAGE/REIMBURSEMENT

CODE	FEE	CODE	FEE	CODE	FEE
A4214	\$1.75	A4314	\$25.29	A4326	\$10.37
A4221	\$22.64	A4315	\$22.43	A4327	\$42.27
A4222	\$46.73	A4316	\$24.14	A4328	\$8.88
A4232	\$2.65	A4319	\$6.33	A4330	\$7.15
A4265	\$3.39	A4320	\$5.33	A4331	\$3.18
A4310	\$7.72	A4322	\$3.04	A4332	\$0.12
A4311	\$13.90	A4323	\$8.78	A4333	\$2.20
A4312	\$15.33	A4324	\$2.17	A4334	\$4.93
A4313	\$18.52	A4325	\$1.80	A4338	\$11.81

**CONNECTICUT AND FLORIDA**

**COVERAGE/REIMBURSEMENT**

CODE	FEE	CODE	FEE	CODE	FEE
A4340	\$31.75	A4392	\$8.18	A4628	\$3.74
A4344	\$13.62	A4393	\$9.04	A4629	\$4.63
A4346	\$19.59	A4394	\$2.58	A5051	\$2.07
A4347	\$20.35	A4395	\$0.05	A5052	\$1.49
A4348	\$27.83	A4396	\$40.48	A5053	\$1.48
A4351	\$1.81	A4397	\$4.07	A5054	\$1.79
A4352	\$6.42	A4398	\$13.81	A5055	\$1.42
A4353	\$6.99	A4399	\$12.26	A5061	\$3.52
A4354	\$11.80	A4400	\$48.87	A5062	\$2.22
A4355	\$8.91	A4402	\$1.36	A5071	\$6.01
A4356	\$45.63	A4404	\$1.69	A5072	\$3.43
A4357	\$9.34	A4405	\$3.40	A5081	\$3.30
A4358	\$6.63	A4406	\$5.74	A5082	\$11.89
A4359	\$29.37	A4407	\$8.76	A5093	\$1.95
A4361	\$15.61	A4408	\$9.87	A5102	\$22.58
A4362	\$3.46	A4409	\$6.22	A5105	\$40.76
A4363	\$3.93	A4410	\$9.04	A5112	\$34.62
A4364	\$2.93	A4413	\$5.50	A5113	\$4.00
A4365	\$11.32	A4414	\$4.93	A5114	\$8.94
A4367	\$7.35	A4415	\$6.00	A5119	\$10.85
A4368	\$0.26	A4422	\$0.12	A5121	\$7.46
A4369	\$2.42	A4450	\$0.09	A5122	\$12.85
A4370	\$3.43	A4452	\$0.36	A5123	\$5.67
A4371	\$3.65	A4454	\$2.61	A5126	\$1.32
A4372	\$4.18	A4455	\$1.43	A5131	\$15.86
A4373	\$6.28	A4460	\$1.01	A5200	\$11.30
A4374	\$8.44	A4462	\$3.29	A6010	\$30.96
A4375	\$17.18	A4481	\$0.37	A6011	\$2.28
A4376	\$47.58	A4556	\$12.14	A6410	\$0.39
A4377	\$4.29	A4557	\$21.10	E0749	\$256.13
A4378	\$30.75	A4558	\$5.45	E0756	\$6,569.18
A4379	\$15.02	A4561	\$18.63	E0757	\$4,693.57
A4380	\$37.33	A4595	\$28.81	E0758	\$4,131.42
A4381	\$4.61	A4614	\$23.78	E0781	\$264.87
A4382	\$24.62	A4618	\$8.89	E0782	\$3,287.02
A4383	\$28.19	A4619	\$1.21	E0783	\$7,373.94
A4384	\$9.62	A4621	\$1.39	E0786	\$7,192.83
A4385	\$5.10	A4622	\$57.27	V2520	\$98.45
A4386	\$6.72	A4623	\$6.55	V2521	\$151.24
A4388	\$4.36	A4624	\$2.63	V2522	\$185.68
A4389	\$6.22	A4625	\$6.93	V2523	\$156.04
A4390	\$9.61	A4626	\$3.19		

**FLORIDA ONLY**

**COVERAGE/REIMBURSEMENT**

CODE	FEE	CODE	FEE	CODE	FEE
A4392	\$8.18	E0145	\$20.75	L0460	\$703.39
A4393	\$9.04	K0560	\$1,813.25	L0462	\$316.82
A5052	\$1.49	K0592	\$8.25	L0464	\$324.49
A5054	\$1.79	L0452	\$1,133.93	L0488	\$1,216.86
A5061	\$3.52	L0454	\$1,151.21	L0490	\$228.96
A5071	\$6.01	L0456	\$978.13	L0500	\$113.44
A6410	\$0.39	L0458	\$393.55		

Source: CMS Transmittal AB-03-006, CR 2535

## LABORATORY/PATHOLOGY

### Additional Documentation Requests (ADR) for Ordering Providers of Laboratory Services

On November 23, 2001, CMS published in the *Federal Register* (66 FR 58788) a final rule regarding coverage and administrative policies for clinical diagnostic laboratory services under Medicare Part B. A committee of interested parties, including representatives from hospitals, physicians, laboratories, coding experts and CMS staff developed this rule under the Negotiated Rulemaking Act. A provision of the rule was that “if the documentation provided...does not demonstrate that the service is reasonable and necessary, CMS:

- provides the ordering physician or nonphysician practitioner information sufficient to identify the claim being reviewed,
- requests from the ordering physician or nonphysician practitioner those parts of a beneficiary’s medical record that are relevant to the specific claim(s) being reviewed, and
- if the ordering physician or nonphysician practitioner does not supply the documentation requested, informs the entity submitting the claim(s) that the documentation has not been supplied and denies the claim.”

In accordance with this policy, effective for claims processed on or after July 7, 2003, FCSO will request any additional documentation needed for processing claims submitted for clinical diagnostic laboratory services from the billing provider, and under certain circumstances, from the ordering provider.

Laboratories may still ask the ordering physician or nonphysician practitioner for any appropriate documentation they need to respond to the initial ADR. Thus, the ordering provider could, in some instances, receive requests for documentation from both the laboratory and Medicare.

We will allow 45 days for the receipt of the additional documentation requested from the ordering physician or nonphysician practitioner prior to denying the claim, after the initial ADR to the billing provider, if we need that additional documentation to make a determination on the claim.

Laboratory billing providers are required to supply information sufficient to identify the ordering provider along with the claim. “Sufficient information” would typically consist of the ordering provider’s UPIN (unique physician identification number). However, if a surrogate UPIN is used, if the ordering provider is not located in our processing jurisdiction (i.e., Connecticut or Florida), or if the ordering provider has multiple practice locations under his/her UPIN, the laboratory should indicate the ordering provider’s complete name and address. If this information is not provided, we will adjudicate the claim based only on the documentation received and deny or downcode the service as appropriate.

Source: CMS Transmittal AB-03-021, CR 2504

### Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 1, 2003

The Centers for Medicare & Medicaid Services (CMS) Program Memorandum (PM) AB-02-110 implemented NCDs for clinical diagnostic laboratory services developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. CMS announced in PM AB-02-110 that nationally uniform software would be developed by Computer Sciences Corporation and incorporated into the shared systems so laboratory claims subject to one of the 23 NCDs would be processed uniformly throughout the nation, effective January 1, 2003. The laboratory edit module for the NCDs will be updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The purpose of this article is to announce the changes included in the April 2003 release of the edit module.

1. On January 28, 2003 CMS posted on the Internet a decision memorandum announcing the intent to add the following ICD-9-CM codes to the serum iron studies NCD: 282.60, 282.61, 282.62, 282.63, 282.69, and 285.21. These are codes for anemia in patients with end-stage renal disease and sickle cell anemia. CMS believes these codes flow from the existing narrative in the serum iron studies relating to abnormal blood count values. This NCD change is effective for dates of service November 25, 2002 and after. (See <http://cms.hhs.gov/ncdr/memo.asp?id=74> for additional information regarding this change.)

Pursuant to section 1869(f)(1)(B) of the Social Security Act, the term “national coverage determination” means a determination by the Secretary [of the Department of Health and Human Services] with respect to whether or not a particular item or service is covered nationally under this title [XVIII], but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered.” Thus, the assignment of the ICD-9-CM codes to given services will not be subject to review under section 1869(f).

2. Updates to *Current Procedural Terminology (CPT)* codes for 2003 included deletion of seven codes currently in the blood count NCD. CMS is eliminating the following *CPT* codes from the edit software: 85021, 85022, 85023, 85024, 85031, 85590, and 85595, effective for dates of service on or after April 1, 2003. These codes remain in this NCD for dates of service November 25, 2002, through March 31, 2003. The *CPT* also added new blood count codes for 2003. Therefore, CMS has undertaken an NCD review to add new codes to this policy. Readers may follow the progress of this NCD review on the Internet at: <http://cms.hhs.gov/ncdr/tracking-sheet.asp?id=88>.
3. In PM AB-02-134, question and answer 4 noted that *CPT* codes 87184 and 87186, the susceptibility studies for antimicrobial agents, were not specific to urine. Editing these codes for the diagnoses in the urine culture NCD could result in inappropriate denials when the code was being used for other identifications. CMS stated that the edit module would not edit for these *CPT* codes, but that contractors could develop local edits for them.

CMS has learned that an error was made in developing the edit module and these codes were not removed as planned. The oversight will be corrected in the April update of the edit module and these codes will no longer be reflected in the NCD for any service dates. In the meantime, contractors may bypass the edit module on all claims with *CPT* codes 87184 and 87186. Any inappropriate denials should be adjusted when brought to the contractor's attention.

4. In the serum iron studies NCD, there is a mismatch between the ICD-9-CM codes and the description of the codes in the list of ICD-9-CM codes covered by Medicare. The coding manual is being corrected to display the correct description of ICD-9-CM codes 562.02 and 562.03 to reflect that these codes indicate diverticulosis and diverticulitis of the small intestine with hemorrhage. No changes in the software are necessary for this change.
5. Several changes were made to the NCDs as produced in PM AB-02-110. These changes were incorporated in the January 1, 2003, edit module release, and in the Laboratory NCD Manual that is on the Internet at: <http://cms.hhs.gov/ncd/manual.pdf>. These changes do not reflect substantive changes to the policies, but rather reflect correction of typographical errors and/or ministerial coding updates that have taken place prior to the January 2003 release. The changes to the NCDs are tracked in the NCD Manual Updates section of the NCD Manual.

Below is a listing of changes that were made in the January release. CMS believes most of the typographical errors and ministerial coding update changes have been captured, and future changes of this nature will be limited.

- Expanded truncated code 780.9 to 780.99 in the urine culture and thyroid NCD
- Corrected code 99.8 to 099.8 in the HIV diagnostic NCD
- Corrected code 99.9 to 099.9 in the HIV diagnostic NCD
- Expanded the range of codes for coronary atherosclerosis to include new code 414.06 in the prothrombin time, blood glucose and lipid NCDs
- Added new code 414.12 to the range of codes for aneurysm and dissection of coronary artery in the blood glucose and lipid NCDs
- Expanded truncated code 459.1 to 459.10-459.13 and 459.19 in the prothrombin time NCD
- Expanded truncated code 633.9 to 633.90 and 633.91 in the human chorionic gonadotropin NCD
- Expanded truncated code 521.0 to 521.00 in the blood counts NCD
- Expanded truncated code V59.0 to V59.01, V59.02, and V59.09 in the blood count NCD
- Corrected last code in range 813.30-813.38 to 813.33 in the prothrombin time NCD
- Expanded truncated code 863.9 to 863.90 in the prothrombin time NCD
- Expanded truncated code 790.0 to 790.01 and 790.09 in the serum iron studies NCD
- Expanded truncated code 256.3 to 256.31 and 256.39 in the collagen crosslinks and thyroid NCDs
- Expanded truncated code 564.0 to 564.00-564.02, and 564.09 in the thyroid and fecal occult blood NCDs
- Expanded truncated code 200.0 to 200.00 in the serum iron studies NCD
- Deleted sentence 2 of Limitation #1 in the urine culture NCD as the reference was to a code that had been deleted from the *CPT*
- Added new code 277.03 to the alpha-fetoprotein NCD
- Added new code 537.84 to the partial thromboplastin time, serum iron studies, and fecal occult blood NCDs
- Added new code 569.86 to the serum iron studies and fecal occult blood NCDs
- Added new codes 771.81 - 771.83 to the urine culture NCD
- Added codes 634.00-634.02, 642.30-642.34, 642.40-642.74, 642.90-642.94 to the human chorionic gonadotropin NCD that were included in the final rule but inadvertently omitted from the PM AB-02-110
- Added code 216.0-216.9 to the blood counts NCD that were included in but were inadvertently omitted from PM AB-02-110
- Corrected typo in code 401.1 to make it 401.0 in the lipid NCD as originally stated in the final rule
- Corrected typo in code 780.2 to make it 780.02 in the urine culture NCD
- Expanded truncated code 780.9 to 780.99 in the thyroid NCD
- Expanded truncated code 733.1 to 733.10 in the prothrombin time NCD
- Modified the codes description for the following codes: 85007, 85008, 85014, 85025, 85027, 85048, 780.99, 414.10, 214.0, 402.01, 402.11, 402.91, 428.0, 627.2, 627.4 in the NCD Manual.

The changes enumerated in the bullets above are already incorporated in the lab edit module software and the coding manual on the Internet.

Source: CMS Transmittal AB-03-030, CR 2578

## New CLIA Waived Tests

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), effective December 17, 2002. The *Current Procedural Terminology (CPT)* codes for these new tests must have the modifier QW to be recognized as a waived test.

Test	Effective Date	CPT Code
Meridian BioScience ImmunoCard STAT! <i>H.pylori</i> Whole Blood Test	August 9, 2002	86318QW
Matritech, Inc. NMP22® BladderCheck™ Test for Professional and Prescription Home Use	August 12, 2002	86294QW
Phamatech QuickScreen One Step Amphetamine Test	August 23, 2002	80101QW
Phamatech QuickScreen One Step Cocaine Screening Test	August 23, 2002	80101QW
Phamatech QuickScreen One Step Methamphetamine Test	August 23, 2002	80101QW
Phamatech QuickScreen One Step Opiate Screening Test	August 23, 2002	80101QW
Phamatech QuickScreen One Step PCP Screening Test	August 23, 2002	80101QW
DE Healthcare Products, TruView Strep A Test	October 23, 2002	87880QW
Henry Schein Inc, One Step+ Strep A Test	October 23, 2002	87880QW
Polymer Technology Systems CardioChek PA Analyzer {PTS Panels Lipid Panel Test Strips}	November 21, 2002	82465QW, 83718QW, 84478QW and 80061QW
Lifescan Harmony™ INR Monitoring System — Prescription Home Use and Professional Use	December 2, 2002	85610QW
ThermoBiostar™ PocketChem™ UA	December 6, 2002	81003QW

The complete list of tests granted waived status under CLIA is available on the Centers for Medicare & Medicaid Services (CMS) Web site at [http://cms.hhs.gov/manuals/pm\\_trans/AB03013.pdf](http://cms.hhs.gov/manuals/pm_trans/AB03013.pdf). The list of CLIA waived tests has been reorganized so that the column mentioning the CPT code is listed first. Approved waived tests are listed under their appropriate CPT code, the list is sorted primarily by CPT code, and the information in the “Use” column explains the purpose of the waived test. Page 1 lists those waived tests that have a unique CPT code for the waived test that does not require a QW modifier. In addition, two tests that had a CPT code of “Pending” in previous lists (i.e., Micro Diagnostics Spuncrit Model DRC-40 Infrared Analyzer for hematocrit and Chemtrak AccuMeter *H. pylori* Test [for whole blood]) have been deleted.

Source: CMS Transmittal AB-03-013, CR 2533

## MENTAL HEALTH

### Medicare Payments for Part B Mental Health Services

*This article is published at the CMS' request to assist the provider community about requirements for payment of Part B mental health services.*

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare Part B payments for mental health services and recommended that we promote provider awareness of the requirements for payment of these services. OIG reports can be accessed at <http://www.oig.hhs.gov/oei/oeisearch.html>. This article explains Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E/M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

#### Qualification Requirements for Mental Health Providers

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their State Scope of Practice Act and licensed or certified to perform mental health services by the state in which the services are performed. Qualification requirements for mental health professionals are listed below.

- **A qualified physician must:**

1. Be legally authorized to practice by the state in which he/she performs the functions or actions, and
2. Be acting within the scope of his/her license.

- **A clinical psychologist must:**

1. Hold a doctoral degree in psychology; and
2. Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he/she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Refer to regulations found at 42 CFR section 410.71 and the Medicare Carriers Manual Part 3, Chapter II, section 2150 for the covered services of a clinical psychologist.

- **A clinical social worker must:**

1. Possess a master's or doctor's degree in social work;
2. After obtaining the degree, have performed at least two years of supervised clinical social work; and
3. Be licensed or certified as a clinical social worker by the state in which the services are performed.

In states that do not provide for licensure or certification as a clinical social worker, the individual must:

1. Be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed; and
2. Have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic.

Refer to regulations found at 42 CFR section 410.73 and the Medicare Carriers Manual Part 3, Chapter II, section 2152 for the covered services of a clinical social worker.

- **A nurse practitioner must:**

1. Be a registered professional nurse who is authorized to practice as a nurse practitioner delivering mental health services by the laws of the state in which services are furnished; and
2. Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be:
  - A registered professional nurse who is authorized to practice as a nurse practitioner by the laws of the State in which the services are furnished, and has been granted a Medicare billing number as a nurse practitioner by December 31, 2000;
  - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2001; or
  - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2003, and possesses a master's degree in nursing.

Refer to regulations found at 42 CFR section 410.75 and the Medicare Carriers Manual Part 3, Chapter II, section 2158 for the covered services of a nurse practitioner.

- **A clinical nurse specialist must:**

1. Be a registered nurse who is currently licensed to practice in the state where he/she practices and authorized to perform the services of a clinical nurse specialist in accordance with state law;
2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
3. Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

Refer to regulations found at 42 CFR section 410.76 and the Medicare Carriers Manual Part 3, Chapter II, section 2160 for the covered services of a certified nurse specialist.

- **A physician assistant must:**

1. Be a physician assistant who is licensed to practice as a physician assistant by the laws of the state in which services are furnished; and
2. Have graduated from a physician assistant educational program accredited by the Commission on Accreditation of Allied Health Education Programs, or passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

Refer to regulations found at 42 CFR section 410.74 and the Medicare Carriers Manual Part 3, Chapter II, section 2156 for the covered services of a physician assistant.

### “Incident to” Services

Certain nonphysician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants may have services furnished incident to their professional services. To the extent that they are licensed or authorized by the state to furnish mental health services, these practitioners could have others provide some services as an incident to overall mental health services. There is no national policy that specifies the qualifications for individuals who may furnish these incidental services. In the absence of national policy, contractors can implement local medical review policies that determine who can furnish mental health services incident to the professional services of these specific nonphysician practitioners. Therefore, inconsistencies may be found in policy in terms of billing and payment to nonphysician practitioners for incident to mental health services. The requirements found in the Medicare Carriers Manual Part 3, Chapter II, section 2050.1 are also applicable to services furnished incident to the professional services of certain nonphysician practitioners.

Refer to the following requirements found on the American Psychological Association's (APA) Web site at <http://www.apa.org/practice/medincident.html>:

- Qualifications of Ancillary Personnel
- Graduate Medical Education (GME). (Current psychiatric residency programs require the teaching physician to be present during the “key portion” of **any** service in which a resident is involved. This would require **either direct observation of the service, or use of a one-way mirror or video equipment** (emphasis added). Thus, if psychiatry interns provide services, they must be observed.)

### Reasonable and Necessary Services

Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services, including mental health services, must be “reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.” For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

### Reasonable Expectation of Improvement

Services must be for the purpose of diagnostic study or be reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. “Improvement” in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that a patient's condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met.

### General Principles of Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history;
  - Physical examination findings and prior diagnostic test results;
  - Assessment, clinical impression, and diagnosis;
  - Plan for care; and
  - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported on health insurance claim form should be supported by documentation in the medical record.

### **Documentation Guidelines for E/M Services Involving a General Psychiatric Examination or the Single System Psychiatric Examination**

Providers should **thoroughly** familiarize themselves with documentation guidelines for E/M services. These guidelines are available on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/medlearn/emdoc.asp>.

The *Medicare Resident & New Physician Training* manual, Chapter 6, (March 2002 edition) also contains the latest revisions to documentation guidelines for E/M services. Publication is available at <http://www.cms.hhs.gov/medlearn> or upon request from the Medicare Learning Network at [medlearn@cms.hhs.gov](mailto:medlearn@cms.hhs.gov).

### **Documentation Guidelines for Psychiatric Diagnostic or Evaluative Interview Procedures, Psychiatric Therapeutic Procedures, Central Nervous System Assessment, and Health and Behavior Assessment**

Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (CPT codes 90801-90802, 90804-90899 under the Psychiatry Section), overview and definitions for central nervous system assessment (CPT codes 96100-96117), and health and behavior assessment (CPT codes 96150-96155) as described in the *Physicians' Current Procedural Terminology*, which is an annual publication developed by the American Medical Association (AMA). Available from the AMA at <http://www.ama-assn.org/ama/pub/category/3113.html>.

Refer to Program Memorandum A-02-129 dated January 3, 2003 for the 2003 update of the hospital outpatient prospective payment system (OPPS), which provides current revenue and HCPCS codes for the partial hospitalization program.

Providers should confer with the local carrier to determine if a local medical review policy has been written regarding documentation requirements.

Source: CMS Transmittal AB-03-037, CR 2520

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## MAMMOGRAPHY

### Screening and Diagnostic Mammography Claims

CMS recently updated sections 4601.2 and 4601.6 of the Medicare Carriers Manual (MCM), effective for services rendered on or after April 1, 2003. These revisions pertain to identifying screening and diagnostic mammography claims, and diagnostic and screening mammography performed with new technologies, respectively.

#### Coding for Screening Mammography and Diagnostic Mammography

Specific CPT and HCPCS codes used for mammography claims are listed below. These codes are paid under the Medicare physician fee schedule.

##### CPT/HCPCS Codes

76092 *Screening mammography, bilateral (two view film study of each breast)*

76090 *Mammography; unilateral*

76091 *Mammography; bilateral*

G0202 Screening mammography, producing direct digital image, bilateral, all views.

G0204 Diagnostic mammography, producing direct digital image, bilateral, all views.

G0206 Diagnostic mammography, producing direct digital image, unilateral, all views.

76085 *Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography. (List separately in addition to code for primary procedure)*

G0236 Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography. (List separately in addition to code for primary procedure)

##### Modifier

GG Performance and payment of a screening mammogram and diagnostic mammography on the same patient, same day.

*Note: Modifier GG should be used to show that the diagnostic test performed on the same date as the screening test is appropriate.*

#### Add-On Codes for Digitization of Film Radiographic Images with Computer Analysis

Code 76085 has been established as an add-on code that can be billed in conjunction with primary service code G0202 as well as 76092. There is no Part B deductible; however, coinsurance is applicable. Code G0236 has been established as an add-on code that can be billed in conjunction with primary service code G0204 or G0206 as well as existing codes 76090 or 76091. The Part B deductible and co-insurance apply. The add-on codes cannot be billed alone. Medicare will deny the claim if only an add-on code is billed, using remark code N122, "Mammography add-on code can not be billed by itself."

#### Billing for Screening and Diagnostic Mammography Performed with New Technologies

Screening and diagnostic mammography can be billed together, if appropriate (using the GG modifier). However, providers may *not* submit claims reflecting both a *film* screening mammogram (76092) and a *digital* screening mammogram (G0202). Similarly, do not submit claims reflecting codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Claims with both a film *and* digital screening mammogram, or a film *and* digital diagnostic mammogram will be denied.

#### Submitting the Mammography Certification Number

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

For more information concerning recent updates to the MQSA, please see the related article in this issue.

Source: CMS Transmittal 1775, CR 2332; MCM 4601.2, 4601.6  
CMS Transmittal AB-02-149, CR 1729

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## Update to the Mammography Quality Standards Act File for Certified Digital Mammography Centers

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. Medicare pays for film mammography and digital mammography at different rates and pays for a service only if the provider or supplier is certified by the Food and Drug Administration (FDA) to perform those types of mammogram for which payment is sought.

In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, the FDA, via the CMS mainframe telecommunication system, will provide contractors with an updated certification file on a weekly basis.

**Effective April 1, 2003**, Medicare uses an additional indicator on the Mammography Quality Standards Act (MQSA) file to identify the FDA-approved mammography facilities for digital mammography. This additional indicator provides Medicare with the necessary information for the new digital mammography codes that have a higher payment rate.

The FDA must certify facilities to perform film mammography and digital mammography. In this case, the facility's name and FDA certification number will show up on this file twice. One line will indicate film certification with effective date/expiration date, while a second line will indicate digital certification with effective date/expiration date. The facilities may not have the same effective date and expiration date for both film and digital certification.

Source: CMS Transmittal AB-02-149, CR 1729

## NEUROLOGY/NEUROSURGERY

### Deep Brain Stimulation for Essential Tremor and Parkinson's Disease

Deep brain stimulation (DBS) refers to high-frequency electrical stimulation of anatomic regions deep within the brain utilizing neurosurgically implanted electrodes. These DBS electrodes are stereotactically placed within targeted nuclei on one (unilateral) or both (bilateral) sides of the brain. There are currently three targets for DBS – the thalamic ventralis intermedialis nucleus (VIM), subthalamic nucleus (STN) and globus pallidus interna (GPi).

Essential tremor (ET) is a progressive, disabling tremor most often affecting the hands. ET may also affect the head, voice and legs. The precise pathogenesis of ET is unknown. While it may start at any age, ET usually peaks within the second and sixth decades. Beta-adrenergic blockers and anticonvulsant medications are usually the first line treatments for reducing the severity of tremor. Many patients, however, do not adequately respond or cannot tolerate these medications. In these medically refractory ET patients, thalamic VIM DBS may be helpful for symptomatic relief of tremor.

Parkinson's disease (PD) is an age-related progressive neurodegenerative disorder involving the loss of dopaminergic cells in the substantia nigra of the mid-brain. The disease is characterized by tremor, rigidity, bradykinesia and progressive postural instability. Dopaminergic medication is typically used as a first line treatment for reducing the primary symptoms of PD. However, after prolonged use, medication can become less effective and can produce significant adverse events such as dyskinesias and other motor function complications. For patients who become unresponsive to medical treatments and/or have intolerable side effects from medications, DBS for symptom relief may be considered.

**Effective on or after April 1, 2003**, Medicare will cover *unilateral or bilateral thalamic VIM DBS* for the treatment of ET and/or Parkinsonian tremor and *unilateral or bilateral STN or GPi DBS* for the treatment of PD only under the following conditions:

1. Medicare will only consider DBS devices to be reasonable and necessary if they are Food and Drug Administration (FDA) approved devices for DBS or devices used in accordance with FDA-approved protocols governing Category B Investigational Device Exemption (IDE) DBS clinical trials.
2. For thalamic VIM DBS to be considered reasonable and necessary, a patient must meet all of the following criteria (which must be documented in the patient's medical record):
  - a. Diagnosis of essential tremor (ET) based on postural or kinetic tremors of hand(s) without other neurologic signs, or diagnosis of idiopathic PD (presence of at least 2 cardinal PD features [tremor, rigidity or bradykinesia]) which is of a tremor-dominant form.
  - b. Marked disabling tremor of at least level 3 or 4 on the Fahn-Tolosa-Marin Clinical Tremor Rating Scale (or equivalent scale) in the extremity intended for treatment, causing significant limitation in daily activities despite optimal medical therapy.
  - c. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.
3. For STN or GPi DBS to be considered reasonable and necessary, a patient must meet all of the following criteria (which must be documented in the patient's medical record):

- a. Diagnosis of PD based on the presence of at least 2 cardinal PD features (tremor, rigidity or bradykinesia).
- b. Advanced idiopathic PD as determined by the use of Hoehn and Yahr stage or Unified Parkinson's Disease Rating Scale (UPDRS) part III motor subscale.
- c. L-dopa responsive with clearly defined "on" periods.
- d. Persistent disabling Parkinson's symptoms or drug side effects (e.g., dyskinesias, motor fluctuations, or disabling "off" periods) despite optimal medical therapy.
- e. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

DBS is not reasonable and necessary and is not covered for ET or PD patients with any of the following:

1. Non-idiopathic Parkinson's disease or "Parkinson's Plus" syndromes.
2. Cognitive impairment, dementia or depression that would be worsened by or would interfere with the patient's ability to benefit from DBS.
3. Current psychosis, alcohol abuse or other drug abuse.
4. Structural lesions such as basal ganglionic stroke, tumor or vascular malformation as etiology of the movement disorder.
5. Previous movement disorder surgery within the affected basal ganglion.
6. Significant medical, surgical, neurologic or orthopedic co-morbidities contraindicating DBS surgery or stimulation.

Patients who undergo DBS implantation should not be exposed to diathermy (deep heat treatment including shortwave diathermy, microwave diathermy and ultrasound diathermy) or any type of MRI which may adversely affect the DBS system or adversely affect the brain around the implanted electrodes.

DBS should be performed with extreme caution in patients with cardiac pacemakers or other electronically controlled implants that may adversely affect or be affected by the DBS system.

For DBS lead implantation to be considered reasonable and necessary, providers and facilities must meet all of the following criteria:

1. Neurosurgeons must: (a) be properly trained in the procedure; (b) have experience with the surgical management of movement disorders, including DBS therapy; and (c) have experience performing stereotactic neurosurgical procedures.
2. Operative teams must have training and experience with DBS systems, including knowledge of anatomical and neurophysiological characteristics for localizing the targeted nucleus, surgical and/or implantation techniques for the DBS system, and operational and functional characteristics of the device.
3. Physicians specializing in movement disorders must be involved in both patient selection and post-procedure care.

4. Hospital medical centers must have: (a) brain imaging equipment (MRI and/or CT) for pre-operative stereotactic localization and targeting of the surgical site(s); (b) operating rooms with all necessary equipment for stereotactic surgery; and (c) support services necessary for care of patients undergoing this procedure and any potential complications arising intraoperatively or postoperatively.

#### Allowable Covered Diagnosis Codes

Deep brain stimulation is covered for the following ICD-9-CM diagnosis codes:

332.0	Parkinson's disease, with paralysis agitans
333.1	Essential and other specified forms of tremor

#### CPT/HCPCS Coding

The following CPT and HCPCS codes are available for use when billing for covered deep brain stimulation:

E0752	Implantable Neurostimulator Electrode, Each
E0756	Implantable Neurostimulator Pulse Generator
61862	<i>Twist drill, burr hole, craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)</i>
61880	<i>Revision or removal of intracranial neurostimulator electrodes</i>
61885	<i>Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array</i>
61886	<i>Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays</i>
61888	<i>Revision or removal of cranial neurostimulator pulse generator or receiver</i>
95961	<i>Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance</i>
95962	<i>Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure) (Use 95962 in conjunction with code 95961)</i>

95970	<i>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming</i>		<i>surements); complex brain, spinal cord, or peripheral (except cranial nerve); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, additional 30 minutes after hour (List separately in addition to code for primary procedure) (Use 95973 in conjunction with code 95972)</i>
95971	<i>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple brain, spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming</i>		<b>Ambulatory Surgical Centers</b> The following procedure codes are approved for billing in Ambulatory Surgical Centers (ASC):  61885                   ASC payment group 02 61888                   ASC payment group 01  <b>Note:</b> Pulse generator is payable in an ASC; implantation of electrodes are not.
95972	<i>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour</i>		<b>Additional Payment Requirements</b> Payment and pricing information is on the basis of the Medicare physician fee schedule database (MPFSDB). Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge.  <b>Advance Notice Statement</b> Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See <a href="http://www.cms.hhs.gov/medicare/bni">www.cms.hhs.gov/medicare/bni</a> for details concerning ABNs.  Source: CMS Transmittal AB-03-023, CR 2553
95973	<i>Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance mea-</i>		<small>Italicized and/or quoted material is excerpted from the American Medical Association <i>Current Procedural Terminology</i>. CPT codes, descriptions and other data only are copyrighted 2002 (or other such date of publication of CPT) American Medical Association. All rights reserved. Applicable FARS/DFARS apply.  <b>Third party Web sites.</b> 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.</small>

## PHYSICAL THERAPY/OCCUPATIONAL THERAPY

### Implementation of the Financial Limitation for Outpatient Rehabilitation Services

Section 4541(a)(2) of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33), which added section 1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system for outpatient rehabilitation services.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of

a hospital) of an annual per beneficiary limit of \$1500 for all outpatient physical therapy (PT) services (including speech-language pathology services) and a separate \$1500 limit for all occupational therapy (OT) services. The \$1500 limit is based on incurred expenses and includes applicable deductible (\$100) and coinsurance (20 percent). The annual limitation does not apply to services furnished directly or under arrangement by a

hospital to an outpatient, or to a hospital inpatient who is not in a covered Part A stay. The BBA provided that the \$1500 limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002. This indexed amount is \$1590 for 2003.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the service. Therefore, physical therapists, speech-language pathologists, occupational therapists, as well as physicians and nonphysicians practitioners could render a therapy service.

### Moratorium on Therapy Claims

Section 211 of the Balanced Budget Refinement Act of 1999 placed a two-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000 through December 31, 2001. Section 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, extended the moratorium on application of the financial limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. Therefore, the moratorium was for a three-year period and applied to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

### Application of Financial Limitation

The moratorium on the application of the financial limitation on outpatient rehabilitation services is no longer in effect. As a result, beginning with claims submitted for dates of service on and after July 1, 2003, Medicare contractors will apply the financial limitation for OT and PT services (including speech-language pathology) in a prospective manner, through December 31, 2003. For calendar year (CY) 2003, the financial limitation could not be implemented prior to July 1, 2003 because of system limitations. For each subsequent CY the financial limitations will be effective for the entire year.

There are two separate \$1590 limitations: one for PT (including speech-language pathology) services and the other for OT services. Effective July 1, 2003, for claims with dates of service on or after July 1, 2003, the Common Working File (CWF) will track the \$1590 PT (which includes speech language pathology services) and the \$1590 OT financial limitation for outpatient rehabilitation services.

This financial limitation is an annual per beneficiary limitation. The \$1590 limitation is on the allowed incurred expenses, which are defined as the Medicare Physician Fee Schedule (MPFS) amount prior to any application of deductible (\$100) and coinsurance (20 percent). If the beneficiary has already satisfied the Medicare Part B deductible, the maximum amount payable by the Medicare program is \$1272; that is 80 percent of the \$1590 for PT (including speech language pathology) and 80 percent of the \$1590 for OT. The beneficiary is responsible for paying the remaining 20 percent coinsurance.

See the following examples:

**EXAMPLE I - Part B Deductible Previously Met:**  
\$1590 (MPFS allowed amount) x 80 percent = \$1272 (Medicare reimbursement).

The amount applied to the limitation in this example is \$1590. The Medicare program pays \$1272 and the beneficiary is responsible for \$318 coinsurance.

**EXAMPLE II - Part B Deductible Not Met:**  
\$1590 (MPFS allowed amount) - \$100 (Part B deductible) = \$1490 x 80 percent = \$1192 (Medicare reimbursement).

The amount applied to the limitation in this example is \$1590. The Medicare program pays \$1192 and the beneficiary is responsible for \$398, (\$100 Part B deductible and \$298 coinsurance).

**EXAMPLE III - Part B Deductible Previously Met:**  
\$800 (MPFS allowed amount) x 80 percent = \$640 (Medicare reimbursement).

The amount applied to the limitation in this example is \$800. The Medicare program pays \$640 and the beneficiary is responsible for \$160 coinsurance.

**EXAMPLE IV - Part B Deductible Not Met:**  
\$800 (MPFS allowed amount) - \$100 (Part B deductible) = \$700 x 80 percent = \$560 (Medicare reimbursement).

The amount applied to the limitation in this example is \$800. The Medicare program pays \$560 and the beneficiary is responsible for \$240, (\$100 Part B Deductible and \$140 coinsurance).

*Note: In the above examples the MPFS allowed amount is the lower of actual charges or the MPFS rate times the unit.*

The CWF will be tracking the financial limitation based on presence of therapy modifiers GN, GO, and GP; therefore, providers/physicians/suppliers must continue to report one of these modifiers for any therapy service that is provided. The definitions of the therapy modifiers have been changed effective January 1, 2003; they are as follows:

- GN** Services delivered under an outpatient speech-language pathology plan of care
- GO** Services delivered under an outpatient OT plan of care
- GP** Services delivered under an outpatient PT plan of care

These modifiers do not allow a provider to deliver services they are not recognized by Medicare to perform.

If an audiology procedure (HCPCS) code is performed by an audiologist (specialty code 64), the above modifiers should not be reported, as these procedures are not subject to the financial limitation.

All claims containing any of the following list of "Applicable Outpatient Rehabilitation HCPCS Codes" should contain one of the therapy modifiers (GN, GO, GP), except as follows: Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes 50 (nurse practitioner), 89 (clinical

nurse specialist), and 97 (physician assistant) do not have to contain modifiers for the HCPCS codes for casts and splints as noted with a "+" sign below.

All other claims submitted by physicians or nonphysician practitioners (as previously noted above) containing these applicable HCPCS codes without therapy modifiers will be returned to the provider as unprocessable.

If specialty codes 65 (occupational therapy), 67 (physical therapy), 73 (mass immunization roster biller), or 74 (radiation therapy center) are present and an applicable CPT/HCPCS code is submitted without one of the therapy modifiers (GN, GO, or GP) the claim will be returned as unprocessable.

Once the financial limitation has been reached, beneficiaries may receive outpatient rehabilitation services furnished directly by or under arrangement with a hospital.

### Applicable Outpatient Rehabilitation HCPCS Codes

The following codes apply to each financial limitation except as noted.

*Note: Listing of the following codes does not imply that services are covered.*

29065+	29075+	29085+	29086+
29105+	29125+	29126+	29130+
29131+	29200	29220	29240
29260	29280	29345+	29355+
29365+	29405+	29425+	29445+
29505+	29515+	29520	29530
29540	29550	29580	29590
64550	90901	90911	92506
92507	92508	92526	92601++
92602++	92603++	92604++	92607
92608	92609	92610	92611
92612	92614	92616	95831
95832	95833	95834	95851
95852	96000	96001	96002
96003	96105	96110	96111
96115	97001	97002	97003
97004	97012	97016	97018
97020	97022	97024	97026
97028	97032	97033	97034
97035	97036	97039	97110
97112	97113	97116	97124
97139	97140	97150	97504*
97520	97530	97532	97533
97535	97537	97542	97601+
97703	97750	97799	V5362
V5363	V5364	G0279	G0280
G0281	G0283	0020T	0029T

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

+ These codes for casts and splints will not apply to the financial limitations when billed by physicians and nonphysician practitioners, as appropriate. These codes, when billed by other providers or physical therapists or occupational therapists in private practice, specialty codes 65, 67, 73, or 74, must be billed with a GO or GP modifier.

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

### Notification Requirements

Providers should notify beneficiaries of the therapy financial limitations, and that these limits are applied in all settings except hospital outpatient departments. Advance Beneficiary Notices (ABNs) cannot be used because of the statutory nature of the financial limitations. Therefore, providers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy \$1590 limit, unless this outpatient care is furnished directly or under arrangement by a hospital. It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits and that, where necessary, appropriate care above the \$1590 limit can be obtained at a hospital outpatient therapy department. Providers are to use the Notice of Exclusion from Medicare Benefits (NEMB) form to inform beneficiaries of the therapy financial limitation at their first therapy encounter with the beneficiary. When using the NEMB form, the practitioner checks box #1 and writes the reason for denial in the space provided at the top of the form. For CY 2003, provide the following: "Medicare will not pay for: PT and speech-language pathology services over \$1590 (including dates of service from July 1, 2003 through December 31, 2003)." This same information is provided for OT services over the \$1590 limit for the same time period, as appropriate. The NEMB form can be found at: <http://www.cms.hhs.gov/medlearn/refABN.asp>. Providers are reminded that a plan of care must be on file.

Source: CMS Transmittal AB-03-018, CR 2183

*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.

## **Outpatient Physical or Speech Therapy Certification—Clarification Outpatient Certification and Physician Signature Requirements**

Per section 2206.1 of the Medicare Carriers Manual (MCM):

Since the certification is closely associated with the plan of treatment, the same physician who established or reviews the plan of treatment must certify the necessity for services. [Carriers must] obtain certification at the time the plan of treatment is established or as soon thereafter as possible.

First Coast Service Options, Inc. (FCSO), carrier for Connecticut and Florida, requires that if there is a delay with obtaining the certification, the reason for the delay must be explained in the medical record, (e.g., doctor on vacation for two weeks).

### **30-Day Re-Certification Period**

MCM section 2206.1 also states:

When outpatient physical therapy or speech pathology services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and estimate how long services are needed. [Carriers must] obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. The physician who reviews the plan of treatment signs the recertifications. The form of the recertification and the manner of obtaining timely recertification is up to the individual clinic.

FCSO does not count the days between the office visit when the physician gives the prescription to the patient and the date of the evaluation in the 30 days. The 30-day clock begins with the performance of the evaluation by the therapist.

# ELECTRONIC MEDIA CLAIMS

## THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

### HIPAA Makes Electronic Claims Submission the Best Choice

*The following is a reprint of a narrative written by Cathy Benoit, CMS Atlanta Regional Office HIPAA Coordinator:*

Today, a health care provider may do business with a number of health plans, each with its own version of forms, code sets, or identifiers required for payment. The Health Insurance Portability and Accountability Act (HIPAA) sets out to change that. Under HIPAA, all health plans are required to use the standards set forth in this regulation.

The standards established by HIPAA will enable administrative efficiency all across the healthcare industry. Physicians' offices will have more time for patients and spend less time on paperwork. We will have standard data, which will yield better data; and better data will yield better information. This, in turn, will yield better health outcomes for all of us.

All covered entities must comply with the HIPAA privacy regulations. It is true that if you are a 100% paper office, you are not a 'covered entity' and, thus, do not have to comply with the HIPAA rules. But, is that a good business decision? We live in a competitive market. The organizations that embrace HIPAA as a business opportunity and prepare their organization for the future of health care will be able to realize the benefits.

Other industries have gone through their own standardization processes. For example, the banking and grocery industries have embraced technology and standardization to streamline their costs. There was a time when we had to wait in line for a bank teller to process all of our transactions, but now we can use the telephone, computer, or ATM for access to our accounts 24 hours a day, 7 days a week. We are also capable of processing transactions from any banking institution, not just the one where we first opened our account.

Do you recall when the stock clerks worked all night to fill the grocery shelves with priced items, and the cashier had to type in the price of each item into a cash register? Then, when we checked-out, we received a generic receipt. Now, every item is identified by a bar code and is scanned for an itemized receipt. In fact, the grocery stores have streamlined the process to the point that we can checkout ourselves via the U-SCAN-it stations. These changes have proved to provide customers greater benefits while saving the industry's service providers money in the long run.

In both of these industries and many more, the use of electronic standards have revolutionized the way business is conducted. Implementing HIPAA will require the health care industry to change many long used and familiar business processes. Change is difficult for most people, and HIPAA is about change. A change of this magnitude will not happen overnight. It will take time, hard work, communication and possibly investment capital.

HIPAA is the first step in an e-commerce platform for the health care industry. Once the standards are in place, more and more products will be developed that will provide greater benefits to providers and to patients.

Over the past few decades, we have seen healthcare costs continue to rise. HIPAA will result in more efficient business processes, which should make more money available for healthcare delivery. We are at a turning point in the healthcare industry.

It is important for all health care providers to realize that HIPAA is about the future of healthcare. HIPAA is a long-term benefit rather than a short-term cost or inconvenience. The providers that embrace HIPAA as an opportunity will be in a better position to adjust to changes and take advantage of the EDI [Electronic Data Interchange] benefits. I urge you to consider the following questions.

- Where are the banks that have not embraced ATMs?
- Where are the companies that have not embraced personal computers (or cell phones)?
- Where are the grocery stores that have not embraced checkout scanners?
- If given the choice between Dr. A and Dr. B where the services are equal, and if Dr. A is obligated by Federal law to protect your health records and Dr. B is not, whom would you choose?

It is a fact that we live in a competitive market, so I encourage you to consider HIPAA as the first step in preparing your organization for the future of healthcare.

Can you afford not to?

## HIPAA-AS Transactions and Code Sets: Testing and Updates

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

The Administrative Simplification Compliance Act requires entities that requested a one-year extension to start testing their systems no later than April 16, 2003 (this requirement relates to their own internal testing, not testing with Medicare).

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

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

1-904-791-6250 for Connecticut  
1-904-791-6055 for Florida

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

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

### Support Continues for Low Cost HIPAA Billing Software

CMS will continue support of low cost HIPAA Medicare billing software through FY 2004 and beyond. FCSO supports the PC-ACE Pro32® software. To learn more about this using this software call 1-904-791-8767, extension 1.

## FCSO to Begin Testing and Support of HIPAA-AS Addenda Transactions

Effective April 7, 2003, FCSO began supporting the Addenda version (4010A1) for the following transactions:

- X12N 837 Inbound Claims Transaction
- X12N 835 Remittance Advice
- X12N 276/277 Claim Status Inquiry/Response

All current healthcare claim and remittance advice formats will be supported through October 16, 2003. *As of October 16, 2003, only the ANSI 4010 Addenda version of the transactions noted above will be supported.*

**Important note:** *If you do not contact us to schedule your test before July 2003, it may not be possible to guarantee a testing date before the October 16, 2003 compliance deadline. We strongly encourage you to call early to schedule your testing.*

### 837–Inbound Claims Transaction

Effective October 16, 2003, Medicare will accept **only** the Addenda version of the ANSI 837 claims transaction. Between April 7, 2003, and October 15, 2003, Medicare will support both the 4010 and 4010 Addenda versions of the 837 Inbound Claims Transaction.

Senders/submitters and vendors who have not previously been approved to send Medicare B claim files in ANSI version 4010 must schedule testing for the 4010 Addenda. Those currently approved to transmit electronic files in ANSI version 4010 are not required to re-test. In addition, if your vendor has supplied you with 4010 Addenda software, you are not required to re-test.

**Testing of the Addenda version is anticipated to begin April 7, 2003. To schedule testing, or for additional information about the 837 transaction:**

- for **Connecticut**, please call Michelle Hackett at 1-904-791-6250, or via email at [Michelle.Hackett@fcs.com](mailto:Michelle.Hackett@fcs.com).
- for **Florida**, please call Floyd Rosenberger at 1-904-791-6055, or via email at [Floyd.Rosenberger@fcs.com](mailto:Floyd.Rosenberger@fcs.com).

### 835–Remittance Advice Transaction

Effective October 16, 2003, Medicare will generate **only** the 4010 Addenda version of the ANSI 835 remittance advice. Between April 7, 2003, and October 15, 2003, Medicare will generate both the 4010 and 4010 Addenda versions of the 835 remittance advice.

Testing of the 4010 Addenda version of the remittance advice is anticipated to begin April 7, 2003. Users who have successfully tested the 4010 remittance advice transaction are not required to re-test the 4010 Addenda transaction.

For those users who have not tested version 4010, although not required, we encourage testing of the outbound remittance advice in either version 4010 or 4010 Addenda.

**To schedule testing or for additional information about the 835 transaction:**

- for **Connecticut**, please call Kathy Blackshear at 1-904-791-8492, or via email at [Kathy.Blackshear@fcso.com](mailto:Kathy.Blackshear@fcso.com).
- for **Florida**, please call Elizabeth Templeton at 1-904-791-6895, or via email at [Elizabeth.Templeton@fcso.com](mailto:Elizabeth.Templeton@fcso.com).

**276/277–Claim Status Request and Response**

Effective April 7, 2003, *only* the 4010 Addenda version of the 276/277 transaction will be accepted, version 4010 will not be accepted at anytime. Testing is anticipated to begin at that time.

**To schedule testing or for additional information about the 276/277 transactions:**

- for **Connecticut**, please call 1-203-639-3160, option 5.
- for **Florida**, please call Mike Morton at 1-904-791-8610, or via email at [Mike.Morton@fcso.com](mailto:Mike.Morton@fcso.com).

**How to Obtain Addenda Information**

The final updated Designated Standards Maintenance Organizations (DSMO) Addenda pages for all transactions are available at [http://hipaa.wpc-edi.com/HIPAAAddenda\\_40.asp](http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp).

Additional information regarding the ANSI version 4010 Addenda transactions will be provided to senders, vendors, and clearinghouses as it becomes available.

**Special Information for PC-ACE Pro32® Users**

PC-ACE Pro32® anticipates the addenda version (4010A1) will be available to all existing PC-ACE Pro32® users April 1, 2003.

- For **Connecticut**, distribution of the upgrade will continue according to the existing migration schedule. If you have a question about the migration date, or wish to migrate ahead of schedule, contact Technical Support at 1-203-639-3160, option 2.
- For **Florida**, senders who have elected to download the program were notified via email by April 1, 2003. All other senders were provided with a CD upgrade between April 7–9, 2003. If you wish to switch from receiving a CD to start downloading updates, please contact Technical Support at 1-904-355-0313.

**ASCX12N 270/271 Eligibility Benefit Inquiry and Response Transaction—Real Time Access**

The ASCX12N 270/271 Eligibility Benefit Inquiry and Response Transaction is a “paired” transaction (270 is an inbound eligibility inquiry; 271 is an outbound eligibility response). The 270/271 (004010X092A1) Implementation Guide may be downloaded without charge from [www.wpc-edi.com/HIPAA](http://www.wpc-edi.com/HIPAA).

First Coast Service Options, Inc. (FCSO), the Medicare carrier for Connecticut and Florida, will support provider access to real-time eligibility information via the ASCX12N 270/271 using TCP/IP (Transmission Control Protocol/Internet Protocol) connectivity on or about July 1, 2003. FCSO will build upon existing network connectivity to provide a TCP/IP port connecting to the Common Working File (CWF) supplied eligibility module. The interface runs in a CICS (Customer Information Control System) mainframe environment. Providers will be able to dial in and connect directly to the CWF module through an IP socket. Billing services, clearinghouses, network service vendors and providers that want to use this connectivity are required to have supporting software and technical expertise to implement this communication method.

Providers who prefer to obtain eligibility data in an EDI format but not use the ASCX12N 270/271 Eligibility Benefit Inquiry and Response Transaction may contract with a clearinghouse to translate the information on their behalf; however, such providers would be liable for any clearinghouse costs.

We have added detailed information to our provider education Web sites ([www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com)) pertaining to the Addenda version of the ASCX12N 270/271 and related connectivity requirements. If you do not have access to the Internet, please contact us at 1-904-791-8131 to request a hard copy of this information.

To help providers make educated and timely decisions, Medicare will furnish basic information on the Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA-AS) standard transaction requirements (such as the 270/271). However, Medicare will *not* furnish in-depth training on the use and interpretation of the standards' Implementation Guides. Providers who need in-depth training for their staff are expected seek it from commercial vendors, their clearinghouse, or through standards development organizations.

Thank you for your continued support of the eligibility transaction.

Source: CMS Transmittal AB-03-036, CR 2576

## Health Care Claim Status Request and Response ASC X12N 276/277

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee. These codes can be found at [http://www.wpc-edi.com/StatusCategory\\_40.asp](http://www.wpc-edi.com/StatusCategory_40.asp) and [http://www.wpc-edi.com/ClaimStatus\\_40.asp](http://www.wpc-edi.com/ClaimStatus_40.asp). Included in the code lists are specific details such as the date when a code was added, changed or deleted.

We will provide information in future issues of the *Medicare B Update!* regarding implementation of the update to the claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response, ASC X12N 276/277. In addition, we will inform providers of any new codes that may be seen in ASC X12N 277 responses.

Source: CMS Transmittal AB-03-029, CR 2555

### HIPAA Information Series

In the Second Quarter 2003 *Medicare B Update!* CMS' first edition to its HIPAA Information Series was reproduced. That edition, called "HIPAA 101," has now been supplemented with editions two and three. To access this information, visit the CMS Web site at [www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/](http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/) for "Are you a covered entity?" and "Key HIPAA dates and tips for getting ready." Seven additional installments are coming soon. You can also visit [www.cms.hhs.gov/hipaa/hipaa2/](http://www.cms.hhs.gov/hipaa/hipaa2/) for CMS's all-in-one reference site for HIPAA-AS including a countdown for upcoming compliance deadlines.

### Provider HIPAA Readiness Checklist

CMS has developed a checklist to help you determine your office's readiness for HIPAA compliance. We published this checklist in the Second Quarter 2003 *Medicare B Update!* (pages 22-23); it is also available on the CMS Web site at [www.cms.hhs.gov/hipaa/hipaa2/education/readinesschklist.doc](http://www.cms.hhs.gov/hipaa/hipaa2/education/readinesschklist.doc).

### HIPAA Resources

Updated 03/27/03

#### CMS

##### Products / Resources

- **Web site** – <http://www.cms.hhs.gov/hipaa/hipaa2/> – Answers to Frequently Asked Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.
- **New Regulations** – HHS recently published two rules, the Modifications Rule (modifies the Electronic Transactions and Code Sets Rule) and the final Security Rule. You can find both rules at <http://www.cms.hhs.gov/hipaa/hipaa2/>.
- **Small Provider Checklist Tool** – Use this to help you determine first steps you should be taking to prepare for HIPAA. <http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLst.pdf>. Also available in Spanish version: <http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLstEsp.pdf>.
- **CMS HIPAA 101 Paper for Providers** – This short paper gets straight to the point describing HIPAA and what it means to providers. This is part of a larger series being developed that walk providers through what they need to know about the electronic transactions and code sets. Stay tuned for more information on the remainder of the series. <http://www.cms.hhs.gov/hipaa/hipaa2/education/HIPAAPaper101-1of1.pdf>. Spanish version: <http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLstEsp.pdf>.
- **Covered Entity Decision Tool** – Need help determining if you are covered by HIPAA? Try using this tool found at: <http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp>.
- **FREE HIPAA Roundtable Conference Call** – This is a good source of information and a forum to get answers to your questions on HIPAA Administrative Simplification. Check the CMS Web site at <http://www.cms.hhs.gov/hipaa/hipaa2/> for future call information.
- **FREE Video and CD-ROM** – Coming Soon! CMS' HIPAA 101 Video and CD-ROM are packed with tips for preparing your office for HIPAA. Stay tuned to our website for information.
- **FREE Listserves** – Both listserves are operated by the U.S. Department of Health & Human Services
  - **Regulations** – <http://www.cms.hhs.gov/hipaa/hipaa2/regulations/lsnotify.asp> – Sign up to receive notification when proposed or final rules on HIPAA have been published in the Federal Register (The Federal Register is the place where the government, upon passing a law, tells the public how the law will be implemented).
  - **New! Outreach** – <http://list.nih.gov/archives/hipaa-outreach-1.html> – Sign up here to receive free notices on HIPAA announcements, new tools and educational material, and related information.

- **CMS Medicaid HIPAA web address** – <http://www.cms.hhs.gov/medicaid/hipaa/adminsimpl/>.
- **Medicare free / low cost billing software** – <http://cms.hhs.gov/providers/edi/> – If you bill Medicare, there is software available to you free or for a small charge. This software is designed only for Medicare claims. Check the above link for the appropriate contact in your state for more information.
- **White Paper: Am I A Covered Entity Provider?**  
<http://www.wedi.org/snip/public/articles/coveredEntity.pdf>.
- **White Paper: How HIPAA Is Reshaping The Way We Do Business**  
<http://www.wedi.org/snip/public/articles/centMedicarecaid.pdf>.

#### Contact info for CMS

- CMS E-Mailbox – [askhipaa@cms.hhs.gov](mailto:askhipaa@cms.hhs.gov). Send HIPAA administrative simplification questions here.
- CMS HIPAA Hotline – 1-866-282-0659 – This hotline has been established to help answer your HIPAA administrative simplification questions.

#### Other Resources

- **HHS' Office for Civil Rights (Privacy)** – <http://www.hhs.gov/ocr/hipaa/> – The U.S. Department of Health & Human Services' Office for Civil Rights oversees the privacy requirements.
- **New! OCR posts Frequently Asked Questions** to their Web site at: <http://www.hhs.gov/ocr/hipaa/whatsnew.html>  
Model "Business Associate Agreement" at: <http://www.hhs.gov/ocr/hipaa/contractprov.html>.  
"Guidance Explaining Significant Aspects of the Privacy Rule" at: <http://www.hhs.gov/ocr/hipaa/privacy.html>.  
Contact information:  
[OCRPrivacy@hhs.gov](mailto:OCRPrivacy@hhs.gov) or  
Call 1-866-627-7748.
- **WEDI SNIP Web site** – <http://www.wedi.org/snip/> – WEDI is an organization working to foster widespread support for the adoption of electronic commerce within healthcare and SNIP is a collaborative healthcare industry-wide process resulting in the implementation of standards and furthering the development and implementation of future standards. This website contains various resources on HIPAA administrative simplification. Materials from CMS HIPAA Workshop for Small / Rural Health Care Providers – <http://www.wedi.org/snip/public/articles/details%7E56.htm>.  
Find out if your state has a local WEDI SNIP affiliate – Go to <http://www.wedi.org/snip/public/articles/index%7E8.htm>.

Source: CMS Region IV HIPAA Coordinator

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## Important Information for Providers about HIPAA

The April 14, 2003, HIPAA privacy deadline and the April 16, 2003, testing deadline have passed, and the October 16, 2003, deadline for compliance with the HIPAA electronic transactions and code set standards is approaching quickly. Many providers are only now starting to think about what they need to do to become HIPAA compliant. To avoid being a HIPAA-covered entity, some consultants are suggesting that providers consider switching from electronic transmission to paper claims. This advice is extremely shortsighted and certainly not a panacea, especially for Medicare providers. Consider the following:

### Requirement to Go to Electronic Claims

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

### Negative Fiscal Impact of Paper Claims

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

### Changes to Business Processes

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

## General HIPAA Information

### What is HIPAA?

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

1. Electronic Transactions and Code Sets
2. Unique Identifiers
3. Privacy
4. Security

### What are the HIPAA Transactions?

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

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

### What is a HIPAA Covered Entity?

Under HIPAA, all health care clearinghouses, all health plans, and those health care providers that conduct certain transactions in electronic form or who use a billing service to conduct transactions on their behalf are considered covered entities.

### What Is “Electronic?”

The term “electronic” is used to describe moving health care data via the Internet, and extranet, leased lines, dial-up lines such as for “direct data entry” (DDE), private networks, points of service, and health care data that is physically moved from one location to another using

magnetic tape, disk, or CD media. For example, if a provider transmits information electronically by transmitting claims, conducting eligibility queries, conducting claim status queries or referrals, they would be considered a covered entity under HIPAA.

### A Benefit to Consider

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

### HIPAA Deadlines

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

### Where To Go For Help:

CMS Web site: <http://www.cms.hhs.gov/hipaa/hipaa2>

HIPAA hotline: 1-866-282-0659

AskHIPAA mailbox, send an email to

[askhipaa@cms.hhs.gov](mailto:askhipaa@cms.hhs.gov)

For more information on privacy, visit <http://www.hhs.gov/ocr/hipaa>

[www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)

For privacy questions, call 1-866-627-7748

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# GENERAL INFORMATION

## FRAUD, ABUSE, AND WASTE

**The article originally published in this area has been removed at the request of the Center for Medicare & Medicaid Services.**

**Source: CMS JSM-05190, February 8, 2005**

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### Deported Medicare Beneficiaries

CMS has restated the payment policy, as mandated by the Social Security Act, in which a deported beneficiary is not entitled to receive Medicare-covered services.

A recent audit of Medicare payments by the Office of Inspector General identified vulnerability for the Medicare trust fund with respect to this issue. The study identified improper payments for beneficiaries who, on

the date of service on the claim, had been deported. To address this vulnerability, CMS is establishing claim level editing using data from the Social Security Administration.

### Medicare Payment Policy

No payments may be made for Medicare benefits furnished to an individual who has been deported from the United States.

**Appeal Rights**

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis of deportation status.

**Implementation of Payment Policy**

Effective for claims processed on or after April 1, 2003, Medicare contractors will deny claims for items

and services furnished to deported beneficiaries using reason code 96 (noncovered charges) and remark code N126 – “Social Security records indicate that this individual has been deported. The payer does not cover items and services furnished to individuals who have been deported.”

Source: CMS Transmittal AB-02-162, CR 2377

**HOME HEALTH CONSOLIDATED BILLING****Independent Therapists and DME Suppliers—Billing for Services That May Be Part of a Home Health Stay**

Before you provide services to a Medicare beneficiary, you need to be certain whether or not a home health episode of care exists for that beneficiary, and whether or not an actual home health discharge date exists. This article provides information that will help you determine whether Medicare will pay separately for your service or whether payment for the services are consolidated into Medicare’s payment to a home health agency (HHA). Claims consolidated in the HHA’s payment will continue to be denied and you will not receive payment! Additionally, Medicare will adjust claims paid on or after April 1, 2003, for services already consolidated into the HHA’s payment and will recover your payment for these services. You will receive a remittance advice on any denied claim that will read as follows:

- **reason code B15: “Claim denied/reduced because this procedure/service is not paid separately,”** and
- **remark code N70: “Home health consolidated billing and payment applies.”**

To help you determine whether the beneficiary is in a home health episode of care, the Centers for Medicare & Medicaid Services (CMS) has plans to make home health inquiry information available to you electronically, through the Eligibility Benefit Inquiry/Response (270/271) Transaction System. Until and unless you have access to this system, it is your responsibility to simply ask the beneficiary (or his/her authorized representative) if he/she is presently under a home health plan of care. Payment for the services denied by Medicare may be sought from the beneficiary, but you should advise them of their obligation for payment prior to delivering the service.

As a last resort, if you feel that you are unable to determine or obtain this information from the beneficiary (or his/her authorized representative), you do have the option of calling your carrier and requesting the home health eligibility information from the Customer Service Representative. This eligibility information is not available through the Interactive Voice Response (IVR) system.

Remember, you are responsible for determining if the beneficiary you wish to serve is eligible to receive additional Medicare payment for your services. Services provided to a beneficiary who is not eligible to receive those services are not payable and are considered services provided to an ineligible beneficiary.

Source: CMS Transmittal B-03-021, CR 2619

**MEDICARE SECONDARY PAYER (MSP)****How to Submit Claims to Medicare When There are Multiple Primary Payers**

There are situations where more than one primary payer makes payment on a Medicare Part B claim and Medicare may still make a secondary payment. Physician and suppliers must comply with Section 1.4.2, titled “Coordination of Benefits,” found in the 837 version 4010 Professional Implementation Guide regarding the submission of Medicare beneficiary claims to multiple payers for payment. Providers must follow model 1 in section 1.4.2.1 that discusses the provider to payer to provider methodology of submitting electronic claims. When there are multiple primary payers to Medicare, you must follow the instructions cited below when sending the claim to Medicare for secondary payment.

**Submission of Electronic MSP Claims With Multiple Primary Payers, But With Only One Insurance Type Code**

Where there is more than one primary payer on a MSP claim and the primary payers identify the same insurance type code (e.g., the claims show two employer group health plans made payment on the claim which is identified as insurance type code 12), physicians and suppliers can send these claims electronically using the 837 version 4010 claim submission format. When sending these types of claims, you must do the following:

**Primary Payer Paid Amounts:** For line level services, physicians and suppliers must add all primary payer paid amounts for that service line and put the total amount in loop ID 2430 SVD02 of the 837. If only claim level information is sent to Medicare, providers and suppliers must add all other payer paid amounts for that claim and place the total amount in loop ID 2320 AMT02 AMT01=D of the 837.

**Primary Payer Allowed Amount:** For line level services, physicians and suppliers must take the higher of the allowed amount for that service line, or the total of the other payer paid amounts, whichever is higher, and put the amount in loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837. If only claim level information is sent to Medicare, take the higher of the claim level allowed amount, or the total of the other payer paid amounts, whichever is higher, and put the amount in Loop ID 2320 AMT02 AMT01 = B6.

**Obligated to Accept as Payment in Full Amount (OTAF):** For line level services, physicians and suppliers must take the lowest OTAF amount for that

service line, which must be greater than zero, and put the amount in loop 2400 CN102 CN 101 = 09. If only claim level information is sent to Medicare, take the lowest claim level OTAF amount, which must be greater than zero, and put this information in loop 2300 CN102 CN101 = 9.

### **Submission of Hardcopy MSP Claims with Multiple Primary Payers, But With More Than One Insurance Type Involvement**

There may be situations where two or more insurer types make payment on a claim; for example, an auto insurer makes a primary payment on a line of service and, subsequently, a group health plan makes a primary payment for the same line of service. Claims with more than one insurance type involvement cannot be sent electronically to Medicare. A hardcopy claim must be submitted. Use the current Form CMS-1500 when submitting Part B hard copy claims. Physicians and suppliers must attach the other payers EOB, or remittance advice, to the incoming claim when sending it to Medicare for processing.

Source: CMS Transmittal AB-03-011, CR2050

## **Medicare Secondary Payer (MSP) and the Debt Collection Improvement Act of 1996 (DCIA)**

MSP DCIA activities include all Group Health Plan based debts, including those where a debtor is the provider, physician, other supplier, or beneficiary. MSP DCIA activities also now include liability and no-fault based debts of all types for all debtors, as well as workers' compensation based debts for all debtors.

The DCIA requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and/or offset. The Centers for Medicare & Medicaid Services (CMS) is mandated to refer all eligible debt over 180 days delinquent, for cross-servicing, including the Treasury Offset Program (TOP).

For the purpose of DCIA debt selection/referred criteria, a debt becomes 'delinquent' if it has not been paid (in full) by the payment date specified in the agency's initial written notification (i.e., overpayment demand letter), unless other payment arrangements have been made, or if at any time thereafter the debtor defaults on a repayment agreement.

Further, specific to MSP, 'delinquent' is defined as a debt not being paid in full unless other arrangements have been made, no response from the debtor regarding the debt, and/or no valid documented defense to the debt.

Source: CMS Transmittal AB-02-102, CR 2145

### **MSP Recoveries/Debt-Related Issues—Frequently Asked Questions and Answers**

#### **Q1 How does a MSP debt arise?**

A1 An MSP debt arises when Medicare learns that it made primary payment for services provided to a Medicare beneficiary that should have been the primary payment responsibility of another third party payer. The law requires Medicare to recover the payment from a party the law or regulations identify as responsible to repay Medicare.

#### **Q2 Why didn't Medicare pay right in the first place?**

A2 Medicare contractors make every effort to avoid mistaken primary payments. There are other cases where Medicare may not learn that the group health plan coverage existed until after some claims have been paid.

If a workers' compensation, no-fault or liability insurance does not pay a beneficiary's claim promptly, the law requires Medicare to make a

"conditional" primary payment. Medicare recovers its "conditional" primary payments from the insurance proceeds once the beneficiary's claim is resolved.

#### **Q3 What process does Medicare use to recover MSP debts?**

A3 The recovery process begins with a "recovery demand letter" to an entity responsible for resolving the debt. The letter explains how the debt arose; provides detail about Medicare's recovery claim; and explains what must be done to resolve the matter. The matter may be resolved either through payment or presentation of a documented valid defense.

If the responsible entity does not resolve the matter timely, Medicare sends a second "recovery demand letter." A copy of the original "recovery demand letter" is provided. This second letter

explains that, if the matter is not resolved within 60 days, Medicare will refer the debt to the Department of Treasury for further collection action. This letter is often referred to as a “Notice of Intent to Refer” letter.

If the matter is still not resolved 60 days after the date of the “Notice of Intent to Refer” letter, Medicare refers the debt to the Department of Treasury for further collection actions. Treasury may collect the debt in a variety of ways, including offset of Federal payments to the responsible entity. Treasury may also ask the Department of Justice to take legal action to collect the debt.

**Q4 Who is responsible for resolving group health plan-related MSP debts?**

A4 The law makes all entities “responsible for payment under a group health plan” jointly and severally responsible for resolving these debts. These entities include the employer sponsoring or contributing to the plan; other plan sponsors (e.g., a union or other employee organization); the insurer or third party administrator (TPA) (TPAs administer plans for employers that self-insure); and the plan itself if it is a separate legal entity.

**Q5 How do group health plan-related MSP debts occur?**

A5 A provider bills Medicare for primary payment for services provided to a Medicare beneficiary for whom a group health plan should have been the primary payer and Medicare mistakenly pays. Group health plans are primary payers for aged beneficiaries covered as a result of their own or a spouse’s current employment status; disabled beneficiaries covered as a result of their own or a family member’s current employment status; beneficiaries with end-stage renal disease for a 30-month coordination period) covered on any basis (including retirement).

**Q6 How does Medicare pick whom to pursue for this type of MSP debt?**

A6 Medicare law allows for the pursuit of recoupment of a Medicare mistaken payment to all entities who are individually or jointly liable for repayment. In 1997, Medicare began sending the recovery demand letters to the employer (if known) because some insurers/TPAs were routinely non-responsive and because a Circuit Court decision limited Medicare’s ability to recover from TPAs. An employer is always responsible for the actions of any group health plan that it sponsors or to which it contributes.

**Q7 How can Medicare hold an employer that purchased insurance responsible for resolving the debt? Why doesn’t Medicare go after the insurer?**

A7 An employer is always responsible for the conduct of any group health plan that it sponsors or to which it contributes. An employer cannot transfer legal obligations to a third party through a con-

tract. This is explained in an enclosure to the initial recovery demand letter entitled, “Important Information for Employers.”

An employer may direct its insurer to resolve the debt on the employer’s behalf. However, if the insurer does not do so, the employer remains responsible for either paying the debt or documenting why it is not responsible.

**Q8 What documentation does Medicare consider sufficient to demonstrate that a group health plan-related MSP debt is not owed?**

A8 At the time the debt is being pursued, it has been reviewed several times to determine that it is valid. It is possible that the debtor has other information not available to Medicare that demonstrates that the debtor has no legal obligation to repay Medicare. Such information would include the following:

- The Medicare beneficiary was not covered by the group health plan or the group health plan was not obligated to be the primary payer when the services were provided (see prior question, “How do group health plan-related debts occur?”);
- The services provided to the Medicare beneficiary were not covered under any circumstances by the group health plan;
- The group health plan had already made full primary payment to the provider of services or the Medicare beneficiary prior to the date of the initial recovery demand letter; and
- No entity responsible for payment under the plan had knowledge that the services had been provided to the Medicare beneficiary within the longer of the group health plan’s timely filing requirements or the period during which the law authorizes Medicare to seek recovery.

These are explained below.

**Q9 When is a “Medicare beneficiary not covered by the group health plan or the group health plan was not obligated to be the primary payer when the services were provided”? What would be proper documentation of this defense?**

A9 It is possible that a beneficiary, entitled to Medicare on the basis of age or disability, did not have coverage under any employer plan based on their own or a spouse’s or a family member’s (for disability) current employment status at the time the services were provided, because the individual or his/her spouse or family member (for disability) had retired or left employment. Proper documentation would consist of all of the following:

1. A copy of the individual claim paid by Medicare and referenced in the original demand letter;
2. Date of Medicare’s original demand letter containing the claim;
3. Associated reported identification numbers for that claim as provided in the demand letter;
4. Identification of the individual through whom the beneficiary had coverage; and

5. Certification of the date of retirement or termination of that individual.

Failure to provide all the above information could result in Medicare not accepting the documentation or not applying it properly.

In the case of a beneficiary entitled to Medicare on the basis of end-stage renal disease, the debt is still valid if the beneficiary had coverage under any group health plan on any basis.

**Q10 What exactly does the “coverage limitation” defense encompass? What would be proper documentation of this defense?**

A10 A beneficiary, who has employer plan coverage that is obligated to be a primary payer, may have had services not covered by the employer’s plan. This would mean that the services are not the responsibility of the employer’s plan. If properly documented, this would be a valid defense to the debt associated with those services. Proper documentation would consist of the following:

- A copy of the individual claim with the non-covered services annotated;
- Date of the original demand letter containing the claim;
- Associated report identification number; and
- Copy of plan documents (e.g., Employee Services Handbook, Member Services Booklet, etc.) that establishes that the services are not covered under the plan with the applicable coverage terms annotated.

**Q11 What should a responsible entity do if the group health plan paid primary for the services for which Medicare seeks to recover? What should a responsible entity do if the group health plan is an HMO and the services were covered by the HMO’s capitation payment?**

A11 It is possible that both Medicare and an employer plan made primary payment for the services identified on any unique MSP claim. If properly documented, an employer plan’s full primary payment for the services on an MSP claim is a valid defense to the debt that had been associated with that claim. Proper documentation generally would consist of the following:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated report identification number for that claim as provided in the demand letter;
- Explanation of how the prior primary payment was determined; and
- Proof of payment (e.g., copy of remittance advice).

If the employer plan is an HMO and the employer plan’s full primary payment responsibility was resolved by a capitation payment to the provider, physician or other supplier that treated the Medicare beneficiary, proper documentation would consist of the following:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated report identification number for that claim as provided in the original demand letter;
- Copy of the relevant portions of the HMO contract with the provider, physician or other supplier stipulating that the only payment obligation of the HMO was payment of a capitated amount; and
- Proof that the capitated amount for the individual for the time period when the services were furnished was paid.

In these instances, Medicare will recover from the medical provider or supplier that received Medicare’s payment.

**Q12 What is a group health plan’s timely filing defense? When is Medicare not bound by a group health plan’s timely filing requirements? What documentation is needed?**

A12 Most group health plans (GHPs) have established time limits during which claims must be submitted in order to qualify for payment. If a GHP or any entity responsible for payment under the plan (employer, insurer, third party administrator [TPA], or other plan sponsor [“responsible entities”]) does not receive a claim within those time limits, the plan is not obligated to make payment (even if it would be obligated to make payment if the claim had been submitted prior to the expiration of the time limit). These time limits are typically called “timely filing” requirements. Applicable Federal law limits the ability of any responsible entity (including the employer/insurer/TPA/GHP/other plan sponsor) that received a demand letter to assert a timely filing defense to an MSP-based debt.

As a first point, the date of Medicare’s original demand letter is the date applicable to any defense that the recipient of the demand letter, or any entity acting on its behalf, may have to the debt or any portion of the debt. This is true regardless of which of these entities the original demand letter is issued to, and regardless of whether or not the demand is immediately shared among these entities. For example, the insurer may not establish a timely filing defense on behalf of an employer based upon the date the insurer received the demand letter from the employer. The insurer may only establish a timely defense for the employer based upon the date of the demand letter to the employer.

Additionally, two different rules are applicable to the MSP claims that comprise the Medicare debts. These rules are explained below.

The first rule applies to all services, regardless of the date those services were provided. The recipient of the demand letter (regardless of whether it is the employer/insurer/TPA or other

responsible entity) does not have a valid timely filing defense if either the employer, the insurer, the TPA, or other responsible entity had knowledge within the plan's timely filing period that the services were provided. This knowledge could come from a variety of sources, but is often due to the receipt of a claim from a provider, physician or other supplier (or the plan member), which included the services at issue.

The second rule applies to services provided on or after August 5, 1997, and further restricts the use of a timely filing defense. The Balanced Budget Act of 1997 eliminated timely filing defenses for at least 3 years from the date of the service. For services on or after August 5, 1997, there is no timely filing defense if Medicare's original demand letter is dated within 3 years of the date of the service. This rule applies even if the plan's timely filing period is less than 3 years. (If the services were on or after August 5, 1997, and Medicare's original *demand letter is not dated within 3 years from the date of the service, then the first rule applies.*)

Under the first rule, proper documentation of a timely filing defense would consist of the following:

- A copy of the individual Medicare claim supplied with the demand letter with the services for which the defense is offered annotated by the entity asserting the defense;
- The date of the original Medicare demand letter containing the claim (and the associated report identification number for Data Match recoveries);
- A copy of plan documents that establish the timely filing period with the applicable provisions annotated; and
- A written statement by or on behalf of the recipient of the demand letter that claims records of all responsible entities exist for the time period when the services were provided, were searched, and no record of the services being provided to the beneficiary were found.
- Remember that if a demand letter is sent to an employer and another responsible entity such as an insurer or TPA responds, the responding entity is assumed to be acting as the agent of the employer. In this situation, the date of the original demand letter to the employer is the date applicable to any asserted timely filing defense.

**Q13 Is an employer still responsible for resolving a group health plan-related MSP debt if the employee became enrolled in a group health plan other than the one identified in the initial recovery demand letter?**

A13 The health plan information that Medicare provided in the original demand letter was, in almost all cases, provided by the employer in response to

Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match questionnaires. In other cases, the health plan information was obtained from the beneficiary, the insurer, or the provider/physician/other supplier that furnished services to the beneficiary. Thus, the information is presumed to be accurate as of the time it was provided. Many employers offer employees the opportunity periodically to choose among several available group health plans. Because CMS was not advised of changes in employees' group health plan choices, the group health plan Medicare identified as providing the health insurance may not be correct as of the date particular services were provided to an identified beneficiary.

The MSP debt is still valid as long as the Medicare beneficiary, entitled to Medicare on the basis of age or disability, had coverage under any employer plan based on his/her own or a spouse's or family member's (for disability) current employment status. In the case of a beneficiary entitled to Medicare on the basis of ESRD, the debt is still valid if the beneficiary had coverage under any employer plan on any basis. If you are unclear about your responsibility relative to ESRD, please call the Medicare contractor.

**Q14 How does a responsible entity determine the proper amount to pay Medicare? How is interest determined? What documentation should be provided to assure proper crediting of the payment?**

A14 The original demand letters explain that interest is due on any debt that is not resolved timely (60 days from the date of the original demand letter) and includes the applicable interest rate. Interest applies from the date of the demand letter for each 30-day period that the debt is unresolved. (Periods of less than 30 days are treated as a full 30-day period.) Accordingly, to resolve any MSP claim for which payment is due, the responsible entity (group health plan, employer, insurer, third party administrator [TPA], or other plan sponsor) must pay both the principal due and the applicable interest. To assist the responsible entity in determining the amount due on any individual unresolved MSP debt, the responsible entity should contact the Medicare contractor who issued the demand letter.

The responsible entity (employer, insurer, third party administrator [TPA], group health plan, or other plan sponsor) should contact the Medicare contractor with any question on the exact amount the responsible entity owes.

**Q15 Can a responsible entity avoid the interest portion of the group health plan-related MSP debt by making a full primary payment to the provider of services following receipt of the original demand letter, Notice of Intent to Refer to Department of Treasury letter, or demand letter from the Department of Treasury or one of its collection agents?**

- A15 No. The law requires that the responsible payer pay Medicare, not some other party. Medicare will continue to look to the responsible entity for payment of all interest accrued to the date of payment to the provider. Medicare will recover the principal from the party that the group health plan paid.
- Q16 Is a responsible entity required to repay Medicare for a group health plan-related debt if it no longer has the records necessary to prove it is not responsible?**
- A16 Yes. A responsible entity's failure to maintain the records necessary to prove it is not responsible does not relieve the entity of responsibility to resolve the debt.
- Q17 How long can Medicare pursue recovery of an MSP debt?**
- A17 The United States may undertake legal action to collect an MSP debt up to 6 years from the date of the original demand letter. In addition, these debts may be collected by offset of Federal government payments to the debtor for 10 years from the date of the original demand letter without undertaking legal action.
- Q18 With whom should a responsible entity deal in resolving a group health plan-related MSP debt?**
- A18 Debtors should work with the entity that sent them the most recently dated recovery demand letter with respect to a particular debt. Prior to referral of a debt to the Department of Treasury, this would be the Medicare contractor. Once a debt has been referred to the Department of Treasury for collection action and a responsible entity has been contacted by either the Department of Treasury itself or a Treasury collection agent, the responsible entity should work with the Department of Treasury or its collection agent.
- Q19 Where is Medicare sending the original recovery demand letter and the Notice of Intent to Refer letter for group health plan-related debts? Employer representatives responsible for resolving such issues often first learn of the debt when a copy of the demand letter from the Department of Treasury is forwarded to that official from elsewhere in the employer's organization.**
- A19 The original recovery demand letter and the Notice of Intent to Refer letter are sent via certified mail/return receipt to the address of the employer provided in the employer's response to the IRS/SSA/CMS Data Match questionnaire or the entity that identified the employer as responsible. Employers are encouraged to advise all components of the company that demand letters involving Medicare should be forwarded to a particular unit (e.g., Benefits Management) if the employer wishes that unit to respond.
- Q20 What can an employer or other responsible entity do to minimize further collection activities related to group health plan MSP debts in the future?**
- A20 Recovery actions will be minimized if Medicare is aware that another payer is primary to Medicare when claims are presented to Medicare for payment. If Medicare is aware that another payer is a primary payer to Medicare, Medicare advises the entity that submitted the claim to Medicare that it should bill the other payer. The best way for employers and/or insurers to be sure that Medicare has such knowledge is through quarterly Voluntary Data Sharing Agreements with Medicare. Interested parties may contact the Coordination of Benefits Contractor at 1-800-999-1118 for more information or visit their Web site at [www.cms.gov/medicare/cob](http://www.cms.gov/medicare/cob).
- Q21 Why are Medicare beneficiaries receiving a Notice of Medicare's Intent to Refer a debt to the Department of Treasury, as well as a recovery demand letter from Treasury?**
- A21 Generally, these letters are related to unresolved MSP debts arising from the failure of a beneficiary to pay a Medicare recovery claim arising from a judgment, settlement or award a beneficiary received from workers' compensation, liability or no-fault insurance. If the Medicare beneficiary does not resolve the debt, the Department of Treasury may collect through offset of Federal payments to the beneficiary. This could include offsets against the beneficiary's Social Security retirement checks.
- Q22 What should a beneficiary do when in receipt of a Notice of Medicare's Intent to Refer letter?**
- A22 It is important that the beneficiary respond in order to avoid collection from the beneficiary's Social Security retirement check. The original demand letter attached to the Notice of Intent to Refer letter explains the actions the beneficiary can take.
- Q23 What is a Voluntary Data Sharing Agreement?**
- A23 As an alternative to completing the annual IRS/SSA/CMS Data Match questionnaires, these agreements allow employers/insurers to provide plan coverage information to Medicare on a quarterly basis. CMS is able to update its internal records and immediately avoid making mistaken primary payments. In exchange, CMS provides the employer or insurer with Medicare eligibility information on employees who are no longer working. These are situations where Medicare is usually the primary payer. Savings to employers and insurers can be significant. Interested parties can contact the Coordination of Benefits Contractor at 1-800-999-1118 or visit their Web site at [www.cms.gov/medicare/cob](http://www.cms.gov/medicare/cob).

Source: CMS FAQs, January 29, 2003

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## MEDICARE REGISTRATION/ENROLLMENT

### 2003 Medicare Participating Physician/Supplier Directory (MEDPARD)— Revised Availability

The Centers for Medicare & Medicaid Services (CMS) has provided instructions for release of the 2003 Medicare Participating Physicians/Suppliers Directory (MEDPARD). Due to the extension of the enrollment period for Medicare Part B providers, the 2003 MEDPARD will be posted to our provider education Web site on or before May 29, 2003. Medicare beneficiaries will not be able to access the latest MEDPARD information until that time. Beneficiaries who have any questions regarding participating providers in their area may contact our customer service representatives at:

Connecticut	Florida
1-800-982-6819 (toll-free)	1-800-333-7586 (toll-free)
1-866-359-3614 (hearing impaired)	1-800-754-7820 (hearing impaired)
The hours of operation for the Connecticut beneficiary center are 8:30 a.m. to 4:00 p.m., Monday through Friday (excluding holiday closings).	The hours of operation for the Florida beneficiary call center are 9:00 a.m. to 4:30 p.m., Monday through Friday, Eastern and Central time zones (excluding holiday closings).

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

### FCSO Announces Change in Unique Physician Identification Number (UPIN) Directory Access

To increase service to our customers who rely on provider-specific UPIN data, FCSO has changed the way this information is made available on our Medicare provider education Web sites [www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com).

Specifically, this change consists of establishing a link to a recently developed Web site dedicated to providing only UPIN information ([www.UPINRegistry.com](http://www.UPINRegistry.com)). This newly designed site was implemented by National Heritage Insurance Company (NHIC – the entity contracted with CMS to issue Medicare UPINs) to allow providers access to UPIN information as early as the day of issue.

Additional changes to our provider education Web sites (in addition to the [UPINRegistry.com](http://www.UPINRegistry.com) link) include disconnection and removal of the existing UPIN database.

### Specialty Codes Update

Effective April 1, 2003, section 2207 of the Medicare carriers manual (MCM), “Coding Physician Specialty,” has been changed to read “Specialty Codes.” In addition, this section is revised to provide more information when receiving a request to expand the specialty code list. “Osteopathic Crosswalk” has been deleted because the crosswalk has been phased out since 1992. It has been replaced with “Primary/Secondary Codes” to include language on how to handle a request for a primary or secondary specialty code. The following codes have been added and redefine osteopathic and Group Practice Prepayment Plan (GPPP) codes.

- 09 Interventional Pain Management (IPM), allows for differences in treatment approaches, training, utilization patterns and costs between pain management specialists and IPM specialists.
- 32 Anesthesiologist Assistants (AAs), simplifies a planned study by the Agency for Healthcare Research and Quality. AAs previously were grouped with Certified Registered Nurse Anesthetists (43).
- 43 Certified Registered Nurse Anesthetist, removed AAs to code “32.”
- 65 Physical Therapist in Private Practice, removed “independently practicing” and added “Private Practice.”
- 67 Occupational Therapist in Private Practice, removed “independently practicing” and added “Private Practice.”
- 71 Registered Dietician/Nutrition Professional (added per Change Request 2142).
- 72 Pain Management (added per Change Request #1872).
- 73 Mass Immunization Roster Biller, added to make them more identifiable.
- 74 Radiation Therapy Centers, added to differentiate them from Independent Diagnostic Testing Facilities (IDTF’s).
- 75 Slide Preparation Facilities, added to differentiate them from IDTF’s.

Source: CMS Transmittal: 1779, CR 2337; MCM section 2207

## SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

### Proper Use of Modifier CB

Information was published in the Second Quarter 2003 *Medicare B Update!* (page 29) concerning revisions to common working file (CWF) edits for skilled nursing facility (SNF) consolidated billing to permit payment for certain diagnostic services furnished to beneficiaries receiving treatment for end stage renal disease (ESRD) at an independent or provider-based dialysis facility. Providers were notified of a new modifier (CB - services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit, is not part of the

composite rate, and is separately reimbursable) to be used to indicate the service was rendered to an ESRD beneficiary in a SNF Part A stay who is receiving chronic dialysis related services at an independent or provider-based dialysis facility.

Modifier CB is applicable *only* to diagnostic tests (e.g., pathology or radiology services). Please refer to the Second Quarter 2003 *Update!* for additional guidelines on the appropriate use of modifier CB.

## GENERAL INFORMATION

### Notice of Interest Rate for Medicare Overpayments and Underpayments

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

The Secretary of the Treasury has notified the Department of Health and Human Services that effective **February 11, 2003**, the PCR has been changed to **10.75 percent**. The notice of the PCR was published in the **Federal Register** (Vol. 68, No. 28 dated 02/11/03). Therefore, the PCR will remain in effect until a new rate change is published. Reaffirmed interest rates for prior periods are available at [http://cms.hhs.gov/manuals/pm\\_trans/AB03019.pdf](http://cms.hhs.gov/manuals/pm_trans/AB03019.pdf).

Source: CMS Transmittal AB-03-019, CR 2430

### Remittance Advice Remark and Reason Code Update

CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010 Implementation Guide (IG). Under the Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X12-recognized maintainers instead of proprietary codes to explain any adjustment in the payment. As a result, CMS received a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities. These additions and modifications may not impact Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare

staff in conjunction with a policy change. Contractors are notified of those new/modified codes in the corresponding implementation instructions in the form of a Program Memorandum (PM) or manual instruction implementing the policy change, in addition to the regular code update PM. The code changes initiated by Medicare have been identified in this article in accordance with PM AB-03-012 to single out codes implemented by contractors effective April 1, 2003.

The list of remark codes is available at <http://www.cms.gov/providers/edi/hipaadoc.asp> and <http://www.wpc-edi.com/hipaa/>, and the list is updated each March, July, and November. The following list summarizes changes made through October 31, 2002.

#### New Remark Codes

Code	Current Narrative	Medicare Initiated
N117	This service is paid only once in a lifetime per beneficiary.	Y
N118	This service is not paid if billed more than once every 28 days.	Y
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or SNF (Part B) facility within those 28 days.	Y

N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was discharged/readmitted during payment episode.	Y
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.	Y Y
N122	Mammography add-on code can not be billed by itself.	Y
N123	This is a split service and represents a portion of the units from the originally submitted service.	Y Y
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.	Y
N125	<p>Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases:</p> <ul style="list-style-type: none"> <li>• If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or</li> <li>• If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.</li> </ul> <p>If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.</p>	Y
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.	Y
N127	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.	Y
N128	This amount represents the prior to coverage portion of the allowance.	
N129	This amount represents the dollar amount not eligible due to the patient's age.	
N130	Consult plan benefit documents for information about Restrictions for this service.	
N131	Total payments under multiple contracts cannot exceed the allowance for this service.	

N132	Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.	
N133	Services for predetermination and services requesting payment are being processed separately.	
N134	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.	
N135	Record fees are the patient's responsibility and limited to the specified co-payment.	
N136	To obtain information on the process to file an Appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.	
N137	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.	
N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.	
N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	
N140	You have not been designated as an authorized OCONUS provider, therefore, are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	
N143	The patient was not in a hospice program during all or part of the service dates billed.	
N144	The rate changed during the dates of service billed.	
N145	Missing/incomplete/invalid provider identifier for this place of service.	
N146	Missing/incomplete/invalid/not approved screening document.	
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	
N148	Missing/incomplete/invalid date of last menstrual period.	
N149	Rebill all applicable services on a single claim.	
N150	Missing/incomplete/invalid model number.	
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.	
N152	Missing/incomplete/invalid replacement claim information.	
N153	Missing/incomplete/invalid room and board rate.	

N154	This payment was delayed for correction of provider's mailing address.	
N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	
N156	The patient is responsible for the difference between the approved treatment and the elective treatment.	

**Modified Remark Codes**

M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.	Y
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: <ul style="list-style-type: none"> <li>• If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or</li> <li>• If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.</li> </ul>	Y
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the	Y

	patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.	
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	
MA01	(Initial Part B determination, Medicare carrier or intermediary) If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.	Y
MA02	(Initial Medicare Part A determination) If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.	Y
MA03	(Medicare Hearing)—If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.	Y
N22	This procedure code was changed because it more accurately describes the services rendered.	Y
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at <a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a> .	Y

**X12 N 835 Health Care Claim Adjustment Reason Codes**

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. An updated list is posted three times a year after each X12 trimester meeting at <http://www.wpcedi.com/hipaa/>. All reason code changes from July 2002 to October 2002 are listed here. The current reason code set was installed April 1, 2003.

In most cases, reason code additions, modifications and retirements are requested by non-Medicare entities; Medicare may occasionally request changes. If the request comes from Medicare, it may be included in a Medicare instruction in addition to the regular code update PM. Code changes requested by entities other

than Medicare would not be routinely included in a Medicare instruction as part of a policy change, but modification or retirement of an existing code could impact Medicare. CMS will periodically issue a PM to provide a summary of changes in the reason and remark codes introduced since the last update PM, and will establish the deadline for Medicare contractors to implement the reason and remark code changes applicable to Medicare that may not already have been implemented as part of a previous Medicare policy change instruction.

The committee approved the following reason code changes in October 2002:

**New Reason Codes**

149	Lifetime benefit maximum has been reached for this service/benefit category.	Y
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	Y
151	Payment adjusted because the payer deems the information submitted does not support this many services.	Y
152	Payment adjusted because the payer deems the information submitted does not support this length of service.	Y
153	Payment adjusted because the payer deems the information submitted does not support this dosage.	Y
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	Y

**Modified Reason Codes**

35	Lifetime benefit maximum has been reached.	
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**Retired Reason Codes**

57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. (Inactive for version 4050)	Y
88	Adjustment amount represents collection against receivable created in prior overpayment. (Inactive for version 4050)	

Source: CMS Transmittal AB-03-012, CR 2546

**Changes to Medicare Provider Remittance Advice Notices**

Providers currently receive remittance advice notices as individual pages (front page only). Effective April 7, 2003, FCSO began duplexing provider remittance advice notices (printing front-and-back). This will significantly reduce the amount of money spent on postage. This also applies to remittance advice notices attached to checks, but has no effect or changes to the check itself.

Source: Medicare Carriers Manual (MCM) Chapter 7, Section 30.1.

## Hospice Care Enhances Dignity and Peace As Life Nears Its End

*This article, published at the request of CMS, addresses the issue of the Medicare hospice benefit and emphasizes the benefits of hospice care for beneficiaries. It advises physicians that they need not be concerned about CMS penalties when certifying an individual for hospice care. The article notes that CMS is aware that terminal illness does not always have a predictable course and can be extended beyond the initial six-month certification.*

Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs. Hospice care, a fully reimbursable Medicare Part A benefits option for beneficiaries and providers since 1983, offers the services designed to address the physical and emotional pain through effective palliative treatment when cure is not possible. In the event that a beneficiary has been advised by his/her physician, that a cure for his/her illness is no longer possible, Medicare beneficiaries may discuss hospice care as an option. Physicians and other health care practitioners can be encouraged that the Medicare program includes a hospice benefit that provides coverage for a variety of services and products designed for those with terminal diagnoses. When properly certified and appropriately managed, hospice care is a supportive and valuable covered treatment option.

Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six-month prognosis, if the illness runs its usual course.

Hospice care that is covered by Medicare is chosen for specified amounts of time known as "election periods." Essentially, a physician may certify a patient for hospice care coverage for two initial 90-day election periods, followed by an unlimited number of 60-day election periods. Each election period requires that the physician certify a terminal illness. Payment is made for each day of the election period based on one of four per diem rates set by Medicare, commensurate with the level of care.

Generally speaking, the hospice benefit is intended primarily for use by patients whose prognosis is terminal, with six months or less of life expectancy. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses; therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period.

Recognizing that prognoses can be uncertain and may change, Medicare's benefit is not limited in terms of time. Hospice care is available as long as the patient's prognosis meets the law's six-month test.

This test is a general one. As the governing statute says: "The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

CMS recognizes that making medical prognostication of life expectancy is not always an exact science. Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.

Many physicians appreciate the fact that hospice care enables family and loved ones to participate in the experience and to get help from the hospice in managing their own feelings and reactions to the illness. The value of hospice care is recognized and advanced by many physicians and other health professionals. One professional organization, the American Academy of Hospice and Palliative Medicine (formerly the Academy of Hospice Physicians) focuses its efforts on the "prevention and relief of suffering among patients and families" through palliative therapy, education and counseling. Among the Academy's objectives are to "bring the hospice approach into mainstream medicine and eliminate the dichotomy whereby patients receive either curative or palliative care."

This distinction is important because despite a growing appreciation for hospice care both as a philosophy and as a fully covered Medicare benefit, there appears to be two perceived barriers to its broader acceptance.

First is an understandable reticence to contemplate the end of life. A 1999 survey conducted by the National Hospice and Palliative Care Organization (NHPCO) found that Americans generally are reticent to discuss hospice care with their elderly parents. According to the survey, less than one in four of us have put into writing how we wish to be cared for at life's end. About one in five have not contemplated the subject at all, and a slightly smaller number told the surveyors they have thought about it but have not shared their thoughts with others.

The second perceived barrier is a lack of knowledge on the part of both patients and practitioners that the covered hospice benefits are both broad and readily available virtually everywhere in the country. As with other covered services, payments for hospice care generally are made to providers based on prospectively-set rates that are updated every year for inflation. Hospice care is primarily a specialized type of home health care, and as is the case with the home health care benefit, hospices are served by regional intermediaries for Medicare billings, payments, cost reports and audits.

Medicaid also covers hospice care in many states. Medicare covers a number of specific services as defined in regulation and in the Medicare Hospice Program Manual. Most of these services are familiar to health care professionals and other practitioners who have worked with skilled nursing facilities (SNFs) and home health services. Covered services include:

- Medical and nursing care
- Medical equipment (such as wheelchairs or walkers)
- Pharmaceutical therapy for pain relief and symptom control
- Home health aide and homemaker services
- Social work services
- Physical and occupational therapy
- Speech therapy
- Diet counseling
- Bereavement and other counseling services
- Case management

Hospice care also is covered by Medicaid in many states.

In 1999, 474,270 individuals received hospice care at 2,281 certified hospice programs in the United States. In 2000, there were 2,266 certified hospices. In 2001, approximately 580,000 individuals received hospice care at 2,277 (as of August 2001) certified hospice programs.

The hospice setting also is appropriate for patients who suffer from terminal illnesses such as lung disease or end-stage heart ailments, cancer, Alzheimer's disease, and terminally ill AIDS patients. Hospice is not about death, but rather about the quality of life as it nears its end, for all concerned – the patient, family and friends, and the health professional community.

For more information: go online to the Medicare Learning Network at [www.cms.gov/medlearn/](http://www.cms.gov/medlearn/); or see a related informational brochure on hospice care at: [www.medicare.gov/Publications/home.asp](http://www.medicare.gov/Publications/home.asp).

Source: CMS Transmittal AB-03-040, CR 2570

*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.

## Colorectal Cancer Screening Awareness for Health Care Providers

Colorectal cancer (CRC) is the second leading cause of cancer-related death in the United States. The American Cancer Society (ACS) estimates that there will be 147,500 new cases and 57,100 deaths from CRC in 2003. However, CRC is one of the most preventable cancers, as well as one of the most curable when detected at an early stage. Screening can help prevent CRC by detecting polyps so they can be removed before they turn into cancer. According to the ACS, if the cancer is detected early and appropriately treated, the 5-year survival rate is approximately 90 percent. It has been estimated that widespread screening for CRC could save more than 20,000 lives each year.

### The Importance of Screening

Despite the proven effectiveness and availability of various CRC screening tests, many Americans are not being screened for the disease. Screening for CRC lags far behind screening for other cancers. Only 21 percent of people aged 50 and older who responded to the Behavioral Risk Factor Surveillance System in 1999 reported having had a fecal occult blood test (FOBT) within the recommended timeframe of one year. Only 34 percent of respondents had undergone sigmoidoscopy or colonoscopy within the recommended timeframe of five years. These findings underscore the need to increase awareness and promote the use of colorectal cancer screening exams at regular intervals.

As a consequence of the low level of CRC screening, only 37 percent of cases are diagnosed when the disease is still localized. Later diagnosis results in a significantly lower 5-year relative survival rate than would occur if patients were diagnosed when the disease was localized. If the cancer is detected early, the 5-year survival rate is approximately 90 percent. When the cancer has spread regionally, the survival rate drops to 65 percent; and when it has metastasized, the rate lowers to only nine percent. These considerable differences in survival rates point to the importance of screening in

preventing this disease and in detecting it at its earliest stage, when treatment is most effective.

According to the 2000 U.S. census, there are approximately 76.5 million Americans who are aged 50 and older, with an expected increase of 20 million Americans in this age group through 2005. By 2030, the number of Americans age 65 and older is expected to increase by over 200 percent. If prevention and early detection of CRC are not significantly improved, the increase in morbidity and mortality from CRC in the aging population will be even more pronounced than it is today.

### Incidence and Mortality

CRC usually strikes men and women over the age of 50 (90 percent of cases). The incidence rate is similar among men and women until age 50. At that age, it becomes higher in men than in women. CRC incidence and mortality rates vary substantially by race and ethnicity, with both incidence and death rates being highest in African Americans and lowest in American Indian/Alaska Natives and Hispanics. Death rates for CRC began declining in women in 1950 and in men beginning in 1985. Despite this encouraging trend, the death rates for CRC are unacceptably high. It has been suggested that the incidence and mortality of CRC could be reduced by 60 and 80 percent, respectively, if compliance were 60 percent with initial testing and 80 percent with follow-up.

### Screening Tests and Intervals

Several screening regimens have been proven to be effective (in various degrees) in reducing mortality from CRC: the FOBT, flexible sigmoidoscopy, double-contrast barium enema (DCBE), and colonoscopy. These allow detection of adenomatous polyps so they can be removed before they become cancerous and the removal of early-stage CRC when the disease is still highly curable. Each procedure differs in accuracy, cost and risk.

Regular CRC screening is recommended for all adults aged 50 or older who have no known risk factors. (Seventy-five percent of all new cases of CRC occur in individuals with no risk factors for the disease, and as stated above, more than 90 percent of cases of the disease occur in people over the age of 50.) Screening guidelines have been developed by several scientific agencies and organizations, including the U.S. Preventive Services Task Force; the ACS; and the Interdisciplinary Task Force, which is convened by the Agency for Healthcare Research and Quality (AHRQ) and supported by five major gastroenterology societies. All recommend the following screening procedures:

- Annual FOBT, or
- Flexible sigmoidoscopy every 5 years, or
- Annual FOBT plus flexible sigmoidoscopy every 5 years, or
- Total colon examination by colonoscopy every 10 years or by DCBE every 5-10 years.

These guidelines emphasize the key health benefit of CRC screening—finding precancerous polyps so they can be removed before they turn into cancer, and finding early stage CRC, so it can be treated. Currently, data are insufficient to determine the best single screening approach. Each option has advantages and disadvantages that may vary for individual patients and practice settings. AHRQ recommends developing a screening strategy based on patient preferences, medical contraindications, patient adherence, and available resources for testing and follow-up. AHRQ advises clinicians to speak with patients about the benefits and potential harms associated with each option before selecting a screening strategy.

**Note:** For the most up-to-date guidelines, refer to [www.guideline.gov](http://www.guideline.gov), the National Guidelines Clearinghouse.

### The Role of the Health Care Professional in Increasing Screening Rates

Health care professionals should offer screening according to currently accepted guidelines to all individuals aged 50 and older who are at average risk for CRC. Those at higher than average risk should be counseled according to the accepted guidelines for those at increased risk. As with other screening tests, a recommendation by a health care professional is an important influence in determining whether or not individuals decide to be screened for CRC. Primary care providers play a very important direct role in facilitating compliance with screening. In general, when primary care providers recommend a screening procedure to patients, patients follow through.

The ACS reports that the low prevalence of CRC screening is due in part to limited communication between physicians and their patients. Patients may be unaware of the benefits of screening unless their health care professionals discuss them. However, physicians may be unlikely to suggest screening unless the patient

asks about it. Clinicians should take advantage of every opportunity to recommend preventive care to patients (e.g., during visits for acute care). Reminders should be given at every visit.

Reminder systems have been shown to increase preventive services and screening rates in practices that use them. They are strongly recommended to ensure that cancer-screening programs are ongoing rather than a one-time event. Reminder systems are more efficient and effective when they include the participation of office staff. Reminders can be active (e.g., at point of service) or passive (e.g., receiving a postcard in the mail). Follow-up and surveillance should be built into reminder systems. At a minimum, health care professionals can use the *Put Prevention Into Practice* system (obtainable from AHRQ at 1-800-358-9295 or [ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov)).

Numerous educational materials are available on CRC and screening. See the order form for materials that have been developed as a part of the *Screen for Life: National CRC Action Campaign*. A description of the campaign and the order form follow. Most materials can be obtained from the Centers for Medicare & Medicaid Services (CMS) at no charge.

### Who Should Be Tested

Patients with symptoms require immediate diagnostic testing. Symptoms include:

- Rectal bleeding
- Frequent abdominal discomfort or pain for no reason
- Bloating
- A change in bowel habits, such as having stools that are narrower than usual
- Iron deficiency anemia
- Unexplained weight loss

For asymptomatic patients, routine screening is recommended for:

- Men and women aged 50 and older. As stated earlier, at least 75 percent of colorectal cancers occur in people with no personal or family history of CRC and no known risk factors.
- Patients at increased risk for developing CRC. These patients may need to be screened earlier and more frequently than other patients. Those considered at increased risk have:
  - A close relative (sibling, parent, or child) who has had CRC or an adenomatous polyp;
  - A personal or family history of familial adenomatous polyposis;
  - A personal or family history of hereditary nonpolyposis CRC;
  - A personal history of adenomatous polyps;
  - A personal history of CRC; or
  - Inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Medicare covers the following tests/procedures:

Colorectal Cancer Screening Test/Procedure	HCPCS Code	Medicare Coverage
Colorectal cancer screening; fecal-occult blood t, 1-3 simultaneous determinations	G0107	Once every 12 months for patients age 50 and older.
Colorectal cancer screening; flexible sigmoidoscopy	G0104	Once every 48 months for patients age 50 and older when performed by a doctor of medicine or osteopathy, or a physician assistant, nurse practitioner, or clinical nurse specialist.
Colorectal cancer screening; colonoscopy on individual at high risk	G0105	Once every 24 months for patients at any age who are at high risk for colorectal cancer, when performed by a doctor of medicine or osteopathy.
Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	G0121	Once every 10 years but not within 48 months of a screening sigmoidoscopy for patients at any age who are not at high risk, when performed by a doctor of medicine or osteopathy.
Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema *	G0106	Physicians may substitute a barium enema examination for flexible sigmoidoscopy every four years for patients age 50 and older.
Colorectal cancer screening; alternative to G0105 (screening colonoscopy), barium enema*	G0120	Physicians may substitute a barium enema examination for colonoscopy every two years for high-risk patients.
Colorectal cancer screening; barium enema (not performed as an alternative to G0105 or G0104)	G0122	This service is denied as <i>noncovered</i> , because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

\*The screening barium enema must be ordered in writing after determining that the test is the appropriate screening test. The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential estimated for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the patient.

**Note:** If during the course of a screening colonoscopy (or screening flexible sigmoidoscopy), a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy (or flexible sigmoidoscopy) with biopsy or removal should be billed and paid rather than G0121 (or G0104).

**Note:** For additional information on covered services, HCPCS Codes, and coverage criteria for colorectal cancer screening services:

- View CMS' Carrier Manual, Part 3, Chapter IV – Claims Review and Adjudication Procedures at: [http://cms.hhs.gov/manuals/14\\_car/3b4010.asp](http://cms.hhs.gov/manuals/14_car/3b4010.asp). See Section 4180 for CRC screening.
- Read *Medicare Resident & New Physician Training*, Screening for Colorectal Cancer, pp. 48-51. To obtain a hardcopy of this publication or a CD, send an e-mail note to [Medlearn@cms.hhs.gov](mailto:Medlearn@cms.hhs.gov). Also visit CMS' Medlearn site, which was established for health care professionals, at: <http://www.cms.hhs.gov/medlearn/>.

### Screen for Life National CRC Action Campaign and National CRC Awareness Month Campaign

CMS partners with the Centers for Disease Control and Prevention (CDC) to increase CRC screening within the Medicare population and the general population aged 50 and above. Together CDC and CMS develop and implement the *Screen for Life: National Colorectal Cancer Action Campaign* (SFL), which informs men and women aged 50 years and older about the importance of CRC screening for early detection and prevention of the disease. (For more information about SFL, visit: [www.cdc.gov/cancer/screenforlife](http://www.cdc.gov/cancer/screenforlife).) In addition, in March, CMS joins 50 agencies and organizations to carry out the National CRC Awareness Month Campaign, which generates widespread awareness about CRC and encourages people to learn more about how to reduce their risk

of the disease through regular screening and a healthy lifestyle. The Cancer Research and Prevention Foundation (CRPF) leads this national campaign. (For more information on the NCCAM campaign, visit CRPF's Internet site at [www.preventcancer.org](http://www.preventcancer.org) or call 1-800-227-2732.) Medicare Carriers, Intermediaries, and Quality Improvement Organizations join CMS and its partners in this effort by making people with Medicare aware of the importance of regular CRC screening and by encouraging health care professionals to: (1) educate themselves and their patients about the benefits of screening for prevention and early detection of colorectal cancer; (2) recruit patients for initial colorectal cancer screening; and (3) ensure patient

compliance with current screening tests and appropriate follow-up. Both campaigns produce and distribute CRC materials for patients and health care professionals.

### Materials, Education and Training

Screen for Life has developed numerous materials (e.g., brochures, fact sheets, posters), which health care professionals can make available to patients and use to inform them about the importance of screening. The publications can be obtained free of charge from CMS or CDC. See the table entitled: "Materials on Colorectal Cancer Screening for Health Care Professionals" for information on available print materials and how they may be ordered or downloaded from the Internet.

In addition to the print materials, CDC has developed a slide presentation, "A Call to Action: Prevention and Early Detection of Colorectal Cancer." This was developed to generate awareness among primary care professionals of the importance of CRC screening in the prevention and early detection of CRC. CDC encourages health care professionals to download and present the slides to their colleagues. CDC also offers Web-based tools that health care professionals can use to help patients select screening options (e.g., suggestions for communicating effectively with patients about CRC). The slide presentation and online tools may be viewed, ordered, or downloaded at: [www.cdc.gov/cancer/colorctl/calltoaction/](http://www.cdc.gov/cancer/colorctl/calltoaction/).

Information for this article was taken from:

1. The American Cancer Society's *Cancer Facts & Figures 2002* (Special Section: Colorectal Cancer and Early Detection) and *Cancer Facts & Figures 2003*.
2. CDC's Cancer Prevention and Control, CRC Prevention and Control Initiatives Web site, including *Colorectal Cancer: The Importance of Prevention and Early Detection 2002 Fact Sheet*.
3. CDC's Cancer Prevention and Control, *Screen for Life: National CRC Action Campaign* Web site, including materials from the campaign.
4. CDC's *MMWR Weekly*, March 9, 2001/50(09); 162-6, "Trends in Screening for Colorectal Cancer—United States, 1997 and 1999."
5. Cancer Research and Prevention Foundation's (formerly the Cancer Research Foundation of America) *Confronting Colorectal Cancer: Action Steps for Change*, October 2002.
6. CMS' *Medicare Resident & New Physician Training, Sixth Edition, 2002*, Screening for Colorectal Cancer.
7. CMS' *Carrier Manual, Part 3, Chapter IV – Claims Review and Adjudication Procedures, Section 4180*.

Source: CMS Transmittal AB-03-033, CR 2580

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## Colorectal Cancer (CRC) Screening Publications

### To Order Copies From CMS – Fax, E-mail, or Telephone:

#### Orders from CMS For 1 copy:

- Phone: 1-800-MEDICARE (1-800-633-4227)

#### Orders from CMS For 1-99 copies:

- Fax: 1-410-786-4786
- E-Mail: [LBeasley@cms.hhs.gov](mailto:LBeasley@cms.hhs.gov)
- Phone: If you have questions, or cannot fax or e-mail requests, call Larry Beasley 1-410-786-7843.

#### Orders for 100 or more copies:

- Fax: 1-410-786-1905
- E-Mail: [STaylor@cms.hhs.gov](mailto:STaylor@cms.hhs.gov)
- Phone: If you have questions, or cannot fax or e-mail requests, call Susie Taylor 1-410-786-7849.

Note: **Please order publications via fax or e-mail when possible. Because of the large volume of requests, you may not receive an acknowledgment return call for orders placed on voice mail.**

### To Order or Download Publications from CMS' Internet Site:

- Internet: To download copies of "Let's Break the Silence" brochures (English and Spanish) from the CMS Internet site, visit: [www.medicare.gov](http://www.medicare.gov). Click "Health Information." Then click "Colorectal Cancer."

### To Order or Download Publications from CDC:

- Internet: <http://www.cdc.gov/cancer/screenforlife>,  
To download slide presentation, visit: [www.cdc.gov/cancer/colorctl/calltoaction/index.htm](http://www.cdc.gov/cancer/colorctl/calltoaction/index.htm).
- Phone: 1-888-842-6355, or
- E-mail: [cancerinfo@cdc.gov](mailto:cancerinfo@cdc.gov).

### To View Materials Before Ordering:

- Internet: Visit the CDC site at: <http://www.cdc.gov/cancer/screenforlife>

**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.

## Materials on Colorectal Cancer (CRC) Screening for Health Care Professionals

Campaign Material	Version	CMS – CDC Pub No.	Additional Information
Health Professionals' Fact Sheet <i>BEING UPDATED</i>	CRC Health Professionals' Facts on Screening	CDC # 099-6487 ORDER FROM CDC	To order or download copies: 1) visit <a href="http://www.cdc.gov/cancer/screenforlife">www.cdc.gov/cancer/screenforlife</a> ; 2) e-mail to <a href="mailto:cancerinfo@cdc.gov">cancerinfo@cdc.gov</a> ; or phone 1-888-842-6355. Contains table with info on screening tests including scientific evidence supporting the tests, frequency, purpose, important considerations, insurance/ Medicare coverage; etc. Currently, may only be downloaded.
Slide Presentation for Health Professionals	"A Call to Action: Prevention and Early Detection of CRC"	ORDER FROM CDC See "Additional Information."	Developed by CDC to generate a greater awareness among primary care providers of the importance of prevention and early detection of CRC. Visit: <a href="http://www.cdc.gov/cancer/colorctl/calltoaction/index.htm">www.cdc.gov/cancer/colorctl/calltoaction/index.htm</a> . Download and present slides to colleagues.
Poster (English/Sp.)	"Medicare Good News" - Caucasian Audience - African-Amer. Audience - Asian- Amer. Audience - Hispanic Audience (Sp.)	CMS #10122 CMS #10124 CMS #10125 CMS #10142	Posterboard backing.
Poster	"No Symptoms"	CMS #10183 CDC #099-6478	Order version with posterboard backing from CMS. For version that folds, order from CDC (max 50 copies from CDC).
Poster	"True or False"	CMS #02256 (large) CMS #02255 (small)	Colorful poster with 4 questions about CRC & other info. Folds. Large-17"x22" Small-11"x17"
Basic Fact Sheet for Patients (literacy version)	"CRC Basic Facts on Screening"	CMS#11011	8 ½ x 11", 2-sided sheet. Low literacy (low version of the detailed fact sheet (see below). Info provided is similar to brochure, <i>CRC Screening Saves Lives</i> .
Detailed Fact Sheet for Patients	"CRC Facts on Screening"	CMS#11012	8 ½ x 11", 2-sided sheet. Includes a chart on the back, with information on frequency/cost estimate, purpose, important considerations, etc.
Brochure for Patients (Eng.)	"CRC Screening Saves Lives"	CMS#11010	8 ½ x 11" trifold. Information on types of tests, how screening saves lives, who is at high risk, symptoms, insurance coverage, etc.
Brochure for Patients (English/Sp.)	"Let's Break the Silence"	CMS #95173 (Eng.) CMS #10158 (Sp.)	8 ½ x 11" trifold. Discusses terms related to CRC screening, who is at risk, steps to take, talking with the doctor, insurance, symptoms, preventing cancer, etc. Includes diagram of colon and rectum.
Pamphlet on Preventive Services Covered by Medicare (for Patients)	"Medicare Preventive Services.... To Help Keep You Healthy"	CMS #10110 (Eng.)	Includes a chart that explains which preventive services are covered by Medicare, for whom they are covered, and what the beneficiary pays. Tear-off cards provide detailed information on some of the preventive benefits.

To view these materials, visit: <http://www.cdc.gov/cancer/screenforlife/preview.htm>.

**GENERAL INFORMATION - FLORIDA ONLY****Medicare Stop Smoking Program**

The Medicare Stop Smoking Program (MSSP) is a research demonstration project funded through the Centers for Medicare & Medicaid Services (CMS). Its goal is to test the effectiveness and cost-effectiveness of three variations of a Medicare smoking cessation benefit against usual care procedures. The demonstration is being conducted in seven states: Alabama, Florida, Missouri, Nebraska, Ohio, Oklahoma and Wyoming. Each state is divided into four regions corresponding with four Intervention Arms.

**Qualifying Criteria**

- Medicare beneficiaries (current Part B fee for service coverage)
- Age 65 or older
- Current smoker (cigarettes)
- Interest in trying to quit smoking
- Anticipated residence in the designated study locale for at least nine months

In addition, beneficiaries living in either of the provider counseling arms must name the provider they plan to see, who must also be located in the regions/state assigned to provider counseling.

**Enrollment into the MSSP Program**

Medicare beneficiaries voluntarily call the MSSP Enrollment Call Center at TrailBlazer Health Enterprises, LLC to learn more about the program. An MSSP customer service representative screens callers for eligibility and performs a telephone-administered registration survey. Once the beneficiary qualifies for the demonstration program, they are assigned to one of the following Intervention Arms: Provider Counseling, Provider Counseling with Pharmacotherapy Coverage, Quitline (specific telephone number to assist with quitting smoking), or Usual Care (pamphlets mailed to the beneficiary).

**Provider Information & Reimbursement**

A packet of information outlining the project, its limitations, and special claims processing procedures is mailed to providers who have patients enrolled in the Provider Counseling Intervention Arm or the Provider Counseling Intervention Arm with Pharmacotherapy. Providers should submit all counseling sessions on a Medicare Stop Smoking Claim form to:

TrailBlazer Health Enterprises, LLC  
P.O. Box 4705  
Timonium, MD 21094  
1-866-652-3446

Forms may be faxed to 1-410-683-2944. The total reimbursement rate for each counseling session is \$36.98. Your patient is expected to pay the usual Medicare co-payment.

Source: TrailBlazer Health Enterprises

**THE FLORIDA PATIENT FRIENDLY ADVISORY**

The information on the following page was provided by Florida Medical Quality Assurance, Inc., and may be reproduced and shared with your patients who are interested in the Medicare Stop Smoking Program.

# **New Demonstration Project Available for Seniors with Medicare Who Smoke**

A new program is available for seniors with Medicare who smoke and want to quit. For a limited time, seniors living in Alabama, *Florida*, Missouri, Ohio, Oklahoma, Nebraska and Wyoming may participate in the Medicare Stop Smoking Program. This program is sponsored by the Department of Health and Human Services to study approaches to help seniors stop smoking. As a part of the demonstration project a variety of services are offered to help seniors who smoke and want to quit. These services may include counseling, drugs that help seniors quit smoking such as the nicotine patch, special consumer booklets and a telephone information line staffed by professional counselors.

The Medicare Stop Smoking Program is a great way for seniors in the demonstration project states to take control of their own health and quality of life. Seniors who are interested in quitting smoking may join the program from now until September 30, 2003.

Seniors interested in joining the program must: be 65 years or older; have Medicare Part B coverage; be in the Medicare fee-for-service program; live in one of the seven states that offers the program; and be a cigarette smoker who is thinking about quitting.

Smoking is the single most preventable cause of disease and death in the United States. It can cause and worsen many conditions including heart attacks, strokes, lung disease, high blood pressure, cancer and complications from diabetes. Reports show that the body can enjoy immediate benefits from quitting, even after 30 or more years of heavy smoking. These benefits include improvements in breathing and circulation. In fact, seniors can reduce their risks for heart disease and stroke to that of a non-smoker's within one to five years of quitting. Also, older smokers have been shown to be more successful in their quit attempts than younger smokers.

The Centers for Medicare & Medicaid Services, the agency that oversees Medicare, is offering this new and exciting demonstration project. Results will be used to understand how to best help seniors help themselves to stop smoking.

Seniors who would like more information about the Medicare Stop Smoking Program demonstration project should call TrailBlazer Health Enterprises toll-free at 1-866-65BEGIN (1-866-652-3446).

# CONNECTICUT MEDICAL REVIEW

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

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs on our provider education Web site, [www.connecticutmedicare.com](http://www.connecticutmedicare.com). Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP comment/response summaries may be printed from the Part B Medical Policy section.

## Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs; the date the LMRP is posted to the Web site is considered the notice date.

## Electronic Notification

To receive quick, automatic notification when new and revised LMRPs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, [www.connecticutmedicare.com](http://www.connecticutmedicare.com); click on the yellow "Join our electronic mailing list" bar and follow the prompts.

## More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP, contact Medical Policy at:

Attention: Medical Policy  
First Coast Service Options, Inc.  
P.O. Box 9000  
Meriden, CT 06450-9000  
Phone: 1-866-419-9455

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## Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 6 for details concerning ABNs.

## Self Administered Drugs (SAD) List

CMS issued instructions regarding Medicare payment for drugs and biologicals incident to a physician's service. Guidelines provide contractors a process for determining if an injectable drug is *usually self-administered* and therefore, not covered by Medicare. Providers may read the instructions in CMS Transmittals AB-02-072 (CR 2200) and AB-02-139 (CR 2311).

We are required to establish a SAD list on our provider education Web site, listing drugs that have been evaluated and determined to be usually self-administered. Currently, injectable drugs on the Connecticut Medicare Part B SAD list are as follows:

J0270	Alprostadil, 1.25 mcg
J1438	Etanercept, 25 mg (Enbrel®)
J1815	Insulin, 5 units (formerly J1820)
J1830	Interferon beta-1b, 0.25mg (Betaseron®)
J2940	Somatrem, 1mg
J2941	Somatropin, 1 mg
J3030	Sumatriptan succinate, 6mg (Imitrex®)
J3490	Kineret™, per 100mg
J3490	Ribef®
J9218	Leuprolide acetate, per 1 mg
Q2010	Compaxone® per 20 mg

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for changes affecting their practice. You may access the SAD list online at [www.connecticutmedicare.com](http://www.connecticutmedicare.com), in the "General Info" section.

## COMPREHENSIVE DATA ANALYSIS

### 36245: Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterizations

A recent study was performed by the New York peer review organization (PRO) in conjunction with the Centers for Medicare & Medicaid Services (CMS) PRO staff in response to a carrier referral related to payments for potential medically unnecessary diagnostic procedures performed in conjunction with primary cardiac catheterizations. The study focused on a review of Medicare beneficiaries who underwent renal arteriogram during inpatient admission for cardiac catheterization. The NY carrier medical director, through claims data, determined a number of physicians were billing for both cardiac catheterization and a renal arteriogram on the same day. Because the carrier and fiscal intermediary do not have jurisdiction over inpatient quality of care and medical necessity for the inpatient portion of the service, a collaborative team was formed to address these issues from a more global standpoint. Both Part A and B data were extracted to identify if there were any significant billing/performing patterns visible. The study focused on more than 1,000 inpatient medical records of Medicare beneficiaries admitted to the top 30 hospitals for cardiac catheterization, who, based on analysis of the data, also underwent extracardiac arteriography, particularly renal arteriograms. The study focused on the following:

- Were cardiologists performing the renal arteriograms?
- Were the renal arteriograms carried out at the same time as the cardiac catheterization?

- Were the renal studies medically necessary?
- Did this pattern of performance constitute poor quality of care?

Preliminary findings demonstrated that medical necessity for the renal arteriogram was not substantiated by documentation in the medical record. They also identified quality of care concerns related to performing a medically unnecessary invasive procedure associated with high risk.

The study group, NY PRO/CMS/Contractor, have been presenting their findings to the medical community, especially cardiologists, and at hospitals on both a local and regional level. The hope is that a follow-up study will demonstrate more appropriate use of renal artery arteriography consistent with current medical evidence post provider education.

The data analysis staff noted the following on initial review:

- A total of \$2,875,602 was paid to all performing providers in Florida, from January through September 2001, who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization. A total of 8,953 renal arteriograms, by 261 providers, were billed for the same time frame.
- A total of \$9,894, accounting for 53 services, was paid to the seven performing providers in Connecticut, from January through September 2001, who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization.

We will be performing a widespread medical review across Connecticut and Florida, which may result in specific medical necessity guidelines, PRO referrals and/or provider education. Please assure that when billing

these services (*CPT 36245* with *CPT 93512* or *93526*), the renal arteriogram is both medically necessary and performed in accordance with the intention of the *CPT* Editorial Panel.

## 88311: Article Clarification

An article pertaining to Comprehensive Data Analysis Findings on Pathology Codes was published in the Third Quarter 2002 *Medicare B Update!* (page 29). In response to this article, pathology providers offered comments and clarification.

The American Medical Association, the entity considered responsible for providing interpretation of the *CPT* codes, defines the unit of service for the special stains codes as follows:

The specimen is defined as tissue or tissues that is (are) submitted for individual and separate

attention, requiring individual examination and pathologic diagnosis. The special stain codes should therefore be reported per stain, per specimen as it is defined above regardless of the number of blocks cut or slides stained.

For example, if one special stain were used on multiple blocks of the same specimen, the appropriate special stain code would be reported only once. If one specimen received three different special stains, the correct special staining code would be reported with three units.

## Comprehensive Data Analysis Findings—Eye Exams

The Comprehensive Data Analysis department recently reviewed several *CPT* codes used for billing ophthalmological procedures. The following codes were reviewed in the analysis:

*92020 Goniocopy (separate procedure)*

*92083 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)*

*92135 Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral*

If practice patterns in Connecticut were similar to the rest of the nation, \$2,251,226 would not have been expended by Medicare.

The following table depicts by procedure code the carrier allowed dollars per 1,000 enrollees, nationally allowed dollars per 1,000 enrollees, and what percent Connecticut's expenditure is of the national expenditure per code.

July - December 2001			
Procedure Code	Carrier Allowed \$ per 1,000 Enrollees	Nationally Allowed \$ per 1,000 Enrollees	Percent of Nation
92020	\$789	\$366	2.69
92083	\$3,167	\$1,907	2.08
92135	\$2,382	\$1,103	2.70

Goniocopy, visual field examination, and scanning computerized ophthalmic diagnostic imaging will not be covered if performed on a routine or screening basis in the absence of disorders of the eye or abnormal signs and symptoms. Services will be denied proactively and retroactively if documentation submitted does not establish medical necessity of the service under Section 1862 (a)(1) of Title XVIII of the Social Security Act (the Act). The Code of Federal Regulations (CFR), section 411.15 and section 1862(a)(7) of the Act exclude routine physical examinations. Section 1833 (e) of the Act prohibits Medicare payment for any claim that lacks information necessary to process the claim.

Data suggests that some Connecticut providers may be overutilizing and/or billing inappropriately. It is essential that providers follow established Medicare guidelines. Please ensure you are following guidelines published in the Part B local medical review policy (LMRP) for goniocopy and visual field examinations, as well as following the established guidelines of the Act and/or the CFR.

Full-text LMRPs may be viewed at [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

*Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2002 (or other such date of publication of CPT) American Medical Association. All rights reserved. Applicable FARS/DFARS apply.*

### Widespread Probe—Eye Exam Codes

The Statistical Medical Data Analysis department recently conducted an analysis of the following CPT codes for eye exams:

92225 *Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial*

92226 *Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent,*

92235 *Fluorescein angiography with interpretation and report. Fluorescein dye is injected in a peripheral vein to enhance imaging. Serial multiframe angiography is performed to evaluate choroidal and retinal circulation*

92250 *Fundus photography with interpretation and report.*

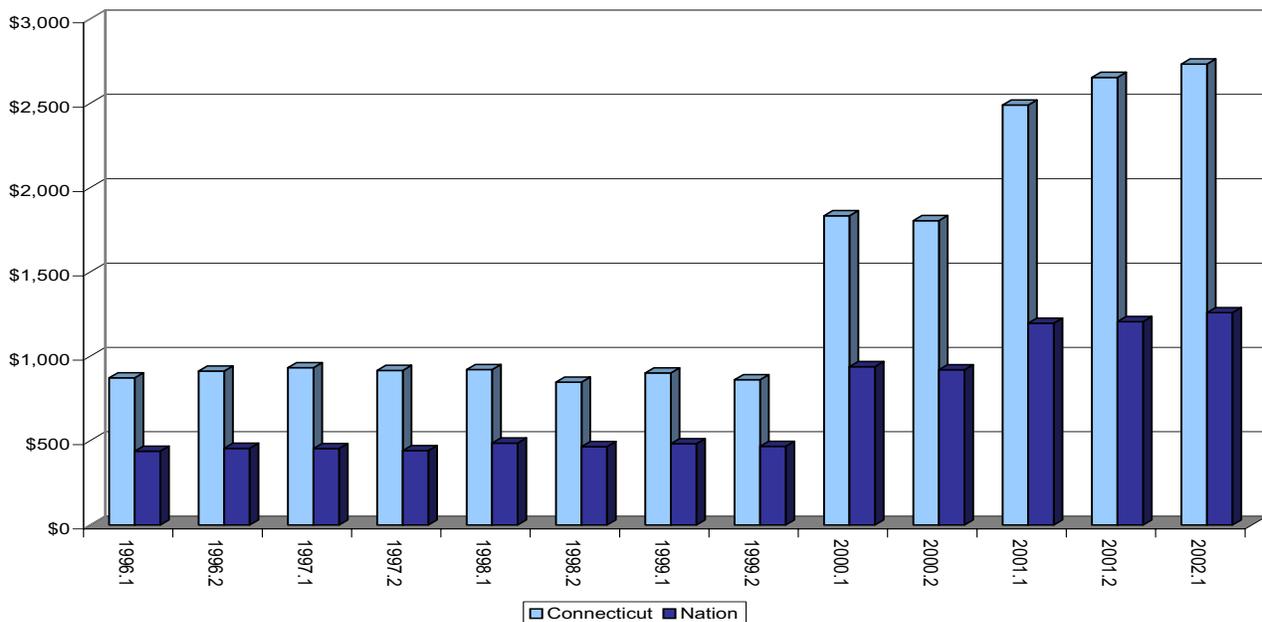
If practice patterns in Connecticut were similar to the rest of the nation, \$4,724,976 would not have been expended by Medicare.

The following table depicts by procedure code the carrier allowed dollars per 1,000 enrollees, nationally allowed dollars per 1,000 enrollees, and what percent Connecticut's expenditure is of the national expenditure per code.

January–June 2001			
Procedure Code	Carrier Allowed \$ per 1,000 Enrollees	Nationally Allowed \$ per 1,000 Enrollees	Percent of Nation
92225	\$1,807	\$868	2.60
92226	\$4,063	\$1,759	2.89
92235	\$3,655	\$2,131	2.75
92250	\$2,654	\$1,206	2.12

A comprehensive data analysis has been conducted on these procedure codes. As a result, three widespread probes were recommended. The first and second probes are for the purpose of revising and/or enhancing the current local medical review policy (LMRP). The first widespread probe involves CPT codes 92225 and 92226; the second involves CPT code 92235. The third widespread probe recommended is for CPT 92250, for possible development of LMRP.

**CPT Code 92250 - Connecticut v. Nation  
Allowed \$ per 1,000 beneficiaries**



*Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2002 (or other such date of publication of CPT) American Medical Association. All rights reserved. Applicable FARS/DFARS apply.*

## LOCAL MEDICAL REVIEW POLICY (NEW)

### ZEVALIN: Ibritumomab Tiuxetan (Zevalin™) Therapy

#### New Policy

Ibritumomab Tiuxetan (Zevalin™), as part of a specific therapeutic regimen, was FDA approved on February 19, 2002, for treatment of patients with relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with Rituximab (Rituxan®) refractory follicular non-Hodgkin's lymphoma. The regime includes Rituximab, In-111 Zevalin, and Y-90 Zevalin. Ibritumomab Tiuxetan (Zevalin™) therapy is a two-step process, which includes both a diagnostic and therapeutic portion. Zevalin is a radiolabeled monoclonal antibody that targets the CD20 antigen, which is found on the surface of normal and malignant B-lymphocytes. Its mechanism of action is twofold: when Zevalin binds to malignant cells, it activates a direct immune response, while the attached radioactive isotope emits radiation to the cell.

The therapy begins with the administration of Rituximab (Rituxan®), J9310, followed by the administration of one dose of Zevalin, a monoclonal antibody that is linked to the radioisotope, indium-111 (In-111 Zevalin). Imaging studies are then performed within 2-24 hours post infusion to assess the biodistribution of the In-111 Zevalin. Assessment of biodistribution may involve a second scan performed 48-72 hours after the initial infusion of In-111 Zevalin. In some rare instances, a third scan may be required which should be performed

90-120 hours after the initial infusion. If the biodistribution is not acceptable, then the therapy is stopped.

If biodistribution is acceptable, another infusion of Rituximab is administered once during days 7-9. Within 4 hours of this infusion, Zevalin linked to the radioisotope yttrium-90 (Y-90 Zevalin) is administered.

Ibritumomab Tiuxetan (Zevalin™) therapy is intended and considered a single course treatment regime. The efficacy, safety, and toxicity of multiple courses of the therapy have not been established and more than one course of treatment is considered not reasonable and necessary. In addition, doses of Y-90 Zevalin greater than 32 mCi are considered excessive and are, therefore, not medically necessary. This therapy is contraindicated in patients with platelet counts  $<100,000/\text{mm}^3$ .

We have received numerous inquiries regarding the appropriate procedure codes to use when billing for these services. For services performed on or after January 1, 2003, new codes have been assigned. These codes, as well as interim instructions, are addressed in a new local medical review policy (LMRP), which is effective for services rendered on or after February 19, 2002, processed on or after June 30, 2003. The full-text LMRP is available on our provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

### J1440: G-CSF (Filgrastim, Neupogen®)

#### New Policy

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

The full-text local medical review policy for Filgrastim, effective for claims processed on or after June 30, 2003, is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

### J3490: Pegfilgrastim (Neulasta™)

#### New Policy

Pegfilgrastim (Neulasta™) is a Colony Stimulating Factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby stimulating proliferation, differentiation, commitment, and end cell functional activation. This drug was Food and Drug Administration (FDA) on January 31, 2002, to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia. Current Medicare coverage is for the FDA-approved indication only. The drug is billed using the unclassified drug code J3490 and requires a dual diagnosis. An ICD-9-CM code from both List I and List II is required.

#### List I

140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin and breast
179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites

200.00-202.88	Malignant neoplasm of lymphatic and hematopoietic tissue
203.00-203.81	Multiple myeloma and immunoproliferative neoplasms
204.00-204.81	Lymphoid leukemia
273.3	Waldenström's macroglobulinemia

**List II**

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

This new local medical review policy (LMRP) is effective for services rendered on or after January 31, 2002, processed on or after June 30, 2003. The full-text LMRP is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

**88230: Cytogenetic Studies***New Policy*

Cytogenetics is the study of chromosomes by light microscopy. Cytogenetic testing is used to study an individual's chromosome makeup. The term karyotyping refers to the arrangement of cell chromosomes in order from the largest to the smallest to analyze their number and structure. Cytogenetic testing involves the determination of chromosome number and structure; variations in either can produce numerous abnormalities. With cytogenetic testing, the total chromosome count is determined first, followed by the sex chromosome complement and then by any abnormalities. A normal karyotype of chromosomes consists of a pattern of 22

pairs of autosomal chromosomes and a pair of sex hormones; XY for the male, and XX for the female. A plus (+) or minus (-) sign indicates, respectively, a gain or loss of chromosomal material.

Medicare coverage of cytogenetic studies (88230-88299) has been determined by the Centers for Medicare & Medicaid Services (CMS) and is outlined in the Coverage Issues Manual, Section 50-29.

This new local medical review policy (LMRP) is effective for services processed on or after June 30, 2003. The full-text LMRP is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

**LOCAL MEDICAL REVIEW POLICY (REVISED)****A0425: Ground Ambulance Services***Revised Policy*

The Medicare program includes an ambulance benefit, which can be provided by a free standing ambulance supplier or a participating Part A provider. Three basic requirements must be met for ambulance services to be covered:

1. the ambulance and crew must meet specific requirements;
2. the transportation must be medically reasonable and necessary; and
3. the origin and destination requirement must be met.

The coding and definition of these services has evolved over the past two years, with new HCPCS codes in 2001 and 2002. In addition, CMS implemented the new ambulance fee schedule payment methodology on April 1, 2002. Based on these changes, local medical review policy (LMRP) was revised to further define and provide clarification on coverage for transportation by an ambulance, including air transport, effective for services processed on or after January 24, 2003.

The full-text LMRP is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

**J2430: Pamidronate (Aredia®, APD)**

(formerly 96LMRP017 - V1.2: Aredia® [pamidronate disodium] 30 mg)  
*Revised Policy*

The local medical review policy (LMRP) for Aredia® has been revised, effective for claims processed on or after April 14, 2003.

- The title and policy number have been changed to Pamidronate (Aredia®, APD) - J2430.
- The policy has been reformatted to comply with the latest template specified by CMS.
- Diagnosis code V10.3 (personal history of malignant neoplasm; breast) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.
- Pamidronate is FDA-approved as an adjunct treatment of osteolytic lesions of breast cancer and myeloma.

**Please note that the billing of Pamidronate for metastatic breast cancer requires a dual diagnosis.** To ensure reimbursement for this indication, dual diagnoses must be submitted. The primary site or personal history (V10.3) and secondary site of the malignancy must both be billed to indicate that the breast malignancy is metastatic (i.e., both ICD-9-CM codes 198.5 and 174.0-175.9 or V10.3 must be billed).

The full-text LMRP is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

## 97001: Physical Medicine and Rehabilitation

### Revised Policy

The local medical review policy (LMRP) for physical medicine and rehabilitation was published in the May 1995 Provider Newsletter. Changes have been made to this LMRP based on recent CMS Program Memoranda (PM), effective for services performed on or after April 1, 2003:

- Changes have been made to reflect the coverage and billing requirements for electrical stimulation for the treatment of wounds (PM AB-02-161, CR 2313).
- Changes have been made to reflect the coverage requirements for neuromuscular electrical stimulation (NMES) to enhance walking for Spinal Cord Injury (SCI) patients (PM AB-02-156, CR 2314).

The full-text LMRP may be found on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

## 97802: Medical Nutrition Therapy (MNT)

### Revised Policy

The local medical review policy (LMRP) for MNT was published in the Fourth Quarter 2002 *Medicare B Update!* Since that time, CMS issued Program Memorandum AB-02-151 dated October 25, 2002, which added verbiage for clarification of the differences between the MNT benefit and the Diabetes Outpatient Self-Management Training benefit.

The full-text LMRP for MNT is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

## 98041 V1.1 FINAL: Mammography

### Revised Policy

The local medical review policy (LMRP) for mammography was published in the August 1998 Medicare Provider Newsletter. Since then, CMS issued Transmittal 1775, Change Request 2332, which required changes be made to the mammography LMRP. These changes are reflected in the coverage guidelines and in new CPT and HCPCS codes for both screening and diagnostic mammography.

In addition, the policy number is being changed to 76090. The revised LMRP is effective for services performed on or after April 1, 2003.

The full-text LMRP is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

## 99183: Hyperbaric Oxygen Therapy (HBO Therapy)

### Revised Policy

Effective April 1, 2003, a national coverage decision expanded the use of HBO therapy to include coverage for treatment of diabetic wounds of the lower extremities, and clarified the special supervision and credentialing requirements for physicians who perform this service. Local medical review policy (LMRP) has been revised to reflect these changes effective for services rendered on or after April 1, 2003.

The full-text LMRP is available on the provider education Web site [www.connecticutmedicare.com](http://www.connecticutmedicare.com).

## LOCAL MEDICAL REVIEW POLICY (RETIRED)

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

Indications and limitations for these services are included in the administrated policies for the Negotiated Rulemaking for Clinical Diagnostic Laboratory Services, published in the *Federal Register* on November 23, 2001. These national coverage decisions (NCDs) replace local medical review policy (LMRP) in place at the local carriers, effective for services rendered on or after November 25, 2002. As a result, the LMRPs listed below have been retired.

97032 V1.1	Blood Counts
97026 V1.0 - Final	Glycated Hemoglobin/Glycated Protein
94LMRP003 V1.3	Prostate Specific Antigen (PSA) Testing
97033 - V1.0 FINAL	Serum Iron Studies (Iron, Total Iron Binding Capacity [TIBC], Transferrin, Ferritin)
97025 V1.0 Final	Thyroid Testing Including TSH
94LMRP002 V1.3	Tumor Antigens (Tumor Markers)

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

### Clarification on Certain Pathology Codes

We have become aware of issues impacting adjudication of Part B claims billed with certain pathology codes. The following is a brief description of the issues and the corrective action we are taking:

- A National Coverage Determination (NCD) policy for certain pathology codes was implemented nationally effective 11/25/2002. With the implementation of the NCD policy, certain LMRPs were retired. In addition to retirement of the LMRP, any local policy system editing (i.e., procedure-to-diagnosis and utilization screens) was also discontinued.
- The LMRPs on nine procedure codes were discontinued effective November 25, 2002. However, the procedure-to-diagnosis edit associated with these codes was not removed from the system. Therefore, system logic was inappropriately applying automated rules for certain codes, and caused inappropriate denial. The applicable procedures are: 85009, 84437, 84480, 84481, 84482, 83719, 84703, 86294, and 82274.
- This situation has been corrected and claims for 85009, 84437, 84480, 84481, 84482, 83719, 84703, 86294, and 82274 are now adjudicating appropriately. In addition, a mass claims adjustment will be performed within the next 45-60 days to reprocess the claims denied in error. **Therefore, it is not necessary to resubmit claims for payment.**

If you have any further questions or issues after the mass adjustments occur, please contact our provider call center at 1-866-419-9455.

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## Retirement of Local Medical Review Policies for Evaluation and Management Services

CMS has established national criteria for evaluation and management (E/M) services. Therefore, effective February 14, 2003, the following policies are being retired because they are related to E/M procedures and diagnoses:

- 92002: Evaluation and Management Services in Ophthalmology and Optometry
- 92004: Initial Evaluation of Glaucoma Patient
- 98039 V1.0 Final: Co-management of Surgical Procedures

# CONNECTICUT EDUCATIONAL RESOURCES

## Form CMS-1500 Claim Filing Requirements

As a result of our recent transition to the Multi-Carrier System (MCS), it is more important than ever that claims be completed correctly to avoid unprocessable claims. We are seeing many claims returned to providers for invalid or missing information. The Connecticut Medicare Education and Outreach Team has designed the following listing of required or conditional information for items 1-33 on Form CMS-1500. Comprehensive details were published in the Fourth Quarter 2002 *Medicare B Update!* (pages 6-11). More information is also available in the Medicare Carriers Manual reference at the end of this article.

We are providing this information as tool to help billing specialists complete their claims accurately. If you have any questions regarding this tool, or would like to offer your comments, you may call the Provider Customer Service department toll-free at 1-866-419-9455.

<b>Item 1</b>	Enter the type of health insurance coverage applicable to the claim by checking the appropriate box (e.g., <b>if a Medicare claim is being filed, check the Medicare box</b> ).
<b>Item 1a</b>	The patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.
<b>Item 2</b>	The patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.
<b>Item 3</b>	The patient's 8-digit birth date (MMDDCCYY) and sex.
<b>Item 4</b>	If the patient has insurance primary to Medicare, either through the patient or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. <b>If Medicare is primary, leave blank.</b>
<b>Item 5</b>	The patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.
<b>Item 6</b>	The patient's relationship to insured when item 4 is completed.
<b>Item 7</b>	The insured's address and telephone number. When the address is the same as the patient's, use the word SAME. <b>Complete only when items 4 and 11 are completed.</b>
<b>Item 8</b>	The patient's marital status and whether employed or a student.
<b>Item 9</b>	The last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, use the word SAME. If no Medigap benefits are assigned, leave blank. ( <b>Note:</b> <i>only</i> participating physicians and suppliers are to complete item 9 and its subdivisions and <i>only</i> when the patient wishes to assign his/her benefits under a Medigap policy to the participating physician or supplier.)
<b>Item 9a</b>	The policy and/or group number of the Medigap insured preceded by <b>MEDIGAP, MG or MGAP</b> .
<b>Item 9b</b>	The Medigap insured's 8-digit birth date (MMDDCCYY) and sex.
<b>Item 9c</b>	Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer is shown. Use an abbreviated street address, two letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card.
<b>Item 9d</b>	The 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exist, then the Medigap insurance program or plan name is shown.
<b>Item 10a-10c</b>	<b>Check "YES" or "NO" to indicate whether employment, auto liability, or other</b> accident involvement applies to one or more of the services described in item 24. The State postal code must be shown. Any item checked "YES," indicates there may be other insurance primary to Medicare. Primary insurance information must then be showN in item 11.
<b>Item 10d</b>	Use exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, item 10d must show the patient's Medicaid number preceded by <b>MCD</b> .

<b>Item 11</b>	<p>The word <b>NONE</b> if no insurance primary to Medicare. <b><i>This item must be completed.</i></b> <i>By completing this item, the physician/supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer.</i></p> <p>If there is insurance primary to Medicare, enter the insured's policy or group number and then proceed to <b>items 11a – 11c</b>. Must also complete items 4, 6, and 7.</p> <p><b>Note:</b> The appropriate information in item 11c is shown if insurance primary to Medicare is indicated in item 11. If there is no insurance primary to Medicare, the word "NONE" is used and then proceed to item 12.</p> <p><b>Note:</b> For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payers explanation of benefits (EOB) notice must be forwarded with the claim.</p>
<b>Item 11d</b>	Leave blank. Not required by Medicare.
<b>Item 12</b>	<p>The patient or authorized representative must sign and enter either 6-digit date (MMDDYY), 8-digit date (MMDDCCYY), or an alphanumeric date (e.g., January 1, 1998) unless the signature is on file.</p> <p><b>Note:</b> the patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider or supplier accepts assignment on the claim.</p>
<b>Item 13</b>	Signature authorizes payment of mandated Medigap benefits to the participating physician/supplier if required Medigap information is included in item 9 and its subdivisions.
<b>Item 14</b>	The patient's 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date of current illness, injury, or pregnancy. For chiropractic services, enter either a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date of initial treatment or exacerbation of the existing condition.
<b>Item 15</b>	Leave blank. Not required by Medicare.
<b>Item 16</b>	The patient is employed and is unable to work in current occupation; a 6-digit (MMDDYY) OR 8-digit (MMDDCCYY) date must be shown when a patient is unable to work. An entry in this field may indicate employment related insurance coverage.
<b>Item 17</b>	The name of the referring or ordering physician must be shown if the service or item was ordered or referred by a physician. (Mandatory for diagnostic laboratory, diagnostic radiology, consultative services, and durable medical equipment).
<b>Item 17 a</b>	Referring physician's UPIN (mandatory for diagnostic laboratory, diagnostic radiology, consultative services and durable medical equipment).
<b>Item 18</b>	The 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
<b>Item 19</b>	<p>The 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file.</p> <p>The drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs. A concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise an attachment must be submitted with the claim.</p> <p>All applicable modifiers when modifier 99 (multiple modifiers) is entered in item 24d. If modifier 99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a 99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.</p> <p>Any narrative comments.</p>
<b>Item 20</b>	This item is completed when billing for diagnostic tests subject to purchase price limitations. The purchase price under charges must be shown if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates, "No purchased tests are included on the claim." <b>When "yes" is annotated, item 32 must be completed. When billing for purchased diagnostic tests, each test must be submitted on a separate claim form.</b>
<b>Item 21</b>	The patient's diagnosis/condition. Must use an ICD-9-CM code number, and code to the highest level of specificity.
<b>Item 22</b>	Leave blank. Not required by Medicare.

<b>Item 23</b>	<p>The 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.</p> <p>The investigational device exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.</p> <p>For care plan oversight services the 6-digit Medicare provider number of the home health agency (HHA) or hospice.</p>
<b>Item 24a</b>	The 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service or supply. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column C. Different months cannot be billed on the same line.
<b>Item 24b</b>	The appropriate <b>2-digit</b> place of service code is mandatory.
<b>Item 24c</b>	Type of service (entered by the carrier).
<b>Item 24d</b>	<p>The procedures, services, or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.</p> <p>The specific procedure code must be shown without a narrative description. However, when reporting an “unlisted procedure code” or a NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.</p>
<b>Item 24e</b>	The diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Only one reference number per line item. When multiple services are performed, the primary reference number for each service; either a 1, or a 2, or a 3, or a 4 is shown.
<b>Item 24f</b>	The charge for each listed service (charges are mandatory).
<b>Item 24g</b>	The days or units are mandatory if more than 1. Anesthesia services require total number of minutes.
<b>Item 24h-24j</b>	Leave blank. Not required by Medicare.
<b>Item 24k</b>	The PIN of the performing provider of service or supplier if he/she is a member of a group/clinic.
<b>Item 25</b>	The provider of service or supplier’s Federal Tax I.D. (employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax I.D. number is required for mandated Medigap transfer.
<b>Item 26</b>	The patient’s account number assigned by the provider of service or suppliers accounting system (optional).
<b>Item 27</b>	Provider or supplier accepts assignment of Medicare benefits, “Yes” or “No” must be checked this is mandatory. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier must also be a Medicare participating provider of service or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.
<b>Item 28</b>	The total charges for the services (i.e., the total of all charges in item 24f) is mandatory.
<b>Item 29</b>	Total amount the patient paid on the covered services only.
<b>Item 30</b>	Leave blank. Not required by Medicare.
<b>Item 31</b>	The signature of the practitioner or supplier, or his/her representative, and either the 6-digit date (MMDDYY), 8-digit (MMDDCCYY), or alphanumeric date (e.g., January 1, 1998 ) the form was signed.
<b>Item 32</b>	The name, address and ZIP code of the facility if the services were furnished other than the patient’s home or physicians office. Providers of service must identify the supplier’s name, address, ZIP code and PIN when billing for purchased diagnostic tests. If the supplier is a certified mammography screening center, the supplier must enter the 6-digit FDA-approved certification number.
<b>Item 33</b>	The practitioner’s/suppliers billing name, address, ZIP code, and telephone number. The PIN for the performing provider of service or supplier who is not a member of a group practice. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field. Providers who are in a group/clinic practice use their five-digit group/clinic number prefixed with a C.

Source: MCM section 4020, “Review of the Health Insurance Claim Form – CMS 1500”

# FLORIDA MEDICAL REVIEW

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

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs on our provider education Web site, [www.floridamedicare.com](http://www.floridamedicare.com). Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP comment/response summaries may be printed from the Part B Medical Policy section.

### Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date claims are *processed*, not the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs; the date the LMRP is posted to the Web site is considered the notice date.

### Electronic Notification

To receive quick, automatic notification when new and revised LMRPs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, [www.floridamedicare.com](http://www.floridamedicare.com); click on the yellow "Join our electronic mailing list" bar and follow the prompts.

### More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP, contact Medical Policy at:

Medical Policy  
 First Coast Service Options, Inc.  
 P.O. Box 2078  
 Jacksonville, FL 32231-0048  
 1-904-791-8465

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## Advance Notice Statement

**A**dvançe Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 6 for details concerning ABNs.

## Proper Billing for Correction of Trichiasis—Clarification

We have a clarification regarding the proper billing for correction of trichiasis as outlined in the American Medical Association's (AMA) *Current Procedural Terminology (CPT)* manual and *CPT Assistant*. The procedure codes are:

67820 Correction of trichiasis; epililation, by forceps only (revise eyelashes)  
67825 epililation, by other than forceps (eg, by electrosurgery, cryotherapy, laser surgery)

Medicare reimbursement is on a per-procedure basis, regardless of the number of eyelashes or eyelids from either eye (RT/LT) involved during the performance of that procedure (i.e., these procedures **should not be billed with more than one in the "days or units" field** – item 24G on Form CMS-1500 or its electronic equivalent). Proper use of these codes as defined by the AMA was published in the *CPT Assistant* Volume 8, Issue 7, July 1998. That issue contained a question and answer article regarding coding of these procedures. Please refer to those coding guidelines when billing for these services.

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## Proper Reporting of Electrocardiac Mapping System

The PRIME ECG electrocardiac mapping system is a computer-based diagnostic instrument that simultaneously measures and records electrical activity from the heart at 80 locations on the body surface. The services provided by this system do not represent the services involved in performing myocardial perfusion imaging; therefore, these services should *not* be billed under CPT code 78465. Currently, a unique CPT code to describe this service does not exist. Claims for this service should be billed using CPT code 93799 (unlisted cardiovascular service or procedure). Documentation should be included with the claims consisting of: history and physical, office notes, progress notes, and test results.

## Ptosis/Blepharoplasty Procedures

Many providers have recently begun to bill for ptosis/blepharoplasty procedures through electronic media claims (EMC) submission. Because a 100% prepayment review edit has been in place, claims have been denied for no documentation being submitted for medical review.

Based on feedback received from the provider community, we have re-evaluated prepayment review of these procedures. Since the majority of these services are allowed once the appropriate documentation is submitted, we have removed the 100% prepayment review parameter for these services, effective Monday, March 31, 2003. These services can now be billed electronically *without* submitting medical records.

Utilization of these services will be monitored through the contractor's ongoing data analysis process and medical review may occur on a postpayment basis, if warranted. Providers should ensure that services billed for these procedures meet the medical necessity requirements found in local medical review policy 67000: Upper Eyelid and Brow Surgical Procedures. Services performed that *do not* meet medical necessity requirements will be denied based on Medicare's exclusion of cosmetic procedures. Therefore, such services should be billed with modifier GY (item or service statutorily excluded or does not meet the definition of any Medicare benefit).

## Proper Reporting of Quantitative Sensory Testing

Quantitative sensory testing (QST) services provided by a pressure-specified sensory device do not represent the services involved in performing neuromuscular junction studies and; therefore, should not be billed under CPT code 95937. Currently, a unique CPT code to describe QST does not exist. Therefore, claims for this service should be billed using CPT code 95999 (unlisted neurological or neuromuscular diagnostic procedure). Documentation should be included with the claims consisting of: history and physical, office notes, progress notes, and test results.

## Self Administered Drugs (SAD) List

CMS issued instructions regarding Medicare payment for drugs and biologicals incident to a physician's service. Guidelines provide contractors a process for determining if an injectable drug is *usually self-administered* and therefore, not covered by Medicare. Providers may read the instructions in CMS Transmittals AB-02-072 (CR 2200) and AB-02-139 (CR 2311).

We are required to establish a SAD list on our provider education Web site, listing drugs that have been evaluated and determined to be usually self-administered. Currently, injectable drugs on the Florida Medicare Part B SAD list are as follows:

J0270	Alprostadil, 1.25 mcg
J1438	Etanercept, 25 mg (Enbrel®)
J1815	Insulin, 5 units (formerly J1820)
J1830	Interferon beta-1b, 0.25mg (Betaseron®)
J2940	Somatrem, 1mg
J2941	Somatropin, 1 mg
J3030	Sumatriptan succinate, 6mg (Imitrex®)
J3490	Kineret™, per 100mg
J3490	Ribef®
J9218	Leuprolide acetate, per 1 mg
Q2010	Compaxone® per 20 mg

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for changes affecting their practice. You may access the SAD list online at [www.floridamedicare.com](http://www.floridamedicare.com), in the Part B Medical Policy section.

# COMPREHENSIVE DATA ANALYSIS

## Myocardial Perfusion Studies

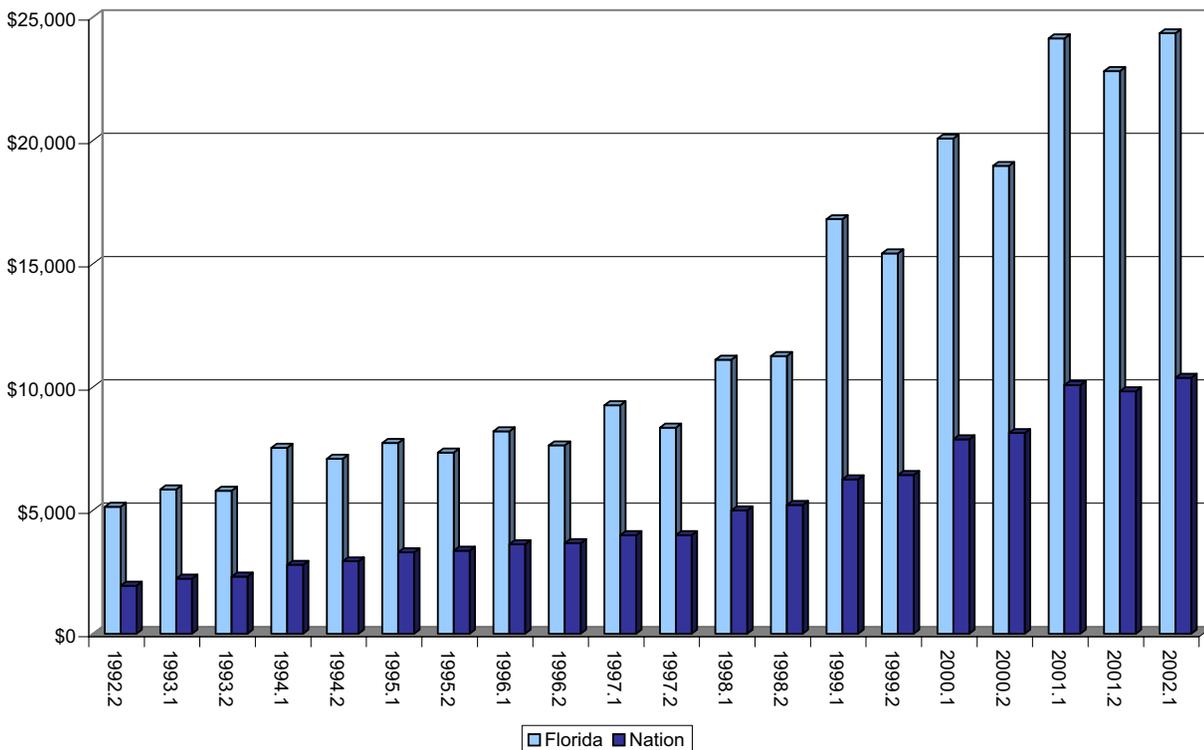
The Statistical Medical Data Analysis department conducted an analysis of CPT codes 78465, 78478, and 78480 as part of the follow-up process on a focused medical review study from fiscal year 1998. As a result of the analysis a widespread probe was recommended for the following procedure codes:

- 78465 *Myocardial perfusion imaging; tomographic (SPECT), single study at rest or stress with or without quantification*
- 78478 *Myocardial perfusion study with wall motion, qualitative or quantitative study*
- 78480 *Myocardial perfusion study with ejection fraction*

The data revealed that Florida expended \$24,139 per 1,000 enrollees, opposed to the national expenditure of \$10,081 per 1,000 enrollees. Additionally, Florida represents 15.36% of the nation in terms of dollars. If practice patterns in Florida were similar to the rest of the nation, \$27,408,739 would not have been expended by Medicare. A drill-down of the data also suggests that repeat myocardial perfusion studies are frequent; however, medical necessity of the repeat studies is often unclear.

A widespread probe has been recommended as a result of these findings. The purposes of the review are to determine if services billed to Medicare were documented as having been performed, and to determine the medical necessity of initial and repeat myocardial perfusion imaging studies. A recommendation was also made to utilize the information found in the widespread probe for the purpose of policy enhancement.

**CPT Code 78465 - Florida v. Nation  
Allowed \$ per 1,000 beneficiaries**



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### Laboratory Procedures

The Statistical Medical Data Analysis department identified the following codes as being aberrant when compared to the rest of the nation for fiscal year 2003:

- 80053 *Comprehensive metabolic panel*
- 80076 *Hepatic function panel*
- 82248 *Bilirubin; direct*
- 84295 *Sodium, serum*

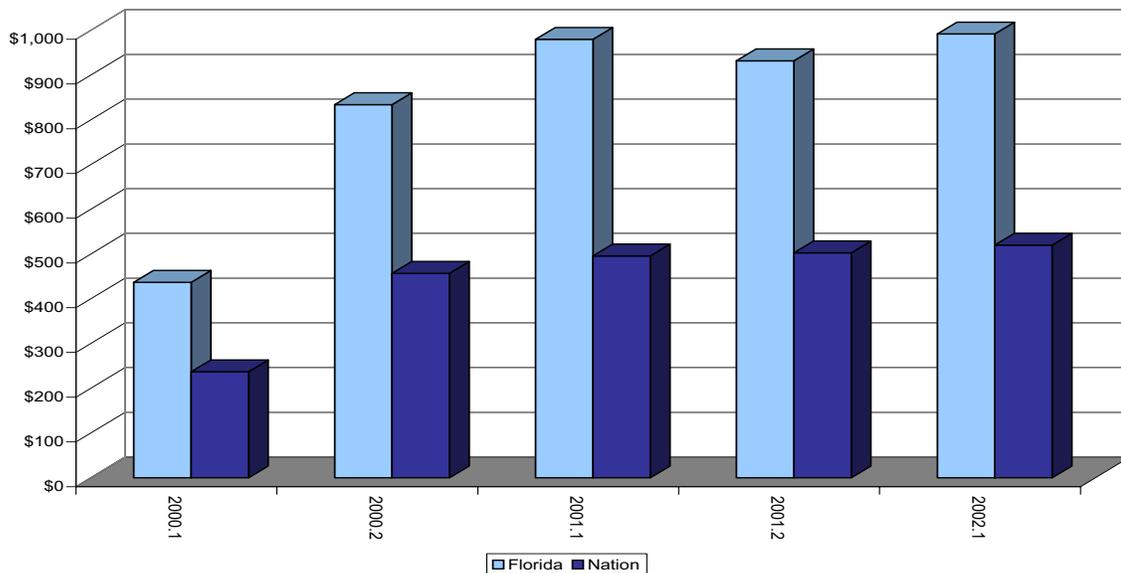
The following table depicts by procedure code the carrier allowed dollars per 1,000 enrollees, nationally allowed dollars per 1,000 enrollees, and the percent of the nation that Florida represents.

July 2001 – December 2001			
Procedure Code	Carrier Allowed \$ per 1,000 Enrollees	Nation Allowed \$ per 1,000 Enrollees	Percent of Nation
80053	\$4,172	\$2,758	9.70
80076	\$932	\$503	11.88
82248	\$160	\$54	19.05
84295	\$174	\$37	30.42

A comprehensive data analysis was conducted on these procedure codes. Data reveals the top three diagnoses for hepatic panel were ICD-9-CM codes 272.4, 272.0, and 272.2, which are disorders of lipid metabolism. We would not expect a hepatic panel (80076) to be billed for patients with a diagnosis of hyperlipidemia/hypercholesterolemia in the absence of medication management. We would expect patients on drug therapy for hyperlipidemia/hypercholesterolemia to be monitored every 6 to 12 months (after medication is established). As a result of the analysis, a widespread probe was recommended for procedure code 80076. The purpose of the widespread probe is to determine if hepatic panels are being billed for beneficiaries with the diagnosis of hyperlipidemia/hypercholesterolemia that are not being managed with medication and to identify the appropriateness of said situation.

A secondary finding was the majority of claims were submitted with no modifier, which was expected. However, the second most frequent modifier submitted was “GA,” indicating the provider anticipated denial of the claim. Several articles have been published regarding advance notice requirement and the use of the GA modifier. Please refer to the article entitled “Advance Notice Requirements” on page 5 for more information on use of the GA modifier.

**CPT Code 80076 - Florida v. Nation  
Allowed \$ per 1,000 beneficiaries**



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## 88311: Article Clarification

An article pertaining to Comprehensive Data Analysis Findings on Pathology Codes was published in the Third Quarter 2002 *Medicare B Update!* (page 60). In response to this article, pathology providers offered comments and clarification.

The American Medical Association, the entity considered responsible for providing interpretation of the *CPT* codes, defines the unit of service for the special stains codes as follows:

The specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. The special stain codes should therefore be reported per stain, per specimen as it is defined above regardless of the number of blocks cut or slides stained.

For example, if one special stain were used on multiple blocks of the same specimen, the appropriate special stain code would be reported only once. If one specimen received three different special stains, the correct special staining code would be reported with three units.

## Pulmonary Function Tests

Pulmonary function tests are procedures that measure the function of the lungs, revealing problems in the way a patient breathes. These tests can determine the cause of shortness of breath, and may help confirm lung diseases, such as asthma, bronchitis or emphysema. The tests may be performed before any major surgery to determine if reduced lung capacity will be harmful to the patient.

The Statistical Medical Data Analysis department has identified the following codes as being aberrant when compared to billing patterns in the rest of the nation:

- 94240 *Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method*
- 94260 *Thoracic gas volume*
- 94360 *Determination of resistance to airflow, oscillatory or plethysmographic method*
- 94370 *Determination of airway closing volume, single breath test*
- 94620 *Pulmonary stress testing; simple*
- 94720 *Carbon monoxide diffusing capacity, any method*
- 94725 *Membrane diffusion capacity*
- 94750 *Pulmonary compliance study*

If practice patterns in Florida were similar to the rest of the nation, \$5,468,530 would not have been expended by Medicare.

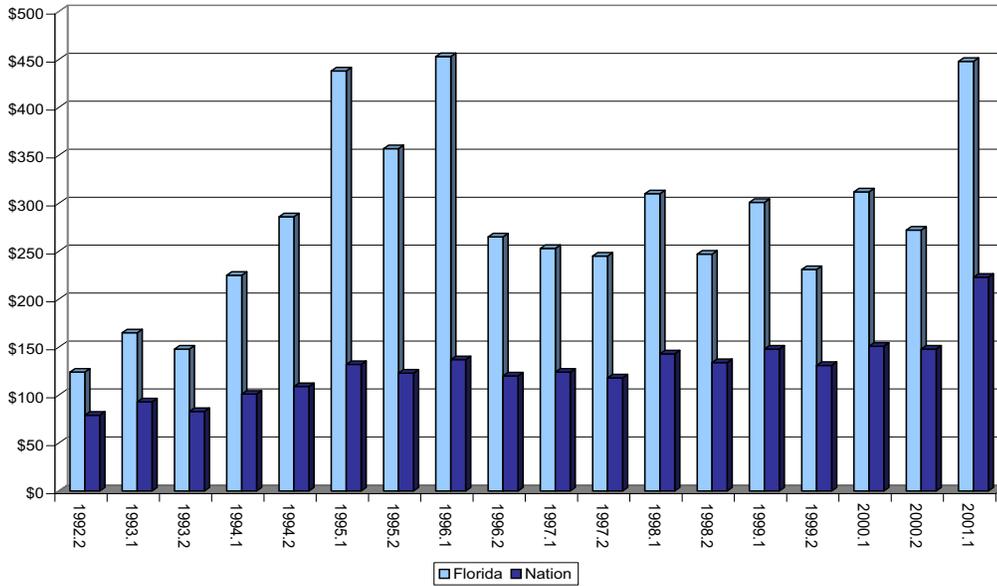
The following table depicts by procedure code the carrier allowed dollars per 1,000 beneficiaries, nationally allowed dollars per 1,000 beneficiaries, and what percent Florida's expenditure is of the national expenditure per code.

January – June 2001			
Procedure Code	Carrier Allowed \$ per 1,000 Enrollees	Nationally Allowed \$ per 1,000 Enrollees	Percent of Nation
94240	\$448	\$223	47.80
94260	\$67	\$29	14.62
94360	\$116	\$47	15.85
94370	\$118	\$22	35.13
94620	\$101	\$57	11.49
94720	\$560	\$360	11.73
94725	\$31	\$5	39.25
94750	\$282	\$28	65.10

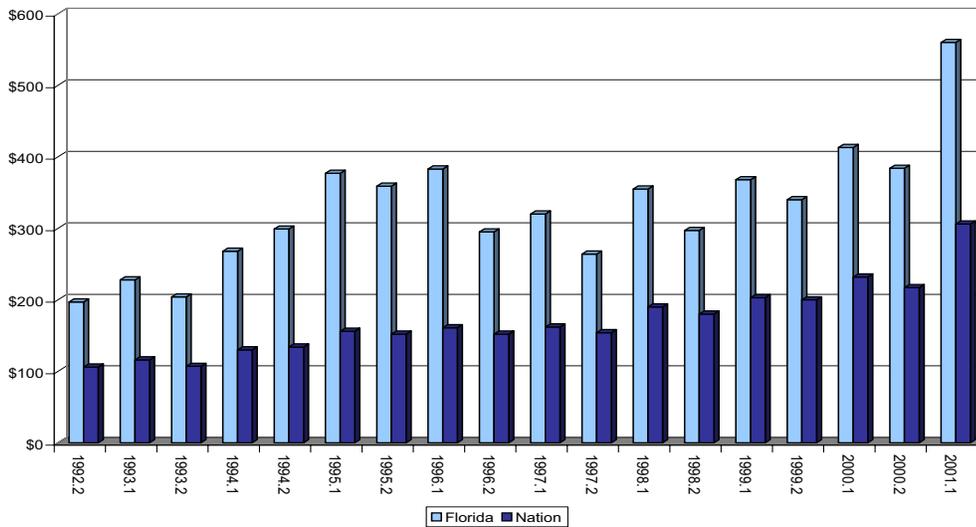
A comprehensive data analysis was conducted on the codes listed above. As a result of the analysis two widespread probes were recommended. The purpose of the widespread probes will be to determine if services billed to Medicare were documented as having been performed, if the services were coded correctly, to determine the medical necessity of those services, and to develop and/or enhance local medical review policy as necessary.

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**CPT Code 94240 - Florida v. Nation  
Allowed \$ per 1,000 beneficiaries**



**CPT Code 94720 - Florida v. Nation  
Allowed \$ per 1,000 beneficiaries**



## 99341-99350: New and Established Physician Home Visit Services to Undergo Widespread Probe of Multiple Providers in Florida

The Statistical and Medical Data Analysis Department conducted an in depth analysis of all nine codes in this family of evaluation and management (E/M) services in early 2002. These services were selected for review because their utilization in Florida had steadily increased over the course of multiple years. The carrier allowed dollars and the percent Florida was of the nation in expended dollars continued to rise.

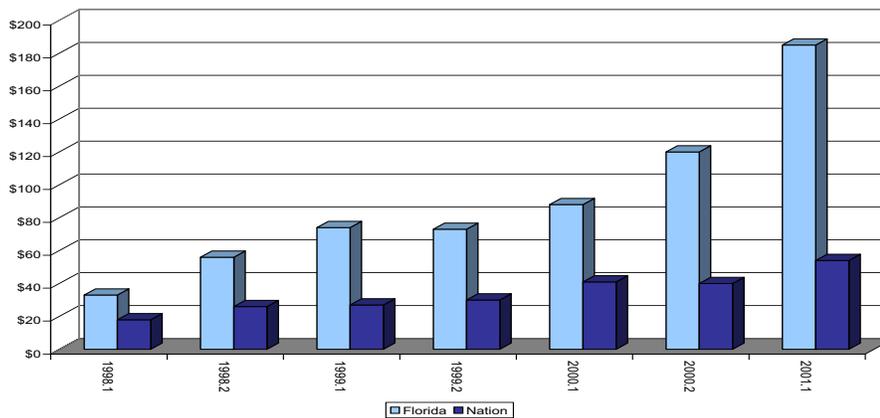
Data reveals that Florida Medicare expended more than \$3,652 per 1,000 beneficiaries, whereas the national expenditure was \$2,011 per 1,000 beneficiaries for the E/M services in this analysis. Approximately \$3.1 million would not have been expended in Florida if medical practice patterns in this state had followed the same patterns as seen across the nation.

As a result of this analysis, both provider-specific probes and a widespread probe were recommended as necessary corrective actions. The provider-specific probes looked at the need for multiple home visits over a six-month period on the same beneficiary, with associated invasive procedures and multiple questionable diagnoses. The widespread probe is directed toward:

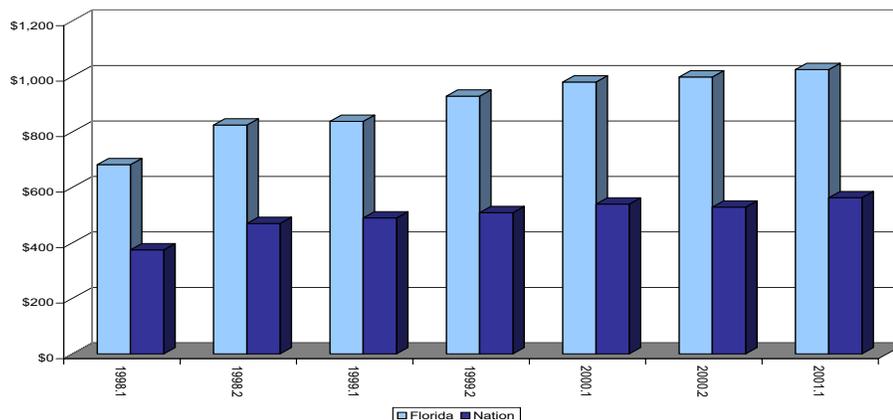
- determining if services billed to Medicare were documented as having been performed
- determining if services were coded correctly
- determining the medical necessity of the services
- identifying the various courses of treatment being used by our provider population
- development of a local medical review policy that provides a clear picture of these services

The widespread probe will be divided between providers' billing for new visit codes and established visit codes, to ascertain how and why these services are being performed. We will also be looking at the use of concurrent invasive procedures and the need for multiple repeat procedures, most significantly with beneficiaries who are seeing a second physician in an office setting.

**CPT Code 99344 - Florida v. Nation**  
Allowed \$ per 1,000 beneficiaries



**CPT Code 99348 - Florida v. Nation**  
Allowed \$ per 1,000 beneficiaries



## LOCAL MEDICAL REVIEW POLICY (NEW)

### A0434: Specialty Care Transport

#### *New Policy*

Specialty care transport (SCT), procedure code A0434, is a hospital-to-hospital transport of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies or services, at a level beyond the scope of the Emergency Medical Technician-Paramedic. Since inception of this level of transport in January 2001, all Florida Medicare claims for this service have suspended for prepayment medical review. In keeping with our long-term goal of

eliminating prepayment medical review for all ground ambulance services, local medical review policy (LMRP) was developed to communicate the requirements for SCT, and to identify the indications and limitations of coverage. This policy is effective for services processed on or after June 30, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

### J0640: Leucovorin (Wellcovorin®)

#### *New Policy*

Leucovorin (Wellcovorin®) is a reduced form of folic acid, which is readily converted to other reduced folic acid derivatives. It is used as an antidote, antianemic and as a chemotherapeutic adjunct. Florida Medicare will consider Leucovorin medically reasonable and necessary when used for any of the following FDA-approved indications:

- as an antidote for the toxic affects of the folic acid antagonists such as methotrexate, pyrimethamine, or trimethoprim;
- as a rescue agent after high-dose methotrexate therapy;
- as an adjunct to fluorouracil in the palliative treatment of advanced colorectal cancer; *and*
- as a treatment for megaloblastic anemias associated with sprue, nutritional deficiency, pregnancy, and infancy when oral folic acid therapy is not feasible.

**Note:** Leucovorin is not recommended for use in the treatment of pernicious anemia or other megaloblastic anemias secondary to lack of Vitamin B12, since it may produce hematologic remissions while neurologic manifestations continue to progress.

Florida Medicare will cover Leucovorin for the FDA-approved indications as well as for the treatment of the following off-labeled indications:

- Head and neck squamous cell carcinoma, when used in combination with agents such as fluorouracil or high-dose methotrexate
- Ewing's sarcoma when used in combination with high-dose methotrexate
- Non-Hodgkin's lymphoma when used in combination with high-dose methotrexate
- Gestational trophoblastic tumors when used in combination with high-dose methotrexate
- Breast carcinoma when used in combination with fluorouracil
- Gastric carcinoma when used in combination with fluorouracil
- Pancreatic carcinoma when used in combination with fluorouracil
- Bladder carcinoma when used in combination with fluorouracil
- Prostate carcinoma when used in combination with fluorouracil
- Ovarian carcinoma when used in combination with fluorouracil
- Cervical carcinoma when used in combination with fluorouracil
- Endometrial carcinoma when used in combination with fluorouracil
- Malignant neoplasm of the small intestine
- Esophageal carcinoma when used in combination with fluorouracil
- Liver carcinoma when used in combination with fluorouracil
- Gallbladder and extrahepatic bile duct carcinoma when used in combination with fluorouracil
- Cancer of unknown primary site (CUPs)
- Adrenal cortex carcinoma when used in combination with fluorouracil
- Vulvar carcinoma when used in combination with fluorouracil
- Penile carcinoma when used in combination with fluorouracil

Leucovorin is used as an antineoplastic agent as well as an antidote and an antianemic and is administered in a variety of ways depending on the clinical situation. Therefore, the appropriate chemotherapy administration codes are to be used when this drug is being used as an antineoplastic therapy. Appropriate therapeutic infusion and injection codes are to be used when Leucovorin is being used as an antidote or an antianemic.

The full-text of this local medical review policy is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com), and is effective for services processed on or after June 30, 2003.

## J3490: Pegfilgrastim (Neulasta™)

### New Policy

Pegfilgrastim (Neulasta™) is a Colony Stimulating Factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby stimulating proliferation, differentiation, commitment, and end cell functional activation. This drug was approved by the Food and Drug Administration (FDA) on January 31, 2002, to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia. Current Medicare coverage is for the FDA-approved indication only. The drug is billed using code J3490 (Unclassified drugs) and requires a dual diagnosis. An ICD-9-CM diagnosis code from both List I and List II is required.

### List I

140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin and breast
179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites
200.00-202.88	Malignant neoplasm of lymphatic and hematopoietic tissue
203.00-203.81	Multiple myeloma and immunoproliferative neoplasms
204.00-204.81	Lymphoid leukemia
273.3	Waldenström's macroglobulinemia

### List II

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

This new local medical review policy (LMRP) is effective for services rendered on or after January 31, 2002, processed on or after June 30, 2003. The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## ZEVALIN: Ibritumomab Tiuxetan (Zevalin™) Therapy

### New Policy

Ibritumomab Tiuxetan (Zevalin™), as part of a specific therapeutic regimen, was FDA approved on February 19, 2002, for treatment of patients with relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with Rituximab (Rituxan®) refractory follicular non-Hodgkin's lymphoma. The regime includes Rituximab, In-111 Zevalin, and Y-90 Zevalin. Ibritumomab Tiuxetan (Zevalin™) therapy is a two-step process, which includes both a diagnostic and therapeutic portion. Zevalin is a radiolabeled monoclonal antibody that targets the CD20 antigen, which is found on the surface of normal and malignant B-lymphocytes. Its mechanism of action is twofold: when Zevalin binds to malignant cells, it activates a direct immune response, while the attached radioactive isotope emits radiation to the cell.

The therapy begins with the administration of Rituximab (Rituxan®), J9310, followed by the administration of one dose of Zevalin, a monoclonal antibody that is linked to the radioisotope, indium-111 (In-111 Zevalin). Imaging studies are then performed within 2-24 hours post infusion to assess the biodistribution of the In-111 Zevalin. Assessment of biodistribution may involve a second scan performed 48-72 hours after the initial infusion of In-111 Zevalin. In some rare instances, a third scan may be required which should be performed

90-120 hours after the initial infusion. If the biodistribution is not acceptable, then the therapy is stopped.

If biodistribution is acceptable, another infusion of Rituximab is administered once during days 7-9. Within 4 hours of this infusion, Zevalin linked to the radioisotope yttrium-90 (Y-90 Zevalin) is administered.

Ibritumomab Tiuxetan (Zevalin™) therapy is intended and considered a single course treatment regime. The efficacy, safety, and toxicity of multiple courses of the therapy have not been established and more than one course of treatment is considered not reasonable and necessary. In addition, doses of Y-90 Zevalin greater than 32 mCi are considered excessive and are, therefore, not medically necessary. This therapy is contraindicated in patients with platelet counts <100,000/mm<sup>3</sup>.

We have received numerous inquiries regarding the appropriate procedure codes to use when billing for these services. For services performed on or after January 1, 2003, new codes have been assigned. These codes, as well as interim instructions, are addressed in a new local medical review policy (LMRP), which is effective for services rendered on or after February 19, 2002, processed on or after June 30, 2003. The full-text LMRP is available on our provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 78300: Bone and/or Joint Imaging

### *New Policy*

Procedure code 78306 was chosen for comprehensive data analysis based on data from January 2000 through June 2000, which revealed a carrier-to-nation ratio of allowed dollars of 1.93 to 1. Based on the conclusion of the findings, the performance of this service was considered a widespread problem; therefore, a probe was conducted to determine the medical conditions for which the service was being performed. Using the results of the widespread probe a local medical review policy (LMRP) was developed to address the indications for coverage and define the criteria for performing the different bone scan techniques (e.g., limited versus whole body, three-phase study) to include bone scan codes 78300, 78305, 78315, and 78320. This policy is effective for services processed on or after June 30, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 96000: Comprehensive Motion Analysis

### *New Policy*

Comprehensive computer-based motion analysis is the quantification and evaluation of human motion, which includes measurement of muscle activity, joint motion and forces, and pressure under the feet during walking.

Motion analysis has been used to evaluate walking and other functional activities, primarily in children with neuromuscular disorders such as cerebral palsy or meningomyelocele. A dedicated facility-based motion analysis laboratory uses a computer-based analysis of videotaping and 3-D kinematics, tracking retro reflective markers along the body. Surface electromyography is used to identify information about the firing pattern of individual muscles during walking. Fine-wire electromyography is also used to assess the firing pattern of deep muscles. Plantar pressure and force plate devices are able to measure the pressure distribution on the foot and the direction of force, while walking and during stance phase. The entire gait laboratory analysis may take 2-3 hours.

This local medical review policy (LMRP) is effective for claims processed on or after June 30, 2003. The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 96920: Laser Treatment for Psoriasis

### *New Policy*

Psoriasis is a common chronic recurrent disease of the skin that is characterized by dry, well circumscribed, silvery, scaling papules and plaques of various sizes. The effective use of photochemotherapy (PUVA) and ultraviolet light therapy (UVB) used in the treatment of psoriasis is well documented in the medical literature. The 308-nanometer (nm) excimer laser uses a XeCl gas mixture to generate an ultraviolet laser light source of UVB radiation that can concentrate energy solely on a psoriasis plaque and avoid damage to surrounding healthy skin. This concentrated UVB allows for higher treating dosages of ultraviolet light than that using general UVB or PUVA. The 308-nm excimer laser has been shown to be an effective treatment in clearing plaque type psoriasis. The excimer laser is widely used in a variety of medical procedures and treatments, however, at this time only the Excimer Laser Phototherapy System, AL7000 developed by Acculase, Inc. has received approval from the Food and Drug Administration to be used for the treatment of psoriasis.

Procedure codes 96920, 96921, and 96922 represent the use of a laser for the treatment of psoriasis. These are new CPT codes for the year 2003. Local medical review policy (LMRP) is being developed to allow providers access to this new technology, and to provide indications, limitations, and provide utilization guidelines for this procedure. This policy is effective for services processed on or after June 30, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## LOCAL MEDICAL REVIEW POLICY (REVISED)

### A0425: Ground Ambulance Services

#### Revised Policy

The Medicare program includes an ambulance benefit, which can be provided by a free-standing ambulance supplier or a participating Part A provider. Three basic requirements must be met for ambulance services to be covered:

1. the ambulance and crew must meet specific requirements;
2. the transportation must be medically reasonable and necessary; and
3. the origin and destination requirement must be met.

The coding and definition of these services has evolved over the past two years, with new Healthcare Common Procedure Coding System (HCPCS) codes in 2001 and 2002. In addition, the Centers for Medicare & Medicaid Services (CMS) implemented the new ambulance fee schedule payment methodology on April 1, 2002. Based on these changes, local medical review policy (LMRP) was revised to further define and provide clarification on a basic life support (BLS) and advanced life support (ALS) assessment and intervention. Examples of BLS and ALS level of transport were also added to this policy. Services for specialty care transport, HCPCS code A0434, have been removed from this policy and further defined in a separate LMRP. The revisions to policy A0425 are effective June 30, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

### A0430: Air Ambulance Services

#### Revised Policy

The local medical review policy (LMRP) for air ambulance services has been revised to provide limitation for services rendered based on a standing order. In addition, language has been added to provide clarification for cancellations of air ambulance services due to death prior to transport, or aborted transport due to bad weather or circumstances beyond the pilot's control. This revision is effective January 24, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

### G0108: Diabetes Outpatient Self-Management Training (DSMT)

#### Revised Policy

The local medical review policy (LMRP) for DSMT was published in the Fourth Quarter 2001 *Medicare B Update!* Since that time, the Centers for Medicare & Medicaid Services (CMS) issued Program Memorandum (PM) AB-02-151 dated October 25, 2002, which added verbiage defining eligible providers and clarifying the differences between the DSMT benefit and the medical nutrition therapy benefit (LMRP 97802).

The full-text LMRPs are available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

### J0585: Botulinum Toxin Type A (Botox)

#### Revised Policy

When using Botulinum Toxin Type A (Botox) for the treatment of bilateral blepharospasm, CPT code 64612 may be billed once for each eye with the appropriate modifier. However, code 64612 is allowed at 150 percent when performed bilaterally. Effective for services processed on or after February 24, 2003, the coding guidelines section of the local medical review policy (LMRP) has been revised to reflect this information.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

### J0636: Vitamin D Analogs in Chronic Renal Disease

#### Revised Policy

The local medical review policy (LMRP) for Vitamin D Analogs in Chronic Renal Disease was published in the Third Quarter 2002 *Medicare B Update!* (pages 30-33). Policy verbiage related to "least costly alternative" has not become effective; therefore, the statement below has been added to the policy. Once CMS communicates the effective date of the "Least Costly Alternative Pricing for Vitamin D Analogs," the Florida carrier will implement this statement per CMS direction.

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).

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## J1440: (G-CSF) (Filgrastim, Neupogen)

### Revised Policy

This local medical review policy (LMRP) for filgrastim was published in the November/December 1999 *Medicare B Update!* Effective for services processed on or after April 7, 2003, the policy has been revised to include an additional indication. ICD-9-CM diagnosis code 238.7 (Myelodysplastic syndrome) has been added under the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## J9212: Interferon

### Revised Policy

The local medical review policy (LMRP) for Interferon was published in the June 2001 Special Issue *Medicare B Update!* (pages 9-11). The purpose of this revision is to remove all verbiage that refers to LMRP J0001: Self-Administered Drugs, which is being retired effective June 30, 2003 (see related article in this issue).

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## NCSVCS: The List of Medicare Noncovered Services

### Revised Policy

The List of Medicare Noncovered Services local medical review policy (LMRP) has been revised **effective for services rendered on or after January 1, 2003**, to reflect the deletion of procedure codes J1051 and 0019T from local noncoverage; the addition of procedure codes G0279 and G0280 to local noncoverage; and the addition of procedure codes 99026 and 99027 to national noncoverage.

### Local Noncoverage

#### Deletions

- J1051 Injection, medroxyprogesterone acetate, 50 mg (Effective for services processed on or after May 1, 2003, for services rendered on or after January 1, 2003.)
- 0019T\* *Extracorporeal shockwave therapy; involving musculoskeletal system* (Invalid for Medicare purposes, per CMS Program Memorandum [PM] AB-03-035.)

#### Additions

- G0279\* Extracorporeal shock wave therapy; involving elbow epicondylitis
- G0280\* Extracorporeal shock wave therapy; involving other than elbow epicondylitis or plantar fasciitis

\* = Services that are noncovered due to their being investigational/experimental.

### National Noncoverage

#### Additions

- 99026 *Hospital mandated on call service; in-hospital, each hour*
- 99027 *Hospital mandated on call service; out-of-hospital, each hour*

Procedure codes 99026 and 99027 are nationally noncovered per CMS PM AB-03-035.

In addition, procedure code J1055 (Injection, medroxyprogesterone acetate for contraceptive use, 150 mg) has been added to national noncoverage. (This service is already nationally noncovered by Medicare.)

**Effective for services rendered on or after April 1, 2003**, procedure code 90871 (*Electroconvulsive therapy [includes necessary monitoring]; multiple seizures, per day*) (MECT) is noncovered, according to CMS PM AB-03-003 (CR 2499). This procedure has been added to national noncoverage.

#### Correction

In the "Policy Changes Related to the 2003 HCPCS Update" article published in the Second Quarter 2003 *Medicare B Update!* (pages 47-51), procedure code G0283 was inadvertently referred to under "The List of Medicare Noncovered" Services as G0238. We apologize for any inconvenience this may have caused.

The full text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

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## 00001: Independent Diagnostic Testing Facility (IDTF)

### Revised Policy

The local medical review policy (LMRP) for IDTF was published in the Third Quarter 2002 *Medicare B Update!* (pages 37-52). Since that time, CMS Transmittal AB-03-035, CR 2609 changed the physician supervision requirements for procedure code 93660 (*Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention*). The following identifies the level of physician supervision required, effective for services rendered on or after January 1, 2003.

Code	Physician Supervision
93660	2

A physician supervision level of “2” indicates that the procedure must be performed under the direct supervision of a physician.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

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## 36515: Protein A Column Apheresis

### Revised Policy

The local medical review policy (LMRP) for protein A column apheresis was recently updated to include low-density lipoprotein apheresis as an accepted therapy for patients who have familial hypercholesterolemia (FH) for which strict diet and medication management has not been effective. The LMRP title was also revised, and will now be referred to as “Therapeutic Apheresis Using Adsorption Columns.”

Effective for dates of services on or after January 1, 2003, Florida Medicare will consider LDL Apheresis medically necessary for the treatment of the following patients with FH:

- LDL is greater than 300 mg/dL despite a six month trial of diet therapy and maximum tolerated combination drug therapy\* or

\*These LDL levels for the indicated patient populations are baseline LDL levels obtained after the patient has had, at a minimum, a six month trial of an AMA Step II diet (or equivalent) and a maximum tolerated combination drug therapy designed to reduce LDL. A maximum tolerated trial includes drugs from at least two separate classes of hypolipidemic agents such as, bile acid sequestrants, HMG-CoA reductase inhibitors, fibric acid derivatives, Niacin/Nicotinic Acid, etc. Baseline lipid levels are to be determined after stabilization on diet and drug therapy by making two measurements during a two to four week period. (Note the two values should be within 10% of each other, indicating a stable condition.)

- LDL is greater than 200 mg/dL and documented coronary artery disease\*\*.

\*\*Documented CHD includes documentation of CAD by angiography or a history of MI, CABG, PTCA or alternative revascularization procedure (stent), or progressive angina documented by exercise or non-exercise stress test.

LDL Apheresis requires careful patient selection and long-term commitment to therapy. Additionally, patients should simultaneously be treated with diet and drug therapy as tolerated.

For more information and important coverage guidelines for this therapy, the full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 61862: Deep Brain Stimulation

### Revised Policy

The local medical review policy (LMRP) for deep brain stimulation was published in the March 1998 *Medicare B Update!* (pages 50-51). Since that time, the policy has been revised based on CMS Program Memorandum AB-03-023 (CR 2553) dated February 14, 2003. Verbiage has been added to the “LMRP Description” and “Indications and Limitations” sections of the policy. In addition, procedure codes 95961, 95962, 95972, and 95973 were added to the “CPT/HCPCS” section of the policy. This revision is effective for dates of service on or after April 1, 2003.

The full text LMRP is available on the provider education Web site at [www.floridamedicare.com](http://www.floridamedicare.com)

## 70370: Dysphagia/Swallowing Diagnosis and Therapy

### Revised Policy

The local medical review policy (LMRP) for Dysphagia/Swallowing Diagnosis and Therapy was published in the 2<sup>nd</sup> Quarter 2003 *Medicare B Update!* (page 49). Since that time language has been removed from the “Coding Guidelines” section of the policy, effective for services processed on or after April 7, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 73721: Magnetic Resonance Imaging (MRI) of Any Joint of the Lower Extremities

### Revised Policy

The local medical review policy (LMRP) for magnetic resonance imaging (MRI) of any joint of the lower extremities was published in the First Quarter 2001 *Medicare B Update* (pages 67-69). Effective for claims processed on or after April 7, 2003, ICD-9-CM diagnosis code 198.5 (secondary malignant neoplasm, bone, and bone marrow) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 74150: Computed Tomography of the Abdomen

### Revised Policy

The local medical review policy (LMRP) for computed tomography of the abdomen was published in the June 2001 *Medicare B Update!* (pages 19-21). Effective for claims processed on or after April 7, 2003, ICD-9-CM diagnosis code 996.62 (infection and inflammatory reaction due to other vascular device, implant, and graft) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The full-text of this LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 90801: Psychiatric Diagnostic Interview Examination

### Revised Policy

The local medical review policy (LMRP) for psychiatric diagnostic interview examination was published in the March/April 2000 *Medicare B Update!* Effective for claims processed on or after March 24, 2003, the policy has been revised to provide further clarification regarding when an additional psychiatric interview examination is considered medically reasonable and necessary and to allow coverage for additional ICD-9-CM diagnosis codes.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 90857: Interactive Group Psychotherapy

### Revised Policy

The local medical review policy (LMRP) for interactive group psychotherapy was published in the December 1997 Special Issue *Medicare B Update!* Effective for claims processed on or after February 18, 2003, this policy has been revised to provide further clarification regarding the documentation requirements for interactive group psychotherapy and provide coverage for Alzheimer's disease (ICD-9-CM diagnosis code 331.0).

The full-text LMRP is available on the provider education Web site at [www.floridamedicare.com](http://www.floridamedicare.com).

## 92135: Scanning Computerized Ophthalmic Diagnostic Imaging

### Revised Policy

The local medical review policy (LMRP) for scanning computerized ophthalmic diagnostic imaging was published in the July/August 2000 *Medicare B Update!* Effective for claims processed on or after April 21, 2003, the policy has been revised to further define the indications and limitations of coverage.

The full-text LMRP is available on the provider education Web site at [www.floridamedicare.com](http://www.floridamedicare.com).

## 97010: Physical Medicine and Rehabilitation

### Revised Policy

The local medical review policy (LMRP) for physical medicine and rehabilitation was published in the Second Quarter 2002 *Medicare B Update* (pages 74-82). Changes have been made to this LMRP based on recent CMS Program Memoranda (PM), effective for services performed on or after April 1, 2003.

- Changes have been made to reflect the coverage and billing requirements for electrical stimulation for the treatment of wounds (PM AB-02-161, CR 2313).
- Changes have been made to reflect the coverage requirements for neuromuscular electrical stimulation (NMES) to enhance walking for Spinal Cord Injury (SCI) patients (PM AB-02-156, CR 2314).

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 97802: Medical Nutrition Therapy (MNT)

### Revised Policy

The local medical review policy (LMRP) for MNT was published in the Fourth Quarter 2002 *Medicare B Update!* Since that time, CMS issued Program Memorandum AB-02-151 dated October 25, 2002, which added verbiage for clarification of the differences between the MNT benefit and the Diabetes Outpatient Self-Management Training (DSMT) benefit (LMRP G0108).

The full-text LMRPs for MNT and DSMT are available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## 99183: Hyperbaric Oxygen Therapy (HBO Therapy)

### Revised Policy

Effective April 1, 2003, a national coverage decision expanded the use of HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities, and to clarify the special supervision and credentialing requirements for physicians who perform this service. Local medical review policy (LMRP) has been revised to reflect these changes effective for services rendered on or after April 1, 2003.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

## LOCAL MEDICAL REVIEW POLICY (RETIRED)

### J0001: Self-Administered Drugs

#### Retirement of Policy

Effective June 30, 2003, the local medical review policy (LMRP) for self-administered drugs will be retired. Self-administered drugs are defined according to instructions recently issued by CMS. Providers may view the CMS guidelines and the self-administered drug (SAD) list on [www.floridamedicare.com](http://www.floridamedicare.com), in the Part B Medical Policy section.

### J1820: Insulin Injection

#### Retirement of Policy

Effective August 1, 2002, the local medical review policy (LMRP) for insulin injection is retired. Procedure code J1820 has been replaced with J1815, which is on the carrier's list of self-administered drugs (see related article "Self-Administered Drugs (SAD) List," in this issue).

## LOCAL MEDICAL REVIEW POLICY (CORRECTIONS)

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

Indications and limitations for these services are included in the administrated policies for the Negotiated Rulemaking for Clinical Diagnostic Laboratory Services, published in the *Federal Register* on November 23, 2001. These national coverage decisions replace local medical review policy (LMRP) in place at the local carriers, effective for services rendered on or after November 25, 2002. As a result, several LMRPs were retired, a list of which was published in the Second Quarter 2003 *Medicare B Update!* (page 55).

The LMRP for Iron (83540) was inadvertently omitted from that publication. We apologize for any inconvenience this may have caused.

#### Clarification on Certain Pathology Codes

We have become aware of issues impacting adjudication of Part B claims billed with certain pathology codes. Below is a brief description of the issues and the corrective action we are taking.

- A National Coverage Determination (NCD) policy for certain pathology codes was implemented nationally effective November 25, 2002. With the implementation of the NCD policy, certain LMRPs were retired. In addition to retirement of the LMRP, any local policy system editing (i.e., procedure-to-diagnosis and utilization screens) was also discontinued.
- The LMRPs on nine procedure codes were discontinued effective November 25, 2002. However, the procedure-to-diagnosis edit associated with these codes was not removed from the system. Therefore, system logic was inappropriately applying automated rules for certain codes, and caused inappropriate denial. The applicable procedures are: 85009, 84437, 84480, 84481, 84482, 83719, 84703, 86294, and 82274.
- This situation has been corrected and claims for 85009, 84437, 84480, 84481, 84482, 83719, 84703, 86294, and 82274 are now adjudicating appropriately. In addition, a mass claims adjustment will be performed within the next 45-60 days to reprocess the claims denied in error. **Therefore, it is not necessary to resubmit claims for payment.**

If you have any further questions or issues after the mass adjustments occur, please contact our provider call center toll-free at 1-866-454-9007.

### 90804: Individual Psychotherapy; 90810: Interactive Individual Psychotherapy

#### Correction

The local medical review policies (LMRP) for individual and interactive individual psychotherapy were published in the Second Quarter 2003 *Medicare B Update!* (pages 55 and 56) with an incorrect effective date. The correct effective date is for claims processed on or after **January 27, 2003**. We apologize for any inconvenience this may have caused.

The full-text LMRPs are available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

### 90853: Group Psychotherapy

#### Correction

The local medical review policy (LMRP) for group psychotherapy was published in the Second Quarter 2003 *Medicare B Update!* (page 56) with an incorrect effective date. The correct effective date is for claims processed on or after **March 18, 2003**. We apologize for any inconvenience this may have caused.

The full-text LMRP is available on the provider education Web site [www.floridamedicare.com](http://www.floridamedicare.com).

# FLORIDA EDUCATIONAL RESOURCES

## Web Cast Schedule and Registration Information

As announced in the Second Quarter 2003 *Medicare B Update!* FCSO is now offering live online instructor-led educational sessions, called Web casts, at no cost, through our Florida provider education Web site ([www.floridamedicare.com](http://www.floridamedicare.com)).

FCSO will be facilitating the following Web casts at the dates and times indicated:

Date	Time	Topic
Thursday, May 8, 2003*	3:30 – 5:00 EDT 2:30 – 4:00 CDT	How to Get Paid Under HIPAA
Tuesday, July 1, 2003	3:30 – 5:00 EDT 2:30 – 4:00 CDT	Procedure Code to Diagnosis or Other Current Issue
Thursday, July 31, 2003	3:30 – 5:00 EDT 2:30 – 4:00 CDT	CY 2003 Medicare Physician Fee Schedule and Overpayments for January and February Services, or Other Current Issue
Thursday, September 4, 2003	3:30 – 5:00 EDT 2:30 – 4:00 CDT	HIPAA Transaction from a FCSO EDI Perspective

\* If you were unable to attend the May 8 session live, the recorded session will be available for you to view on our Web site approximately ten days after the event.

## Web Cast FAQs

The following frequently asked questions (FAQs) have been developed to give you further details on how to register and attend these Web casts:

### 1Q What is a Web cast?

1A A Web cast, also known as a Webinar or Web conference, is an interactive, Internet-based educational delivery method that allows the user to attend at a time and location convenient to his/her schedule. An Internet browser is used to view presentation slides, tour Web sites displayed by the presenter, submit questions through the chat room feature, respond to questions asked by the presenter, and to complete course evaluation forms. The audio portion of the presentation is delivered through a sound card in the user's personal computer (PC) or telephone.

### 2Q What are the system requirements needed to participate?

2A **Browser:** Netscape Navigator 4.0 or higher, Microsoft Internet Explorer 4.01 or higher, Java™ and JavaScript™ and cookies-enabled browser

**Computer:** Pentium-based PC with Windows 95, 98, 2000, XP, or NT 4.0; Mac OS 9.x or later; PowerPC Macintosh G3; Solaris 7, or Solaris 8

**Internet Connection:** 56 Kbps or faster

**Display:** 800 X 600 resolution or higher; optimal viewing at 1024 X 768 resolution

### 3Q Is there a cost to participate in a Web cast?

3A There are no costs associated with participating in a Web cast, other than those associated with traveling to a registered host site in your local area.

### 4Q Why is registration being conducted through host sites?

4A In order to reach the maximum number of providers through this medium, FCSO has developed a host site registration process. FCSO is partnering with various hospital and medical facilities throughout Florida, including places not typically reached through traditional training methods, to provide you with a variety of host sites for these events. The host site list has been posted to our provider education Web site. The list of host sites may change periodically; so continue to monitor our Web site for the most current information. As an additional feature, you will have the ability to register online or print a registration form and fax it directly to the host site of your choice!

**5Q** *How can I locate a registered host site in my area?*

5A To access a list of registered host sites in your area, perform the following steps:

1. Go to [www.floridamedicare.com](http://www.floridamedicare.com)
2. Click on the *e-Learning* link on the *What's New* or *Education-Training* page
3. Click on the *Host Site Information* link at the top of the FCSO *e-Learning* page
4. On the Florida map, locate and click on the city where your office is located
5. Choose a host site at a convenient location

**6Q** *Once I find a host site in my area, how do I register to participate in the Web cast?*

6A Once you have located a registered host site with an open status at a convenient location, you may:

- Register online by clicking the *Online Registration* link at the top of the page, or
- Print a registration form and fax it to the number indicated. To access the Faxable Registration Form, click on the link at the top of the page, or
- Call the contact person indicated

**Note:** If status indicates *full*, then look for another host site in your area.

**7Q** *How often is the host site information updated?*

7A The host site information is updated frequently, so check our Web site for the most current information!

**8Q** *If I cannot attend the live event, can I view a recording?*

8A Yes. FCSO will record each session and place a link to the archived video and audio recording on our provider education Web site. The session can be accessed up to 90 days from the date of the event. Your PC must possess a sound card to hear the audio recording.

**9Q** *How can I access the archived event?*

9A Approximately two days after the event, a link to the archived event will be posted on our provider education Web site.

**10Q** *Can I obtain a CD-ROM containing the recorded event and presentation materials?*

10A Yes. CD-ROMs containing the recorded event and presentation materials will be available at a nominal cost that includes development, shipping, and handling. Ordering information will be posted to the provider education Web site approximately two days after the event.

## Index to Connecticut and Florida *Medicare B Update!* - Fiscal Year 2003

The following is a comprehensive index covering all articles published the *FCSO Medicare B Update!* during fiscal year 2003 (including special electronic-only issues).

Separate Connecticut and Florida issues of the *Update!* were published for the First Quarter 2003. Beginning in January 2003, the *Update!* is consolidated into one issue for both states. In this index, content published for both Connecticut and Florida are listed first, followed by content published only for Connecticut, then content published only for Florida.

**Note:** Electronic issues denoted with an asterisk (\*) are *not* produced in hard copy format, and are available only on FCSO's provider education Web sites, [www.connecticutmedicare.com](http://www.connecticutmedicare.com) and [www.floridamedicare.com](http://www.floridamedicare.com).

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<input type="checkbox"/>	<b>2003 Fee Schedule</b> – The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered March 1, 2003, through December 31, 2003, is available free of charge online at <a href="http://www.connecticutmedicare.com">www.connecticutmedicare.com</a> and <a href="http://www.floridamedicare.com">www.floridamedicare.com</a> . Providers who do not have Internet access may purchase a hardcopy. The Fee Schedule contains calendar year 2003 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the <i>Medicare B Update!</i> Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	\$5.00 (CT) \$10.00 (FL)

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## CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

### Attention: Accounting

Use this attention line to return duplicate payments or overpayment refunds.

### Attention: Correspondence

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

### Attention: Fraud and Abuse

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

### Attention: Freedom of Information (FOIA)

This department handles requests for information available under the Freedom of Information Act.

### Attention: Medical Review

Questions regarding Local Medical Review Policies and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

### Attention: MSP

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

### Attention: Pricing/ Provider Maintenance

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

### Attention: Resolutions

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

### Attention: Hearings

If you believe that your review determination was incorrect and want it reviewed by a Hearing Officer, send your inquiry to the attention of the Hearing Department. A request for a hearing must be made within six months of the date of the Review Department determination and at least \$100.00 must remain in controversy from this decision.

## MAILING ADDRESS EXCEPTIONS

We have established special P.O. boxes to use when mailing your review requests, or to contact Medicare EDI:

### Attention: Review

Please mail only your requests for reviews to this P.O. Box. *DO NOT* send new claims, general correspondence, hearings, or other documents to this location; doing so will cause a delay in the processing of that item. This P.O. Box is only for appeals.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for review must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include review requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should not be sent as a review. These resubmitted claims should be sent in as new claims.

### Post Office Box for Reviews:

**Attention: Appeals**  
**First Coast Service Options, Inc.**  
**P.O. Box C-1016**  
**Meriden, CT 06450-1016**

### Attention: EDI

The Electronic Data Interchange department handles questions and provides information on electronic claims submission (EMC).

### Post Office Box for EDI:

**Attention: CT Medicare EDI**  
**First Coast Service Options, Inc.**  
**P.O. Box 44071**  
**Jacksonville, FL 32231-4071**

## CONNECTICUT MEDICARE PHONE NUMBERS

### Provider Services

**First Coast Service Options, Inc.**  
**Medicare Part B**  
**1-866-419-9455 (toll-free)**

### Beneficiary Services

**First Coast Service Options, Inc.**  
**Medicare Part B**  
**1-800-982-6819 (toll-free)**  
 1-866-359-3614 (*hearing impaired*)

### Electronic Data Interchange (EDI) Enrollment

1-203-639-3160, option 1

### PC-ACE® PRO-32

1-203-639-3160, option 2

### Marketing and Reject Report Issues

1-203-639-3160, option 4

### Format, Testing, and Remittance Issues

1-203-639-3160, option 5

### Electronic Funds Transfer Information

1-203-639-3219

### Hospital Services

Empire Medicare Services  
 Medicare Part A  
 1-800-442-8430

### Durable Medical Equipment

HealthNow NY  
 DMERC Medicare Part B  
 1-800-842-2052

### Railroad Retirees

Palmetto GBA  
 Medicare Part B  
 1-800-833-4455

### Quality of Care

Peer Review Organization  
 1-800-553-7590

## OTHER HELPFUL NUMBERS

### Social Security Administration

1-800-772-1213

### American Association of Retired Persons (AARP)

1-800-523-5800

### To Report Lost or Stolen Medicare Cards

1-800-772-1213

### Health Insurance Counseling Program

1-800-994-9422

### Area Agency on Aging

1-800-994-9422

### Department of Social Services/ConnMap

1-800-842-1508

### ConnPace/

### Assistance with Prescription Drugs

1-800-423-5026

## WEB SITES

### PROVIDER

#### Connecticut

[www.connecticutmedicare.com](http://www.connecticutmedicare.com)

#### Centers for Medicare & Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

### BENEFICIARY

#### Connecticut

[www.connecticutmedicare.com](http://www.connecticutmedicare.com)

#### Centers for Medicare & Medicaid Services

[www.medicare.gov](http://www.medicare.gov)

**FLORIDA MEDICARE  
PART B MAIL  
DIRECTORY**

**CLAIMS SUBMISSIONS**

**Routine Paper Claims**

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

**Participating Providers**

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

**Chiropractic Claims**

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

**Ambulance Claims**

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

**Medicare Secondary Payer**

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

**ESRD Claims**

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

**COMMUNICATIONS**

**Review Requests**

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

**Fair Hearing Requests**

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

**Administrative Law Judge Hearing**

Administrative Law Judge Hearing  
P. O. Box 45001  
Jacksonville, FL 32232-5001

**Status/General Inquiries**

Medicare Part B Correspondence  
P. O. Box 2360  
Jacksonville, FL 32231-0018

**Overpayments**

Medicare Part B Financial Services  
P. O. Box 44141  
Jacksonville, FL 32231-4141

**DURABLE MEDICAL EQUIPMENT (DME)**

**DME, Orthotic or Prosthetic Claims**

Palmetto GBA Medicare  
DMERC Operations  
P. O. Box 100141  
Columbia, SC 29202-3141

**ELECTRONIC MEDIA CLAIMS (EMC)**

**EMC Claims, Agreements and Inquiries**

Medicare EDI  
P. O. Box 44071  
Jacksonville, FL 32231-4071

**MEDICARE PART B ADDITIONAL  
DEVELOPMENT**

**Within 40 days of initial request:**

Medicare Part B Claims  
P. O. Box 2537  
Jacksonville, FL 32231-0020

**Over 40 days of initial request:**

**Submit the charge(s) in question, including information requested, as you would a new claim, to:**

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

**MISCELLANEOUS**

**Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:**

Medicare Registration  
P. O. Box 44021  
Jacksonville, FL 32231-4021

**Provider Change of Address:**

Medicare Registration  
P. O. Box 44021  
Jacksonville, FL 32231-4021  
*and*

Provider Registration Department  
Blue Cross Blue Shield of Florida  
P. O. Box 41109  
Jacksonville, FL 32203-1109

**Provider Education:**

**For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:**

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

**For Seminar Registration:**

Medicare Part B  
Medicare Education and Outreach  
P. O. Box 45157  
Jacksonville, FL 32232-5157

**Limiting Charge Issues:**

**For Processing Errors:**

Medicare Part B  
P. O. Box 2360  
Jacksonville, FL 32231-0048

**For Refund Verification:**

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

**Medicare Claims for Railroad Retirees:**

MetraHealth RRB Medicare  
P. O. Box 10066  
Augusta, GA 30999-0001

**Fraud and Abuse**

First Coast Service Options, Inc.  
P. O. Box 45087  
Jacksonville, FL 32232-5087

**FLORIDA  
MEDICARE  
PHONE NUMBERS**

**BENEFICIARY**

**Toll-Free:**

1-800-333-7586

**Hearing Impaired:**

1-800-754-7820

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

**PROVIDERS**

**Toll-Free**

Customer Service:  
1-866-454-9007  
Interactive Voice Response (IVR):  
1-877-847-4992

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

1-904-791-8103

**EMC**

**Format Issues & Testing:**

1-904-354-5977 option 4

**Start-Up & Front-End Edits/Rejects:**

1-904-791-8767 option 1

**Electronic Funds Transfer**

1-904-791-8016

**Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:**

1-904-791-6895

**PC-ACE Support:**

1-904-355-0313

**Marketing:**

1-904-791-8767 option 1

**New Installations:**

(new electronic senders; change of address or phone number for senders):  
1-904-791-8608

**Help Desk:**

(Confirmation/Transmission):  
1-904-905-8880 option 1

**OCR**

**Printer Specifications/Test Claims:**

1-904-791-8132

**DME, Orthotic or Prosthetic Claims**

**Palmetto GBA Medicare**

1-803-735-1034

**MEDICARE PART A**

**Toll-Free:**

1-877-602-8816

**WEB SITES**

**PROVIDER**

**Florida**

[www.floridamedicare.com](http://www.floridamedicare.com)

**Centers for Medicare & Medicaid Services**

[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARY**

**Florida**

[www.medicarefla.com](http://www.medicarefla.com)

**Centers for Medicare & Medicaid Services**

[www.medicare.gov](http://www.medicare.gov)



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***MEDICARE B UPDATE!***

**FIRST COAST SERVICE OPTIONS, INC. P.O. Box 2078 JACKSONVILLE, FL 32231-0048**  
**P.O. Box 9000 MERIDEN, CT 06454-9000**

**\* ATTENTION BILLING MANAGER \***

