MEDICARE INFORMA

División Medicare/Parte-B

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Le incluimos, en la página 58, copia de la Forma que debe llenar para acogerse a este método de depósito.

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For more information you may call at (787) 749-4232 or 1-877-715-1921.

IC/8-2000/MCM4430

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Additional no-cost copies are available on our website at www.triples-med.org

Emission Date: September 4, 2001 ***Volume 67 / July - August - Sept. 2001***

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http://www.triples-med.org

Health Care Financing Administration

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MOA2001

TABLA DE CONTENIDO

TABLA DE CONTENIDO cont.

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MOA2001

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NUEVO NOMBRE PARA HCFA

El nuevo Secretario de Salud, Tommy Thompson, anunció los primeros cambios para reformar y fortalecer las operaciones del Health Care Financing Administration (HCFA) para mejorar el acceso e información disponible para los 70 millones de beneficiarios de Medicare y Medicaid y los proveedores del cuidado de la salud.

El Secretario Thompson divulgó el nuevo nombre de HCFA, de ahora en adelante la agencia se conocerá como el Centro de Servicios de Medicare y Medicaid. Entre los cambios esperados se entiende que el nuevo Centro de Servicios Medicare y Medicaid se dividirá de la siguiente forma:

1. El Centro para la Administración de Medicare (sus siglas en inglés CMM) se concentrará en la administración tradicional del Programa de Medicare de pago por servicio. Esto incluye el desarrollo de políticas de pago y la administración de los contratistas de Medicare (carriers) que están bajo el sistema de pago servicio.

2. El Centro de Alternativas para el Beneficiario (sus siglas en inglés CBC) se concentrará en el Programa Medicare+Choice. Además proveerá a los beneficiarios información de Medicare, alternativas de Medicare (Select Medicare), Medicare+Choice y opciones Medigap. También incluye administración de los Planes Medicare+Choice, estudios de mercado y demostraciones, funciones de querellas y apelaciones.

3. El Centro para Medicaid y Operaciones del Estado (siglas en inglés CMSO) se concentrará en programas administrados por los estados. Estos incluyen Medicaid, Programa del Cuidado de Salud de Niños del Estado (siglas en inglés SCHIP), funciones para regulación de seguro, encuestas y certificaciones y de la ley para Mejoramiento de servicios de Laboratorio Clínico (siglas en inglés CLIA).

NEW NAME FOR HCFA

The new Secretary of Health and Human Services, Tommy Thompson, announced the first wave of improvements to reform and strengthen HCFA operations and to improve access to information available to nearly 70 million Medicare and Medicaid beneficiaries and the health care providers who serve them.

As part of this effort, Secretary Thompson unveiled the new name for the Health Care Financing Administration (HCFA) – the Centers for Medicare & Medicaid Services (CMS).

1. *The Center for Medicare Management (CMM) will focus on management of the traditional fee-for-service Medicare program. This includes development of payment policy and management of the Medicare fee-for-services contractors.*

2. *The Center for Beneficiary Choices (CBS) will focus on the Medicare+Choice program and providing beneficiaries with the information on Medicare, Medicare Select, Medicare+Choice and Medigap options. It also includes management of the Medicare+Choice plans, consumer research and demonstrations, and grievance and appeals functions.*

3. *The Center for Medicaid and State Operations (CMSO) will focus on programs administered by State. This includes Medicaid, the State Children's Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act (CLIA).*

Gonzalo V. González, MD FACP

DIABETES OUTPATIENTS SELF-MANAGEMENT TRAINING

The purpose of the Diabetes Outpatient Self-Management Training program is to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in the self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management of their diabetes.

Background

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished by a certified provider who meets certain quality standards.

Diabetes outpatient self-management services may be covered by Medicare only if the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed by sending an original referral form to the diabetes education program. The referral for education must be done under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's conditions.

All certified providers that provide other individual items or services on a fee for service basis and that meet quality standards can receive reimbursement for diabetes training. Certified providers must be currently receiving payment for other Medicare services.

The statute states that a 'certified provider' is a physician or other individual or entity designated by the Secretary that, in addition to providing diabetes outpatient self-management services, provides other items or services for which payment may be made under title XVIII such as medical services or durable medical equipment, and meets certain quality standards.

General Conditions of Coverage

- The training must be ordered by the physician or qualified nonphysician practitioner treating the beneficiary's diabetes.
- The order must be part of a comprehensive plan of care established by the physician or qualified nonphysician practitioner and describe the training that the referring physician or qualified non-physician practitioner is ordering and/or any special concerns such as the need for general training, or insulin-dependence.
- The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered.
- The order must also include a statement signed by the physician that the service is needed.
- The provider of the service must maintain documentation in file that includes the original order from the physician and any special conditions noted by the physician.

When the training under the order is changed, the change must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the beneficiary's file at the provider of the training.

Outpatient diabetes self-management training is classified as initial or follow-up training. When a beneficiary has not yet received initial training meeting the quality standards of this section, they are eligible to receive 10 hours of initial training within a continuous 12-month period. The 12-month period does not need to be on a calendar-year basis. Nine hours of initial training must be provided in a group setting consisting of 2 to 20 individuals who need not all be Medicare beneficiaries unless the ordering physician or nonphysician practitioner certifies that a special condition exists that makes it impossible for the beneficiary to attend a group training session.

Those conditions include but are not limited to:

- No group session is available within 2 months of the date the training is ordered.
- The beneficiary has special needs resulting from problems with hearing, vision, or language limitations.

For all beneficiaries, one hour of initial training may be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training. The 10 hours of initial training may be provided in any combination of half-hour increments within the 12-month period and less than 10 hours of initial training may be used in the 12-month period if, for example, the beneficiary does not attend all of the sessions or the physician does not order the full training program.

Medicare also covers 2 hours of follow-up training each year starting with the calendar year following the year in which the beneficiary completes the initial training. The 2-hours of training may be given in any combination of half-hour increments within each calendar year on either an individual or group basis without the certification of the ordering physician or nonphysician practitioner that special conditions exist.

Beneficiaries Eligible for Coverage

Medicare covers initial training for beneficiaries who have the following medical conditions present prior to the physician's or nonphysician practitioner's order for the training.

- New onset diabetes.
- Inadequate glycemic control as evidenced by a glycosylated hemoglobin (HBA1c) level of 8.5 percent or more on two consecutive HbA1c determinations 3 or more months apart in the year before the beneficiary begins receiving training.
- A change in treatment regimen from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- High risk for complications based on inadequate glycemic control (documented acute episodes of sever hypoglycemia or acute severe hyperglycemia occurring in the past year during which the beneficiary needed emergency room visits or hospitalization).
- High risk based on at least one of the following:
  - Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation.
  - Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye.

- Kidney complications related to diabetes, when manifested by albuminuria, without other cause, or elevated creatinine.

The condition requiring training must be documented in the beneficiary's medical record maintained by the referring physician or qualified nonphysician practitioner.

Beneficiaries are eligible to receive follow-up training each calendar year following the year in which they have been certified as requiring initial training. The beneficiaries with diabetes, becoming newly eligible for Medicare, can receive diabetes outpatient self-management training in this program.

Quality Standards

The outpatient diabetes self-management training program must be accredited as meeting approved quality standards, except during the first 18-months after February 27, 2001, HCFA (now CMS) will accept recognition of the American Diabetes Association (ADA) as meeting the National Standards for Diabetes Self-Management Training Programs. Programs without ADA recognition or accreditation by a HCFA-approved national accreditation organization are not covered after February 27, 2001.

Enrollment

If you qualify to bill for this service and are currently enrolled in the Medicare program, you must submit a Form HCFA 855 form along with your ADA recognition certificate to receive reimbursement.

HCPCS Coding and Diabetes Training Hours

The HCPCS code descriptors have been revised to reflect the half-hour increments and each 30-minute session represents one unit of service. Diabetes outpatient self-management services are subject to deductible and co-insurance. Following are the HCPCS codes descriptors and billing instructions:

G0108—Diabetes outpatient self-management training services, individual, per 30 minutes.

G0109—Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Billing Before January 1, 2002

If a 1 hour session of diabetes education has been performed, you must bill code G0108 or G0109 with a 1 in the item 24 G (days/units column) of the HCFA 1500 form. Even though the definition of the codes reads 30 minutes, the rate that you will receive is for 60 minutes. Providers that perform a 30 minute service, should not bill until a full hour is completed and use as the date of service, the day the hour was complete. Providers that bill for a 2 hour session must use a 2 in the units column and not a 4.

Billing After January 1, 2002

On January 1, 2002 the fee for codes G0108 and G0109 will change to comply with their description. Providing 30 minutes of diabetes training will represent 1 unit of service. For example, if you bill for a 30 minute session then a 1 must be in the units column. For an hour session a 2 must be in the units column and for a 2 hour session a 4 must be placed in the units column.

As stated above, under the final rule for diabetes education, beneficiaries with diabetes can initially receive one hour of individual training and/or assessment and nine hours of group training. This can be followed by 2 hours of follow-up training in each subsequent calendar year. Nine hours of initial training must be provided in a group setting consisting of 2 to 20 individuals who need not all be Medicare beneficiaries.

General Payment Conditions

To receive reimbursement, providers/suppliers must meet the following conditions:

- Payment may only be made for diabetes training services actually attended by the beneficiary and documented on attendance sheets, and a referral from the treating physician or non-physician practitioner must be part of the patient's file maintained by the provider of the diabetes outpatient self-management training.
- Claims for payment for diabetes training from DMEPOS suppliers must be submitted to and processed by local carriers.
- If billing for initial diabetes training, the beneficiary must not have already received initial training from an ADA recognized program.
- For initial or follow-up diabetes training, the beneficiary must not be receiving services as an inpatient in a hospital, skilled nursing facility, under a hospice or home health benefit, or be a resident of a nursing home.
- For initial or follow-up diabetes training, the beneficiary must not be receiving services as an outpatient in a rural health clinic or a federally qualified health center.

CR 1455/Trans.B01-40/06-15-2001/MM
CR1789/ Trans. AB-01-109/dmg

Contractor's policy number
VI/PR-01-016

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Anesthesia

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HCFA National Coverage Policy
Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

HCFA Region
New York, Region II

HCFA Consortium
Northeastern

Original Policy Effective Date
N/A

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description

Anesthesia is a loss of sensation resulting from pharmacologic depression of nerve function or from neurologic dysfunction.

Anesthesia services are paid under the Medicare physician fee schedule. However, instead of relative value units (RVUs), anesthesia pay is based on the anesthesia relative value guide (RVG) with adjustments made to the conversion factor (CF) to ensure payments are consistent with other services considered to be of comparable value. Geographic adjustments are made to the CF. Payment is calculated by using the anesthesia RVG with base units per procedure and "actual time" units for personally performed and medically directed services.

Indications and Limitations of Coverage and/or Medical Necessity

Additional benefits are not allowed for any of the following modifying circumstances:

Patient with severe systemic disease
Patient with severe systemic disease that is a constant threat to life
Moribund patient not expected to live 24 hours with or without operation
Patient under one year or over 70 years of age
Anesthesia complicated by emergency
Hypothermia
Controlled hypotension
Complicated field avoidance
Double Lumen Endotracheal Tube
Payment for multiple anesthesia procedures is based on the base units of the highest base unit value and time units of the actual anesthesia time for the multiple procedures.
Reimbursement for modifying circumstances has been incorporated into the total base units allowed for each of the CPT anesthesia procedure codes.

CPT/HCPCS Section & Benefit Category
Anesthesia

CPT/HCPCS codes
00100-01999

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
N/A

Diagnosis that Support Medical Necessity
N/A

ICD-9 Codes that do not Support Medical Necessity
N/A

Diagnosis that do not Support Medical Necessity
N/A

Reasons for denial
N/A

Noncovered ICD-9 codes
N/A

Noncovered diagnosis
N/A

Coding guidelines
00100 - 00222 Anesthesia, Head
00300 - 00352 Anesthesia, Neck
00400 - 00474 Anesthesia, Thorax (Chest Wall and Shoulder Girdle)
00500 - 00580 Anesthesia, Intrathoracic
00600 - 00670 Anesthesia, Spine and Spinal Cord
00700 - 00796 Anesthesia, Upper Abdomen
00800 - 00884 Anesthesia, Lower Abdomen
00900 - 00955 Anesthesia, Perineum
01000 - 01190 Anesthesia, Pelvis (except hip)
01200 - 01274 Anesthesia, Upper leg (except knee)
01300 - 01444 Anesthesia, Knee and popliteal area
01460 - 01522 Anesthesia, Lower leg (below knee)
01600 - 01682 Anesthesia, Shoulder and Axilla
01700 - 01784 Anesthesia, Upper Arm and Elbow
01800 - 01860 Anesthesia, Forearm, Wrist and Hand
01900 - 01922 Anesthesia, Radiological Procedures
01990 - 01999 Anesthesia, Other procedures

The charges for a CVP line (36489, 36491), arterial line (36220-36625), Swan Ganz (93503), hyperbaric pressurization should be listed separately from the total anesthesia charge.

Monitored anesthesia is the subject of another policy.

This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.

Documentation requirements
To facilitate claims processing, a description of the surgical procedure performed should be submitted with a claim when the unlisted anesthesia code (01999) is used.

Utilization guidelines
- General Payment Rule - The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992, is with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. Do not allow separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical service. In that case, payment for the anesthesia service is made through the payment for the medical or surgical service. For example, do not allow separate payment for the surgeon's.·

- Anesthesia Time and Calculation of Anesthesia Time Units – Anesthesia time means the time during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an

equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished on or after January 1, 2000, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

- Actual anesthesia time is reported on the claim. For anesthesia services furnished on or after January 1, 1994, compute time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. Do not recognize time units for codes 01995 or 01996.

Other comments
N/A

Sources of Information and Basis for Decision
Physicians' Current Procedural Terminology (CPT)
MCM 15018

Advisory Committee Notes
This policy does not represent the sole opinion of the Carrier or the Carrier Medical Director. This policy was developed in consultation with the medical community via the Carrier Advisory Committee, which includes representatives from all related specialties.

Start date of comment period
June 5, 2001

End date of comment period
July 20, 2001

Start date of notice period
August 28, 2001

Revision history
N/A

GGL-1527

/s/

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Contractor's policy number
VI/PR-01-017

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Troponin

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HCFA National Coverage Policy
Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

·42CFR410.32. Diagnostic tests may only be ordered by a treating physician (or other treating practitioner acting within the scope of their license and Medicare requirements).

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

HCFA Region
New York, Region II

HCFA Consortium
Northeastern

Original Policy Effective Date
N/A

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Troponin is the contractile regulatory protein of striated muscle. Is a muscle protein that attaches to both actin and tropomyosin. It is concerned with calcium binding and inhibiting cross-bridge formation. Troponin has three isoforms (C, I, and T):

- Troponin C the calcium-binding subunit
- Troponin I the actomyosin-adenosine triphosphatase-inhibiting subunit
- Troponin T the tropomysin-binding subunit

The distribution of these isoforms varies between cardiac muscle and slow-and fast-twitch skeletal muscle. Troponin I and Troponin T are useful in the diagnosis of acute coronary syndromes, however, Troponin C is not useful in the management of myocardial infarction.

Indications and Limitations of Coverage and/or Medical Necessity
Troponin is usually not detectable in the serum of healthy individuals. Cardiac specific isoforms can be identified and are elevated within 4-6 hours of an Acute Myocardial Infarction (AMI) remaining elevated for 10-15 days. Troponin measured alone or along with other cardiac enzymes may be useful in the diagnosis of myocardial damage and in estimating the degree of cardiac damage.

CPT/HCPCS Section & Benefit Category
Laboratory

CPT/HCPCS codes

84484	Troponin, quantitative
84512	Troponin, qualitative

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity

410.00-410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
411.89	Other acute and subacute forms of ischemic heart disease
413.0	Angina decubitus
413.1	Prinzmetal angina
413.9	Other and unspecified angina pectoris
426.0-426.9	Conduction disorders
428.0	Congestive heart failure
429.0	Myocarditis, unspecified
786.50-786.59	Chest pain

Diagnosis that Support Medical Necessity

Same as above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for denial
- Medicare statutorily excludes from coverage those laboratory tests performed for screening purposes only.

- Tests ordered for diagnoses not listed as covered in this policy or for excessive frequency will be denied as not medically necessary.

- Claims submitted for an unusual frequency of any of these services or services ordered for a diagnosis not listed as covered in this policy will be denied as not medically necessary in the absence of supportive documentation in the patient's record.

- Services furnished in settings other than those specified in the Indications and section as covered will be denied.

Noncovered ICD-9 codes
Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
CPT code 84512 is a generic code for qualitative Troponin. CPT code 84484 is a generic code for quantitative Troponin. Typically physicians order "Troponin-qualitative", and if positive, "Troponin-quantitative". One specimen is drawn and the laboratory assays the reports positive or negative for the qualitative test and the level of Troponin I or Troponin T for the quantitative test. Regardless of the number of isoforms or mixture of isoforms provided, only one unit may be billed for each code. One unit of Troponin is defined as one order for 84484 or one order for 84512. It is not necessary to monitor both T and I.

Documentation requirements
There is a general presumption of medical necessity for the laboratory services. However, medical necessity documentation for the laboratory services must be in the patient's medical record.

Utilization guidelines
Request for troponin is not usually done in doctor's offices.

Other comments
Frequency and indication of this test will be monitored to prevent overutilization.

Sources of Information and Basis for Decision
HCFA transmittal AB-01-51
Interpretation of Laboratory Tests; Walach VII Edition

Diagnostic tests: Second Edition, Nicole et al
Scientific American Cardiology Section
J. American College of Cardiology 1995; March 1; 25(3); 874-81

Advisory Committee Notes
This policy does not represent the sole opinion of the Carrier or the Carrier Medical Director. This policy was developed in consultation with the medical community via the Carrier Advisory Committee, which includes representatives from all related specialties.

Start date of comment period
June 5, 2001

End date of comment period
July 20, 2001

Start date of notice period
August 28, 2001

Revision history
N/A

GGL-1528

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Contractor's policy number
VI/PR-01-18

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Prothrombin time (PT)

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HCFA National Coverage Policy
-Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

-Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be reasonable and medically necessary.

-Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

-HCFA publication 14-3, Medicare Carrier Manual, section 5114.1-5114.3

-42CFR410.32 - Diagnostic tests may only be ordered by a treating physician.

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

HCFA Region
New York, Region II

HCFA Consortium
Northeastern

Original Policy Effective Date
N/A

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Plasma coagulation function is readily assessed with a few simple laboratory tests: the partial thromboplastin time (PTT), prothrombin time (PT), thrombin time, (TT), or a quantitative fibrinogen determination. The PTT screens the intrinsic limb of the coagulation system and tests for the adequacy of factors XII, XI, IX, and VIII. The PT screens the extrinsic or tissue factor dependent pathway. This test also evaluates the common coagulation pathway involving all the reactions that occur after the activation of factor X.

Indications and Limitations of Coverage and/or Medical Necessity
The prothrombin time (PT) test is an in vitro laboratory test used to asses the extrinsic coagulation pathway. This is commonly used to measure the effect of warfarin (Coumadin) and regulate its dosage. Certain disease states may also affect a patient's coagulation and require a PT: liver disease, disseminated intravascular coagulation, other acquired and congenital coagulopathies and thrombotic states, malabsorption, etc. The need to repeat this test is determined by the changes in the underlying medical condition and/or the dosage of warfarin, and the use of other medications known to affect coagulation or warfarin metabolism.

A prothrombin time is performed to evaluate:

-the extrinsic coagulation system;
-dysfibrinogenemia;
-afibrinogenemia (complete);
-heparin, coumarin or warfarin effect/therapy;
-liver failure;
-disseminated intravascular coagulation (DIC)
-congenital deficiencies of factors II, V, VII, X;
-prothrombin deficiency;
-vitamin K deficiency

The PT is most commonly used to measure the effect of Warfarin (Coumadin) and regulate its dosing.

Other than during transitions from heparin to warfarin therapy (usually in hospital) it is unusual that both the PT and PTT are necessary together. Each must be justified separately.

Medicare does not pay for routine screening tests. ICD-9 CM code V82.9 (special screening of other conditions, unspecified condition) or comparable narratives should be used to indicate screening tests performed in the absence of a specific sign, symptom or complaint. Use of V82.9 or comparable narrative will result in the denial of claims as non-covered screening services.

Reviewing results of laboratory tests, phoning results to patients, filing such results, and such activities as obtaining, reviewing and analyzing the appropriate diagnostic tests, etc., are services which are covered by the program and payment for these services is included in the payment for the evaluation and management (E & M) services to the patient.

CPT/HCPCS Section Benefit Category
Pathology

CPT/HCPCS Codes
85610 Prothrombin time

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity

286.0-286.9	Coagulation defects
287.0	Allergic purpura
287.2	Other nonthrombocytopenic purpuras
287.8-287.9	Other and unspecified hemorrhagic conditions
570-573.9	Acute and chronic liver failure/hepatitis
578.0-578.9	Gastrointestinal hemorrhage
586	Chronic renal failure and uremia
593.81	Vascular disorders of kidney
596.7	Hemorrhage into bladder wall
599.7	Hematuria
V58.61	Long-term (current) use of anticoagulants
E934.2	Agents primarily affecting blood constituents, anticoagulants
V65.8	Other reasons for seeking consultation

Diagnosis that Support Medical Necessity
Same as above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for Denial
Claims submitted with diagnoses other than those listed as covered will be denied as not medically necessary.

Non-covered ICD-9 codes
Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding Guidelines

1) If the PT test is being done to monitor warfarin, then the correct primary diagnosis code to use is V58.61; the reason the patient is on the warfarin (e.g. atrial fibrillation, stroke, prosthetic valve, phlebitis, etc.) should appear as a secondary diagnosis code.

2) If the primary diagnosis is coagulopathy (i.e., 286.0-286.9), then the reason for the coagulopathy should appear as a secondary diagnosis. If the coagulopathy is related to underlying liver disease, use ICD-9 code 286.7, deficiency of coagulation factor due to liver disease.

Report procedure 85610 when billing for a prothrombin time test.

- Any claim for a test listed in "HCPCS codes" above must be submitted with an ICD-9 CM diagnosis code or comparable narrative.

- ICD-9 CM code V82.9 (special screening of other conditions, unspecified condition), or comparable narratives should be used to indicate screening tests performed in the absence of a specific sign, symptom or complaint. Use of V82.9 or comparable narrative will result in the denial of claims as non-covered screening services.

- All ICD-9 diagnosis codes must be coded to the highest level of specificity

Documentation Requirements
Documentation supporting the medical necessity, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

Documentation supporting the medical necessity of these tests, such as ICD-9 diagnosis codes or comparable narrative must be submitted on the claims. Failure to do so may result in rejection or denial of claim(s). The ordering physician should retain in the patient's medical record, history and physical, examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs/symptoms or abnormal laboratory test results, appropriate to one of the covered indications. The patient's clinical record should further indicate changes/alterations in medications prescribed for the treatment of the patient's condition. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record. Documentation must be submitted to Medicare upon request.

Utilization guidelines
N/A

Other Comments

Sources of Information and Basis for Decision
Isselbacher et al ,Harrison's Principles of Internal Medicine Mc Graw Hill 14th Edition.
Interpretation of diagnostic tests 7th Edition J. Walach.
CMD Clinical Laboratory Workgroup
2001 CPT Physicians' Current Procedural Terminology, American Medical Association
Wintrobe's Clinical Hematology 9th Edition Lea and Febiger.

Advisory Committee Notes
This policy does not represent the sole opinion of the Carrier or the Carrier Medical Director. This policy was developed in consultation with the medical community via the Carrier Advisory Committee, which includes representatives from all related specialties.

Start date of comment period
June 5, 2001

End date of comment period
July 20, 2001

Start date of notice period
August 28, 2001

Revision history
N/A

GGL-1529

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Contractor policy number
VI/PR-01-19

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Partial Thromboplastin Time

AMA CPT copyright statement
"CPT codes, descriptions and other data only are copyright 2001 American Medical Association. All rights reserved. Applicable FARS/DFARS Clauses Apply".

HCFA National Coverage Policy
Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be reasonable and medically necessary.

Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim. -HCFA Publication 14-3, Medicare Carrier Manual, section 5114.1-5114.3 -42CFR410.32. Diagnostic tests may only be ordered by a treating physician.

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

HCFA Region
New York, Region II

HCFA Consortium
Northeastern

Original Policy Effective Date
N/A

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Plasma coagulation function is readily assessed with a few simple laboratory tests: The partial thromboplastin time (PTT), prothrombin time (PT), thrombin time (TT), or a quantitative fibrinogen determination. The partial thromboplastin time (PTT) test is an in vitro laboratory test used to assess the intrinsic coagulation pathway. The PTT primarily tests for the adequacy of the hemophilia factors or to monitor heparin therapy.

Indications and Limitations of Coverage and/or Medical Necessity
The PTT is most commonly used to quantitate the effect of therapeutic heparin and to regulate its dosing. Monitoring of heparin effect, for anticoagulation control, occurs almost always in the inpatient setting. Except during transitions from heparin to warfarin therapy (usually in hospital), it is unusual that both the PTT and PT are necessary together. Each must be justified separately. In addition to the hemophilias, certain other disease states can also affect a patient's intrinsic coagulation and justify the PTT: liver disease, disseminated intravascular coagulation, other acquired and congenital coagulopathies as well as thrombotic states. The PTT is not useful in determining the effects of coumadin on a patient's coagulation. The need to repeat this test is determined by changes in the underlying medical condition and/or the dosing of heparin.

-Reviewing results of laboratory tests, phoning results to patients, filing such results, and such activities as obtaining, reviewing, and analyzing the appropriate diagnostic tests, etc., are services which are covered by the program, and payment for these services is included in the payment for the evaluation and management (E& M services to the patient).

CPT/HCPCS Section & Benefit Category
Pathology and Laboratory
Diagnostic Testing - Title XVIII of the Social Security Act, section 1861 (s) (3)

CPT/HCPCS codes
85730 Thromboplastin time, partial (PTT); plasma or wholeblood

Not Otherwise Classified (NOC)
N/A

ICD-9 codes that Support Medical Necessity
Please be aware it is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid, but in addition, the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the beneficiary's medical record must support the medical necessity for the test(s) provided. (See also, Reasons for Denial; Coding Guidelines; and Documentation Requirements below.)

286.0	Congenital factor VIII disorder - Hemophilia A
286.1	Congenital factor IX disorder - Hemophilia B
286.2-286.3	Other congenital factor deficiencies
286.4	Von Willebrand's disease
286.5	Hemorrhagic disorder due to circulating anticoagulants
286.6	Defibrination syndrome
286.7	Acquired coagulation factor deficiency
287.9	Unspecified hemorrhagic conditions

570	Acute and subacute necrosis of liver
E934.2	Agents primarily affecting blood constituents, anticoagulants [Heparin]
V65.8	Other reasons for seeking consultation

Diagnosis that Support Medical Necessity
Same as above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for denial
Screening tests, in the absence of associated signs, symptoms or complaints are denied under 1862 (a)(7).

-A claim for a test listed in "HCPCS CODES" above submitted without an ICD-9-CM diagnosis code or comparable narrative will be returned as an incomplete claim under 1833(e)

-A claim for a test listed in "HCPCS CODES" above submitted with an ICD-9-CM diagnosis code or comparable narrative other than those listed in "ICD-9-CM Codes That Support Medical Necessity" will be denied as not medically necessary under 1862 (a) (1) (A).

-It is understood that any diagnosis information submitted must have (in the patient record) medical justification for components of the test. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under 1862 (a)(1)(A).

Noncovered ICD-9 codes
Any ICD-9-CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
-Any claim for a test listed in "HCPCS CODES" above must be submitted with an ICD-9-CM diagnosis code or comparable narrative.

-All ICD-9 diagnosis codes must be coded to the highest level of specificity.

- If the partial thromboplastin time (PTT) is being done to monitor heparin therapy, then the correct ICD-9 code to use is *E934.2,* as the primary diagnosis, and the reason the patient is on the heparin (i.e., phlebitis, etc.) should appear as a secondary diagnosis code.

- If the primary diagnosis is a coagulopathy (286.0-286.5), then the reason for the coagulopathy should appear as a secondary diagnosis. If the coagulopathy is related to underlying liver disease, use ICD-9 code 286.7 (Deficiency of coagulation factor due to liver disease).

- EMC and hard copy claims will be monitored for appropriateness and frequency.

Documentation requirements
Documentation supporting the medical necessity of these tests, such as ICD-9 diagnosis codes or comparable narrative must be submitted on the claims. Failure to do so may result in rejection or denial of claim(s). The ordering physician should retain in the patient's medical record, history and physical, examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs/symptoms or abnormal laboratory test results, appropriate to one of the covered indications. The patient's clinical record should further indicate changes/alterations in medications prescribed for the treatment of the patient's condition. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record. Documentation must be submitted to Medicare upon request.

Utilization guidelines
N/A

Other comments
N/A

Sources of Information and Basis for Decision
-CMD Clinical Laboratory Workgroup
-2001 CPT Physicians' Current Procedural Terminology, American Medical Association -Scientific American Medicine
-Wintrobe's Clinical Hematology; 9th Ed, 1993, Lea and Febiger
-Harrison's Textbook of Medicine
-Interpretation of diagnostic tests 7th Ed Walach guide to diagnostic tests: Second edition; Nicole et al

Advisory Committee Notes
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Start date of comment period
June 5, 2001

End date of comment period
July 20, 2001

Start date of notice period
August 28, 2001

Revision history
N/A

GGL-1538

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Contractor policy number
VI/PR-01-020

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Glutamyltransferase, GAMMA (GGT)

AMA CPT copyright statement
"CPT codes, descriptions and other data only are copyright 2001 American Medical Association. All rights reserved. Applicable FARS/DFARS Clauses Apply".

HCFA National Coverage Policy
-Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations.

-Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Primary Geographic Jurisdiction
Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

HCFA Region
New York, Region II

HCFA Consortium
Northeastern

Original Policy Effective Date
N/A

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description

This enzyme is present in liver, pancreas and kidney. Monitoring its level is especially useful in the diagnosis of obstructive jaundice, intrahpeatic cholestasis, pancreatic diseases, exposure to hepatotoxins (such as the organic solvents) certain neoplasms, alcohol abuse/dependence and drug or medication (such as phenobarbital or carbamazepine) induced hepatic abnormalities. GGT levels are normal in pregnancy, childhood, adolescence and bone disease. GGT levels frequently parallel those of other tests such as the alkaline phosphatase. This policy will define the conditions under which this type testing and its frequency can be allowed if medical necessity exists.

Indications and Limitations of Coverage and/or Medical Necessity

Indications

1. To provide information about known or suspected hepatobiliary disease, for example:

    a. following chronic alcohol or drug ingestion;
    b. following exposure to hepatoxins;
    c. when using medication known to have a potential for causing liver toxicity (e.g., following the drug manufacturer's recommendations);or
    d. following infection (e.g., viral hepatitis and other specific infections such as amebiasis, tuberculosis, psittacosis, and similar infections.

2. To assess liver injury/function following diagnosis of primary or secondary malignant neoplasms.

3. To assess liver injury/function in a wide variety of disorders and diseases known to cause liver involvement (e.g., diabetes mellitus, malnutrition, disorders of iron and mineral metabolism, sarcoidosis, amyloidosis, lupus, and hypertension).

4. To assess liver function related to gastrointestinal disease.

5. To assess liver function related to pancreatic disease.

6. To assess liver function in patients subsequent to liver transplantation.

7. To differentiate between the different sources of elevated alkaline phosphatase activity.

Limitations

When used to assess liver dysfunction secondary to existing non-hepatobiliary disease with no change in sings, symptoms, or treatment, it is generally not necessary to repeat a GGT determination after a normal result has been obtained unless new indications are present.

If the GGT is the only "liver" enzyme abnormally high, it is generally not necessary to pursue further evaluation for liver disease for this specific indication.

When used to determine if other abnormal enzyme tests reflect liver abnormality rather than other tissue, it generally is not necessary to repeat a GGT more than one time per week.

Because of the extreme sensitivity of GGT as a marker for cytochrome oxidase induction or cell membrane permeability, it is generally not useful in monitoring patients with known liver disease.

CPT/HCPCS Section & Benefit Category
Pathology and Laboratory

CPT/HCPCS CODES
82977

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity

072.71	Mumps hepatitis
074.8	Other specified diseases due to Coxsackievirus
075	Infectious mononucleosis
078.5	Cytomegaloviral disease
084.9	Other pernicious complications of malaria
130.5	Hepatitis due to toxoplasmosis
135	Sarcoidosis
153.0 to 153.9	Malignant neoplasm of colon
154.0	Malignant neoplasm rectosigmoid junction
154.1	Malignant neoplasm of rectum
154.8	Malignant neoplasm of other sites
155.0	Malignant neoplasm of liver, primary
155.2	Malignant neoplasm of liver, not specified as
157.0 to 157.9	Malignant neoplasm of pancreas
174.0 to 174.9	Malignant neoplasm of female breast
175.0 to 175.9	Malignant neoplasm of male breast
186.9	Malignant neoplasm of other and unspecified testis
197.5	Secondary malignant neoplasm of large intestine and rectum
197.7	Secondary malignant neoplasm of liver
197.8	Secondary malignant neoplasm of other digestive organs and spleen
198.81	Secondary malignant neoplasm of breast
211.5	Benign neoplasm of liver and biliary passages
211.6	Benign neoplasm of pancreas, except islets of Langerhans
230.3	Carcinoma in situ of colon
230.8	Carcinoma in situ of liver and biliary system
230.9	Carcinoma in situ of other and unspecified digestive organs
235.2	Neoplasm of uncertain behavior of stomach, intestines and rectum
235.3	Neoplasm of uncertain behavior of liver and biliary passages
235.5	Neoplasm of uncertain behavior of other and unspecified digestive organs
238.3	Neoplasm of uncertain behavior of breast
239.0	Neoplasm of unspecified nature of digestive system
275.0	Disorders of iron metabolism
275.1	Disorders of copper metabolism
277.00	Cystic fibrosis without mention of meconium ileus
282.60-282.69	Sickle cell anemia
289.4	Hypersplenism
291.0	Alcohol withdrawal delirium
291.1	Alcohol amnestic syndrome
291.2	Other alcoholic dementia
291.3	Alcohol withdrawal hallucinosis

291.4	Idiosyncratic alcohol intoxication
291.5	Alcoholic jealousy
303.00 to 303.03	Alcohol dependence syndrome
303.90 to 303.93	Other and unspecified alcohol dependence, unspecified drunkenness
305.00 to 305.93	Nondependent alcohol abuse, unspecified drunkenness
570	Acute and subacute necrosis of liver
571.0 to 571.9	Alcoholic fatty liver
572.0 to 572.8	Abscess of liver
573.0 to 573.9	Other disorders of liver
574.30 to 574.51	Choleithiasis
575.0 to 575.9	Other disorders of Gallbladder
576.0 to 576.9	Other disorders of biliary tract
577.0 to 577.9	Disease of pancreas
774.4	Perinatal jaundice due to hepatocellular damage
789.1	Hepatomegaly
980.0-982.8	Toxic effects of nonmedicinal sources
V11.3	Personal history of alcoholism
V58.69	Encounter for long term (current) use of other medications
V65.8	Other reasons for seeking consultation

Diagnosis that Support Medical Necessity
Same as above.

ICD-9 Codes that do not Support Medical Necessity
Any ICD-9 codes not listed as payable in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Diagnosis that do not Support Medical Necessity
Any diagnosis not listed as payable in the "Diagnosis that Support Medical Necessity" section of this policy will be denied as not medically necessary.

Reasons for denial
When the claim lacks diagnosis documentation to support the medical necessity:

- Tests that are not ordered by a treating physician and in compliance with Medicare requirements will be denied as not reasonable and necessary.

- Failure of the laboratory performing the test to have the appropriate Clinical Laboratory Improvement Act (CLIA) certificate for the testing performed will result in denial of claims.

Noncovered ICD-9 codes
Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
82977 Glutamyltransferase, gamma (GGT)

Documentation requirements
N/A

Utilization guidelines
Office records should clearly document the reason for performing this test and its frequency. A history and physical exam and progress notes which document findings and the results of treatment if provided must be available for review if requested.

Other comments
N/A

Sources of Information and Basis for Decision

- FR HCFA 03/10/00 PR 65 FR 13081
- Physicians' Current Procedural Terminology (CPT)
- Laboratory Test Handbook (Lexi-Comp, Inc), pp 230, 1994.
- Scientific American Medicine
- Interpretation of Diagnostic Tests, 7th Edition; Jacques Wallach, MD

Advisory Committee Notes
This policy does not represent the sole opinion of the carrier or Carrier Medical Director. This policy was developed in consultation with the medical community via the Carrier Advisory Committee, which includes representatives from all related specialties.

Start date of comment period
June 5, 2001

End date of comment period
July 20, 2001

Start date of notice period
August 28, 2001

Revision history
N/A

GGL-1539

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Health Insurance Portability and Accountability Act (HIPAA)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) ADMINISTRATIVE SIMPLIFICATION

Note: As part of a series of educational efforts to furnish you with the information you may need to comply with this transition, we are providing further information on HIPAA provisions. This carrier have already published articles on this matter on volumes 55 & 63 of our provider bulletin.

The Health Insurance Portability and Accountability Act of 1996 (known as HIPAA) is a federal legislation, which includes several provisions related to health care and health insurance. Included in HIPAA is the Administrative Simplification Act which mandates new standard formats for electronically submitted health care transactions. The transaction standards were developed by the American National Standard Institute (ANSI). Among the transactions which will be standardized are the electronic claim (ANSI-837) , the electronic remittance notice (ANSI-835) and the Claim Status Request/Response (ANSI 276/277). Version 4010 of these transactions will be required under HIPAA. The law requires that all HIPAA provisions be fully implemented by October 16, 2002. Our goal is to make transition of your Electronic Data Interchange (EDI) activities as simple as possible with minimal disruption to your billing processes.

These are some facts every provider should know:

Transaction 837 for Coordination of Benefits

- Medicare will switch to exclusive use of the outbound X12N 837 for COB by October 16, 2002;
- Medicare will cease issuance of non-version 4010 COB transactions and acceptance of non-837 version 4010 electronic claims by October, 2002;
- Each provider that has selected to submit claims electronically must submit all of their claims in compliance with the requirements in the X12N 837 version 4010, or if they contract with a clearinghouse to translate their claim data into the X12N 837 (4010) format, they must furnish that clearinghouse all data required by X12N 837 version 4010;
- Each trading partner that has elected to exchange COB electronically must accept version 4010 of the X12N 837, or contract with a clearinghouse to translate data from X12N 837 version 4010 standard on their behalf;
- Any provider, provider agent, trading partner, or clearing house that elects to use a clearinghouse for translation services is liable for those costs;
- The version 4010 X12N 837 implementation guide can be downloaded without charge from http://www.wpc-edi.com/HIPAA;
- If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for a specific transaction and is using the same program to generate the transaction for all of their clients, then all clients of the vendor/clearinghouse/billing service will not be required to test prior to Carrier/DMERC acceptance of production data. Appointment slots will be assigned on a first come basis. A testing schedule including deadlines to request testing will be published in a future through the web site, BBS bulletin board and the provider remittance.

- COB trading partners must either request system compatibility testing for use of the X2N 837 COB prior to October 2002 or be confident that they have completed system changes as required to accept production X12N 837 COB transactions by October 2002. Current trading partners will automatically be sent production X12N 837 COB transactions in October, 2002 unless they want to terminate their COB agreement;
- As result of the large number of providers, agents, clearinghouses, and trading partners that could request to be tested and the number of HIPAA standard transactions, it may not be feasible to test each entity during the last quarter of the transition process;
- There is no Medicare charge for this system testing.

Transaction 835 Payment/Remittance Advice

- Each provider that has elected to receive an ERA must accept version 4010 of the 835, or contract with a clearinghouse to translate data from the 835 version 4010 standard on their behalf;
- Any provider, provider billing service, trading partner, vendor or clearinghouse that elects to use a clearinghouse for translation services is liable for those costs;
- The PC-Print software will not be issued for use with 835 version 4010.
- The version 4010 835 implementation guide can be downloaded without charge from http://www.wpc-edi.com/HIPAA.
- Providers, agents, and clearinghouses who prefer advance testing to assure system compatibility of version 4010 of the 835 must schedule testing with their carrier or DMERC. Appointment slots will be assigned on a first come basis. A testing schedule including deadlines to request testing will be published in a future through the web site, BBS bulletin board and the provider remittance. Carriers and DMERCs will not be able to guarantee completion of testing by the end of September 2002 for any entities that delay requesting a testing appointment until late in the transition period. Unless a provider requests discontinuation of receipt of ERAs, current 835 and NSF remittance recipients will automatically be sent production 835 version 4010 transactions in October 2002;
- As result of the large number of providers, agents, clearinghouses, and trading partners that could request to be tested and the number of HIPAA standard transactions, it may not be feasible to test each entity during the last quarter of the transition process;
- Standard Systems and carriers will complete system changes to enable reporting of a 20 character patient account number in an X12N 835 version 4010 when a number that large is submitted in a 4010 claim. Providers who request a copy of a previously issued ERA after: 1) a patient account number in excess of 17-characters has been purged from Medicare records will be sent only the first 17-characters of that patient account number; and 2) provider line item control numbers have been purged from Medicare records will not receive those control numbers in the ERA copy. The patient account number limitation applies to SPRs also. Line item control numbers are never reported in SPRs;
- There is no Medicare charge for this system testing; and

- Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for their transition to the HIPAA standards, Medicare will not furnish in-depth training on the use and interpretation of the standards implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

Transaction 277/276 Health Care Claim Status Request

- EDI requests for claims status must be submitted via a 276 version 4010 query effective October 2002, and for each valid 276 will be issued a 277 version 4010 response. Prior claim status formats will be discontinued effective October 2002, although the information will still be available via ARU or other non-EDI method that the Carrier has elected to continue to support;

- A provider that prefers to obtain claim status data in an EDI format but who does not choose to support the 276/277 may contract with a clearinghouse to translate the information on their behalf; however, that provider would be liable for those clearinghouse costs;

- The version 4010 276/277 implementation guide can be downloaded without charge from http://www.wpc-edi.com/HIPAA.

- Providers, agents, and clearinghouses are not required, in most cases, to be tested on their 276/277 interface prior to initial submission of a 276 or request for receipt of a 277, although are required to notify the Contractor when they plan to begin submitting 276 version 4010 queries. Appointment slots will be assigned on a first come basis. A testing schedule including deadlines to request testing will be published in a future through the web site, BBS bulletin board and the Provider Remittance.

- There is no Medicare charge for this system testing; and

- Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for their transition to the HIPAA standards, Medicare will not furnish in-depth training on the use and interpretation of the standards implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

Trans. B-01-06/CR1534/02-06-01
Trans. B-01-35/CR1523/04-30-01
Trans. AB-01-106/CR1784/08-01-01
RG/JS

ATTESTATION OPTION FOR SUBMISSION REQUIREMENT FOR CLINICAL LABORATORIES BILLING THE TECHNICAL COMPONENT OF PHYSICIAN PATHOLOGY SERVICES TO HOSPITAL PATIENTS

Background and Scope

This is a clarification to a requirement in the instructions that were given in the article *Independent Laboratory Billing for the Technical Component of the Physician Pathology Services to Hospital Patients,* published on page 59 of our April, May, June 2001 bulletin as required by CMS. Said article gives details for implementing §542 of the Benefits Improvement and Protection Act of 2000 (BIPA).

The basic requirement for a carrier to continue to pay an independent laboratory for the technical component (TC) of a specimen for a hospital inpatient or outpatient is that the hospital must have had an agreement as of July 22,1999, with an independent laboratory for an independent laboratory to do the TC. If the hospital meets that requirement, it is called a "covered hospital".

The instruction requires the independent laboratory to forward to its carrier(s) a copy of the agreement or other documentation to establish that there was an arrangement on or before July 22,1999, between the laboratory and the hospital for the processing of the TC by the independent lab.

CMS is amending the instruction regarding submission of an agreement or other documentation to clarify that an attestation will suffice to meet the requirement if no written agreement is available.

It also presents the elements necessary for an effective attestation for the purposes of meeting the submission requirement stated in the instruction. We are neither providing an attestation form nor specifying the content of the attestation. However, an attestation that contains all the elements listed below would be sufficient on its face.

- Legal name (and if necessary to ensure proper identification, the business name)of each entity;
- Mailing addresses for both entities;
- Medicare billing numbers for both entities and the Clinical Laboratory Improvements Amendments of 1988 (CLIA) number for the laboratory;
- Statement to the effect that on July 22,1999,this arrangement existed between this laboratory (or a predecessor independent laboratory) and the hospital;
- Statement of any limitation to the agreement, e.g., only certain tests are covered under this agreement or certain time restrictions were imposed;
- Date of the attestation;
- Original signature of the representative of the laboratory (if the laboratory had the arrangement with the hospital as of July 22,1999) or a representative of the hospital (if the hospital had an arrangement with a different laboratory as of July 22,1999); and
- Statement that the signer is authorized to sign on behalf of the entity furnishing the attestation.

REVISION OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES

SUMMARY

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy and pharmacological management delivered via a telecommunications system. Eligible geographic areas will be expanded beyond rural health professional shortage areas to include counties not in a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location. An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous 'store and forward' technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specifies that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) will be equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) and a medical practitioner as described in §1842(b)(18) (C) of the Act. BIPA also expands payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous, 'store and forward' telecommunications system. BBA 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA requires that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for current teleconsultation provision. The current teleconsultation provision as authorized by §4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR §§410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

EXPANSION OF MEDICARE PAYMENT FOR TELEHEALTH SERVICES

Eligibility Criteria

Beneficiaries eligible for telehealth services. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in either a rural health professional shortage area (HPSA) as defined by §332(a)(1) (A) of the Public Health Services Act or in a county outside of a MSA as defined by §1886(d)(2)(D) of the Act.

Exception to rural HPSA and non MSA geographic requirements. Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

Originating site defined. An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are listed below.

- The office of a physician or practitioner.
- A hospital.
- A critical access hospital.
- A rural health clinic.
- A federally qualified health center.

Coverage of Telehealth

Scope of coverage. The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacological management. These services and corresponding current procedure terminology (CPT) codes are listed below.

- Consultations (CPT codes 99241 - 99275).
- Office or other outpatient visits (CPT codes 99201 - 99215).
- Individual psychotherapy (CPT codes 90804 - 90809).
- Pharmacological management (CPT code 90862).

Conditions of Payment

Technology. For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Exception to the interactive telecommunications requirement. In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous 'store and forward technology', in single or multimedia formats, is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program.

Store and forward defined. For purposes of this instruction, store and forward means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

NOTE: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis and or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Telepresenters. A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

Payment Methodology for Physician/Practitioner at the Distant Site

Distant site defined. The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

Payment amount (professional fee). The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacological management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

Medicare practitioners who may receive payment at the distant site (i.e., at a site other than where beneficiary is). As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacological management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

Medicare practitioners who may bill for covered telehealth services are listed below (subject to State law).

- Physician.
- Nurse practitioner.
- Physician assistant.
- Nurse midwife.
- Clinical nurse specialist.
- Clinical psychologist.*****
- Clinical social worker.*****

*****Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Originating Site Facility Fee Payment Methodology

Originating site defined. The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

Facility fee for originating site. For consultation, office or other outpatient visit, psychotherapy and pharmacological management services delivered via a telecommunications system furnished from October 1, 2001, through December 31, 2002, the originating site fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated annually by the Medicare Economic Index (MEI).

Payment amount. For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of $20. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. The originating site facility fee payment methodology for each type of facility is clarified below.

- Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system. Payment is not based on current fee schedules or other payment methodologies.
- Hospital inpatient. For hospital inpatients, payment for the originating site facility fee must be made outside the Diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).
- Critical access hospitals. When the originating site is a critical access hospital, make payment as described above, separately from the cost-based reimbursement methodology.
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of the actual charge or $20 regardless of geographic location. Do not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician fee schedule.

Submission of Telehealth Claims

Professional Service - *Carriers*

Distant site practitioners. Claims for professional consultations, office visits, individual psychotherapy, and pharmacological management provided via a telecommunications systems for dates of service October 1, 2001, and later must be submitted to the carriers that processes claims for the practitioners service area. Submit such claims with the appropriate CPT code for the professional service provided and the telehealth modifier "GT" – "via interactive audio and video telecommunications system."

By using the "GT" modifier to bill for the telehealth service, the distant site practitioner verifies that the beneficiary was located at an eligible originating site at the time of the telehealth service.

Exception for store and forward (non-interactive) telehealth. In the case of a Federal telemedicine demonstration program conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. When store and forward technologies are used, submit the appropriate CPT code and telehealth modifier "GQ", "via asynchronous telecommunications system."

(See "Store and forward defined" and "Medical practitioners who may receive payment at the distant site" sections).

By using the "GQ" modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Eligibility Criteria" and "Conditions of Payment" sections.)

Originating Site Facility Fee - *Carriers and Intermediaries*

To receive the facility payment, submit claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services."

By submitting "Q3014" HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

The facility fee will be updated yearly based upon the Medicare economic index and will be announced in an annual PM for carriers and intermediaries. Carriers and intermediaries must use these fees to pay the correct amount for this service. The Medicare physician fee schedule database will indicate that this claim is carrier-priced. This process is similar to the process currently used for the payment of certain mammography services.

Physicians' and practitioners' offices must bill the appropriate Medicare carrier for the originating site facility fee.

Intermediary claims processing. The appropriate bill types for this benefit are: 12X, 13X, 71X, 73X, and 85X. The originating site can be located in a number of revenue centers within a facility, such as an emergency room (450), operating room (360), or clinic (510). Instruct your providers to report this service under the revenue center where the service was performed and include HCPCS code "Q3014, telehealth originating site facility fee."

Note that the originating site facility fee is a Part B payment. Pay the originating site facility fee outside of current fee schedules or other payment methodologies (e.g., payment must be made in addition to the DRG, outpatient prospective payment system.) (See "Originating site facility fee payment methodology".)

Hospitals and critical access hospitals bill their intermediary for the originating site facility fee. Independent and provider-based RHCs and FQHCs bill the appropriate intermediary using the RHC or FQHC bill type and billing number. HCPCS code "Q3104, telehealth originating site facility fee" is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the providers bill type and billing number. Independent RHCs and FQHCs must bill the carrier for all other non-RHC/FQHC services.

If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code "Q3014 telehealth originating site facility fee" on a separate revenue line from the RHC/FQHC visit.

The telehealth professional service payment and originating site facility fee are subject to post payment verification.

Enrollment

The physician or practitioner at the distant site and the originating site facility are not subject to separate enrollment procedures for telehealth.

Trans.AB-01-69/CR1650/5-1-01/LV

ATENCIÓN A LOS PROVEEDORES DE SERVICIOS DE ANESTESIA

Con el propósito de orientar a nuestros proveedores de servicios de anestesia, a continuación les ofrecemos la información necesaria para calcular la tarifa a facturar por dichos servicios:

MÉTODO PARA CALCULAR LA TARIFA A FACTURAR POR SERVICIOS DE ANESTESIA

La siguiente, es la ecuación para efectuar el cálculo de la tarifa a facturar:

UNIDAD BASE* + UNIDAD DE TIEMPO REAL X FACTOR**

DE CONVERSIÓN* = CANTIDAD A FACTURAR**

***Las unidades base asignadas a cada código de procedimiento de anestesia se proveen en la lista incluida

****Las unidades de tiempo real se calculan de la siguiente forma:

Ejemplo de duración de la anestesia, 1 hora 10 minutos.

1 unidad = 15 minutos

1 hora = 60 minutos

60 minutos ÷ 15 minutos = 4 unidades

10 minutos ÷ 15 minutos = 2/3 unidades

Total unidades de tiempo real = 4 + 2/3 = 4 2/3 unidades

*****El factor de conversión se publica anualmente en el libro de Tarifas Fijas para Médicos

A continuación se explica la forma en que se calcula la cantidad a ser aprobada por Medicare:

CÓMPUTO DEL PAGO DE ANESTESIA

Ejemplo:

Procedimiento: **01756** Tiempo de duración: **60 minutos** Unidades base para este procedimiento: **6**

Factor de conversión para proveedor participante en PR en el año 2001: **$14.40**

1) El tiempo se convierte a unidades de 15 minutos:
   60 ÷ 15 = 4 unidades de tiempo real
2) Al número de unidades de tiempo se suman las unidades base del procedimiento:
   4 + 6 = 10
3) El resultado se multiplica por el factor de conversión de anestesia del año:
   10 x $14.04 = $140.40

$140.40 es la cantidad a ser aprobada por Medicare para este procedimiento

8-2001/DG-LV

ATTENTION ANESTHESIA SERVICES PROVIDERS

In order to keep our anesthesia services providers informed, we are providing the following necessary instructions on how to calculate the fee for such services:

HOW TO CALCULATE THE ANESTHESIA SERVICES FEE TO BE BILLED

This is the equation that is used to calculate the fee that the provider will bill to Medicare:

BASE UNITS* + ACTUAL TIME UNITS** X CONVERSION FACTOR = AMOUNT TO BE BILLED***

**Base Units assigned to each anesthesia procedure code are provided in the included list*

***Actual Time units are calculated as follows:*

Anesthesia Time Example, 1 hour 10 minutes

1 unit = 15 minutes

1 hour= 60 minutes

60 minutes ÷ 15 minutes = 4 units

10 minutes ÷ 15 minutes = 2/3 units

Total actual time units = 4 + 2/3 units

****Conversion factor is published annually in the Physician Fee Schedule Manual*

Following, we explain the method to calculate the amount that Medicare will approve:

EXAMPLE OF THE CALCULATION OF THE AMOUNT TO BE APPROVED BY MEDICARE

Procedure: ***01756*** *Actual Time:* ***60 minutes*** *Base Units assigned to this procedure:* ***6***

Conversion Factor for a participant provider in PR in 2001: ***$14.40***

1) *Time is converted into 15-minutes units:*
   60 ÷ 15 = 4 *actual time units*

2) *The procedure's base units are added to the actual time units:*
   4 + 6 = 10

3) *The sum is multiplied by the conversion factor for that year:*
   10 x $14.40 = $140.40

   $140.40 is the amount to be approved by Medicare for this anesthesia procedure

Reimbursement

La siguiente tabla les informa las unidades base correspondientes a cada procedimiento de anestesia:

The following table list the correspondent base unit for each anesthesia procedure:

Código	Unidad Base 2001	Código	Unidad Base 2001	Código	Unidad Base 2001	Código	Unidad Base 2001
00100	5	00406	13	00702	4	00900	3
00102	6	00410	4	00730	5	00902	4
00103	5	00450	5	00740	5	00904	7
00104	4	00452	6	00750	4	00906	4
00120	5	00454	3	00752	6	00908	6
00124	4	00470	6	00754	7	00910	3
00126	4	00472	10	00756	7	00912	5
00140	5	00474	13	00770	15	00914	5
00142	4	00500	15	00790	7	00916	5
00144	6	00520	6	00792	13	00918	5
00145	6	00522	4	00794	8	00920	3
00147	4	00524	4	00796	30	00922	6
00148	4	00528	8	00800	3	00924	4
00160	5	00530	4	00802	5	00926	4
00162	7	00532	4	00810	6	00928	6
00164	4	00534	7	00820	5	00930	4
00170	5	00537	7	00830	4	00932	4
00172	6	00540	13	00832	6	00934	6
00174	6	00542	15	00840	6	00936	8
00176	7	00544	15	00842	4	00938	4
00190	5	00546	15	00844	7	00940	3
00192	7	00548	15	00846	8	00942	4
00210	11	00550	10	00848	8	00944	6
00212	5	00560	15	00850	7	00946	5
00214	9	00562	20	00855	8	00948	4
00215	9	00563	25	00857	7	00950	5
00216	15	00566	25	00860	6	00952	4
00218	13	00580	20	00862	7	00955	5
00220	10	00600	10	00864	8	01112	5
00222	6	00604	13	00865	7	01120	6
00300	5	00620	10	00866	10	01130	3
00320	6	00622	13	00868	10	01140	15
00322	3	00630	8	00870	5	01150	8
00350	10	00632	7	00872	7	01160	4
00352	5	00634	10	00873	5	01170	8
00400	3	00635	4	00880	15	01180	3
00402	5	00670	13	00882	10	01190	4
00404	5	00700	3	00884	5	01200	4

Código	Unidad Base 2001	Código	Unidad Base 2001	Código	Unidad Base 2001	Código	Unidad Base 2001
01202	4	01432	5	01650	6	01832	6
01210	6	01440	5	01652	10	01840	6
01212	10	01442	8	01654	8	01842	6
01214	10	01444	8	01656	10	01844	6
01215	10	01462	3	01670	4	01850	3
01220	4	01464	3	01680	3	01852	4
01230	6	01470	3	01682	4	01860	3
01232	5	01472	5	01710	3	01904	7
01234	8	01474	5	01712	5	01906	5
01250	4	01480	3	01714	5	01908	5
01260	3	01482	4	01716	5	01910	9
01270	8	01484	4	01730	3	01912	5
01272	4	01486	7	01732	3	01914	6
01274	6	01490	3	01740	4	01916	5
01320	4	01500	8	01742	5	01918	5
01340	4	01502	6	01744	5	01920	7
01360	5	01520	3	01756	6	01921	7
01380	3	01522	5	01758	5	01922	7
01382	3	01610	5	01760	7	01951	3
01390	3	01620	4	01770	8	01952	5
01392	4	01622	4	01772	6	01953	1
01400	4	01630	5	01780	3	01990	7
01402	7	01632	6	01782	4	01995	5
01404	5	01634	9	01810	3	01996	3
01420	3	01636	15	01820	3	01999	0
01430	3	01638	10	01830	3		

8-2001/DG/LV

CHANGE IN JURISDICTION FOR PESSARY CODES

Effective for dates of service on or after January 1, 2002, jurisdiction for processing claims for the following codes will change from the durable medical equipment regional carriers (DMERCs) to the local carriers:

A4561 – Pessary, rubber, any type

A4562 – Pessary, non rubber, any type

CR 1788/TRANS.B-01-53/08-22-2001MM

INTRAVENOUS IRON REPLACEMENT THERAPY DRUGS

Section 45-29 of the Medicare Coverage Issues Carrier Manual; Intravenous Iron Therapy has been expanded to include the following:

Effective December 1, 2000 *sodium ferric gluconate complex in sucrose injection* is covered by Medicare for first line for treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy.

The claims must be submitted with **HCPCS code J2915** with a primary diagnosis code of chronic renal failure (ICD-9 code 585) and one of the following secondary diagnosis codes for iron deficiency (ICD-9 code 280.0,280.1,280.8 or 280.9). Deductible and Coinsurance apply.

Effective October 1, 2001, Medicare also covers *iron sucrose injection* as a first line treatment of iron deficiency anemia when furnished intravenously to patients undergoing chronic hemodialysis who are receiving supplemental erythropoeitin therapy.

Until a specific code is developed, providers must submit their claims with **HCPCS code J3490**, with the explanation of drug name and dosage in item #19 of HCFA 1500 form or in the narrative record of the electronic format. Deductible and coinsurance apply.

CR 1682/TRANS.139/06-01-2001/MM

CORRECTION TO THE 2001 PAYMENT AMOUNTS FOR DMEPOS E0616 CLARIFICATION

On the article Correction to the 2001 payment amounts for DMEPOS of the Medicare Informa, Vol. 66, page 27 we published the code E0616: Inexpensive or Routinely Purchased DME as a deleted code effective on January 1, 2001.

Actually, this code is active and the fee is the amount published on the Medicare Informa Vol. 65, page 27; Changes to 2001 Payment Amounts for DMEPOS.

We apologize for all the inconvenience this could cause.

AB-01-26/CR 1500/02-01-2001
AB-01-40/CR 1577/03-09-2001 MM

CLAIMS FOR SCREENING GLAUCOMA SERVICES

Conditions of Coverage. - The Benefits Improvements and Protection Act of 2000, §102, provides annual coverage for glaucoma screening for eligible Medicare beneficiaries, i.e., those with diabetes mellitus or a family history of glaucoma, and certain other individuals found to be at high risk for glaucoma as determined by CMS through rulemaking later this year. Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law. Coverage applies to glaucoma screening examination services performed on eligible beneficiaries on or after January 1, 2002.

Screening for glaucoma is defined to include:

- A dilated eye examination with an intraocular pressure measurement
- A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

Following are the HCPCS codes to bill for glaucoma screening:

G0117 - Glaucoma screening for high risk patients furnished by a physician.

G0118 - Glaucoma screening for high risk patients furnished under the direct supervision of a physician.

Frequency. - Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start your count beginning with the month after the month in which the previous covered screening procedure was performed.

Diagnosis Coding Requirements. - Bill glaucoma screening using screening ("V") code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma). Claims submitted without a screening diagnosis code will be returned to the provider as unprocessable.

Payment Methodology. – Payment for glaucoma screening will be based on the Medicare physician fee schedule. Deductible and coinsurance apply.

CR 1717/TRANS.B-01-46/07-25-2001/MM

ICD-9-CM DIAGNOSTIC CODES UPDATE

In accordance with instructions issued by the Centers for Medicare & Medicaid Services (CMS) physicians may begin using the new or updated ICD-9-CM codes for claims submitted on or after October 1, 2001. Then, effective for claims received on or after January 1, 2002 the updated codes must be used.

It is important that you use the most recent version of the ICD-9-CM coding book and code the highest level of specificity. The update of the ICD-9-CM codes may be obtained at:

American Medical Association
P.O. Box 7046
Dover, DE 19903
1-800-621-8335

CR 1661/AB-01-91/06-28-2001/MM

REVISED GUIDELINES FOR PROCESSING CLAIMS FOR CLINICAL TRIAL ROUTINE CARE SERVICES

The purpose of this CMS's directive is to provide revised diagnosis coding requirements and claims processing instructions for Medicare qualifying clinical trial services processed by carriers, DMERCS, fiscal intermediaries, Regional Home Health Intermediaries (RHHIs) and Program Safeguard Contractors. In addition, it clarifies Medicare contractor responsibility with respect to local medical review policy edits and requests for medical documentation for clinical trial services.

Revised Diagnosis Reporting Requirements for Routine Care Clinical Trial Services Billed on the Form HCFA-1500 or Electronic Claim Equivalent (Carriers and DMERCs)

Effective for services furnished on or after January 1, 2002, Form HCFA-1500 or electronic equivalent billers will use procedure code modifier "QV" to identify and report routine care for Medicare qualifying clinical trial services. The reporting of diagnosis code V70.5 as a secondary diagnosis on Form HCFA-1500 or the electronic claim equivalent will no longer be required for dates of service on or after January 1, 2002. For dates of service on or after January 1, 2002, the QV modifier constitutes the billers attestation that a service, supply or equipment meets the Medicare qualifying coverage criteria for clinical trial services processed by carriers and DMERCS.

EXCEPTION: Routine care clinical trial services furnished on or after January 1, 2002 to healthy, control group volunteers participating in Medicare qualifying diagnostic clinical trials are to be coded and billed in the following manner:

- The "QV" procedure code modifier is reported at the line item level.
- Diagnosis code V70.7 (Examination of participant in clinical trial) is reported as the primary diagnosis for applicable line items on the Form HCFA-1500 or electronic claim equivalent.

Medical Records Documentation Requirements

When submitting claims for routine items and services furnished in qualifying clinical trials, the billing provider should include information in the beneficiary's medical record about the clinical trial such as: the trial name, sponsor and sponsor assigned protocol number. This information should not be submitted with the claim but should be provided if requested for medical review. A copy of routine items and services should also be made available if requested for medical review activities.

PM AB-01-103/CR 1637/07-27-01/LV

INSTRUCTIONS FOR COVERAGE AND BILLING OF BIOFEEDBACK TRAINING FOR THE TREATMENT OF URINARY INCONTINENCE

Section 35-27.1of the Medicare Carrier Manual has been updated to include coverage specific to biofeedback therapy for the treatment of urinary incontinence. This policy applies to biofeedback therapy rendered by a practitioner in an office or other facility setting.

Biofeedback is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. Biofeedback is not a treatment, per se, but a toll to help patients learn how to perform PME. Biofeedback-assisted PME incorporates the use of a electronic or mechanical device to relay visual and/or auditory evidence of pelvic floor muscle tone, in order to improve awareness of pelvic floor musculature and to assist patients in the performance of PME.

A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Home use of biofeedback therapy is not covered.

The following claim instructions apply for dates of service on or after July 1, 2001.

HCPCS Coding

The following existing HCPCS codes should be used when billing for biofeedback therapy:

- 90901 - Biofeedback training by any modality; and
- 90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry.

Payment for biofeedback training

The payment for biofeedback training will be base on the Medicare Physician Fee Schedule. Deductible and coinsurance apply.

CR 1535/Trans. AB-01-79&138/05-15-2001/MM

Reembolso

ACTUALIZACIÓN DE CÓDIGOS Y PAGOS PARA CENTROS DE CIRUGIA AMBULATORIA

El Centro de Servicios Medicare & Medicaid (CMS por sus siglas en inglés) añadió algunos códigos para los cuales el programa Medicare provee una tarifa de pago por facilidad cuando son prestados en un Centro de Cirugía Ambulatoria certificada por Medicare. Estos cambios coinciden con la revisión annual de códigos realizada por la junta del AMA-CPT.

CMS provee el pago a una facilidad para los códigos de biopsia de mamas que fueron modificados en el CPT de un solo código que incluia guía para ultrasonido a dos nuevos códigos. El procedimiento de laparascopía también fue modificado. Finalmente, un nuevo servicio para catarata en el ojo cubierto previamente en Centros de Cirugía Ambulatoria bajo el código 66984 fue cambiado a un nuevo código.

Efectivo para servicios prestados en o después del 1 de enero de 2001, se pagará la facilidad de Centros de Cirugía Ambulatoria para los siguientes servicios:

Added Code	Payment Group
19102	2
19103	2
58353	4
66982	8

La Sección 103 del *Benefits Improvement and Protection Act of 2000 (BIPA)* requiere que CMS ofrezca una cubierta para la colonospia de cernimiento para individuos que no estén en alto riesgo de cáncer colorectal. Es por tal razón, que el código G0121 el cual describe este procedimiento estará cubierto efectivo el 1 de julio de 2001 para Centros de Cirugía Ambulatoria.

Efectivo para servicios prestados en o después del 1 de julio de 2001, se pagará la facilidad de Centros de Cirugía Ambulatoria para los siguientes servicios:

Added Code	Payment Group
G0121	2

Reimbursement

UPDATE OF CODES AND PAYMENTS FOR AMBULATORY SURGICAL CENTERS (ASCS)

The Centers for Medicare & Medicaid Services (CMS) added some codes for which the Medicare program provides a facility fee payment when they are performed in Medicare-certified ASCs. These changes are in line with the annual coding revisons made by the AMA CPT board.

CMS provides a facility payment for breast biopsy codes that were further refined by CPT from one single covered ASC code that included imaging guidance into two new codes. A covered laparoscopy procedure was also refined. Lastly, a new eye cataract service previously covered in an ASC under a different code (66984) has been further refined by CPT into a new code.

Effective for services performed on or after January 1, 2001 the following codes will be paid as an ASC facility payment:

Section 103 of the Benefits Improvement and Protection Act of 2000 requires that CMS provide a coverage for screening colonoscopy for individuals not at high risk for colorectal cancer. Therefore, the ASC list code G0121 Screening Colonoscopy for individuals not at high risk will be effective July 1, 2001.

***Effective for services performed on or after July 1, 2001 the following code will be paid as an ASC facility payment**:*

CR 1670/Trans.AB-01-81/05-15-2001/MM

Reembolso

ACLARACIÓN DE LOS REQUISITOS PARA EL PAGO Y LUGAR DE SERVICIO EN CENTROS DE CIRUGÍA AMBULATORIA

Los Centros de Cirugía Ambulatoria (ASC por sus siglas en inglés) pueden facturar a Medicare el costo de la facilidad para procedimientos prestados en ASC aprobados y certificados por Medicare. Los servicios facturados que no estén aprobados para el pago por facilidad serán denegados.

No obstante, los médicos y profesionales de la salud (no médicos) pueden facturar a Medicare por procedimientos no aprobados para pago por facilidad pero prestados en un ASC. El pago estará basado en la tarifa de no-facilidad de acuerdo a las tarifas fijas para médicos. Los pagos por procedimientos no indicados para pago en ASC pero prestados en dicha facilidad incluyen pagos por gastos de práctica, y como se mencionara anteriormente no existe pago por separado para la facilidad.

El lugar de servicio para procedimientos realizados en ASC es 24.

Reimbursement

CLARIFICATION OF PAYMENT AND PLACE OF SERVICE REQUIREMENTS FOR ASC CLAIMS

An Ambulatory Surgical Center (ASC) may bill Medicare for a facility fee for a procedure on the Medicare-approved ASC list and performed at the ASC. Claims for ASC facility fees billed for services not on the Medicare-approved ASC list will be deny.

However, physicians and qualified nonphysician practitioners may bill Medicare for procedures not on the Medicare-approved ASC list but performed in an ASC. The payment will be based on the nonfacility rate according to the physician fee schedule. The Medicare physician fee schedule payment for procedures not on the ASC list but performed in an ASC includes payment for all practice expenses, and, as noted above, there is no separate payment of an ASC facility fee.

The Place of Service code is 24 for procedures performed in an ASC.

CR 1680/TRANS. B-01-43/07-18-2001/MM

MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH DIABETES OR RENAL DISEASE

Beginning January 1, 2002, Medical Nutrition Therapy is a covered Medicare service when provided by a qualifying registered dietitian or nutrition professional. Other types of providers do not qualify for reimbursement for this service.

If you are a registered dietitian or nutrition professional and want to become a Medicare provider, please see http://www.hcfa.gov/Medicare/enrollment to determine the local carrier for your area. The carrier will require you to submit a completed Form HCFA-855.

Trans. B-01-48/CR1776/8-7-01/MM

Reembolso

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

Las siguientes pruebas han sido aprobadas por la Administración Federal de Drogas y Alimentos como pruebas de dispensa bajo el *Clinical Laboratory Improvement Amendments (CLIA*). Para que dichas pruebas sean reconocidas como pruebas de dispensa, los códigos CPT para las mismas deberán venir acompañados del modificador QW.

Reimbursement

NEW TESTS TO THE WAIVED CERTIFICATE

The following are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments (CLIA). To be recognized as a waived test, the CPT codes for these new tests must have the modifier QW.

TEST NAME	MANUFACTURER	CPT CODE(S)
*Worldwide Medical Corporation First Check Home Drug Test (THC)	Worldwide Medical Corporation	80101QW (This test may not be covered in all instances)
*Worldwide Medical Corporation, First Check Home Drug Test (THC-COC)	Worldwide Medical Corporation	80101QW (This test may not be covered in all instances)
*Roche Diagnostics Coagu Chek S Systems Test (for prothrombin time)	Roche Diagnostics Corporation	85610QW
*Wyntek Signify Mono Test	Wyntek Diagnositcs, Inc.	86308QW
*Worldwide Medical Corporation First Check Home Drug Test Panel 4 (THC-COC-OPI-MET)	Worldwide Medical Corporation	80101QW (This test may not be covered in all instances)
*OraSure Technologies Q.E.D. A-150 Saliva Alcohol Test	OraSure Technologies, Inc.	82055QW (This test may not be covered in all instances)
*OraSure Technologies Q.E.D. A-350 Saliva Alcohol Test	OraSure Technologies, Inc.	82055QW (This test may not be covered in all instances)
*Genua Menopause Monitor Test,	Genua 1944 Inc.	83001QW
*Bayer Diagnostics/ MICROALBUSTIX Reagent Strip	Bayer Inc.	82044QW, 82570QW
*Cholestech LDX Alanine Aminotransferase (ALT) Test	CHOLESTECH Corporation	84460QW

Los siguientes nuevos códigos han sido asignados para las siguientes pruebas:

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

83001QW for the Genua Menopause Monitor Test;

82570QW for Creatinine performed by the Bayer Diagnostics/ MICROALBUSTIX™ Reagent Strip; and

84460QW for the Cholestech LDX® Alanine Aminotransferase (ALT) Test

Se añadió el código 82570QW para la prueba *Bayer Clinitek 50 Urine Analyzer-* para microalbumina y creatina y el 84460 QW para *Chlestech LDX Alanine Aminotransferase (ALT) Test test.*

The additional CPT code, 82570QW has been added to the Bayer Clinitek 50 Urine Analyzer – for microalbumin and creatinine 84460QW for the Cholestech LDXÒ Alanine Aminotransferase (ALT) Test test.

CR 1751/TRANS.AB-01-95/07-12-2001/MM

Reembolso

ACTUALIZACIÓN EN LA BASE DE DATOS DE LAS TARIFAS FIJAS PARA MÉDICOS

El Centro de Servicios Medicare & Medicaid (CMS) notificó los siguientes cambios en las tarifas fijas de 2001. Los cambios serán efectivos para servicios prestados en o después del 1 de enero de 2001 y se implantarán 30 días después de la fecha de emisión de este boletín.

Los cambios incluidos en esta actualización:

CR 1790/AB-01-108/08-03-2001/MM

Reimbursement

FINAL UPDATE TO THE 2001 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

The Centers for Medicare & Medicaid Services (CMS) made the following changes to the 2001 Medicare Physician Fee Schedule Database. These updates are effective for services performed on or after January 1, 2001 and were implemented 30 days after the emission date of this bulletin.

Changes included in this final update are as follows:

Código CPT *CPT Code*	**REVISION**
A4570	From Status X to Status I
A4580	From Status X to Status I
A4590	From Status X to Status I
	NOTE: Procedure Status change for A4570, A4580, and A4590 effective for dates of service on/after 10/01/2001
G0219	Procedure Status = N
G0219 TC	Procedure Status = N
G0219 26	Procedure Status = N
	NOTE: Procedure Status change G0219, TC and 26 effective for dates of service on/after 07/01/2001
11976	From Global Period XXX To 000
15824	From Global Period XXX To 000
15825	From Global Period XXX To 000
15826	From Global Period XXX To 000
15828	From Global Period XXX To 000
15829	From Global Period XXX To 000
15876	From Global Period XXX To 000
15877	From Global Period XXX To 000
15878	From Global Period XXX To 000
15879	From Global Period XXX To 000
17380	From Global Period XXX To 000
33960	From Global Period XXX To 000
36468	From Global Period XXX To 000
36469	From Global Period XXX To 000
41820	From Global Period XXX To 000
41821	From Global Period XXX To 000
41850	From Global Period XXX To 000
41870	From Global Period XXX To 000

Código CPT *CPT Code*	REVISION
63043	From Bilateral Surgery Indicator 1 To 0
63044	From Bilateral Surgery Indicator 1 To 0
73718	From Bilateral Surgery Indicator 0 To 2
73718 26	From Bilateral Surgery Indicator 0 To 2
73718 TC	From Bilateral Surgery Indicator 0 To 2
73719	From Bilateral Surgery Indicator 0 To 2
73719 26	From Bilateral Surgery Indicator 0 To 2
73719 TC	From Bilateral Surgery Indicator 0 To 2
34800	From Co-Surgery Indicator 0 To 2
34802	From Co-Surgery Indicator 0 To 2
34804	From Co-Surgery Indicator 0 To 2
34808	From Co-Surgery Indicator 0 To 2
34812	From Co-Surgery Indicator 0 To 2
34813	From Co-Surgery Indicator 0 To 2
34820	From Co-Surgery Indicator 0 To 2
34825	From Co-Surgery Indicator 0 To 2
34826	From Co-Surgery Indicator 0 To 2
34830	From Co-Surgery Indicator 0 To 2
34831	From Co-Surgery Indicator 0 To 2
34832	From Co-Surgery Indicator 0 To 2
36870	From Co-Surgery Indicator 1 To 2
43231	From Co-Surgery Indicator 0 To 2
43232	From Co-Surgery Indicator 0 To 2
48554	From Co-Surgery Indicator 0 To 2
48556	Co-Surgery Indicator = 2
17004	From Multiple Procedural Indicator 0 To 2
34826	From Multiple Procedural Indicator 2 To 0
48554	Team Surgery Indicator = 2
48556	Team Surgery Indicator = 2
76977/global	Transition Non-Facility PE = 0.84
76977/global	Fully Implemented Non-Facility PE = 0.84
76977 TC	Transition Non-Facility PE = 0.82
76977 TC	Fully Implemented Non-Facility PE = 0.82
90471	From Malpractice RVUs .01 To 0.00
90472	From Malpractice RVUs .01 To 0.00
93668	From Malpractice RVUs .01 To 0.00

Reembolso

ACTUALIZACION TRIMESTRAL PRECIOS DE MEDICAMENTOS

A continuación, le detallamos el procedimiento utilizado para la actualización trimestral de precios en los medicamentos. Además, le incluimos una lista de códigos actualizados para este trimestre. Estas tarifas serán efectivas para facturas recibidas 30 días después de la fecha de emisión.

Instrucciones para el Cómputo de Precios

Los medicamentos y biológicos se pagan en base al cargo más bajo entre lo facturado o el 95% del "Average Wholesale Price" (AWP) según requerido por el Código de Regulaciones Federales (42 CFR 405.517) y enmendado en el Federal Register (63 FR 58849). Las tarifas para los medicamentos y biológicos se desarrollan como sigue:

- Para medicamentos o biológicos de una sola fuente, el AWP será igual al AWP del único producto existente.
- Para medicamentos o biológicos de distintas fuentes, el AWP será igual a lo menor de lo siguiente:
  - √ La mediana del AWP de todas las formas genéricas del medicamento o biológico
  - √ El menor AWP de los productos de marca
- Después de determinar el AWP, se multiplicará por el 0.95 y éste será el nuevo límite de pago permitido para el medicamento o biológico.

Nota: Para calcular la tarifa de los medicamentos y biológicos, también se pueden utilizar otras concentraciones que no sean las descritas en los códigos de procedimientos HCPCS (ejemplo: dosis que más frecuentemente se administren).

Reimbursement

QUARTERLY PRICING UPDATE FOR DRUGS

The following are the normal drugs pricing and update procedures. In addition, we are including a list of codes updated for this quarter. These new fees will be effective for claims received 30 days after the emission date.

Methodology Used to Determined the Fees

Drugs and biological are paid based on the lower of the billed charge or 95% of the average wholesale price (AWP), as required in the Code of Federal Regulations, 42 CFR 405.517 and amended in Federal Register (63 FR 58849). Fees for drugs and biological are calculated as follows:

- *For a single-source drug or biological, the AWP equals the AWP of the single product.*
- *For a multiple-source drug or biological, the AWP is equal to the lesser of the following:*
  - *√ Median AWP of all of the generic forms of the drugs or biological.*
  - *√ The lowest brand name product AWP.*
- *After determining the AWP, it is multiplied by 0.95. The result is the new drug payment allowance limit.*

Note: Concentrations other than described by the procedure code may be used to calculate fees for drugs and biologicals (e.g., the most frequently administered dose).

CODIGO *CODE*	TARIFA *FEE*	NO-PART *NON-PART*
J0290	$ 1.52	$ 1.44
J0696	$ 2.47	$ 2.35
J0725	$ 2.58	$ 2.45
J0743	$ 15.50	$ 14.72
J0895	$ 13.49	$ 12.82
J1720	$ 1.80	$ 1.71
J1745	$ 65.70	$ 62.41
J2930	$ 3.23	$ 3.07
J3480	$ 0.21	$ 0.20
J9031	$ 167.10	$ 158.74
J9185	$ 258.87	$ 245.93
J8600	$ 2.17	$ 2.06
90659	$ 4.92	N/A

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Trans. B-01-49/CR1797/08-07/01/MM

Reembolso

CAMBIO DE CÓDIGOS

Efectivo el 1 de enero de 2002 se realizarán los siguientes cambios con el propósito de permitirle a los proveedores el facturar a Medicare por servicios no cubiertos para obtener denegaciones y así poder someterlas a pagadores secundarios.

Códigos Eliminados:

A9160 – Non-covered service by podiatrist

A9170 – Non-covered service by chiropractor

A9190 – Personal comfort item, (non-covered by Medicare statute)

Modificador Eliminado:

GX – Service not covered by Medicare

Cambio de Status a "No válido para Medicare"

A9270 – Non-covered item or service

Códigos Nuevos:

Q3015 – Item or service statutorily non-covered, including benefit category exclusion, (used only when no specific code available)

Q3016 – Item or service not reasonable and necessary, (used only when no specific code available)

Modificadores Nuevos:

GY - Item or service statutorily non-covered

GZ - Item or service not reasonable and necessary

Los nuevos códigos Q3015 y Q3016 deben utilizarse cuando no exista un código específico disponible para describir el servicio. Los códigos con la descripción "Not Otherwise Classified" no deben utilizarse en esta situación.

Reimbursement

CODING CHANGES

To allow providers and suppliers to bill Medicare in order to get denials for secondary payers for non-covered items and services, the following coding changes will become effective January 01, 2002:

Deleted Codes:

***A9160**– Non-covered service by podiatrist*

***A9170**–Non-covered service by chiropractor*

***A9190**–Personal comfort item, (non-covered by Medicare statute)*

Deleted Modifier:

***GX** – Service not covered by Medicare*

Status Changed to "Not Valid for Medicare"

***A9270** – Non-covered item or service*

Added Codes:

***Q3015** – Item or service statutorily non-covered, including benefit category exclusion, (used only when no specific code available)*

***Q3016** – Item or service not reasonable and necessary, (used only when no specific code available)*

Added Modifiers:

***GY** -Item or service statutorily non-covered*

***GZ**-Item or service not reasonable and necessary*

The new codes, Q3015 and Q3016, must be used when there is no specific code currently available to describe the item or service. If a specific code is available, it must be used. "Not Otherwise Classified" codes may not be used in these situations.

Reembolso

Los nuevos modificadores GY y GZ deben utilizarse cuando un código en específico está disponible y el proveedor o suplidor quiere indicar que el servicio no está cubierto o no es razonable y necesario.

Información Explicativa

Siempre que los códigos Q3015 y Q3016 se utilicen se debe incluir una descripción de los servicios prestados al igual que una explicación indicando el por qué éstos fueron sometidos. La información debe indicarse en el encasillado 19 de la forma HCFA-1500. En el formato electrónico la información debe reportarse en el CAMPO DE LA NARRATIVA (Formato NSF) o en el "NIVEL DE NOTA DE LA RECLAMACIÓN" (ANSI Format).

En el formato ANSI si se necesita espacio adicional para la narrativa el proveedor debe entrar el "ADD" adecuado en NTE 01 y luego indicar la información adicional en NTE 02. Las instrucciones mencionadas anteriormente aplican también al momento de utilizar los modificadores GY y GZ.

Servicios Considerados como No Razonable y Necesarios:

El proveedor debe someter los códigos HCPCS específicos cuando entiendan que el servicio no razonable y necesario de acuerdo con las políticas y reglamentaciones de Medicare. El HCPCS que describe el servicio o equipo debe someter solo con el modificador GZ. Si no existe un código en específico disponible, el proveedor puede someter la reclamación utilizando el código Q3016.

Servicios Estatutorios No Cubiertos

Los servicios estatutorios no cubiertos por Medicare deben someterse utilizando el código específico con el modificador GY. Incluye reclamaciones sometidas por quiroprácticos por terapias no cubiertas. Si no existe un código en específico disponible, el proveedor debe someter la reclamación con el código Q3015.

Reimbursement

The new modifiers, GY and GZ, must be used when a specific code is available but the provider or supplier wants to indicate that the item or service is not covered or is not reasonable and necessary.

Explanatory Information

Anytime the codes Q3015 or Q3016 are used, the providers must include a description of the services or items provided as well as an explanation of why the services or supplies are being submitted. This information is entered in Item 19 of the HCFA-1500. For the electronic format, providers must report this information in the NARRATIVE RECORD (NSF Format) or CLAIMS LEVEL NOTE (ANSI format).

In the ANSI format if space for additional narrative is needed, the provider or supplier must enter the qualifier "ADD" in NTE01 then enter the additional narrative in NTE02. The instructions mentioned above apply when the modifiers GY or GZ are used.

Items and Services Considered Not Reasonable and Necessary:

The provider or supplier must submit the specific HCPCS code when they believe that the service is not reasonable and necessary according to Medicare policies and regulations. The HCPCS code that describes the service or item furnished must be submitted along with the GZ modifier. If there is no specific code available, the provider or supplier may submit the claim using the Q3016 code.

Statutorily Non-Covered Items or Services:

Items and services that are statutorily non-covered by Medicare, must be sumbitted using the specific code with the GY modifier. This includes claims submitted by chiropractors for statutorily non-covered maintenance therapy. If there is no specific code available, the provider or supplier must submit the claim using the Q3015 code.

Reembolso

Uso de Modificador GA con los Nuevos Códigos y Modificadores:

Cuando un servicio prestado se considera no razonable y necesario bajo circunstancias específicas, es responsabilidad del proveedor el notificarle al beneficiario por escrito a través de la Notificación Adelantada al Beneficiario (ABN por sus siglas en inglés). Se debe utilizar el modificador GA con el código Q3016 o el modificador GZ.

CR 1371/TRANS.B-01-30/04-26-2001/MM

Reimbursement

Use of the GA Modifier with the New Codes and Modifiers:

When a service is performed that is not reasonable and necessary under the specific circumstances, it is the responsibility of the provider to notify the beneficiary in writing through the use of the advance beneficiary notice (ABN). The GA modifier must be used in conjunction with the Q3016 or GZ modifier, not instead or in place of them.

VACCINE CODES FEES CHANGES FOR 2001

Effective 30 days after the emission date of this bulletin, the fees for the following vaccines will be:

CODE	DESCRIPTION	FEE
**90740	***Hepatitis B vaccine*** ,dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	$187.82
**90743	***Hepatitis B vaccine*** , adolescent (2 dose schedule), for intramuscular use	$22.45
*90744	***Hepatitis B vaccine*** , pediatric or pediatric/adolescent dosage (3 dose schedule), for intramuscular use	$21.30
*90747	***Hepatitis B vaccine*** , dialysis or immunosuppessed patient dosage (4 dose schedule), for intramuscular use	$104.69
90723	***Diptheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and poliovirus vaccine*** , inactivated (DTA-HEPB_UV), for intramuscular use	$40.50

*** Change description**

**** New code**

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CLINICAL LABORATORY GAP-FILLED FEES 2001

In our January, February and March 2001, page 39 we published a table indicating the fees for CPT-4 codes 82962, 86294 and 87338 corresponding to Puerto Rico. Following are the CPT-4 with the fees for Puerto Rico and Virgin Islands.

CODIGO	TARIFA/FEE	
CODE	PUERTO RICO	USVI
82962	$6.00	$3.00
86294	$90.00	$22.58
87338	$83.84	$48.28

Reclamaciones

EXTENSIÓN DE LA MORATORIA A LA LIMITACIÓN FINANCIERA EN LOS SERVICIOS AMBULATORIOS DE REHABILITACIÓN

En la sección 421 del Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act of 2000 (BIPA), se extiende la moratoria a la aplicación de la limitación financiera para reclamaciones por servicios de rehabilitación ambulatoria con fecha de servicio del 1 de enero de 2002 al 31 de diciembre de 2002. La anterior moratoria expiraría el 31 de diciembre de 2001, según fue publicado en nuestro boletín correspondiente a enero, febrero y marzo de 2000. Sin embargo, la moratoria ahora se extiende a un periodo de tres años y aplicará a reclamaciones por servicios de rehabilitación ambulatoria con fechas de servicio del 1 enero de 2000 hasta el 31 de diciembre de 2002.

Claims

EXTENSION OF MORATORIUM ON THE APPLICATION OF THE FINANCIAL LIMITATION FOR OUTPATIENT REHABILITATION SERVICES

Section 421 of the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act of 2000 (BIPA), extends the moratorium on application of the financial limitation for claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. The previous moratorium would have ended on December 31, 2001, as published in our provider bulletin (January / February / March 2000). However, the moratorium is now for a 3-year period and will apply to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

Trans. AB-01-36/CR1491/2-23-01/LV

Electronic Media Claims (EMC)

ELECTRONIC MEDIA CLAIM BILLING NUMBERS

On a yearly basis, Medicare Part B Provider Enrollment will be requesting that all providers that hold an electronic media claim billing number update their files with the information pertaining the name of the contact person that submit claims electronically on behalf of the provider.

Please complete HCFA 855 Form, Section 1(A,B,C), 15 and 18. Copies of HCFA 855 forms can be obtained accessing our website at http://www.hcfa.gov or by calling the Medicare Provider Enrollment Section. The information hereby requested should be submitted to our office by **October 31, 2001** or we will find ourselves in the position of having to deactivate your electronic media claim-billing number and not until it is received you will be allowed to submit claims electronically.

SS/8-27-01

¡Qué Bueno Que Preguntó!

Desde la Portada, cont.

¿Cuál es la forma más segura de recibir los pagos que Medicare me envía?

We Are Glad You Asked!

From the Cover Page, cont.

What is the safest way to receive Medicare Payments?

Electronic Funds Transfers Form

U.S. Department of Health and Human Services
Health Care Financing Administration

FORM APPROVED
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFERS

Provider/Physician Name	Provider/Physician ID Number

I hereby authorize _____, hereinafter called COMPANY, to initiate credit entries and if necessary, adjustments for any credit entries in error to my ☐ Checking ☐ Savings account (*select one*) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

Depository Name	Branch	
City	State	Zip Code
Transit Number	Account Number	

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Name (Please Print)	Title (Please Print)
Signature	Date

HCFA-588 (12-92)

For Information Purpose Only. This form should be requested to our Community Relations Department at (787) 749-4232 or 1-877-715-1921.

Contrato

PROVEEDORES SANCIONADOS

Proveedores sancionados son aquellos que han violado las obligaciones de su contrato con Medicare o Medicaid. A estos proveedores no se les permite facturar al Programa Medicare. Los "carriers" reciben mensualmente una lista de parte de HCFA, que contiene las exclusiones y reintegraciones efectuadas por la Oficina del Inspector General (OIG). Las exclusiones son efectivas a los 20 días de la fecha de la notificación al proveedor. Estas exclusiones y reintegraciones serán efectivas a la fecha indicada. Las instrucciones para el manejo de los proveedores sancionados fueron establecidas por HCFA en las secciones 14030.5 a la 14030.13 en el *Medicare Carrier Manual*.

La sección 4304 del "Balanced Budget Act" (BBA) modificó la sección 128A(a) del "Social Security Act". Específicamente, el "BBA" añadió nuevas penalidades monetarias civiles de hasta $10,000 por cada artículo o servicio provisto y hasta tres veces la cantidad reclamada en casos en que una persona se contrata con un proveedor excluído, con el propósito de proveer servicios o artículos para el cuidado de la salud, y dicha persona sabe o debería saber que el proveedor estaba excluído de Medicare.

La sección 1128A del "SSA" define el término "persona" incluyendo "una organización, una agencia u otra entidad, pero excluyendo al beneficiario." Esta provisión aplica a contratos o acuerdos efectuados después del 5 de agosto de 1997.

Para cumplir con nuestro compromiso de educar a los proveedores de Medicare, a continuación presentamos en la siguiente página la lista de los proveedores que han sido excluídos o reintegrados al programa Medicare:

Contract

SANCTIONED PROVIDERS

Sanctioned providers are practitioners who violate their obligations under the "Medicare and Medicaid Programs Protection Act". They are excluded from billing the Medicare Program. Carriers receive a monthly listing from HCFA containing exclusion and reinstatement or withdrawal actions taken by the Office of Inspector General (OIG). Exclusion actions are effective 20 days from the date of the notice to the provider. Reinstatements / withdrawals are effective as of the date indicated. HCFA established the instructions for the handling of sanctioned providers on MCM sections 14030.5 to 14030.13.

Section 4304 of the Balanced Budget Act (BBA) modified Section 1128A(a) of the Social Security Act. Specifically, the BBA added new civil monetary penalties of up to $10,000 for each item or service provided, and triple the claimed amount in cases in which a person contracts with an excluded provider for the provision of health care items or services and the person knows or should have known that the provider was excluded from participation in the Medicare program.

Section 1128A of the Social Security Act defines the term "person" to include "organization, agency, or other entity, but excluding a beneficiary". This provision applies to arrangements or contracts entered into after August 5, 1997.

To comply with our commitment to educate and inform our medical community we have included on next page the most recent list of excluded and/or reinstated providers:

Proveedores Excluídos del Programa Medicare

Providers Excluded from the Medicare Program

NOMBRE *NAME*	DIRECCION *ADDRESS*	PERIODO DE EXCLUSION *PERIOD OF EXCLUSION*	FECHA EFECTIVIDAD *EFFECTIVE DATE*
Ramírez Santoni, David	Cervantes Apt. Santurce, PR 00907	Permanent	March 1, 1991
Bailey, Colin D H	227 Golden Rock Dev Est Christiansted St. croix, VI 008204	Indefinite	April 1, 1992
Escalante Santos, Gilberto	Urb. Summit Hills 596 Torrecillas St. Rio Piedras, PR 00920	Indefinite	June 10, 1994
Alvarado Sánchez, Mayda C.	56 Georgetti St. Comerío, PR 00782	Indefinite	September 3, 1997
Ortíz Ramos, Jorge L.	17St. - 3D1 Covadonga Toa Baja, PR 00949	Indefinite	December 20, 1999
Atocha Sánchez, José M.	720 Ponce De León Ave. San Juan, PR 00918	Indefinite	April 29, 1996
Capó Fernández, Yolanda	Plaza Vega Baja Pearl Vision Express Vega Baja, PR 00693	Indefinite	April 16, 1997
Soto Vázquez, Julio M.	Villa Rosa III B27 - 1St. Guayama, PR 00784	Indefinite	May 17, 1991
Rosado Montalvo, Héctor	Ponce Plaza Alfonso XII - Int. Isabel St. Ponce, PR 00731	Indefinite	May 22, 1997
Stella, Edgar	513 Street Tintillo Hills Bayamón, PR 00966	20 years	January 29, 1986
Rivera Cruz, Carlos	205 Lauro Piñero Ave. Ceiba, PR 00735	Indefinite	December 20, 1999
Moreno Torres, Edwin	134 Calle José I. Quinton Coamo, PR 00769	5 years	December 20, 1998
Mercado Franci, José A.	Villa Clarita 2 6 St. # 46 Fajardo, PR 00738	Indefinite	August 20, 2000
Texidor Sánchez, Carmen I.	25 St. - Z-19 Rio Verde Caguas, PR 00725	Indefinite	August 20, 2000
Rutkowski Whitehead, Morris E.	371 San Jorge St. Santurce, PR 00912	Indefinite	July 14, 1993
Arce Forestier, Nestor	3 Muñoz Rivera St. Camuy, PR 00627	Indefinite	August 20, 1998
Francis Ambulance	99 Manolo Flores St. Fajardo, PR 00738	Indefinite	August 20, 2000
Rivera López, Aixa	Pearl Vision 52-E José De Diego St. Cayey, PR 00736	Indefinite	September 20, 2000
Pérez Cuevas, Reynaldo	Centro Visual de Florida Florida, PR 00650	Indefinite	October 19, 2000
Arrillaga, Abenamar	Ext. Hermanas Davila 23 - J St. Bayamón, PR 00959	20 years	May 18, 2000
Kutcher Olivo, Roberto	Calle Betances 80 Canóvanas, PR 00629	Indefinite	March 20, 2001
Grana Díaz, Roberto	Urb Sagrado Corazón 1616 Calle Sta Eduviges San Juan, PR 00926	Indefinite	May 20, 2001

Relaciones con la Comunidad

LISTA REVISADA DE AREAS HPSA

La reglamentación de Medicare establece que el "Carrier"de la Parte B realice revisiones trimestrales de los pagos efectuados como incentivos a los servicios prestados en áreas de escasez profesionales de la salud (HPSA, por sus siglas en inglés).

La designación y clasificación de las áreas de escasez de profesionales de la salud son hechas por el Servicio de Salud Pública - Oficina para la Designación de Áreas de Escasez (Public Health Service - Office of Shortage Designation). Para reclamar el incentivo, los servicios deben prestarse en un lugar clasificado como de escasez de profesionales de la salud. Además, se deberá utilizar en el encasillado 24d del formulario HCFA 1500 el modificador que aplique de estos dos:

QB: Para los servicios rendidos en áreas rurales de escasez.

QU: Para los servicios rendidos en áreas urbanas de escasez.

A continuación la lista actualizada de los pueblos clasificados como Áreas de Escasez de Profesionales de la Salud, la misma será efectiva treinta (30) días a partir de la fecha de publicación de esta notificación.

Si tiene alguna pregunta relacionada con esta información o cualquier otra información publicada en esta comunicación, puede llamarnos al 749-4232 o al 1-877-715-1921.

Community Relations

UPDATED HPSA LIST

Medicare regulation requires Part B Carriers to conduct quaterly reviews of the incentive payments for services rendered in any rural or urban Health Professional Shortage Area (HPSA).

The designation and classification of these areas are made by the Federal Public Health Service Office of Shortage Designation. To qualify for the incentive payment, the services must be rendered in a HPSA and it is necessary to use the following modifiers in block 24d (procedure code) of the HCFA 1500 form:

***QB**: For services rendered in rural HPSAs.*

***QU**: For services rendered in urban HPSAs.*

The following is an updated list of Health Professional Shortage Areas. This new HPSAs will be effective thirty (30) days after the publication of this communication.

If you have any questions concerning this or any other information published in this communication, please call us at 749-4232 or 1-877-715-1921.

DBHPP:BSPB:ASprenz-2-3-99/Updated 7-2001/LV

LISTA ACTUALIZADA (HPSA)
UPDATED HPSA LIST

PUERTO RICO	VIRGIN ISLANDS
Aguas Buenas	Fredericksted South West, St. Croix
Caguas	Fredericksted North West, St. Croix
Cidra	
Gurabo	
Juncos	

Relaciones con la Comunidad

FACTURACIÓN DE LAS VACUNAS ANTINEUMOCÓCICA (PPV), HEPATITIS B E INFLUENZA

Según la más reciente revisión del *Medicare Carriers Manual*, sección 4480, cuando se factura por las vacunas antineumocócica (PPV), Hepatitis B e Influenza, la asignación es obligatoria. Su cubierta y administración se encuentran disponibles únicamente bajo la parte B de Medicare, independientemente del lugar en el que se prestaron los servicios, aun cuando se haya provisto a un paciente hospitalizado durante una estadía en hospital cubierta por la parte A. El pago de Medicare constituye el 100 por ciento de la cantidad aprobada para las vacunas PPV e Influenza. Ni el deducible de la parte B, ni el coaseguro aplican a las vacunas PPV e influenza. Al facturar por la vacuna de Hepatitis B, tanto el deducible de la parte B, como el 20 porciento correspondiente al coaseguro aplican.

FACTURACIÓN SIMPLIFICADA

Todos aquellos individuos y entidades que van a someter reclamaciones a Medicare por medio de facturación simplificada (roster billing) deben llenar la solicitud de número de proveedor o suplidor (Forma HCFA 855). Dicha forma contiene instrucciones específicas para estos individuos o entidades. Aquellos que utilicen dichas instrucciones, no deben facturar a Medicare por ningún otro servicio que no sea por vacunas PPV y contra la influenza.

Si las Clínicas de Salud Pública (PHCs, por sus siglas en inglés) u otro individuo o entidad cualifican para utilizar el proceso de facturación simplificada, deben utilizar una forma HCFA 1500 preimpresa que contenga información estandarizada sobre la entidad y el beneficio.

Community Relations

BILLING FOR PNEUMOCOCCAL, HEPATITIS B, INFLUENZA VIRUS VACCINES

According to the most recent revision of Medicare Carriers Manual, §4480 of the Medicare Carriers Manual, mandatory assignment applies when billing for pneumococcal (PPV), hepatitis B, and influenza virus vaccines. Their coverage and their administration are available only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A. Payment is 100 percent of the Medicare allowed amount for PPV and influenza virus vaccine. Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine. Part B deductible and 20 percent coinsurance do apply for hepatitis B vaccine.

MCM Trans. 1700/CR1633/4-12-01/LV

SIMPLIFIED ROSTER BILLS

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

If the Public Health Clinics (PHCs) or other individual or entity qualifies to use the simplified billing process, it may use a preprinted Form HCFA-1500 that contains standardized information about the entity and the benefit.

Relaciones con la Comunidad

Las entidades que sometan reclamaciones por medio del proceso de facturación simplificada, deben llenar los siguientes encasillados en una forma HCFA 1500 modificada que sirva como cubierta a la lista de facturas de cada facilidad en la cual se hayan prestado los servicios. Se debe someter una Forma 1500 por cada facilidad en donde se presten los servicios, para que el "carrier" pueda reembolsar correctamente por localidad de pago.

Item 1: An X in the Medicare block

Item 2 (Patient's Name): "SEE ATTACHED ROSTER"

Item 11 (Insured's Policy Group or FECA Number): "NONE"

Item 17A (I.D. Number or Referring Physician): This number is required for PPV and hepatitis B vaccines only. Effective for claims with dates of service on or after July 1, 2000, this number will no longer be required for PPV.

Item 20 (Outside Lab?): An "X" in the NO block

Item 21 (Diagnosis or Nature of Illness):
Line 1:
PPV: "VO3.82"
Influenza Virus: "V04.8"

Item 24B (Place of Service (POS)):
Line 1: "60"
Line 2: "60"

NOTE: POS code "60" must be used for roster billing.

Item 24D (Procedures, Services, or Supplies):
Line 1:
PPV: "90732"
Influenza Virus: "90659"
Line 2:
PPV: "G0009"
Influenza Virus: "G0008"

Community Relations

Entities submitting roster claims to carriers must complete the following blocks on a single modified Form HCFA-1500 which serves as the cover document for the roster for each facility where services are furnished. In order for carriers to reimburse by correct payment locality, a separate Form HCFA-1500 must be used for each different facility where services are furnished.

Item 24E (Diagnosis Code):
Lines 1 and 2: "1"

Item 24F ($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC PPV or influenza virus vaccine claims only if your system is able to accept them.

Item 27 (Accept Assignment): An "X" in the YES block

Item 29 (Amount Paid): "$0.00"

Item 31 (Signature of Physician or Supplier): The entity's representative must sign the modified HCFA-1500.

Item 32 (Name and Address of Facility): "Non-applicable"

Item 33 (Physician's, Supplier's Billing Name): If the provider number is not shown on the roster billing form, the entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or Group Number, as appropriate.

MCM Trans.1700/CR1633/4-12-01/LV
MCM Part 3 Trans.1711/CR1700/6-14-01/LV

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