Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

CAMBIOS (REDUCCIONES) EN LAS TARIFAS DE 2002

Las tarifas de Medicare para el 2002 bajaron en comparación con las del 2001. Este año las tarifas en el Libro de Tarifas Fijas para Médicos reflejan una disminución debido a la baja en el Factor de Conversión (36.1992 para 2002 vs. 38.2581 para 2001) y a los cambios en las Unidades de Valor Relativo de los Gastos de Práctica.

El Factor de Conversión es el multiplicador que transforma los valores relativos en cantidades de pago. La categoría de Gasto de Práctica representa el porciento de aumento en el precio de los insumos no médicos utilizados para un servicio en las oficinas de médicos. Esta categoría consiste de sueldos, salarios y beneficios marginales para el personal no médico y otros insumos no relacionados con la tarea. El componente de Gasto de Práctica

cont. en la página 4

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CHANGES (REDUCTIONS) ON 2002 FEES

Medicare fees for 2002 have decreased if compared to 2001 fees. This year the fees on the 2002 Medicare Physician Fee Schedule reflect a decline due to the lower Conversion Factor (36.1992 for 2002 vs. 38.2581 for 2001) and the changes on the Practice Expense Relative Value Units (PE RVU).

The Conversion Factor is the multiplier which transforms relative values into payment amounts. The Practice Expense (PE) category represents the rate of price growth in nonphysician inputs used to produce a service in physician's offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and

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Este boletín debe ser compartido con todos los profesionales de la salud y administrativos que formen parte de su oficina. Copias adicionales del boletín están disponibles en nuestra página de internet a la siguiente dirección: www.triples-med.org

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: March 8, 2002 **Volume 69 / Jan., Feb., March 2002**

http://www.cms.hhs.gov
http://www.triples-med.org

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TABLA DE CONTENIDO

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MOA2002

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incluye además las siguientes categorías no relacionadas a la tarea – gastos de oficina, materiales médicos y de oficina, seguro de responsabilidad profesional, equipo médico, gastos de auto, entre otros.

Basándonos en las preguntas de nuestra comunidad de proveedores con relación a este asunto, se consultó a los Centros de Servicios para Medicare & Medicaid (CMS por sus siglas en inglés). CMS contesta que este año la reglamentación indicada en el Federal Register Final Rule contiene cambios para virtualmente todo aspecto de la fórmula de la tarifa fija para médicos. El cambio más significativo es la implantación total de la Unidad de Valor Relativo del Recurso Base (Resource Based RVU) de la fórmula para la porción del gasto de práctica (PE, por sus siglas en Inglés).

La gran mayoría de los cambios significativos en las tarifas de reembolso se deben al cambio en el RVU para la porción PE de la fórmula. A continuación incluimos para su conveniencia los Componentes de las Tarifas Fijas para Pago. Bajo la fórmula establecida en la sección 1848(b)(1) del Acta, la cantidad de pago para cada servicio bajo las tarifas fijas de médicos es el producto de tres factores (1) un valor relativo nacional para el servicio; (2) el factor de ajuste geográfico (GAF por sus siglas en inglés) para cada área de la tarifa fija de médicos; y (3) un factor de conversión nacional para cada servicio. El Factor de Conversión convierte los valores relativos en cantidades de pago.

La fórmula general para calcular las tarifas fijas de Medicare para un servicio se expresa de la siguiente forma:

Pago = [(RVU [(RVU work x GPCI work)+ (RVU practice expense x GPCI practice expense)+ (RVU malpractice x GPCI malpractice)] x CF

RVU work (Work Relative Value Unit) = Valor de la Unidad para la Unidad de Valor Relativo del trabajo médico.

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other nonlabor inputs. The PE component also includes the following categories of nonlabor inputs -office expense, medical materials and supplies, professional liability insurance, medical equipment, professional car, and other expenses.

Based on our providers' community inquiries related to this matter, we consulted the Centers for Medicare & Medicaid Services (CMS). CMS response is that this year's Federal Register Final Rule contained changes to virtually every aspect of the physician fee schedule's formula. The most significant change is the full implementation of the Resource Based RVU's for the Practice Expense (PE) portion of the formula.

The vast majority of significant changes in reimbursement amounts are due to the change in the RVU for the PE portion of the formula. Following, we included for your convenience the Components of the Fees Schedule Payment Amounts. Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors- (1) a nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as:

***Payment** = [(RVU work x GPCI work)+ (RVU practice expense x GPCI practice expense)+ (RVU malpractice x GPCI malpractice)] x CF*

***RVU work (Work Relative Value Unit)** = Unit value for the physician work Relative Value Unit.*

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GPCI work (Work Geographic Practice Cost Indices) = Factor de ajuste geográfico utilizado para el cómputo de la tarifa fija.

RVU practice expense = Valor de la Unidad para el Gasto de Práctica. (Referirse al segundo párrafo)

GPCI practice expense (Practice Expense GPCI) = Factor de Ajuste geográfico para el gasto de práctica utilizado en en el cómputo de la tarifa fija.

RVU malpractice (Malpractice Relative Value Unit) = Valor de la Unidad para el Gasto por impericia médica.

GPCI malpractice = Factor de ajuste geográfico para el cómputo de la tarifa fija.

CF (Conversion Factor) = Multiplicador que transforma los valores relativos en cantidades de pago.

La mayoría de los cambios (reducciones) van más allá de aquellas proyectadas en las columnas de RVU implantadas al máximo en las reglamentaciones anteriores.

Las sociedades de especialidades re-evaluaron la porción de gasto de todos los códigos CPT y recomendaron más de 800 cambios al Gasto de Práctica (PE) de los valores de las unidades relativas. En muchos de los casos, estos cambios se deben a una actualización en la tecnología y en los estándares de la práctica médica. En la mayoría de los casos los valores de los gastos de práctica (PE) bajaron por recomendación de la Sociedad de Especialidad PEAC.

Para una discusión más detallada de este proceso puede hacer referencia a la reglamentación incluida en el *Federal Register Final Rule* del 1 de noviembre de 2001 comenzando en la página 55249. También puede obtener información adicional sobre PEAC accesando la página web de CMS: http://www.cms.hhs.gov/professionals.

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GPCI work (Work Geographic Practice Cost Indices) *= Geographic adjustment factor used in computing the fee schedule amount.*

RVU practice expense *= Unit value for the practice expense RVU. (Refer to the 2nd paragraph)*

GPCI practice expense *(Practice Expense GPCI) = Practice expense geographic adjustment factor used in computing the fee schedule amount.*

RVU malpractice (Malpractice Relative Value Unit) *= Unit value for the malpractice expense RVU.*

GPCI malpractice *= Geographic adjustment factor used in computing the fee schedule amount.*

CF (Conversion Factor) *= Multiplier which transforms relative values into payment amounts.*

Many of the changes (reductions) are beyond those projected in the fully implemented RVU columns mentioned in the earlier rules.

The specialty societies reevaluated themselves the expense portion of all CPT codes and recommended over 800 changes to the PE RVU values. In many instances, this was a catch-up on technology and standards of medical practice and in most instances, the PE values decreased based upon the recommendation of the Specialty Society Practice Expense Advisory Committee (PEAC).

For a more detailed discussion of this process you can refer to the November 01, 2001 Federal Register Final Rule starting on page 55249. You can also obtain additional information on PEAC visiting CMS website http://www.cms.hhs.gov/professionals.

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La siguiente tabla es un ejemplo de la aplicación de la fórmula:

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The following table is an example of the formula application:

Código 64420 (Surgery)(FPA)*			**Fee Schedule**	**$45.29**
	A		B	AXB=C (C)
Work RVU	1.18	Work GPCI	0.881	1.03958
PE RVU	0.27	PE GPCI	0.712	0.19224
MP RVU	0.07	MP GPCI	0.275	0.01925
			Total	1.25107
Total	**1.25107**	**Conv. Factor**	**36.1992**	**45.28773**

Código 64420 (Surgery)(N-FPA)*			**Fee Schedule**	**$99.41**
	A		B	AXB=C (C)
Work RVU	1.18	Work GPCI	0.881	1.03958
FPE RVU	2.37	PE GPCI	0.712	1.68744
MP RVU	0.07	MP GPCI	0.275	0.01925
			Total	2.74627
Total	**2.74627**	**Conv. Factor**	**36.1992**	**99.41278**

***FPA** = Facility Practice Amount
***N-FPA** = Non Facility Practice Amount

E-mail S. Lisker - DGill/Feb. 2002/CR#1727/TR. 1716/07-27-01/MM

COVERAGE AND BILLING OF AMBULATORY BLOOD PRESSURE MONITORING (ABPM)

Section 50-42 of the Medicare Coverage Issues Manual has been revised to change the coverage status of the Ambulatory Blood Pressure Monitoring (ABPM) from non-covered to covered and to clarify the conditions under which ambulatory blood pressure monitoring is covered.

Coverage

Ambulatory blood pressure monitoring (ABPM) involves the use of a non-invasive device, which is used to measure blood pressure in 24-hour cycles. These 24-hour measurements are stored in the device and are later interpreted at the physician's office. ABPM must be performed for at least 24 hours to meet coverage criteria. Payment is not allowed for institutionalized beneficiaries. Effective April 1, 2002, ABPM is covered for those beneficiaries with suspected "white coat hypertension". Suspected "white coat hypertension" is defined as:

- Office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
- At least two documented separate blood pressure measurements taken outside the office which are < 140/90 mm Hg; and
- No evidence of end-organ damage.

ABPM is not covered for any other uses. In the rare circumstance that ABPM needs to be performed more than once in a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test.

Carrier Billing Instructions

Applicable HCPCS Codes

- 93784 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report
- 93786 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only
- 93790 - ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

HCPCS code 93788 (ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report) is not approved for Medicare payment.

Payment Requirements

Payment and pricing information will be on the April update of the Medicare Physician Fee Schedule Database (MPFSDB). Payment for ABPM is based on the Medicare Physician Fee Schedule. Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken are subject to the Medicare limiting charge.

CR1985/CIM # 149/PM AB-01-88 /12-18-01/LV

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

CPAP is a non-invasive technique for providing single levels of air pressure from a flow generator via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

Effective for services furnished between and including January 12, 1987 and March 31, 2002:

The diagnosis of OSA requires documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during 6-7 hours of recorded sleep. The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP.

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician, that specifies:

- A diagnosis of moderate or severe obstructive sleep apnea, and
- Surgery is a likely alternative

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

Effective for services furnished on or after April 1, 2002:

The use of CPAP devices are covered under Medicare when ordered and prescribed by the licensed treating physician to be used in adult patients with OSA if either of the following criteria using the Apnea-Hyopopnea Index (AHI) are met:

AHI ³ 15 events per hour, or

AHI ³ 5 and £ 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia or documented hypertension, ischemic heart disease or history of stroke.

The AHI (Apnea-Hypopnea Index) is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e, the AHI may not be extrapolated or projected).

Apnea is defined as a cessation of airflow for at least 10 seconds. Hyopopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least 4% oxygen desaturation.

The polysomnography must be performed in a facility – based sleep study laboratory and not in the home or in a mobile facility.

Initial claims for CPAP devices must be supported by information contained in the medical record indicating that the patient meets Medicare's stated coverage criteria.

GGL-1689/Trans.150/CR#1949

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

ATENCIÓN PROVEEDOR

Le recordamos que las siguientes políticas médicas: Anesthesia, Troponin, Prothrombin Time, Partial Tromboplastin Time y Glutamyltransferase GAMMA (GGT) entraron en vigor el 28 de septiembre de 2001.

ATTENTION PROVIDERS

This is a reminder that the following medical policies: Anesthesia, Troponin, Prothrombin Time, Partial Tromboplastin and Glutamyltransferase GAMMA (GGT) were effective September 28, 2001.

LOCAL MEDICAL REVIEW POLICIES - NOTICE PROCESS

We would like to inform that the Centers for Medicare and Medicaid Services (CMS) extended the notice period for the Local Medical Review Policies from 30 to 45 days. The extension for the 45 days is observed under the headings included in the Local Medical Review Policies “Start date of notice period” and “Effective date”.

(CR1021; Transmittal 9 PIM; July 30, 2001)

Contractor's policy number
VI/PR-01-021

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Bilaminate Skin Substitute (Apligraf)

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".

CMS 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 to diagnose or treat an illness or injury.

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

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

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
March 4, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
The product is a manufactured viable bilaminate graft or skin substitute, designed to be used for treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency and neuropathic diabetic foot ulcers.

Indications and Limitations of Coverage and/or Medical Necessity
Coverage of this modality/product will be considered when all of the following conditions are satisfied and documented.

1. Venous stasis ulcers of greater than three (3) months duration.
2. Neuropathic diabetic foot ulcers of greater than four (4) weeks' duration.
3. Venous stasis ulcers must have failed to respond to documented conservative measures of greater than two (2) months duration.
4. Neuropathic diabetic foot ulcers must have failed to respond to documented conservative measures of greater than one (1) month duration.
5. Partial or full-tickness ulcers.
6. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management and the size at the beginning of skin substitute treatment.
7. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken.

In addition, the ulcer must be free of infection and underlying osteomyelitis; and treatment of the underlying disease must be provided and documented in conjunction with bilaminate skin substitute treatment.

Limitations of coverage are as follows:
1. Use of the skin substitute is limited to three (3) separate applications to any given ulcer.
2. There should be no fewer than six (6) weeks between applications for venous stasis ulcers and there should be no fewer than three (3) weeks between applications for neuropathic diabetic foot ulcers.
3. Treatment of any ulcer will typically last approximately twelve (12) weeks.
4. For venous stasis ulcers, two applications of the skin substitute are indicated. If after twelve (12) weeks of compression treatment and two applications of the skin substitute, a 50% or greater improvement is noted and documented, then reapplication of a third skin substitute will be considered for coverage. Otherwise, reapplication of the skin substitute is not recommended and other treatment modalities should be considered.
5. Re-treatment within one year for venous stasis ulcers is not covered.
6. For neuropathic diabetic foot ulcers, if after nine (9) weeks of treatment, and three (3) applications of the skin substitute is not recommended and other treatment modalities should be considered.

Contraindications:
Apligraf is contraindicated for use on clinically infected wounds;
In patients with known allergies to bovine collagen;or
In patients with known hypersensitivity to the components of the Apligraf agarose shipping medium (which contains agarose, L-glutamine, hydrocortisone/bovine serum albumin, bovine insulin, human

transferrin, triiodothyronine, ethanolamine, O-phosphorylethanolamine, adenine, selenious acid, DMEM powder, HAM's F-12 powder, sodium bicarbonate, calcium chloride, and water for injection).

In *vitro* and in *vivo* histology studies have shown that Apligraf either degrades or its cell viability is reduced when the device is exposed to the following cytotoxic agents: Dakin's solution, Mafenide acetate, Scarlet red dressing, Tincoban, Zinc sulfate, Povodine-iodine solution, Chlorhexidine or Polymixin/ Nystatin. The use of Apligraf with these solutions will be considered not reasonable and necessary and will result in denial of reimbursement.

The safety and effectiveness of Apligraf have not been established for patients receiving more than five device applications.

CPT/HCPCS Section & Benefit Category
Surgery

CPT/HCPCS codes

Q0183 = dermal tissue of human origin, with our without other bioengineered or processed elements, but without metabolically active elements, per square centimeter.

Q0184 = dermal tissue of human origin, with our without other bioengineered or processed elements, with metabolically active elements, per square centimeter.

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
454.0 = varicose veins of lower extremities, with ulcer
454.2 = varicose veins of lower extremities, with ulcer and inflammation
707.1 = chronic ulcer or lower limb

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
1. Infected ulcer
2. Osteomyelitis
3. Allergy to bovine collagen
4. Arterial disease with an ankle brachial index (ABI) of 0.7 or less or in the case of venous stasis ulcers and lack of pedal pulses in the case of neuropathic diabetic foot ulcers.
5. Uncontrolled diabetes; "controlled" diabetes for purposes of this policy would be based on documentation in the medical record.
6. Active Charcot arthropathy of the ulcer extremity
7. Vasculitis

8. Uncontrolled rheumatoid arthritis and/or rheumatoid ulcers
9. Other uncontrolled collagen vascular disease
10. Patients under treatment with high dose corticosteroids immunosuppresants.
11. Patients who have undergone radiation and/or chemotherapy within the month immediately preceding proposed skin substitute treatment.

Reasons for denial
Investigational uses
Presence of diagnosis or diagnoses NOT supporting medical necessity

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

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
Payment limited to three applications for any individual ulcer. Payment for any ulcer will not be made for re-treatment within one year of initial treatment.

Bilaminate skin substitute is to be billed and reimbursed under Q0183 and Q0184.

Documentation requirements
The medical record must clearly show the criteria listed in **Indications and Limitations of Coverage** has been met.

1. The ulcer must be measured at the beginning of conservative treatment, following cessation of conservative treatment, and at the beginning of the skin substitute treatment.
2. The record must document that wound treatment by this method is accompanied by appropriate wound dressing during the healing period and by appropriate compressive dressings during follow-up and, for neuropathic diabetic foot ulcers, appropriate steps to off-load wound pressure during follow-up.

Utilization guidelines
1. Treatment will normally last approximately twelve (12) weeks. If after 12 weeks of compression treatment, and two (2) applications of the skin substitute, satisfactory healing progress is not noted then reapplication of the skin substitute is not recommended and other treatment modalities should be considered.
2. For neuropathic diabetic foot ulcers, treatment will normally last approximately twelve (12) weeks. If after nine (9) weeks of treatment, and three (3) applications of the skin substitute, satisfactory healing progress is not noted then reapplication of the skin substitute is not recommended and other treatment modalities should be considered.
3. No re-treatment would be expected within the first year following successful initial treatment.

Other comments
N/A

Sources of Information and Basis for Decision

1. FDA Approval Notice, dated May 22, 1998.
2. FDA Approval Notice for neuropathic diabetic foot ulcers dated June 20, 2000.
3. CMD Surgery/Surgery New Technology Workgroup
4. Consultants from Podiatry, Vascular Surgery, Orthopedic Surgery, Plastic Surgery.
5. Falanga, V., & Sabolinski, M., "A bilayered living skin construct (Apligraf) accelerates complete closure of hard-to-heal venous ulcers," Wound Repair and Regeneration, Vol. 7, No. 4, July-August 1999.
6. Prescribing Information: Apligraf (graftskin), Organogenesis, Inc.
7. Olin, J.W., Beusterien, K.M., Childs, M.B., Seavy, C., Griffiths, R.I., "Medical costs of treating venous stasis ulcers: evidence from a retrospective cohort study, "Vascular Medicine, Volume 4, pp. 1-7, 1999.
8. Behavior of Tissue Engineered Skin, A Comparison of a Living Skin Equivalent, Autograft and Occlusive Dressing in Human Donor Sites, Muhart, et al., Archive of Dermatology, August 1999 (Reprint).
9. Cadaveric Allograft as Adjunct Therapy for Nonhealing Ulcers, Snyder, et al., Journal of Foot and Ankle Surgery, March/April 1999 (Abstract).
10. Rapid Healing of Venous Ulcers and Lack of Clinical Rejection with an Allogenic Cultured Human Skin Equivalent, Falanga, et al., Archives of Dermatology, March 1998 (Abstract).

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

November 8, 2001

Ending date of comment period

December 24, 2001

Start date of notice period

January 16, 2002

Revision history

N/A

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Contractor's policy number

VI/PR-01-022

Contractor name

Triple-S, Inc.

Contractor number

00973

Contractor type

Carrier

LMRP title

Botulinum Toxin Type A

AMA CPT copyright statement

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CMS 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)(l)(A). This section allows coverage and payment for only those services that are considered to he medically reasonable and necessary.

-HCFA Publication 14-3, Medicare Carriers Manual, Section 2050.5(A)

Primary Geographic Jurisdiction

Puerto Rico and U.S. Virgin Islands

Secondary Geographic Jurisdiction

N/A

CMS Region

New York, Region II

CMS Consortium

Northeastern

Original Policy Effective Date

March 4, 2002

Original Policy Ending Date

N/A

Revision Effective Date

N/A

Revision Ending Date
N/A

LMRP description
Botulinum Toxin Type A injections are used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, twitches, etc. They produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. The resulting chemical-denervation of muscle produces local paresis or paralysis and allows individual muscles lobe weakened selectively. It has the advantage of being a potent neuromuscular blocking agent with good selectivity, duration of action, with the smallest antigenicity, and fewest side effects.

Indications and Limitations of Coverage and/or Medical Necessity
1. Before consideration of coverage may be made, it should be established that the patient(s) has been unresponsive to conventional methods of treatments such as medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions.
2. Coverage of Botulinum Toxin Type A will be limited to those conditions listed in the Covered ICD-9 section of this policy. All other uses will be considered as investigational and therefore, noncovered by Medicare.
3. Botulinum Toxin Type A received FDA approval in 1989 for the "… treatment of strabismus and blepharospasm associated with dystonia including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above." A supplemental approval was obtained in 2000 for "the treatment of cervical dystonia in adults to decrease the severity of abnormal head position and neck pain associated with cervical dystonia." In addition, botulinum toxin type A has been studied, listed as accepted in drug compendia, such as the US Pharmacopoeia's Dispensing Information and Drug Facts and Comparisons and supported by statements from major professional organizations for a wide range of uses. Based upon these sources of evidence, in carefully selected patients, the following conditions may be alleviated by botulinum toxin type A:
    a) Blepharospasm;
    b) Hemifacial spasm;
    c) Cervical dystonia (torticollis);
    d) Spasmodic dysphonia;
    e) Strabismus;
    f) Writer's cramp and other focal dystonias;
    g) Adult spasticity;
    h) Spasticity associated with cerebral palsy;
    i) Chronic anal fissure refractory to conservative treatment
    j) Esophageal achalasia patients in whom surgical treatment is not indicated
4. Botulinum toxin A may be allowed as the first-line treatment for blepharospasm and other facial spasms as physical therapy and other conventional methods of treatment may be ineffective.
5. Botulinum Toxin Type A can be used to reduce spasticity or excessive muscular contractions to relieve pain; to assist in posturing and walking; to allow better range of motion; to permit better physical therapy; to reduce severe spasm in order to provide adequate perineal hygiene.
6. Botox injections can be used to treat limb spasticity. Botox injections encompass different techniques, the number of injections made into each site or muscle, dosage, combinations of muscles injected, etc. Dosage appears to vary from 1-25 units per small muscle (e.g., eye), 50-200 units for medium to larger muscle groups (e.g., deltoid, biceps, quadriceps, hamstrings,

etc.). Note that Americans use mouse units, Europeans use nannograms for a non-Botox medication (Disport), and they are not the same measurement. Dosage should be adjusted for youngsters. The degree of spasticity is also a deciding dose factor. Some recommend no more than 2-4 units/kgm body weight usually. Only 3-400 units are generally injected totally, up to 6-8 sites, into each limb. Some use even higher doses, up to 6-700 units for even more injections sites in select cases where toxicity is not a prime consideration. The failure of two injections in a row, using maximum dose for the size of the muscle, should preclude continued reimbursement. This could be altered initially, however, until a correct dose and site are found. Failure after two successful treatments in a row for initial therapy, using maximum amounts, could preclude additional coverage. If failure occurs, injections could be repeated in a year. It is felt that EMG guidance is generally not necessary, although this is also controversial. An exam which reveals site tenderness or pain is usually good enough to determine the injection site (except in the facial, hand, and neck areas).

7. Botox can also be used in the treatment of achalasia. It appears to be safe and effective. Two-thirds respond within six months and effectiveness lasts on an average of a little over one year for an initial treatment, although shorter and longer durations have been reported. There is some question whether it is as good as or better than conventional therapy, pneumatic dilation or myotomy. Its use should not be endorsed for all patients but it can be considered individually in patients who have one or more of the following:
   - have failed conventional therapy
   - are at high risk of complications of pneumatic dilatation or surgical myotomy
   - have failed a prior myotomy or dilation
   - have had a previous dilation induced perforation
   - have an epiphrenic diverticulum or hiatal hernia both of which increase the risk of dilation - induced perforation

   Some patients may fail a first injection and respond to a second. Further therapy should be questioned if two treatments in a row fail. Therapy can be repeated later in those who fail after an initial response. The usual dosage is about 20 units injected into each of four quadrants of the lower esophageal sphincter region for a total of 80 units.
8. Due to the uncommonness of organic writers cramp, Medicare would not expect to see the treatment of this condition to be billed frequently.
9. There may be patients who require electromyography in order to determine the proper injection site(s). The electromyography procedure codes specified in the HCPCS section of this policy may be covered if the physician has difficulty in determining the proper injection site.
10. Requests may be considered for continued treatment during a treatment period or for resumption at a later date if satisfactory results have not been obtained, if compelling clinical evidence of medical necessity is presented.
11. Medicare will allow payment for one injection per each functional muscle group (eg, elbow flexors or elbow extensors) regardless of the number of injections made into each group or the number of muscles that compose it. If separate functional muscle groups are injected bilaterally (right and left calf muscles), Medicare will allow payment under the bilateral payment policy if the procedure is reported using the appropriate code modifier for bilateral procedures (see Coding Guidelines, below). If separate functional muscle groups are injected that are not bilateral, Medicare will allow payment under the multiple surgical procedures policy if the procedure is reported using the appropriate code modifier for multiple surgical procedures (see Coding Guidelines, below).

CPT/HCPCS Section & Benefit Category
Drugs and Biologicals, Medicine

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

J0585 Botulinum Toxin Type A (Botulinum Toxin Type A) per unit

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

31513 Laryngoscopy, indirect (separate procedure); diagnostic
31570 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31571 With operating microscope
64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64612 Chemodenervation of muscle(s); muscles innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)
64613 Chemodenervation of muscle(s); cervical spinal muscles (eg, for spasmodic torticollis)
64614 Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)
64640 Destruction by neurolytic agent; other peripheral nerve or branch
67345 Chemodenervation of extraocular muscle
92265 Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report.
95860 Needle electromyography, one extremity with or without related paraspinal areas.
95861 Needle electromyography, two extremities with or without related paraspinal areas.
95867 Needle electromyography, cranial nerve supplied muscles, unilateral
95868 Needle electromyography, cranial nerve supplied muscles, bilateral
95869 Needle electromyography thoracic paraspinal muscles.
95870 Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters.

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
333.6 Idiopathic torsion dystonia
333.7 Symptomatic torsion dystonia
333.81 Blepharospasm
333.82 Orofacial diyskinesia
333.83 Spasmodic torticollis
33384 Organic writer's cramp
333.89 Fragments of torsion dystonia, other
334.1 Hereditary spastic paraplegia

340	Multiple sclerosis
341.0	NeuromyeliLis optica
341.1	Schilder's disease
341.8	Other demyelinating diseases of central nervous system
341.9	Demyelinating disease of central nervous system, unspecified
342.11	Spastic hemiplegia, affecting dominant side
342.12	Spastic hemiplegia, affecting nondominant side
343 .0-343 .4	Infantile cerebral palsy
343.8	Other specified infantile cerebral palsy
343.9	Infantile cerebral palsy, unspecified
344.00-344.09	Quadriplegia and quadraparesis
344.1	Paraplegia
344.2	Diplegia of upper limbs
344.30-344.32	Monoplegia of lower limb
344.40-344.42	Monoplegia of upper limb
344.5	Unspecified monoplegia
351.8	Other facial nerve disorders
378.00-378.03	Strabismus and other disorders of binocular eye movements
378.10-378.18	
378.20-378 .24	
378.30-378.3 5	
378.40-378.45	
378.50-378.56	
3 78.60-378.63	
378.71-378.73	
378.81-378.87	
378.9	
478.30-478.34*	Paralysis of vocal cords or larynx
478.75*	Laryngeal spasm
478.79	Other diseases of larynx, not elsewhere classified
530.0**	Achalasia and cardiospasm
546.6	Anal spasm
565.0	Anal fissure
723.5	Torticollis, unspecified
728.85	Spasm of muscle
784.40-784.49*	Voice disturbance (aphonia, dysphonia)

*****Laryngoscopy may not be required for vocal cord injection to treat spasmodic dysphonia. If laryngoscopy not used, another procedure code, such as CPT 64640 may be more appropriate.

******Upper gastrointestinal endoscopy including esophageus, stomach and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices") for patients with achalasia or cardiospasm under ICD-9-CM code 530.0.

Diagnosis that Support Medical Necessity
Same as above.

ICD-9 Codes that do not Support Medical Necessity
701.8 Other specified hypertrophic and atrophic conditions of skin

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
Treatment of wrinkles using botulinum toxin type A is considered to be cosmetic and is not covered in this policy.

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
Irritable colon, biliary dyskinesia or any treatment of other spastic conditions not listed as covered in this policy are considered to be cosmetic, investigational (including the treatment of smooth muscle spasm), not safe and effective, and are not accepted as the standard of practice within the medical community.

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

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

Correct procedure code

31513	laryngoscopy indirect; diagnostic with vocal cord injection
31570	therapeutic laryngoscopy with vocal cord injection;
31571	with operation microscope
64600	destruction by neurolytic agent; trigeminal nerve, supraorbital, infraorbital mental or inferior alveolar branch
64612	Chemodenervation of muscle(s); muscles innervated by facial nerve (eg, for blepharospasm, hemfacial spasm)
64613	Chemodenervation of muscle(s); cervical spinal muscles (eg, for spasmodic torticollis)
64614*	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)
64640	Destruction by neurolytic agent; other peripheral nerve or branch
67345	Chemodenervation of extraocular muscle

Correct ICD-9 codes

340	Multiple sclerosis
478.30-478.34	Paralysis of vocal cords or larynx
478.75.1	spastic dysphonia
478.79	Other diseases of larynx, not elsewhere classified
333.81	blepharospasm

333.82	oral facial dyskinesia (oral mandibular dystonia)
351.8	other facial nerve disorders
333.83	spasmodic torticollis
723.5	torticollis, unspecified
378.00-378.9	strabismus and other disorders of binocular eye movements
333.6	idiopathic torsion dystonia
333.7	symptomatic torsion dystonia
333.84	organic writers cramp
333.89	other fragments of torsion dystonia
334.1	hereditary spastic paraplegia
341.0-341.9	other demyelinating diseases of central nervous system
342.11	spastic hemiplegia and hemiparesis affecting dominant side
342.12	spastic hemiplegia and hemiparesis affecting nondominant side
343.0-343.4	infantile cerebral palsy
343.8	other specified infantile cerebral palsy
343.9	infantile cerebral palsy, unspecified
344.00-344.09	Quadriplegia and quadreaparesis
344.1	Paraplegia
344.2	Diplegia of upper limbs
344.30-344.32	Monoplegia of lower limb
344.40-344.42	Monoplegia of upper limb
344.5	Unspecified monoplegia
530.0	achalasia and cardiospasm
564.6	Anal spasm
565.0	Anal fissure
728.85	spasm of muscle
784.40-784.49	Voice disturbance (aphonia, dysphonia)

To bill medically necessary electromyography guidance, report the appropriate CPT code for the procedure performed. (Only one EMG per injection site may be reported): Needle electromyography (95869), limited study of a specific muscle group (must specify), should be used if only individual muscle groups are being tested.

99265	Needle electromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
95860	Needle electromyography, one extremity with or without related paraspinal areas
95861	Needle electromyography, two extremities with or without related paraspinal areas
95867	Needle electromyography, cranial nerve supplied muscles, unilateral
95868	Needle electromyography, cranial nerve supplied muscles, bilateral
95869	Needle electromyography, thoracic paraspinal muscles
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles or sphincters

2. Botulinum Toxin A is supplied in vials and each contains 100 units. If less than 100 units is given during a single treatment session and the remainder is not used for another patient, bill 100 units in the days-units field (Item 246) of the 1500 claim form. If more than 100 units are billed during a

single treatment session per patient, round up to the nearest 100 units serum only if the remainder was not used. For EMC billing, document the units injected in the units of service field, FAO.18. In each case, Botulinum Toxin A is coded as J0585.

3. Due to the short life of the Botulinum Toxin, Medicare will reimburse the unused portion of this drug, only when the vial is not split between patients. However, documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.
4. Scheduling of more than one patient is encouraged to prevent wastage of Botulinum Toxin Type A. If a vial is split between two patients, the billing in these instances must be for the exact amount of Botulinum Toxin Type A used for each individual patient using 10585. II there is any toxin unused after injecting multiple patients, the remainder can be appropriately billed as wastage on the claim of the last patient injected. For EMC billings, document the units injected in the units service field, FAO.18. Medicare would not expect to see billing for the full fee amount for Botulinum Toxin Type A on each beneficiary when the vial is split between two or more patients.

Documentation requirements

Documentation should include the following elements:

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

Payments can be made on a REVIEW basis for diagnosis other than those listed above.

The utility and need for these services must be documented to be:

1. Safe and effective
2. Appropriate for the diagnosis
3. Not for convenience
4. A need not met by another service already performed

Documentation should include but is not limited to:

1. Peer reviewed medical literature
2. Accepted uses listed in compendia, such as USP-Dispensing Information and Drug Facts and Comparisons
3. Policy of specialty groups
4. Office notes

Utilization guidelines

N/A

Other comments

N/A

Sources of Information and Basis for Decision

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2. Annals Otorhinolaryngology, 103(1): 3 1-35, Jan. '94, (Cricopharyngeal)
3. Annals Neurology, 28:51 2-5, 1990 (Spasticity)
4. Neurology, 184(43): 183-185, Jan. '93 (Writers Cramp)
5. NEIJM, 332(12): 774-816, March '95 (Achalasia)
6. Nengl J Med. 1999; 341(2): 65-69. (anal fissure)
7. Approved package labeling for BOTOX (Botulinum Toxin Type A) purified Neurotoxin Complex (Allergan Inc.)
8. Drug Information for the Health Care Professional. Volume 1. U.S. Pharmacopoeia Dispensing Information 2001. 21st Ed. Englewood, Colo.:MICROMEDEX Thompson Healthcare; 2001: 647-650.
9. Central Nervous System, Botulinum Toxins, Botulinum Toxin Type A. Drug Facts and Comparisons. March 27, 2001. Ophthalmic and Otic, Ophthalmic Surgical Adjuncts, Botulinum Toxin Type A. Drug Facts and Comparisons. March 27, 2001.
10. Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Assessment: the clinical usefulness of botulinum toxin A in treating neurologic disorders. Neurology 1990; 40 (9): 1332-6.
11. National Institutes of Health. Botulinum Toxin Consensus Statement. NIH Consensus Development Conference, November 12-14, 1990, Volume 8, Number 8.
12. American Academy of Otolaryngology – Head Neck Surgery Policy Statement: Botox for spasmodic dysphonia. AAO-HNS Bulletin 1990; 9(12): 8.

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

November 8, 2001

Ending date of comment period

December 24, 2001

Start date of notice period

January 16, 2002

Revision history

N/A

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GGL-1625

Contractors Policy Number
VI/PR-01-023

Contractor's Name
Triple-S, Inc.

Contractors Number
00973

Contractor Type
Carrier

LMRP title
Echocardiography

AMA'S CPT Copyright Statement
"CPT Codes, descriptions and other data only are copyright 2001 American Medical Association. All rights reserved Applicable FARS/DFARS Clauses Apply".

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

Primary Geographic Jurisdiction
Puerto Rico and US Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
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March 3, 2002

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Revision Ending Date
N/A

LMRP Description
Echocardiography includes a family of diagnostic non-invasive procedures that use ultra-high frequency sound waves to record the structure of the heart and the blood flow velocities within the heart throughout the cardiac cycle.

M-Mode Echocardiographv: This is sometimes called the "ice pick" view of the heart Tilting the transducer in different directions allows visualization of the different *areas* of the heart.

Two-Dimensional (2D) Echocardiographv: Two dimensional echocardiographs allow the visualization of a pie-shaped area of the heart. Oscillating a single transducer or rotating a series of transducers allows approximately thirty slices to be obtained.

Doppler Echocardiopraphv: This type of echocardiography uses ultrasound to record blood flow in the cardiovascular system.

Indications and Limitations of Coverage and/or Medical Necessity
Normal or abnormal patterns of cardiac chamber size and contraction, wall thickness, wall motion, valve structure, and valve motion are all well assessed by echocardiographic procedures. This is the method of choice for visualizing abnormal structures, like vegetations of infective endocarditis, intracardiac tumors, mural thrombi, and pericardial effusions.

During and following episodes of cardiac ischemia and/or infarction, echocardiographic images accurately show the extent of myocardial thinning and segmental akinesis or dyskinesis. Complications of myocardial infarction that may be detected by imaging Doppler echocardiography include: pericardial effusion, cardiac tamponade, ruptured papillary muscle, mitral regurgitation due to papillary muscle dysfunction, ventricular septal defect, myocardial rupture with pseudoaneurysm formation, infarct expansion with true aneurysm formation, and right ventricular infarction.

Echocardiography is also indicated to evaluate baseline and follow-up examination following treatment with cardiotoxic drugs, i.e., chemotherapy.

CPT/HCPCS Section and Benefit Category
Diagnostic service/Cardiology/Ultrasound diagnostic procedures

CPT/HCPCS codes
93307 Echocardiography, transthoracic, real-time with image documentation (20) with or without M-mode recording; complete
93308 Follow-up or limited study
93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete
93321 Follow-up or limited study Doppler echocardiography
93325 Doppler echocardiography color flow velocity mapping

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity

086.0	Chagas' disease with heart involvement
93.0	Aneurysm of aorta, specified as syphilitic
093.1	Syphilitic aortitis
093.20	Syphilitic endocarditis of valve, unspecified
093.21	Syphilitic endocarditis of mitral valve
093.22	Syphilitic endocarditis of aortic valve
093.23	Syphilitic endocarditis of tricuspid valve
093.24	Syphilitic endocarditis of pulmonary valve
093.81	Syphilitic pericarditis
093.82	Syphilitic myocarditis
135	Sarcoidosis
164.1	Malignant neoplasm of heart
212.7	Benign neoplasm of heart
265.0	Beriberi
271.0	Glycogenosis
277.3	Amyloidosis
277.5	Mucopolysaccharidosis
277.9	Unspecified disorder of metabolism
334.0	Friedreich's ataxia
359.1	Hereditary progressive muscular dystrophy
359.2	Myotonic disorders
391.0	Acute rheumatic pericarditis
391.1	Acute rheumatic endocarditis
391.2	Acute rheumatic myocarditis
391.8	Other acute rheumatic heart disease
391.9	Acute rheumatic heart disease, unspecified
393	Chronic rheumatic pericarditis
394.0	Mitral stenosis
394.1	Rheumatic mitral insufficiency
394 2	Mitral stenosis with insufficiency
394.9	Other and unspecified mitral valve diseases
395.0	Rheumatic aortic stenosis
395.1	Rheumatic aortic insufficiency
395.2	Rheumatic aortic stenosis with insufficiency
395.9	Other and unspecified rheumatic aortic diseases
396.0	Mitral valve stenosis and aortic valve stenosis
396.1	Mitral valve stenosis and aortic valve insufficiency
396.2	Mitral valve insufficiency and aortic valve stenosis
396.3	Mitral valve insufficiency and aortic valve insufficiency
396.8	Multiple involvement of mitral and aortic valves
398.9	Mitral and aortic valve disease, unspecified
397.0	Diseases of tricuspid valve
397.1	Rheumatic diseases of pulmonary valve
397.9	Rheumatic diseases of endocardium, valve unspecified
398.0	Rheumatic myocarditis
398.90	Rheumatic heart disease, unspecified

402.00-402.91	Hypertensive heart disease
404.0-404.93	Hypertensive heart and renal disease (malignant)
410.0	Acute myocardial infarction of anterolateral wall
410.00	Acute myocardial infarction of anterolateral wall, care unspecified
410.01	Acute myocardial infarction of anterolateral episode of care
410.02	Acute myocardial infarction of anterolateral wall, episode of care
410.1	Acute myocardial infarction of other anterior wall
410.10	Acute myocardial infarction of other anterior wall, episode of care unspecified
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.12	Acute myocardial infarction of other anterior wall, subsequent episode of care
410.2	Acute myocardial infarction of inferolateral wall
410.20	Acute myocardial infarction of inferolateral wall, episode of care unspecified
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care
410.22	Acute myocardial infarction of inferolateral wall, subsequent episode of care
410.3	Acute myocardial infarction of inferoposterior wall
410.30	Acute myocardial infarction of inferoposterior wall, episode of care unspecified
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care
410.32	Acute myocardial infarction of inferoposterior wall, subsequent episode of care
410.4	Acute myocardial infarction of other inferior wall
410.40	Acute myocardial infarction of other inferior wall, episode of care unspecified
410.41	Acute myocardial infarction of other inferior wall, initial episode of care
410.42	Acute myocardial infarction of other inferior wall, subsequent episode of care
410.5	Acute myocardial infarction of other lateral wall
410.50	Acute myocardial infarction of other lateral wall, episode of care unspecified
410.51	Acute myocardial infarction of other lateral wall, initial episode of care
410.52	Acute myocardial infarction of other lateral wall, subsequent episode of care
410.6	True posterior wall infarction
410.60	True posterior wall infarction, episode of care unspecified
410.61	True posterior wall infarction, initial episode of care
410.62	True posterior wall infarction, subsequent episode of care
410.7	Subendocardial infarction
410.70	Subendocardial infarction, episode of care unspecified
410.71	Subendocardial infarction, initial episode of care
410.72	Subendocardial infarction, subsequent episode of care
410.8	Acute myocardial infarction of other specified sites
410.80	Acute myocardial infarction of other specified sites, episode of care unspecified
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.82	Acute myocardial infarction of other specified sites
410.9	Acute myocardial infarction of unspecified site
411.0-411.89	Postmyocardial infarction syndrome to other
413.0	Angina decubitus
413.1	Prinzmetal angina
413.9	Other and unspecified angina pectoris
414.00-414.9	Coronary atherosclerosis, aneurysm of heart and coronary vessels
415.0	Acute cor pulmonale
415.1	Pulmonary embolism and infarction
416.0	Primary pulmonary hypertension
416.1	Kyphoscoliotic heart disease

416.8	Other chronic pulmonary heart disease
416.9	Chronic pulmonary heart disease, unspecified
420.0	Acute pericarditis in diseases classified elsewhere
420.90	Acute pericarditis, unspecified
420.91	Acute idiopathic, pericarditis
420.99	Other acute pericarditis
421.0	Acute and subacute bacterial endocarditis
421.1	Acute and subacute infective endocarditis in diseases classified elsewere
421.9	Acute endocarditis, unspecifed
422.0-422.99	Acute myocarditis
423.0	Hemopericardium
423.1	Adhesive pericarditis
423.2	Constrictive pencarditis
423.8	Other specified diseases of the pericardium
423.9	Unspecified disease of the pericardium
424.0	Mitral valve disorders
424.1	Aortic valve disorders
424.2	Tricuspid valve disorders, specified as nonrheumatic
424.3	Pulmonary valve unspecified
424.90	Endocarditis, valve unspecified, unspecified cause
424.91	Endocarditis in diseases classified elsewhere
424.99	Other endocarditis
425.0425.9	Cardiomyopathies
427.31	Atrial fibrillation
427.32	Atrial flutter
428.0428.1	Heart failure
429.0	Myocarditis, unspecified
429.1	Myocardial degeneration
429.2	Cardiovascular disease, unspecified
429.3	Cardiomegaly
429.4	Functional disturbances following cardiac surgery
429.5	Rupture of chordae tendinae
429.6	Rupture of papillary muscle
429.71	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect
429.79	Sequelae of myocardial infarction NEC
429.81	Other disorders of papillary muscle
435.0435.9	Transient cerebral ischemia
440.0	Atherosclerosis of aorta
441.00441.9	Aortic aneurysm and dissection
444.0-444.89	Arterial embolism and thrombosis
674.80	Other complications of the puerperium, unspecified as to episode
745.0	Common truncus
745.10	Complete transposition of great vessels
745.11	Double outlet right ventricle
745.12	Corrected transposition of great vessels
745.19	Other transposition of great vessels
745.2	Tetrology of Fallot
745.3	Common ventricle

745.4	Ventricular septal defect
745.5	Ostium secundum type atrial septal defect
745.60	Endocardial cushion defect, unspecified type
745.61	Ostium primum defect
745.69	Other endocardial cushion defects
745.7	Cor biloculare
746.00-746.09	Pulmonary valve anomalies
746.1	Tricuspid atresia and stenosis, congenital
746.2	Ebstein's Anomaly
746.3	Congenital Stenosis of Aortic Valve
746.4	Congenital Insufficiency of Aortic Valve
746.5	Congenital mitral stenosis
746.6	Congenital mitral insufficiency
746.7	Hypoplastic left heart syndrome
746.81-746.85	Other specified anomalies of heart
746.9	Unspecified anomaly of heart
780.2	Syncope and collapse
785.0	Tachycardia unspecified
785.1	Palpitations
785.2	Undiagnosed cardiac murmurs
785.3	Other abnormal heart sounds
785.50-785.59	Shock without mention of trauma
786.50	Chest pain
861.00-86113	Injury to heart and lung
958.4	Traumatic shock
996.01.1	Mechanical complications due to cardiac pacemaker (electrode)
996.02	Mechanical complications due to heart valve prosthesis
996.61	Infection and inflammatory reaction due to cardiac device, implant and graft
996.71	Other complications due to heart valve prosthesis
996.72	Other complications due to cardiac device, implant and graft
998.0	Postoperative shock
998.5	Postoperative infection
999.1	Air embolism
V42.1	Organ or tissue replaced by transplant (heart)
V42.2	Organ or tissue replaced by transplant (heart valve)
V43.2	Organ or tissue replaced by other means (heart)
V43.3	Organ or tissue replaced by other means (heart valve)
V58.69	Long term (current use) of high risk medications
V67.2	Cancer chemotherapy follow-up
V67.51	Follow up treatment with high-risk medications, not elsewhere classified

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 ICD-9 codes other than those listed above under the "Codes that support medical necessity"
- Documentation not supporting 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 procedure. (Refer also to Reasons for Denial, Coding Guidelines, and the Documentation Requirements section of this policy).
- Inadequate medical record documentation or failure to submit the requested medical documentation

Noncovered ICD-9 Codes
Any ICD-9 code(s) not listed under the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Noncovered Diagnosis
Any diagnosis not included in this policy.

Coding Guidelines
- Use the appropriate revenue codes, HCPC, ICD-9 and units
- All ICD-9 diagnosis codes must be coded to the highest possible level of specificity

Documentation Requirements
Documentation supporting the medical necessity of this procedure must be kept on the provider's record and available to be furnished upon request. Failure to do so may result in rejection or denial of claim(s). This document should include but is not limited to: history and physical examination, notes documenting evaluation and management with relevant clinical signs, symptoms or abnormal laboratory test results. The patient's clinical record should further indicate changes/alterations and response or non-response in medications prescribed for the treatment of the patient's condition.

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

Utilization guidelines
N/A

Other comments
N/A

Sources of Information and/or Basis for Decision
- ACC / AHA Guidelines for the Clinical Application of Echocardiography, 1997

- Medicare's Coverage Issues manual, CIM, 50-7
- JACC Vol. 16, No. 7 EWY ET AL. December 1990: 1606-28 ACC/AHA TASK FORCE REPORT @1990 by the American College of Cardiology I ACCIAHA TASK FORCE REPORT ACCIAHA Guidelines
- MKSP-ACP-ASIM-12 Section on Cardiology
- Scientific American: Cardiovascular Medicine: I-XIX
- Harrison's: Principles of Internal Medicine: 14th Edition, Cardiology: Part VIII
- ICD-9-CM and CPT 2001
- Representatives from Cardiology Section of the Puerto Rico Medical Association

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
November 8, 2001

Ending Date of Comment Period
December 24, 2001

Start Date of Notice Period
January 16, 2002

Revision History
Revision number 01 in November 2001. Several codes were added to the section of ICD-9 Codes that Support Medical Necessity.

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GGL-1627

Contractor's policy number
VI/PR-01-024

Contractor name
Triple-S, Inc.

Contractor number
00973

Contractor type
Carrier

LMRP title
Self-Administered drugs

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".

CMS National Coverage Policy
Medicare Carriers Manual, Section 2049
Program Memorandum AB-00-21 (Change Request 1164)

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

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
March 4, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
The Center for Medicare and Medicaid Services (CMS) receives numerous inquiries about the coverage of self-administered drugs, as well as requests to add more self-administered drugs to the list of covered benefits.

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

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

Indications and Limitations of Coverage and/or Medical Necessity
Based on national coverage guidelines, drugs and biologicals which are self-administered by the patient are not a benefit of Medicare. The drugs identified in the HPCS Codes" section of this policy have been determined to be self-administered drugs and therefore are not covered.

On the other hand, these medications will be reimbursed by Medicare only if they are administered by the physician or under his direct supervision in his office.

CPT/HCPCS Section & Benefit Category
Drugs and biologicals

CPT/HCPCS codes

J0275	Alprostadil urethral suppository (code may be used for Medicare when drug administered by the physician or under the direct supervision of a physician, not for use when drug is self-administered)
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered by the physician or under the direct supervision of a physician, not for use when drug is self-administered) (Enbrel)
J1825	Injection, interferon beta-la, 33 mcg (code may be used for Medicare when drug administered by the physician or under the direct supervision of a physician, not for use when drug is self-administered)(Avonex)
J1830	Injection, interferon beta-lb, 0.25 mg (code may be used for Medicare when drug administered by the physician or under the direct supervision of a physician, not for use when drug is self-administered)(Betaseron)
J9218	Leuprolide acetate, per 1mg. 02016 Injection, Somatropin 1mg.
Q2016	Injection, Somatropin 1mg.

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
Drugs and biologicals that can be self-administered are not covered by Medicare unless the statute includes a benefit that specifically provides for such coverage. Oral drugs are not covered under the "incident to a physician's service" provision.

Noncovered ICD-9 codes
N/A

Noncovered diagnosis
N/A

Coding guidelines
The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

If the "J" code descriptor can be multiplied to reflect the dosage being administered, use the J-code, with the appropriate number of units, that reflects the dosage given.

It is not appropriate to use the "J" code with a multiplier in the units' field, when there is another "J" code, which more closely describes the amount given.

It is not appropriate to bill for the full amount of a drug when it has been split between two or more patients. Bill only for the amount given to each beneficiary.

NOC codes should only be used for those drugs which do not have a "J" code, which describes the drug being administered or is not a multiple of the "J" code being administered.

1. When appropriate, the NOC code is selected based upon the antineoplastic nature or otherwise therapeutic value of the drug as follows:
    - J9999 Not otherwise classified, antineoplastic drug
    - 90799 Unlisted therapeutic, prophylactic or diagnostic injection

2. When billing with an NOC code, include on the claim, the narrative description reflective of the agent and the dose administered.

Payment for the administration of an injection is included in the payment for the office visit or any other service performed on that day. However, the administration may be paid when performed independently.

Documentation requirements
Documentation must be maintained in the patient's chart to support the medical necessity of the injection given. When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted. The medical record must be available to the carrier upon request. Documentation such as a reference to supporting literature should be included in the medical record for the use of a drug for a purpose not included in the FDA approved labeling or the compendia.

Utilization guidelines
N/A

Other comments
N/A

Sources of information and basis for decision
Drugs Facts and Comparison
2000 Physician's Desk Reference
2001 Physician's Desk Reference

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
November 8, 2001

Ending date of comment period
December 24, 2001

Start date of notice period
January 16, 2002

Revision history
N/A

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GGL-1630

THE USE OF GAMMA CAMERAS AND FULL RING AND PARTIAL RING POSITRON EMISSION TOMOGRAPHY (PET) SCANNERS FOR PET SCANS

As a Carrier of Medicare Part B, our responsibility is to notify the physician community the revisions to the PET Scans coverage. Presently, we have no knowledge of any FDA approved PET Imaging Center operating in Puerto Rico with a PET scanner approved or cleared by the FDA (Federal Drug Administration).

Introduction

This article summarizes the revision to §50-36 of the Coverage Issues Manual (CIM) about types of 2-[F-18] Fluoro-D-Glucose (FDG) PET scanners and provides claims processing information. This decision does not change the covered clinical indications beyond the changes that took effect on July 1, 2001. Please refer to §50-36 of the CIM for further details about coverage. New HCPCS codes are provided to clarify the type of PET scanner used by clinical indication.

General Conditions of Coverage by Allowable Type of FDG PET Scanner

For purposes of this section, "Any FDA approved" means all systems approved or cleared for marketing by the FDA to image radionuclides in the body. "FDA approved" means that the system indicated has been approved or cleared for marketing by the FDA to image radionuclides in the body. "Certain coincidence systems" refers to the systems that have all the following features:

- crystal at least 5/8-inch thick
- techniques to minimize or correct for scatter and/or randoms, and
- digital detectors and iterative reconstruction.

"Certain coincidence systems" must have all three design features. Scans performed with gamma camera PET systems with crystals thinner than 5/8-inch will not be covered by Medicare. In addition, scans performed with systems with crystals greater than or equal to 5/8-inch in thickness, but that do not meet the other listed design characteristics are not covered by Medicare.

	ALLOWABLE TYPE OF FDG PET SYSTEM		
Covered Clinical Condition	**Prior to July 1, 2001**	**July 1, 2001 through December 31, 2001**	**On or after January 1, 2002**
Characterization of single pulmonary nodules	Effective 1/1/1998, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Initial staging of lung cancer (non small cell)	Effective 1/1/1998, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems

	ALLOWABLE TYPE OF FDG PET SYSTEM		
Covered Clinical Condition	**Prior to July 1, 2001**	**July 1, 2001 through December 31, 2001**	**On or after January 1, 2002**
Determining location of colorectal tumors if rising CEA level suggests recurrence	Effective 7/1/1999, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Staging or restaging of lymphoma only when used as an alternative to a gallium scan	Effective 7/1/1999, any FDA approved	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Evaluating recurrence of melanoma prior to surgery as an alternative to a gallium scan	Effective 7/1/1999, any FDA approved.	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Diagnosis, staging, and restaging of colorectal cancer	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of esophageal cancer	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of head and neck cancers (excluding CNS and thyroid)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of lung cancer (non small cell)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of lymphoma	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of melanoma (noncovered for evaluating regional nodes)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Determination of myocardial viability only following an inconclusive SPECT	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Presurgical evaluation of refractory seizures	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring

HCPCS Codes for PET Scans—General Information

On July 1, 2001, new HCPCS codes G0210 - G0230 were added to allow billing for all currently covered indications for FDG PET. Although the codes do not indicate the type of PET scanner, these codes should be used until January 1, 2002 by providers to bill for services in a manner consistent with the coverage policy. Effective January 1, 2002, these codes will have new descriptors to properly reflect the type of PET scanner used. Also effective January 1, 2002 there will be 4 new G codes for covered conditions that may be billed if a gamma camera is used for the PET scan. The changes to the code descriptors are indicated in boldface. As of January 1, 2002, providers should bill using the revised HCPCS codes G0120 - G0234. Fees for codes G0231 - G0234 are listed in the 2002 Physician Fee Schedule.

Reimbursement

HCPCS Codes for PET Scans Performed on or after July 1, 2001 through December 31, 2001

G0210 PET Imaging *whole body;* diagnosis; lung cancer, non-small cell
Short Description: PET img wholebody dxlung ca

G0211 PET Imaging *whole body; initial* staging; lung cancer; non-small cell (**replaces G0126)**
Short Description: PET img wholbody init lung

G0212 PET Imaging *whole body;* restaging; lung cancer; non-small cell
Short Description: PET img wholebod restag lung

G0213 PET Imaging *whole body*; diagnosis; colorectal cancer
Short Description: PET img wholbody dx colorec

G0214 PET Imaging *whole body*; *initial* staging; colorectal cancer
Short Description: PET img wholebod init colore

G0215 PET Imaging *whole body*; restaging*;* colorectal cancer (**replaces G0163)**
Short Description: PET img wholebod restag colre

G0216 PET Imaging *whole body*; diagnosis; melanoma
Short Description: PET img wholebod dx melanoma

G0217 PET Imaging *whole body*; *initial* staging; melanoma
Short Description: PET img wholebod init melano

G0218 PET Imaging *whole body;* restaging; melanoma (**replaces G0165)**
Short Description: PET img wholebod restag mela

G0219 PET Imaging *whole body*; *melanoma <u>for non-covered</u> indications*
Short Description: PET img wholbod melano nonco

G0220 PET Imaging *whole body*; diagnosis; lymphoma
Short Description: PET img wholebod dx lymphoma

G0221 PET Imaging *whole body; initial* staging; lymphoma **(replaces G0164)**
Short Description: PET imag wholbod init lympho

G0222 PET Imaging *whole body;* restaging; lymphoma (**replaces G0164)**
Short Description: PET imag wholbod resta lymph

G0223 PET Imaging *whole body or regional*; diagnosis; head and neck cancer; excluding thyroid and CNS cancers
Short Description: PET imag wholbod reg dx head

G0224 PET Imaging *whole body or regional*; *initial* staging; head and neck cancer; excluding thyroid and CNS cancers
Short Description: PET imag wholbod reg ini hea

G0225 PET Imaging *whole body or regional*; restaging; head and neck cancer, excluding thyroid and CNS cancers
Short Description: PET whol restag headneckonly

G0226 PET Imaging *whole body*; diagnosis; esophageal cancer
Short Description: PET img wholbody dx esophagl

G0227 PET Imaging *whole body; initial* staging; esophageal cancer
Short Description: PET img wholbod ini esophage

G0228 PET Imaging *whole body;* restaging; esophageal cancer
Short Description: PET img wholbod restg esopha

G0229 PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures
Short Description: PET img metaboloc brain pres

G0230 PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study
Short Description: PET myocard viability post s

NOTE: G0125 has a definition change: "PET imaging regional or whole body; single pulmonary nodule"
(Short Description: PET image pulmonary nodule

HCPCS Codes for PET Scans Performed with Full or Partial Ring PET Scanners for Services Furnished on or after January 1, 2002

WhBD = whole body

G0210 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** diagnosis; lung cancer, non-small cell
Short Description: PET img WhBD ring dxlung ca

G0211 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** *initial* staging; lung cancer; non-small cell (**replaces G0126)**
Short Description: PET img WhBD ring init lung

G0212 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** restaging; lung cancer; non-small cell
Short Description: PET img WhBD ring restag lun

G0213 PET Imaging *whole body*; ***full- and partial-ring PET scanners only,*** diagnosis; colorectal cancer
Short Description: PET img WhBD ring dx colorec

G0214 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** *initial* staging; colorectal cancer
Short Description: PET img WhBD ring init colore

G0215 PET Imaging *whole body*; ***full- and partial-ring PET scanners only,*** restaging*;* colorectal cancer (**replaces G0163)**
Short Description: PET img whbd restag col

G0216 PET Imaging *whole body*; ***full- and partial-ring PET scanners only,*** diagnosis; melanoma
Short Description: PET img WhBD ring dx melanom

G0217 PET Imaging *whole body*; ***full- and partial-ring PET scanners only,*** *initial* staging; melanoma
Short Description: PET img WhBD ring init melan

G0218 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** restaging; melanoma (**replaces G0165)**
Short Description: PET img WhBD ring restag mel

G0219PET Imaging whole body; *(full- and partial-ring PET scanners only)* ***for non-covered indications***
Short Description: PET img WhBD ring noncov ind

G0220 PET Imaging *whole body*; ***full- and partial-ring PET scanners only,*** diagnosis; lymphoma
Short Description: PET img WhBD ring dx lymphom

G0221 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** *initial* staging; lymphoma **(replaces G0164)**
Short Description: PET img WhBD ring init lymph

G0222 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** restaging; lymphoma **(replaces G0164)**
Short Description: PET img WhBD ring resta lymp

G0223 PET Imaging *whole body or regional*; ***full- and partial-ring PET scanners only,*** diagnosis; head and neck cancer; excluding thyroid and CNS cancers
Short Description: PET imag WhBD reg ring dx head

G0224 PET Imaging *whole body or regional*; ***full- and partial-ring PET scanners only,*** *initial* staging; head and neck cancer; excluding thyroid and CNS cancers
Short Description: PET img WhBD reg ring ini hea

G0225 PET Imaging *whole body or regional*; ***full- and partial-ring PET scanners only,*** restaging; head and neck cancer, excluding thyroid and CNS cancers
Short Description: PET img WhBD ring restag hea

G0226 PET Imaging *whole body*; ***full- and partial-ring PET scanners only,*** diagnosis; esophageal cancer
Short Description: PET img WhBD dx esophag

G0227 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** *initial* staging; esophageal cancer
Short Description: PET img whbd ini esopha

G0228 PET Imaging *whole body;* ***full- and partial-ring PET scanners only,*** restaging; esophageal cancer
Short Description: PET img WhBD ring restg esop

G0229 PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures; ***full- and partial-ring PET scanners only***
Short Description: PET img metabolic brain ring

G0230 PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study; ***full- and partial-ring PET scanners only***
Short Description: PET myocard viability ring

NOTE: For purposes of this benefit, the Centers for Medicare and Medicaid Services (CMS) uses the terms "initial staging" and "staging" interchangeably.

HCPCS Codes for PET Scans Performed with Gamma Cameras to be Used Only for Services Furnished on or after January 1, 2002

G0231 PET, whole body, for recurrence of colorectal or colorectal metastatic cancer; ***gamma cameras only***
Short Description: PET WhBD colorec; gamma cam

G0232 PET, whole body, for staging and characterization of lymphoma; ***gamma cameras only***
Short Description: PET WhBD lymphoma; gamma cam

G0233 PET, whole body, for recurrence of melanoma or melanoma metastatic cancer, ***gamma cameras only***
Short Description: PET WhBD melanoma; gamma cam

G0234 PET, regional or whole body, for solitary pulmonary nodule following CT, or for initial staging of non-small cell lung cancer; ***gamma cameras only***
Short Description: PET WhBD pulm nod; gamma cam

CR 1886/Trans.AB-01-168/Nov.27, 2001/MM

Reembolso

PRIMERA ACTUALIZACIÓN A LA BASE DE DATOS DE LAS TARIFAS FIJAS PARA MÉDICOS DE 2002

Los Centros para Servicios de Medicare y Medicaid notificó la primera actualización trimestral a la base de datos de las Tarifas Fijas para Médicos del 2002.

Conforme a la Parte 3, §15902 del Manual de Medicare los cambios de esta actualización serán implementados el 1 de abril de 2002. Los cambios serán efectivos para reclamaciones con fechas de servicio del 1 de enero de 2002 en adelante.

Los cambios que se incluyen en esta primera actualización a la Base de Datos de las Tarifas Fijas para Médicos 2002 son las siguientes:

Reimbursement

FIRST UPDATE TO THE 2002 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

The Centers for Medicare and Medicaid Services notified the first Medicare Physician Fee Schedule Database (MPFSDB) quarterly update for 2002.

In accordance with the Medicare Carriers Manual Part 3, §15902, the changes in this update will be implemented on April 1, 2002. The changes will be effective for claims with dates of service January 1, 2002 or later.

Changes included in this first update to the 2002 Medicare Physician Fee Schedule Database are as follows:

CPT/HCPCS Code	**Revision**
J7193	Proc Stat = X
J7195	Proc Stat = X
J7198	Proc Stat = X

CPT/HCPCS Code	**Revision**
10021	PC/TC Indicator = 0
10021 - TC	Procedure Status = H
10021 – 26	Procedure Status = H
10022	PC/TC Indicator = 0
10022 - TC	Procedure Status = H
10022 – 26	Procedure Status = H

CPT/HCPCS Code	**Revision**
17004	Multiple Procedure Indicator = 0

CPT/HCPCS Code	**Revision**
34800	Assistant Surgery Indicator = 2
34802	Assistant Surgery Indicator = 2
34804	Assistant Surgery Indicator = 2
34808	Assistant Surgery Indicator = 2
34812	Assistant Surgery Indicator = 2
34813	Assistant Surgery Indicator = 2
34820	Assistant Surgery Indicator = 2
34825	Assistant Surgery Indicator = 2
34826	Assistant Surgery Indicator = 2

CPT/HCPCS Code	**Revision**
36533	Non-Fac PE RVU = 15.34 Fac PE RVU = 3.50

CPT/HCPCS Code	Revision
76085 – TC	Global = ZZZ

CPT/HCPCS Code	Revision
76390	Proc Stat = N
76390 – 26	Proc Stat = N
76390 – TC	Proc Stat = N

CPT/HCPCS Code	Revision
90887	Proc Stat = N

CPT/HCPCS Code	Revision
92136	Non-Fac PE RVU = 1.95 Fac PE RVU = 1.95
92136 – TC	Non-Fac PE RVU = 1.69 Fac PE RVU = 1.69
92136 – 26	Non-Fac PE RVU = 0.26 Fac PE RVU = 0.26

CPT Code:	92597
Short Desc:	Oral speech device eval
Proc Stat:	I
RVU Work:	1.35
Non-Fac PE RVU:	1.49
Fac PE RVU:	0.54
Malpractice RVU:	0.05

CPT Code:	92598
Short Desc:	Modify oral speech device
Proc Stat:	I
RVU Work:	0.99
Non-Fac PE RVU:	0.76
Fac PE RVU:	0.40
Malpractice RVU:	0.04

CPT Code:	93025
Short Desc:	Microvolt t-wave assess
Proc Stat:	A
RVU Work:	0.75
Non-Fac PE RVU:	6.51
Fac PE RVU:	6.51
Malpractice RVU:	0.11

CPT Code:	93025 - TC
Short Desc:	Microvolt t-wave assess
Proc Stat:	A
RVU Work:	0.00
Non-Fac PE RVU:	6.19
Fac PE RVU:	6.19
Malpractice RVU:	0.09

CPT Code: 93025 - 26
Short Desc: Microvolt t-wave assess
Proc Stat: A
RVU Work: 0.75
Non-Fac PE RVU: 0.32
Fac PE RVU: 0.32
Malpractice RVU: 0.02

CPT Code	Revision
93613	Global = ZZZ
93613	PC/TC Indicator = 0
93613 – TC	Procedure Status = H
93613 – 26	Procedure Status = H

CPT Code	Revision
93662 – TC	Global = ZZZ

CPT Code: 93784
Short Desc: Ambulatory BP monitoring
Proc Stat: A
RVU Work: 0.17
Non-Fac PE RVU: 1.00
Fac PE RVU: 1.00
Malpractice RVU: 0.02

Note: Effective for services performed on or after 04-01-2002

CPT Code: 93786
Short Desc: Ambulatory BP recording
Proc Stat: A
RVU Work: 0.00
Non-Fac PE RVU: 0.93
Fac PE RVU: 0.93
Malpractice RVU: 0.01

Note: Effective for services performed on or after 04-01-2002

CPT Code: 93790
Short Desc: Review/report BP recording
Proc Stat: A
RVU Work: 0.17
Non-Fac PE RVU: 0.07
Fac PE RVU: 0.07
Malpractice RVU: 0.01

Note: Effective for services performed on or after 04-01-2002

CPT Code	Revision
95250	Non-Fac PE RVU = 3.02
95250	Fac PE RVU = 3.02

CPT Code	Revision
95824 – 26	Global = XXX

CPT Code	Revision
95903	Non-Fac PE RVU = 0.81 Fac PE RVU = 0.81
95903 – TC	Non-Fac PE RVU = 0.54 Fac PE RVU = 0.54
95903 – 26	Non-Fac PE RVU = 0.27 Fac PE RVU = 0.27

CPT Code	Revision
96000	Bilt Surg = 2
96001	Bilt Surg = 2
96002	Bilt Surg = 2
96003	Bilt Surg = 2
96004	Bilt Surg = 2

CPT Code	Revision
96567	PC/TC Indicator = 5

CPT/HCPCS Code	Revision
97601	Non-Fac PE RVU = 0.61 Fac PE RVU = 0.61

CPT Code:	99375
Short Desc:	Home health care supervision
Proc Stat:	I
RVU Work:	1.73
Non-Fac PE RVU:	1.57
Fac PE RVU:	1.57
Malpractice RVU:	0.06

CPT Code:	99378
Short Desc:	Hospice care supervision
Proc Stat:	I
RVU Work:	1.73
Non-Fac PE RVU:	1.97
Fac PE RVU:	1.97
Malpractice RVU:	0.06

Code	Setting	PR Fee	VI Fee
36533	Non-Facility	$ 569.91	$ 771.68
	Facility	$ 264.75	$ 333.22
92136	Non-Facility	$ 68.18	$ 93.61
	Facility	$ 68.18	$ 93.61
92136 – TC	Non-Facility	$ 44.16	$ 64.76
	Facility	$ 44.16	$ 64.76
92136 – 26	Non-Facility	$ 24.02	$ 28.85
	Facility	$ 24.02	$ 28.85
93025	Non-Facility	$ 192.80	$ 271.27
	Facility	$ 192.80	$ 271.27
93025-TC	Non-Facility	$ 160.44	$ 232.49
	Facility	$ 160.44	$ 232.49
93025-26	Non-Facility	$ 32.37	$ 38.77
	Facility	$ 32.37	$ 38.77
93662-TC	Non-Facility	$ 31.39	$ 43.70
	Facility	$ 31.39	$ 43.70
93786	Non-Facility	$ 24.07	$ 34.80
	Facility	$ 24.07	$ 34.80
93790	Non-Facility	$ 7.33	$ 8.89
	Facility	$ 7.33	$ 8.89
95250	Non-Facility	$ 77.94	$ 112.20
	Facility	$ 77.94	$ 112.20
95906	Non-Facility	$ 40.41	$ 52.41
	Facility	$ 40.41	$ 52.41
95903-TC	Non-Facility	$ 14.12	$ 20.72
	Facility	$ 14.12	$ 20.72
95903-26	Non-Facility	$ 26.29	$ 31.68
	Facility	$ 26.29	$ 31.68
97601	Non-Facility	$ 32.07	$ 41.51
	Facility	$ 32.07	$ 41.51

Status	Definition
A	Active code
B	Payment for covered services are always bundled into payment for other services not specified
C	Carrier-priced code
D	Deleted code (90-day grace period)
E	Excluded from physician fee schedule by regulation
F	Deleted/discontinued code (code not subject to a 90-day grace period)
G	Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services (code subject to a 90-day grace period)
H	Deleted modifier
I	Code not valid for Medicare purposes; no grace period
L	Local code
N	Non-covered service
P	Bundled/excluded code
R	Restricted Coverage applies
T	Solo code
V	Deleted visit code not payable under fee schedule
X	Statutory exclusion
Z	Electrocardiograms (deleted in 1996)

AB-02-018/CR2036/02-08-02/MM

Reembolso

UNIDADES BASE PARA CÓDIGOS DE ANESTESIA

Los siguientes 19 nuevos códigos de anestesia fueron añadidos para el año 2002 con sus respectivas unidades base.

Reimbursement

2002 ANESTHESIA CONVERSION FACTORS

The following 19 new anesthesia codes were added for the 2002-year with their respective base unit.

CÓDIGO *CODE*	DESCRIPCIÓN *DESCRIPTION*	UNIDAD BASE *BASE UNIT*
00797	anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obsesity	008
00851	anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	006
00869	anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; vasectomy, unilateral/bilateral	003
01905	anesthesia for myelography, diskography, vertebroplasty	005
01924	anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified	005
01925	anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary	007
01926	anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic	008
01930	anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not include access to the central circulation); not otherwise specified	005
01931	anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or circulation (eg. Transcutaneous porto-caval shunt (TIPS))	007
01932	anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular	006
01933	anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central	007
01960	anesthesia for; vaginal delivery only	005
01961	anesthesia for; cesarean delivery only	007
01962	anesthesia for; urgent histerectomy following delivery	008
01963	anesthesia for cesarean histerectomy without any labor analgesia/anesthesia care	008
01964	anesthesia for; abortion procedures	004

Reembolso

La unidad base de los siguientes once códigos ha sido cambiada de manera tal que la unidad base del Centro para Servicios de Medicare & Medicaid (CMS por sus siglas en inglés) y la unidad base de los Valores Relativos de la Sociedad Americana de Anestesiólogos sea la misma.

El cambio aplica para fechas de servicios del 2002 en adelante.

Reimbursement

The base unit of the following eleven codes have been changed so that the Center for Medicare & Medicaid Services (CMS) base unit and the American Society of Anesthesiologist's Relative Value Guide base unit are the same.

This change applies for dates of services effective on 2002.

Código ***Code***	**Valor Base de Anestesia 2001** ***2001 Base Anesthesia Value***	**Valor Base de Anestesia 2002** ***2002 Base Anesthesia Value***
01214	10	8
01916	5	6
00548	15	17
00700	3	4
00800	3	4
00810	6	5
00902	4	5
01150	8	10
01432	5	6
01440	5	8
01770	8	6

CR 1908/Transmittal B-01-69/10-31-2001/IC

SERVICIOS DE TERAPIA NUTRICIONAL MÉDICA (MNT) PRESTADOS POR DIETISTAS REGISTRADOS O PROFESIONALES DE LA NUTRICIÓN

Este artículo informa a los proveedores de los códigos, pago y requisitos para contratación de la §105 de Medicare, Medicaid y *SCHIP Benefits Improvement and Protection Act* (BIPA por sus siglas en inglés) del 2000. La fecha de efectividad de esta provisión es el 1 de enero de 2002. Este artículo también incluye información adicional sobre el procesamiento de reclamaciones relacionadas a este beneficio.

MEDICAL NUTRITION THERAPY (MNT) SERVICES RENDERED BY REGISTERED DIETITIANS OR NUTRITION PROFESSIONALS

This article informs providers of the coding, payment, and enrollment requirements of §105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The effective date of this provision is January 1, 2002. This article also contains additional claims processing information with respect to this benefit.

Reembolso

Trasfondo

La sección 105 de BIPA permite la cubierta por parte de Medicare de los servicios de terapia nutricional médica cuando estos hayan sido prestados por un dietista registrado o por un profesional de la nutrición siempre y cuando se cumplan ciertos requisitos. Este beneficio está disponible para beneficiarios con diabetes o condición renal, cuando es referido por un médico según definido en la §1861 (r) (l) del Acta de Seguro Social (Acta).

El beneficio consistirá de una visita inicial para evaluación; visitas de seguimiento para intervenciones; y re-evaluaciones según necesarias durante el período de 12 meses comenzando con la evaluación inicial (episodio de cuidado) para asegurar el cumplimiento con el plan de dieta. Para propósitos de cubierta, el beneficio se definirá como el máximo número de horas que pueden ser reembolsadas en un episodio de cuidado. El número máximo de horas cubiertas será provisto en un artículo futuro.

Para propósitos de este beneficio, condición renal significa insuficiencia renal crónica y la condición médica de un beneficiario que ha sido dado de alta del hospital luego de un transplante renal exitoso dentro de los 6 meses. Insuficiencia renal crónica significa una reducción en la función renal no tan severa que requiera diálisis o transplante (velocidad de filtración glomerular, GFR, por sus siglas en ingles 13-50 ml/min/1.73m^2). Diabetes se define como diabetes mellitus Tipo 1 (condición auto-imune que destruye las células beta del páncreas, causando una deficiencia de insulina) y Tipo 2 (hipoglicemia familiar). Los criterios para un diagnóstico de diabetes es una glucosa en ayuna mayor o igual a 126 mg/dl. Estas definiciones vienen del *Institute of Medicare 2000 Report, The Role of Nutrition in Maintaining Health in the Nation's Elderly*.

Reimbursement

Background

Section 105 of BIPA permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861 (r) (l) of the Social Security Act (the Act). It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time.

The benefit will consist of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure compliance with the dietary plan. For purposes of coverage, the benefit will be defined as a maximum number of hours that may be reimbursed in an episode of care. The maximum number of hours covered will be provided in a future article when that requirement has been finalized. The Centers for Medicare and Medicaid Services will further define 'intervention' in the national coverage determination process. Note that the number of hours covered for diabetes may be different than the number of hours covered for renal disease.

For the purposes of this benefit, renal disease means chronic renal insufficiency and the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m^2). Diabetes is defined as diabetes mellitus Type 1 (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency) and Type 2 (familial hyperglycemia). The diagnostic criterion for a diagnosis of diabetes is a fasting glucose greater than or equal to 126 mg/dl. These definitions come from the Institute of Medicare 2000 Report, The Role of Nutrition in Maintaining Health in the Nation's Elderly.

Reembolso

Condiciones Generales de Cubierta

Las condiciones generales de cubierta son las siguientes:

- El médico de cabecera debe hacer un referido e indicar un diagnóstico de diabetes o de condición renal;
- El número de horas cubiertas en un episodio de cuidado no se puede sobrepasar;
- Los servicios pueden ser prestados individualmente o en grupo sin restricciones;
- Cuando los seguimientos a los adiestramientos de Automanejo de la Diabetes (DSMT por sus siglas en inglés) y los servicios de MNT* son prestados dentro de un mismo período, las horas de ambos beneficios cuentan hacia el máximo número de horas cubiertas permitidas durante un episodio de cuidado.
- Los servicios de MNT deben ser prestados por un profesional según definido a continuación.

*****Para más información sobre DSMT y MNT, vea las páginas 5-8 y 49 respectivamente, volumen 67 (julio, agosto, septiembre de 2001) de nuestro boletín.

Limitaciones de Cubierta

Las siguientes limitaciones aplican:

- Los servicios de MNT no están cubiertos para beneficiarios que reciben mantenimiento de diálisis para los cuales se paga según la §1881 del Acta.
- Si un beneficiario padece de condición renal y diabetes, solo podrán recibir el número de horas cubiertas bajo este beneficio para la condición renal o la diabetes, cual de las dos sea mayor.
- Un beneficiario no puede recibir MNT si ha iniciado servicios de DSMT en los pasados 12 meses a menos que:

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General Conditions of Coverage

The following are the general conditions of coverage:

- *The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease as described in this article;*
- *The number of hours covered in an episode of care may not be exceeded;*
- *Services may be provided either on an individual or group basis without restrictions;*
- *When follow-up Diabetes Self-management Training (DSMT) and MNT services* are provided within the same time period, hours from both benefits are counted toward the maximum number of covered hours allowed during the episode of care; and*
- *MNT services must be provided by a professional as defined below.*

***** *For more information on DSMT and MNT, see pages 5-8 and 49 respectively, volume 67 (July, August, September 2001) of our bulletin.*

Limitations on Coverage

The following limitations apply:

- *MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under §1881 of the Act.*
- *If a beneficiary has both renal disease and diabetes, they may receive only the number of hours covered under this benefit for either renal disease or diabetes, whichever is greater.*
- *A beneficiary cannot receive MNT if they have received initial DSMT within the last 12 months, unless:*

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- Se haya documentado la necesidad para una re-evaluación y terapia adicional por el médico que refiere como resultado de un cambio de diagnóstico o condición médica; o
- El beneficiario que está recibiendo DSMT es diagnosticado con una condición renal.

• Si un beneficiario diagnosticado con diabetes ha sido referido para servicios de DSMT y MNT, el número de horas que este puede recibir está limitado a la cubierta anual establecida para tratamientos subsiguientes bajo cualquiera de los dos servicios DSMT o MNT, el que sea mayor.

Referidos

Los referidos se pueden hacer solamente por el médico ofreciendo los servicios cuando el beneficiario ha sido diagnosticado con diabetes o condición renal. Este médico debe mantener la documentación existente sobre dicha condición en el expediente del beneficiario. Los referidos deben hacerse por cada episodio de cuidado y cualquier re-evaluación prescrita durante un episodio de cuidado como resultado de un cambio en la condición médica o diagnóstico. El dietista registrado o el profesional de nutrición deberá indicar en su reclamación el nombre y número de UPIN (encasillados 17 y 17A de la forma HCFA 1500) del médico que refiere. Las reclamaciones que no contengan el número de UPIN del médico que refiere serán devueltas.

Horas Adicionales Cubiertas para Re-evaluaciones e Intervenciones

Re-evaluaciones MNT adicionales e intervenciones solo están cubiertas dentro de un episodio de cuidado cuando el médico que refiere determina que hay un cambio en diagnóstico o condición médica dentro del episodio de cuidado que requiere un cambio en la dieta.

Estándares Profesionales para Dietistas y Nutricionistas

Para cubierta Medicare Parte B de MNT, solamente un dietista registrado o profesional de

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- *The need for a reassessment and additional therapy has been documented by the referring physician as a result of a change in diagnosis or medical condition; or*
- *The beneficiary receiving DSMT is subsequently diagnosed with renal disease.*

• *If a beneficiary diagnosed with diabetes has been referred for both follow-up DSMT and MNT services, the number of hours the beneficiary may receive is limited to the number of hours covered under either follow-up DSMT or MNT services annually, whichever is greater.*

Referrals

Only the treating physician may make the referral for the beneficiary that has been diagnosed with diabetes or renal disease. This physician should maintain the documentation relating to the condition in the beneficiary's medical record. Referrals must be made for each episode of care and any reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The registered dietitian or nutrition professional should indicate on it's claim the name and UPIN number (items 17 and 17A Form HCFA-1500 claim form) of the referring physician. Claims that do not contain the referring UPIN of the referring physician will be returned.

Additional Covered Hours for Reassessments and Interventions

Additional MNT reassessments and interventions are only covered within an episode of care when the referring physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary.

Professional Standards for Dietitians and Nutritionists

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may

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nutrición puede proveer los servicios. "Dietista registrados o profesional de nutrición" significa un dietista o nutricionista licenciado al 21 de diciembre de 2000 y deberá someter junto a la forma CMS 855I los siguientes documentos;

- Diploma
- Verificación de licencia (Good-standing)
- Licencia
- Certificado negativo de antecedentes penales

Aquel individuo licenciado en o después del 22 de diciembre de 2000 deberá además someter la siguiente evidencia:

- Grado de bachillerato o más otorgado por un colegio acreditado o universidad del estado (o un grado extranjero equivalente) concretando los requisitos académicos de un programa de nutrición o dietista, acreditado por la organización nacional que se reconozca para estos propósitos.
- Haya completado por lo menos 900 horas de práctica dietetica supervisada por un dietista registrado o profesional de nutrición.

Pago para MNT

El pago se efectuará a dietistas registrados o profesionales de nutrición bajo la tabla de tarifas fijas de proveedores para fechas de servicio del 1 de enero de 2002 en adelante que cumplan los requisitos explicados anteriormente. Los deducibles y co-aseguros aplican. Al igual que el beneficio del adiestramiento para el auto-manejo de la diabetes, el pago es solamente para servicios MNT para los cuales el beneficiario haya asistido y que estén debidamente documentados por el proveedor.

La tarifa que Medicare aprobará para los servicios prestados por un dietista registrado o profesional de nutrición será el menor del 80 porciento del cargo actual o el 80 porciento del 85 porciento de la tarifa fija del proveedor. El co-aseguros será el 20 porciento del menor de las dos cantidades.

El pago se efectuará dentro de los siguientes códigos:

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provide the services. "Registered dietitian or nutrition professional," means a licensed dietitian or nutritionist as of December 21, 2000 and should submit CMS 855I with the following documents for enrollment purposes:

- *Diploma*
- *Good-standing*
- *License*
- *Certification of No-Penal Records*

Those individual licensed on or after December 22, 2000 should in addition submit the following evidence:

- *Bachelor's or higher degree granted by an accredited college or university with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose;*
- *Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.*

Payment for MNT

Payment will be made under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the diabetes self-management training benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The fee Medicare will approve for the services rendered by a registered dietitian or nutrition professional will be the lesser of 80 percent of the actual charge, or 80 percent of 85 percent of the physician fee schedule amount. Coinsurance is based on 20 percent of the lesser of these two amounts.

Payment will be made under the following codes:

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97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. **(NOTE: This CPT code must only be used for the initial visit.)**

97803 Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 Group (2 or more individual(s)), each 30 minutes

Instrucciones para el Uso de los Códigos de Terapia Nutricional Médica

97802 Este código se utilizará una vez al año, para la evaluación inicial de un paciente nuevo. Todas las visitas subsiguientes (incluyendo re-evaluaciones e intervenciones) serán codificadas como 97803. Todas las visitas de grupo subsiguientes serán facturadas como 97804.

97803 Este código se facturará para todas las re-evaluaciones individuales y todas las intervenciones luego de la visita inicial (ver 97802). Este código debe utilizarse también cuando hay un cambio en la condición médica del paciente que afecta el estatus nutricional del paciente (ver la sección de Horas Adicionales Cubiertas para Re-evaluaciones e Intervenciones).

97804 Este código será facturado para todas las visitas de grupo, iniciales y subsiguientes. También puede utilizarse cuando hay un cambio en la condición del paciente que afecta el estatus nutricional del paciente y el paciente está siendo atendido en un grupo.

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97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.* ***(NOTE: This CPT code must only be used for the initial visit.)***

97803 *Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*

97804 *Group (2 or more individual(s)), each 30 minutes*

Instructions for Use of the Medical Nutrition Therapy Codes

97802 *This code is to be used only once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent Group Visits are to be billed as 97804.*

97803 *This code is to be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).*

97804 *This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.*

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NOTA: Los códigos arriba indicados sólo se pagarán si son sometidos por un dietista registrado o profesional de nutrición que cumpla con los requisitos especificados. Estos servicios no pueden ser pagados incidentales a los servicios médicos.

Información General sobre el Procesamiento de Reclamaciones

Los dietistas licenciados y los profesionales de nutrición tiene que aceptar asignación por los servicios facturados a Medicare. Estos proveedores serán tratados al igual que aquellos indicados en el Manual del Contratista Medicare (MCM), §17001.1 E.

Los dietistas licenciados y profesionales de nutrición pueden ser parte de una práctica grupal en cual caso el número de identificación del proveedor debe ser el del dietista registrado o profesional de nutrición que prestó el servicio y debe ser incluido en el encasillado 24k de la forma HCFA-1500.

Según estipulado en las Condiciones General de Cubierta, este beneficio esta cubierta para beneficiarios que padezcan de diabetes o condición renal. Si la reclamación no contiene un diagnóstico, las reclamaciones serán devueltas como no procesables. Si la reclamación no contiene el diagnóstico de diabetes o condición renal, la reclamación será denegada bajo §1862(a)(1)(A) del Acta.

Inscripción de Dietistas y Nutricionistas

Los dietistas licenciados y los profesionales de nutrición se les paga por servicios de MNT a través de los contratistas locales. Para someter reclamaciones de servicios MNT, el dietista licenciado /profesional de nutrición debe estar inscrito como un proveedor del programa Medicare y cumplir con los requisitos señalados. El nuevo número para la especialidad de dietista/ nutricionista es 71. El proceso de inscripción para estos nuevos proveedores es el mismo que cualquier otro proveedor. Los servicios MNT pueden ser facturados con la fecha efectiva de la licencia del proveedor y el establecimiento de la práctica, pero no antes del 1 de enero de 2002.

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NOTE: *The above codes can only be paid if submitted by a registered dietitian or nutrition professional that meets the specified requirements. These services cannot be paid "incident to" physician services.*

General Claims Processing Information

Registered dietitians and nutrition professionals must accept assignment. These providers will be treated the same as those listed in the Medicare Carriers Manual, (MCM), §17001.1 E. This section will be updated in the future adding these new practitioners to the list.

Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in item 24k of Form HCFA-1500.

As stated under "General Conditions of Coverage," this benefit is payable for beneficiaries who have diabetes or renal disease. If no diagnosis is on the claim, the claims will be returned as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, the claim will be denied under §1862(a)(1)(A) of the Act.

Enrollment of Dietitians and Nutritionists

Registered dietitians and nutrition professionals are paid for MNT services through local carriers. In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. The new specialty code for "dietitians/nutritionists" is 71. The enrollment process for these new providers is the same as any other provider. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location, but not before January 1, 2002.

CR 2046/Transmittal B-02-010/February 8, 2002/MM

Reembolso

CAMBIOS DE EMERGENCIA EN LA BASE DE DATOS DE LAS TARIFAS FIJAS PARA MÉDICOS 2002

CMS (Centers for Medicare and Medicaid Services) notificó con carácter de urgencia, los siguientes cambios en la base de datos de las Tarifas Fijas para Médicos 2002. Los cambios serán efectivos para servicios prestados en o después del 1 de enero del 2002.

Los cambios son los siguientes:

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EMERGENCY CHANGES TO THE 2002 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

CMS (Centers for Medicare and Medicaid Services) notified the following emergency changes to the 2002 Medicare Physician Fee Schedule Database. These changes are effective for services performed on or after January 1, 2002.

Changes are as follows:

Código *Code*	**Cambio** *Changes*	**Tarifa para PR** *PR Fee*	**Tarifa para VI** *VI Fee*
G0108	Non-Fac PE RVU=0.82 Fac PE RVU=0.82	$21.23	$30.73
G0109	Non-Fac PE RVU=0.48 Fac PE RVU = 0.48	$12.47	$18.14
G0236	Non-Fac PE RVU =0.41 Fac PE RVU =0.41	$12.68	$18.07
G0236-TC	Non-Fac PE RVU=0.39 Fac PE RVU = 0.39	$10.15	$14.81
76092	Non-Fac PE RVU =1.47 Fac PE RVU =1.47	$61.11	$82.15
76092-TC	Non-fac PE RVU= 1.22 Fac PE RVU = 1.22	$32.04	$47.56
76085	Non-fac PE RVU= 0.41 Fac PE RVU = 0.41	$12.68	$18.00
76085-TC	Non-Fac PE RVU =0.39 Fac PE RVU =0.39	$10.15	$14.81
95951	Non-Fac PE RVU = 39.72 Fac PE RVU = 39.72	$1,220.86	$1,701.53
95951-TC	Non-Fac PE RVU = 37.00 Fac PE RVU = 37.00	$957.41	$1,383.96

AB-01-177 / CR 1971/IC

Códigos CPT *CPT Codes*	Revisión CPT *CPT Revision*
A4263	Procedure Status =B
A4329	Procedure Status =F
A4550	Procedure Status =B
A5064	Procedure Status =F
A5074	Procedure Status =F
A5075	Procedure Status =F
G0025	Procedure Status =B
G0126	Procedure Status =F
G0126TC	Procedure Status =F
G0126-26	Procedure Status =F
G0163	Procedure Status =F
G0163-TC	Procedure Status =F
G0163-26	Procedure Status =F
G0164	Procedure Status =F
G0164-TC	Procedure Status =F
G0164-26	Procedure Status =F
G0165	Procedure Status =F
G0165-TC	Procedure Status =F
G0165-26	Procedure Status =F
G0203	Procedure Status =F
G0205	Procedure Status =F
G0205-TC	Procedure Status =F
G0205-26	Procedure Status =F
G0207	Procedure Status =F
G0207-TC	Procedure Status =F
G0207-26	Procedure Status =F
J7190	Procedure Status =X
J7199	Procedure Status =X
Q0187	Procedure Status =X
Q3014	Procedure Status =X
Q3017	Procedure Status =X
29806	Multiple Procedures Indicator=3 Endoscopic Base Code - 29805
29807	Multiple Procedures Indicator=3 Endoscopic Base Code - 29805
29819	Endoscopic Base Code - 29805
29820	Endoscopic Base Code - 29805
29821	Endoscopic Base Code - 29805
29822	Endoscopic Base Code - 29805
29823	Endoscopic Base Code - 29805
29824	Multiple Procedures Indicator=3 Endoscopic Base Code - 29805
29825	Endoscopic Base Code - 29805
29826	Endoscopic Base Code - 29805
85095	Multiple Procedures Indicator=0
85102	Multiple Procedures Indicator=0

Status de Procedimiento/*Procedure Status*

B= BUNDLE
F= DELETED/DISCONTINUED CODES (NOT SUBJECT TO 90 DAYS GRACE PERIOD)
X=STATUTORY EXCLUSION

Reembolso

ACTUALIZACIONES A LA LISTA DE CLIA PARA PRUEBAS DE DISPENSA

El código de CPT 87804 es un código nuevo para el año 2002. El mismo fue desarrollado para la detección de antígenos de agente infeccioso mediante técnica de inmunoensayo con observación óptica directa; Influenza. Efectivo para fechas de servicio en o después del 1 de enero del 2002, el código de CPT 87804QW sustituye al código de CPT 87899QW para la prueba de Influenza Quidell Quick Vue.

Reimbursement

UPDATE TO THE LIST OF CLIA WAIVED TESTS

CPT code 87804 is a new code for 2002 that was developed for Infectious agent antigen detection by immunoassay with direct optical observation; influenza. Effective for dates of service on or after January 1, 2002, CPT code 87804QW replaces CPT code 87899QW for the Quidell Quick Vue Influenza test.

Código *Code*	Tarifa PR *PR Fee*	Tarifa VI *VI Fee*
87804QW	$15.05	$12.09

Trans. AB-01-187, CR#1976\IC

CORRECCIÓN A LA 2DA ACTUALIZACIÓN DE LAS TARIFAS FIJAS PARA MÉDICOS DEL 2001

Los Centros para Servicios de Medicare y Medicaid (CMS por sus siglas en inglés) han revocado los cambios anunciados para el código CPT 76000, los cuales fueron publicados en el volumen 66 de nuestro boletín Medicare Informa, páginas 20-22. Las tarifas que se indican a continuación corresponden a una corrección hecha por CMS a las del código 76000 y serán efectivas el 20 de diciembre de 2001, para servicios prestados en o después del 1 de enero de 2001.

CORRECTION TO THE 2ND UPDATE TO 2001 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB)

The Centers for Medicare & Medicaid Services (CMS) retracted to the changes announced for CPT code 76000, which we published in the Medicare Informa, Vol. 66, pages 20-22. The fees listed below pertains to the correction made by CMS for this CPT code and will be effective on December 20, 2001 for services rendered on or after January 1, 2001.

HCPCS CODE	CODE STATUS	PARTICIPATING FEE		NON-PARTICIPATING FEE		LIMITING CHARGE	
		P.R	V.I.	P.R	V.I.	P.R	V.I.
76000	A	$44.32	$62.93	$42.10	$59.78	$48.41	$68.75
76000-26	A	$7.51	$9.03	$7.13	$8.58	$8.20	$9.87
76000-TC	A	$36.81	$53.91	$34.97	$51.21	$40.22	$58.89

CR 1937/TRANS.AB-01-167/NOV.27, 2001/MM

Reembolso

CUBIERTA Y FACTURACIÓN DE LA ESTIMULACIÓN DEL NERVIO SACRO

En la pasada edición de nuestro boletín correspondiente a octubre, noviembre y diciembre 2001 (volumen 68), fue publicado el artículo "Estimulación del Nervio Sacro para la Incontinencia Urinaria". A continuación, les incluimos las instrucciones para facturar dicho tratamiento.

El estimulador del nervio sacro es un generador de pulsaciones que transmite impulsos eléctricos a los nervios sacros mediante un alambre implantado. Estos impulsos logran la contracción de los músculos de la vejiga y le permiten al paciente evacuarla correctamente.

De acuerdo a la sección 65-18 del CIM - Estimulación del Nervio Sacro para la incontinencia urinaria (urinary urge incontinence), efectivo el 1 de enero de 2002, la estimulación del nervio sacro estará cubierta para el tratamiento de la incontinencia urinaria, síndrome de urgencia-urinaria y retención urinaria. La estimulación del nervio sacro, en candidatos apropriados, comprende la prueba temporera para determinar si un estimulador implantable es efectivo y la implantación permamente. Ambos servicios están cubiertos.

Las siguientes limitaciones para la cubierta aplican a todas las indicaciones:

- El paciente debe ser refractario a la terapia convencional (conducta documentada, farmacológica y/o terapia quirúrgica correctiva) y que sea un candidato a la implantación quirúrgica de manera que se pueda administrar anestesia.
- Pacientes con incontinencia acentuada, obstrucción urinaria, y condiciones neurológicas (tales como la diabetes con envolvimiento nervioso periferal) las cuales están asociadas con manifestaciones secundarias están excluídas.

Reimbursement

COVERAGE AND BILLING OF SACRAL NERVE STIMULATION

In our previous issue (Volume 68, October, November, December 2001), this carrier published the article "Sacral Nerve Stimulation for Urinary Incontinence". Following are the Medicare billing instructions for this treatment.

A sacral nerve stimulator is a pulse generator, which transmits electrical impulses to the sacral nerves through an implanted wire. These impulses cause the bladder muscles to contract, which gives the patient ability to void more properly.

Section 65-18 of the CIM states that effective January 1, 2002, sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome and urinary retention. Sacral nerve stimulation involves both a temporary test stimulation to determine if an implantable stimulator would be effective and a permanent implantation in appropriate candidates. Both the test and the permanent implantation are covered.

The following limitations for coverage apply to all indications:

- *Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.*
- *Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.*

Cont. on next page

Reembolso

- El paciente debe haber pasado la prueba de estimulación exitosamente para poder resistir la implantación. Antes de que un paciente sea elegible para la implantación permanente el/ella debe demostrar una mejoría de 50% o más en las pruebas de estimulación. El progreso de la mejoría se mide llevando récord diario de las evacuaciones.
- El paciente debe demostrar la habilidad de poder llevar el record de las evacuaciones diarias de manera que los resultados clínicos del procedimiento de implantación puedan ser evaluados apropiadamente.

Códigos

- 64555 - Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excluye el nervio sacro). Este código aplica a servicios realizados antes del 1 de enero de 2002.
- 64561 - Percutaneous implantation of neurostimulator electrodes; sacral nerve. (transforaminal placement). Este código aplica a servicios realizados en o después del 1 de enero de 2002.
- 64575 - Incision for implantantion of neurostimulator electrodes; peripheral nerve (excluye el nervio sacro). Este código aplica a los servicios realizados antes del 1 de enero de 2002.
- 64581- Incision for implantation of neurostimulator electrodes; sacral nerve; (transforaminal placement). Este código aplica a servicios realizados en o antes del 1 de enero de 2002.
- 64585 - Revision or removal of peripheral neurostimulator electrodes.
- 64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling.

Reimbursement

- *Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.*
- *Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.*

Codes

- *64555 - Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve). This code applies to services performed prior to January 1, 2002.*
- *64561 - Percutaneous implantation of neurostimulator electrodes; sacral nerve. (transforaminal placement). This code applies to services performed on or after January 1, 2002.*
- *64575 - Incision for implantantion of neurostimulator electrodes; peripheral nerve (excludes sacral nerve). This code applies to services performed prior to January 1, 2002.*
- *64581- Incision for implantation of neurostimulator electrodes; sacral nerve; (transforaminal placement). This code applies to services performed on or after January 1, 2002.*
- *64585 - Revision or removal of peripheral neurostimulator electrodes*
- *64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling.*

Reembolso

- 64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver.
- A4290 – Sacral nerve stimulation test lead, each.
- E0752 - Implantable neurostimulator electrodes (no cubierto por Medicare).
- E0756 - Implantable neurostimulator pulse generator.

Procedimientos para Centros de Cirugía Ambulatoria (ASC por sus siglas en Inglés)

Códigos Aplicables

- 64575 - Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve). Este código aplica a servicios realizados antes del 1 de enero de 2002.
- 64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver; direct or inductive coupling.
- 64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver

Requisitos para pago

Medicare paga por la estimulación del nervio sacro a base de las tarifas de pago de Medicare (Medicare Physician Fee Schedule). Los deducibles y co-aseguros aplican. Las reclamaciones provenientes de médicos, otros practicantes o suplidores donde no hubo asignación estarán sujetos al cargo límite de Medicare.

Reimbursement

- *64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver.*
- *A4290 – Sacral nerve stimulation test lead, each.*
- *E0752 - Implantable neurostimulator electrodes (non-covered by Medicare).*
- *E0756 - Implantable neurostimulator pulse generator.*

Ambulatory Surgical Centers (ASC) Procedures

Applicable Codes

- *64575 - Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve). This code applies to services performed prior to January 1, 2002.*
- *64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver; direct or inductive coupling.*
- *64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver.*

Payment Requirements

Medicare pays for sacral nerve stimulation on the basis of the Medicare physician fee schedule. Deductible and co-insurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

CR#1881& CR#1936/10-04-01/MM

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:*
  - Ö *Median AWP of all of the generic forms of the drugs or biological.*
  - Ö *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).

ACTUALIZACION TRIMESTRAL PRECIOS DE MEDICAMENTOS
QUARTERLY PRICING UPDATE FOR DRUGS

CODIGO *CODE*	TARIFA *FEE*	NO-PART *NON-PART*	CODIGO *CODE*	TARIFA *FEE*	NO-PART *NON-PART*
J0285	$ 14.59	$ 13.86	J1438	$ 147.91	$ 140.51
J0290	$ 1.54	$ 1.46	J1570	$ 35.23	$ 33.47
J0295	$ 8.69	$ 8.26	J2700	$ 2.65	$ 2.52
J0456	$ 23.21	$ 22.05	J3240	$ 566.67	$ 538.34
J0585	$ 4.65	$ 4.42	J3260	$ 5.86	$ 5.57
J0690	$ 3.06	$ 2.91	J3370	$ 9.31	$ 8.84
J0698	$ 12.52	$ 11.89	J7192	$ 1.12	$ 1.06
J0694	$ 10.86	$ 10.32	J7194	$ 0.59	$ 0.56
J0696	$ 14.91	$ 14.16	J7500	$ 1.23	$ 1.17
J0698	$ 10.83	$ 10.29	J9031	$ 167.10	$ 158.75
J0720	$ 6.81	$ 6.47	J9045	$ 111.11	$ 105.55
J0725	$ 4.11	$ 3.90	J9185	$ 285.41	$ 271.14
J0770	$ 54.15	$ 51.44	J9293	$ 244.19	$ 231.98
J0895	$ 14.15	$ 13.44	J9340	$ 116.97	$ 111.12
J1364	$ 3.86	$ 3.67	***J9300**	**$2,024.67**	**$ 1,923.44**

CR 745/Transmittal AB-00-110/November 14, 2000/MM
Data Source: Red Book CD ROM/ January 2002
***** The fee published for this code on the 2002 Fee Schedule ($18.76) was incorrect.

TARIFAS PARA VACUNAS CONTRA LA INFLUENZA Y LA NEUMONIA

Efectivo el 1 de enero de 2002 las tarifas para los siguientes códigos son:

INFLUENZA & PNEUMOCOCCAL VACCINES FEES

Effective January 1, 2002 the fees for the following codes are:

CODIGO *CODE*	DESCRIPCION *DESCRIPTION*	TARIFA *FEE*
90657	Influenza virus vaccine, split virus, 6-35 months dosage for intramuscular or jet injection use	$3.08
90658	Influenza virus vaccine, split virus, 3 years dosage for intramuscular or jet injection use	$6.17
90732	Pneumococcal Poly Saccharide Vaccine, 23 valent, adult dosage for subcutaneous or intramuscular use	$12.96

CODIGO *CODE*	DESCRIPCION *DESCRIPTION*	P.R	V.I.
G0008	Administration of Influenza Virus Vaccine	$2.68	$4.07
G0009	Administration of Influenza Pneumococcal Vaccine	$2.68	$4.07

CR 745/TRANSMITTAL AB-00-110/November 14, 2000
Data Source: Red Book CR ROM/January, 2002 and MPFSDB 2002

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).* Los códigos CPT (Current Procedural Terminology) deben tener el modificador QW para de esta manera ser reconocidos como pruebas de dispensa.

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). The current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

NOMBRE DE LA PRUEBA ***TEST NAME***	**FABRICANTE** ***MANUFACTURER***	**CODIGO(S) CPT** ***CPT CODE(S)***
*International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Prescription Home Use	International Technidyne	85610QW (contact your Medicare carrier for
* International Technidyne ProTime Microcoagulation System (ProTime 3 Cuvette) Professional Use	International Technidyne	85610QW (contact your Medicare carrier for
* Ostex International Osteomark NTX Point of Care Prescription Home Use	Ostex International Inc.	82523QW
* Embryotech Laboratories Home Diagnostic Screening Test for Male Infertility	Embryotech Laboratories, Inc.	89300QW (This test may not be covered in all Contact your Medicare carrier for
* Metrika A1c Now™ -Professional Use	Metrika, Inc.	83036QW
* Diagnostic Chemicals ImmunoDip™ Urinary Albumin Screen (Urine Dipstick)	Diagnostic Chemicals Limited	82044QW
* FemTek pHEM-ALERT®	FemTek, LLC	83986QW
* Provalis Diagnostics Glycosal™ HbA1c	Provalis Diagnostics Ltd.	83036QW
*Quidel QuickVue+ Infectious Mononucleosis (Whole Blood)	Quidel Corporation	86308QW
* Acon® Strep A Rapid Strip Test	Acon Laboratories, Inc.	87880QW
* Beckman Coulter Primary Care Diagnostics ICON DS Strep A	Acon Laboratories, Inc.	87880QW

***Newly added waived test system**

CR 2033/Transmittal AB-02-024/February 14,2002/MM

CONSOLIDATED BILLING FOR SNF RESIDENTS

Background.—Section 4432(b) of the Balanced Budget Act (BBA) requires CB for SNFs. Under the CB requirement, the SNF must submit Medicare claims to the fiscal intermediary (FI) for all the Part A and Part B services that its residents receive, except for certain excluded services listed in section I-G. The CB requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services.

For services and supplies furnished to a SNF resident covered under the Part A benefit, SNFs will no longer be able to unbundle services to an outside provider of services or supplies that can then submit a separate bill directly to the Medicare carrier. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, power of attorney, or any other direct payment arrangement. (See 42 CFR 424.73.) As a result, the outside provider of the service or supplies must look to the SNF, rather than to the beneficiary or the Medicare carrier, for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary. Most covered services and supplies billed by the SNF, including those furnished under arrangement with an outside provider, for a resident of a SNF in a covered Part A stay are included in the SNF's bill to the FI.

A SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF, or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF, regardless of whether Part A covers the stay.

Effective July 1, 1998, CB became effective for those services and items that were not specifically excluded by law that were furnished to residents of a SNF in a covered Part A stay and also includes physical, occupational and speech therapies in a Part B stay. SNFs became subject to CB once they transitioned to the prospective payment system (PPS). Due to systems limitations, CB was not implemented at that time for residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). In addition, for either type of resident, the following requirements were also delayed: 1) that the physicians forward the technical portions of their services to the SNF to be billed to the FI for payment; and 2) the requirement that the physician enter the facility provider number of the SNF on the claim.

These services will be billed by the hospital or outpatient department directly to the FI. HCPCS codes for these services are included in section II, F.

Also excluded were hospice care and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident.

Effective April 1, 2000, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from CB that therefore had to be billed directly to the carrier or DMERC by the provider or supplier for payment. As opposed to whole categories of services being excluded, only certain specific services and drugs were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services and certain customized prosthetic devices. These specific services and drugs are listed by HCPCS codes in section II, E.

New Procedures.—Effective for claims with dates of service on or after April 1, 2001, for those services and supplies that were not specifically excluded by law and are furnished to a SNF resident covered under the Part A benefit, the following requirements will be made effective in addition to all other previously implemented requirements for this category of residents:

- Physicians will be required to forward the technical portions of any services to the SNF to be billed by the SNF to the FI for payment. Medicare carriers will no longer make payment to physicians and suppliers for technical components of physician services furnished to beneficiaries in the course of a Medicare Part A covered stay.
- Providers will be required to enter the facility provider number of the SNF on the claim.

Determining the End of a SNF Stay.—When a beneficiary leaves the SNF, their status as a SNF resident for CB purposes, along with the SNF's responsibility to furnish or make arrangements for needed services, ends when one of the following events occurs:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary has been discharged from the SNF and receives services from a Medicare-participating home health agency under a plan of care;
- The beneficiary receives emergency or other excluded outpatient services;
- The beneficiary is formally discharged or otherwise departs from the SNF. However, if the beneficiary is readmitted or returns to that or another SNF before midnight of the same day, the beneficiary will still be considered to be in a SNF stay.

Types of Facilities Included in CB.—

- A participating SNF; and
- Any part of a nursing home that includes a participating distinct part SNF. In this situation, place of service must always be coded as "SNF" even if the beneficiary was in a nursing facility (NF) for part of the time.

Types of Facilities Excluded from CB.—

- A nursing home that has no Medicare certification, such as a nursing home that does not participate at all in either the Medicare or Medicaid programs; and
- A nursing home that exclusively participates only in the Medicaid program as a nursing facility.

Types of Services Included in CB.—The CB requirement confers on the SNF the billing responsibility for the entire package of care that Part A residents receive **and** physical, occupational and speech therapy services in the Part B stay. Exception: a limited number of specifically excluded services are outlined below in section I-G.

Types of Services Excluded from Consolidated Billing.—The following services and supplies provided by the following types of providers, are excluded from consolidated billing and are still billed separately to the Medicare carrier. If a service or supply does not appear on this list, or fit into one of these categories, then it is not excluded from CB and should be consolidated by the SNF to the FI for payment. Effective July 1, 1998, per the BBA and by HCFA regulation; the **exclusions** are:

- The professional component (PC) of physician's services furnished to SNF residents except physical, occupational and speech-language therapy services and audio logic function tests. A physician is defined for Medicare purposes in §1861(r) of the Social Security Act.
- In addition, certain services are excluded only when furnished on an outpatient basis by a hospital or a critical access hospital
  - cardiac catheterization services;
  - computerized axial tomography (CT) scans;
  - magnetic resonance imaging (MRIs);
  - ambulatory surgery involving the use of an operating room;
  - radiation therapy;
  - emergency services;
  - angiography;
  - lymphatic and venous procedures; and
  - ambulance services to a facility to receive any of the previously mentioned excluded outpatient hospital services
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Clinical nurse specialist;
- Certified nurse-midwives;
  - Qualified psychologists;
  - Certified registered nurse anesthetists;
  - Certain dialysis-related services including covered ambulance transportation to obtain the dialysis services;
  - Erythropoietin (EPO) for certain dialysis patients;
  - Hospice care related to a beneficiary's terminal condition; and
  - An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge.

Effective for services provided on or after April 1, 2000, to residents in a Part A covered stay, the BBRA excluded from CB a subset of HCPCS codes in the following categories:

- Chemotherapy;
- Chemotherapy administration services;
- Radioisotope services; and
- Customized prosthetic devices.

Clarification of Ambulance Services.—Except as listed under exclusions in section I-G, CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A residential stay.

In most cases, ambulance trips are excluded from CB when resident status has ended. (See section I-C, Determining the End of SNF Stay.) The ambulance company then must bill the carrier directly for payment.

Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services after residency has ended. These ambulance trips are covered by Medicare and are not subject to CB. These consist of:

– A medically necessary round trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded services. (See section I-G.)

– Medically necessary ambulance trips after a formal discharge or other departure from the SNF is excluded from CB, unless the beneficiary is readmitted or returns to that or another SNF before midnight of the same day.

– An ambulance trip for the purpose of receiving dialysis-related services is excluded from CB.

– A trip for an inpatient admission to a Medicare participating hospital or critical care access hospital (CAH).

– After a discharge from the SNF, a medically necessary trip to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care.

– A beneficiary's transfer from one SNF to another before midnight of the same day is not excluded from CB. The first SNF is responsible for billing the services to the FI.

– Carriers are responsible for assuring that payment for ambulance services meet coverage criteria and determining when the services are included in CB and when the supplier may submit a separate bill.

Information for Providers and Suppliers on SNF Contracting with Outside Entities for Ancillary Services.—Except for those services and supplies specifically excluded, under CB an outside provider or supplier can no longer submit a separate bill directly to Medicare for services furnished to a SNF resident. Instead, it must look to the SNF for its payment. This means that in making program payment for services furnished to SNF residents, Medicare deals exclusively with the SNF itself rather than with an outside provider or supplier that the SNF may elect to use.

The law is silent regarding specific terms of a SNF's payment to the outside provider or supplier and currently does not authorize the Medicare program to impose any requirements in this regard. Thus, the issue of the outside provider or supplier's payment by the SNF is a private, contractual matter that must be resolved through direct negotiations between the two parties themselves.

- Services provided under CB arrangements must be provided only by Medicare certified providers that are licensed to provide the service involved.

- Payment may not be made if the provider or supplier is subject to OIG sanctions that would prohibit Medicare payment for the service if the provider or supplier were billing independently.

CLAIMS PROCESSING INSTRUCTIONS, CARRIER AND CWF EDITS

Requirements for Entry of the SNF's Medicare Facility Provider Number.— Per §4432(b)(4) of the BBA, when physicians provide services to a beneficiary residing in a SNF, the physician must include the Medicare facility provider number of the SNF on the claims form or electronic record. The Medicare provider facility number of the SNF is the number assigned to the SNF by the HCFA regional office when they are certified as a Medicare facility. This number is referred to as the OSCAR number.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, verify that on physician bills for professional services furnished to SNF residents in a covered Part A stay, that the Medicare provider number of the SNF, (which must be preceded by the prefix "SNF"), has been entered in the appropriate block of the claims form or electronic record.

1. If the SNF is the location where the services were rendered (Place of Service Code 31), the SNF provider number must be entered in Item 32 of the Form HCFA-1500.

   For electronic submissions, when the physician renders services in a SNF (Place of Service Code 31) to a beneficiary residing in a SNF, the Medicare facility provider number of the SNF should be reported in:

   The National Standard Format: Record EA1, field EA1.04 (Facility/Lab ID); or

   The ANSI X12N 837: Table 2, Position 250, segment/element NM109(Facility ID).

2. If the services were rendered to a SNF beneficiary outside of the SNF, the physician must enter the Medicare facility provider number of the SNF in Item 23 of the Form HCFA-1500.

For electronic submission, when the beneficiary resides in a SNF and a provider renders services to the beneficiary at another facility, the Medicare facility provider number of the SNF where the beneficiary resides must be reported in:

The National Standard Format: Record FB1, field 23, positions 280-294 (this is currently filler); or

The ANSI X12N 837: Line level loop, 2-500-NM1, with a value of "P0" (Patient Facility - facility where patient resides) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the SNF ID in NM109.

The National Standard Format: Record EA1, field 04, (Facility ID/NPI); or

The ANSI X12N 837: Claim level loop, 2-250-NM1, with a value of "61" (Performed at the facility where work was performed) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the facility ID in NM109.

Use of the PC/TC Indicators to Identify Physician's Services.—Codes for diagnostic tests may include both a technical portion, i.e., the test itself and a professional component, i.e., the physician's interpretation of the test. To identify the professional components of physician's services for SNF residents that are billable to the carrier, use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule (MPFS) for payment. For Medicare purposes, physicians and physician's services are defined per §1861(q) and (r) of the Social Security Act.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, pay the physician only for the professional component of physician services that have both technical and professional components or for those physician services that have only professional components. If technical components are billed, either separately or globally, reject that portion of the claim per MCM §3005.

HCPCS Codes to Identify Physical, Occupational and Speech Language Therapy Services and Audiologic Function Tests That Are Subject to CB. Both Part A and Part B stays are subject to CB for therapy services. When coded with the following HCPCS codes with a POS code of 31, carriers must reject the services.

Rehabilitation Services - Physical, Occupational and Speech Language Therapy

11040	11041	11042	11043	11044
29065	29075	29085	29105	29125
29126	29130	29131	29200	29220
29240	29260	29280	29345	29365
29405	29445	29505	29515	29520
29530	29540	29550	29580	29590
64550	90901	90911	92506	92507
92508	92510	92525	92526	92597
92598	95831	95832	95633	95834
95851	95852	96105	96110	96111
96115	97001	97002	97003	97004
97010	97012	97014	97016	97018
97020	97022	97024	97026	97028
97032	97033	97034	97035	97036
97039	97110	97112	97113	97116
97124	97139	97140	97150	97504
97520	97530	97535	97537	97542
97545	97546	97703	97750	97770
97799	G0169	V5362	V5363	V5364

Payment for Code 97010 is bundled with other rehabilitation services. It may be bundled with any therapy code.

Code 97504 should not be reported with code 97116. Codes should be rejected.

Code 97770 is not considered to be an outpatient rehabilitation service when delivered by a clinical psychologist (specialty 68), psychiatrist (specialty 26), or clinical social worker (specialty 80) for the treatment of a psychiatric condition (ICD-9-CM code range 2900 through 319). Edit appropriately.

Audiologic Function Tests

92552	92553	92555	92556	92557	92561
92562	92563	92564	92565	92567	92568
92569	92571	92572	92573	92575	92576
92577	92579	92582	92583	92584	92587
92588	92589	92596	V5299		

Ambulance Claims

- Carriers must reject ambulance claims with HCPCS code A0225 through A0999 if both characters of the HCPCS modifier is N, origin and destination is SNF. These claims must be billed by the SNF to the FI.

Specific Drugs, Services, and Supplies to be Excluded from CB—Claims for services received using the following codes are excluded from CB and should be billed to and paid by the carrier or DMERC as appropriate. Any necessary systems changes should be implemented to allow these services to be paid for SNF residents.

Chemotherapy Drugs

J9000	J9015	J9020	J9040	J9045	J9050	J9060
J9062	J9065	J9070	J9080	J9090	J9091	J9092
J9093	J9094	J9095	J9096	J9097	J9100	J9110
J9120	J9130	J9140	J9150	J9151	J9170	J9181
J9182	J9185	J9200	J9201	J9206	J9208	J9211
J9230	J9245	J9265	J9266	J9268	J9270	J9280
J9290	J9291	J9293	J9310	J9320	J9340	J9350
J9360	J9370	J9375	J9380	J9390	J9600	

Chemotherapy Administration Services

36260	36261	36262	36489	36530	36531	36532
36533	36534	36535	36640	36823	96405	96406
96408	96410	96412	96414	96420	96422	96423
96425	96440	96445	96450	96520	96530	96542

Radioisotope Services

79030	78035	79100	79200	79300	79400	79420
79440						

Customized Prosthetic Devices

L5050	L5060	L5100	L5105	L5150	L5160	L5200
L5210	L5220	L5230	L5250	L5270	L5280	L5300
L5310	L5320	L5330	L5340	L5500	L5505	L5510
L5520	L5530	L5535	L5540	L5560	L5570	L5580
L5585	L5590	L5595	L5600	L5610	L5611	L5613
L5614	L5616	L5617	L5618	L5620	L5622	L5624
L5626	L5628	L5629	L5630	L5631	L5632	L5634
L5636	L5637	L5638	L5639	L5640	L5642	L5643
L5644	L5645	L5646	L5647	L5648	L5649	L5650
L5651	L5652	L5653	L5654	L5655	L5656	L5658
L5660	L5661	L5662	L5663	L5664	L5665	L5666
L5667	L5668	L5669	L5670	L5672	L5674	L5675
L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697
L5698	L5699	L5700	L5701	L5702	L5704	L5705
L5706	L5707	L5710	L5711	L5712	L5714	L5716
L5718	L5722	L5724	L5726	L5728	L5780	L5785
L5790	L5795	L5810	L5811	L5812	L5814	L5816
L5818	L5822	L5824	L5826	L5828	L5830	L5840
L5845	L5846	L5850	L5855	L5910	L5920	L5925
L5930	L5940	L5950	L5960	L5962	L5964	L5966
L5968	L5970	L5972	L5974	L5975	L5976	L5978
L5979	L5980	L5981	L5982	L5984	L5985	L5986
L5988	L6050	L6055	L6100	L6110	L6120	L6130
L6200	L6205	L6250	L6300	L6310	L6320	L6350
L6360	L6370	L6400	L6450	L6500	L6550	L6570
L6580	L6582	L6584	L6586	L6588	L6590	L6600
L6605	L6610	L6615	L6616	L6620	L6623	L6625
L6628	L6629	L6630	L6632	L6635	L6637	L6640
L6641	L6642	L6645	L6650	L6655	L6660	L6665
L6670	L6672	L6675	L6676	L6680	L6682	L6684

L6686	L6687	L6688	L6689	L6690	L6691	L6692
L6693	L6700	L6705	L6710	L6715	L6720	L6725
L6730	L6735	L6740	L6745	L6750	L6755	L6765
L6770	L6775	L6780	L6790	L6795	L6800	L6805
L6806	L6807	L6808	L6809	L6810	L6825	L6830
L6835	L6840	L6845	L6850	L6855	L6860	L6865
L6867	L6868	L6870	L6872	L6873	L6875	L6880
L6920	L6925	L6930	L6935	L6940	L6945	L6950
L6955	L6960	L6965	L6970	L6975	L7010	L7015
L7020	L7025	L7030	L7035	L7040	L7045	L7170
L7180	L7185	L7186	L7190	L7191	L7260	L7261
L7266	L7272	L7274	L7362	L7364	L7366	

Codes for Emergency Services Excluded from CB—Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, the following services rendered in the hospital or CAH are excluded from CB and should be paid by the carrier or DMERC. These claims are identified with place of service code 23.

CT Scans

70450	70460	70470	70480	70481	70482	70486
70487	70488	70490	70491	70491	71250	71260
71270	72125	72126	72127	72128	72129	72130
72131	72132	72133	72192	72193	72194	73200
73201	73202	73700	73701	73702	74150	74160
74170	76355	76360	76365	76370	76375	76380
G0131	G0132					

Cardiac Catheterization

93501	93503	93505	93508	93510	93511	93514
93524	93526	93527	93528	93529	93530	93531
93532	93533	93536	93539	93540	93541	93542
93543	93544	93545	93555	93556	93561	93562
93571	93572					

MRI

70336	70540	70541	70551	70552	70553	71550
71555	72141	72142	72146	72147	72148	72149
72156	72157	72158	72159	72196	72198	73220
73221	73225	73720	73721	73725	74181	74185
75552	75553	75554	75555	75556	76093	76094
76390	76400					

Radiation Therapy

77261	77262	77263	77280	77285	77290	77295
77299	77300	77305	77310	77315	77321	77326
77327	77328	77331	77332	77333	77334	77336
77370	77399	77401	77402	77403	77404	77406
77407	77408	77409	77411	77412	77413	77414
77416	77417	77427	77431	77432	77470	77499
77600	77605	77610	77615	77620	77750	77761
77762	77763	77776	77777	77778	77781	77782
77783	77784	77789	77790	77799		

Angiography

75600	75605	75625	75630	75650	75658	75660
75662	75665	75671	75676	75680	75685	75705
75710	75716	75722	75724	75726	75731	75733
75736	75741	75743	75746	75756	75774	75790
75801	75803	75805	75807	75809	75810	75820
75822	75825	75827	75831	75833	75840	75842
75860	75870	75872	75880	75885	75887	75889
75891	75893	75894	75898	75900	75940	75960
75961	75962	79564	75966	75968	75970	75978
75980	75982	75992	75993	75994	75995	75996

Outpatient Surgery

EXCEPT for the following codes that are included in CB:

10040	11951	17340	29358	31725	53661	69210
10060	11952	17360	29365	31730	53670	95970
10080	11954	17380	29405	36000	53675	95971
10120	11975	17999	29425	36140	54150	95972
11040	11976	20000	29435	36400	54235	95973
11041	11977	20974	29440	36405	54240	95974
11042	15780	21084	29445	36406	54250	95975
11043	15781	21085	29450	36415	55870	95976
11044	15782	21497	29505	36430	57160	
11055	15783	26010	29515	36468	57170	
11056	15786	29058	29540	36469	58300	
11057	15787	29065	29550	36470	58301	
11200	15788	29075	29580	36471	58321	
11300	15789	29085	29590	36489	58323	
11305	15792	29105	29700	36600	59020	
11400	15793	29125	29705	36620	59025	
11719	15810	29126	29710	36680	59425	
11720	15811	29130	29715	44500	59426	
11721	16000	29131	29720	51772	59430	
11740	16020	29200	29730	51784	62367	
11900	17000	29220	29740	51785	62368	
11901	17003	29240	29750	51792	64550	
11920	17004	29260	29799	51795	65205	
11921	17110	29280	30300	51797	69000	
11922	17111	29345	30901	53601	69090	
11950	17250	29355	31720	53660	69200	

Erythropoietin (EPO) Services.—These services are not included in the SNF Part A PPS rate and are excluded from CB. They must be billed to the carrier or DMERC for payment as they currently are per MCM §§2049.5B, 4273 and 5202.3. EPO services are identified by the following HCPCS codes:

- Q9920 - Injection of EPO, per l,000 units, at patient HCT of 20 or less;
- Q9921 through Q9939 - Injection of EPO, per 1,000 units, at patient HCT of 2l through 39;
- Q9940 - Injection of EPO, per l,000 units at patient HCT of 40 or above.

Dialysis.—Home dialysis equipment, home dialysis support services, institutional dialysis services and supplies are excluded from CB and should be billed separately by the supplier to the DMERC or by the ESRD facility to the FI for payment. Claims for services for dialysis patients must have one of the following ICD-9-CM diagnosis codes:

403.01	403.11	403.91	404.02	404.12	404.92	584.5
584.6	584.7	584.8	584.9	585	586	788.5
958.5						

Verify that for SNF residents, claims for home dialysis equipment and home dialysis support services and supplies have at least one of the above diagnosis codes on the claim. Claims submitted without the appropriate diagnosis code should be rejected.

CWF Edits.—When an inpatient Part A bill is received and an outpatient or Part B history bill exists on CWF for specified services, CWF will process the inpatient SNF bill and send an unsolicited auto-cancel response to the carrier or intermediary for the Part B or outpatient bill. The carrier or intermediary must correct its records to agree with CWF and must initiate overpayment procedures to recoup the incorrect outpatient or Part B payment.

B-00-67/CR1256/CR1764/PM-AB-01-159/11-01-01/IC

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 CMS, 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 CMS 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 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 la lista de los proveedores reintegrados al Programa Medicare y en la siguiente página la lista de los proveedores que han sido excluídos 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 CMS 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. CMS 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 Medicare providers, we have included the list of the reinstated providers to the Medicare Program and on the next page the list of excluded providers to the Medicare Program:

PROVEEDORES REINSTALADOS AL PROGRAMA MEDICARE
PROVIDERS REINSTATED FROM THE MEDICARE PROGRAM

Nombre ***Name***	**Dirección** ***Address***	**Fecha de Efectividad** ***Effective Date***
Capó Fernández, Yolanda	Plaza Vega Baja Pearl Vission Express Vega Baja, PR 00693	January 15, 2002

Proveedores Excluídos del Programa Medicare

Providers Excluded from the Medicare Program

PROVEEDORES EXCLUIDOS DEL PROGRAMA MEDICARE
PROVIDERS EXCLUDED FROM THE MEDICARE PROGRAM

Nombre *Name*	Dirección *Address*	Periodo de Exclusión *Period of Exclusion*	Fecha de Efectividad *Effective Date*
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
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 / Río 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
Maisonet Correa, Carlos	61 Marginal / Urb. Santa Rosa Bayamón, PR 00960	Indefinite	September 20, 2001
Jimenez Casso, José	Urb. Santa Rosa 51-37 Ave. Main Bayamón, PR 00959	Indefinite	January 20, 2002
López Morales, Angel	Ave. A Buenas Bloque 20 #31 Urb. Santa Rosa Bayamón, PR 00959	Indefinite	January 20, 2002
Ramos, Mélendez, Marcos U.	P.O. Box 999 Rio Grande, PR 00745	Indefinite	April 20, 2000

Integridad al Programa

DESDE LA UNIDAD DE INTEGRIDAD DEL PROGRAMA

Abuso contra el programa Medicare se define como facturar **por servicios no cubiertos o servicios codificados inapropiadamente**. **Fraude es el engaño o tergiversación intencional** que el individuo ejecuta sabiendo que el engaño **puede resultar en algún beneficio no autorizado para él/ella o para alguna otra persona.**

La Unidad de Integridad de Beneficios es responsable de prevenir, detectar e impedir el fraude y el abuso contra el Programa Medicare. Entre otras funciones, esta unidad identifica incidentes de fraude que existan dentro de su área de servicio y toma la acción apropiada en cada caso; determina los fundamentos reales de alegaciones de fraude hechas por beneficiarios, proveedores, los Centros de Servicios de Medicare/Medicaid, la Oficia del Inspector General y otras fuentes; y desarrolla casos y los refiere a la Oficina de Investigación (OI) para la consideración de procesar civil y/o criminalmente y/o para la aplicación de sanciones administrativas. Este artículo es un resumen y un recordatorio de las acciones que se pueden tomar contra médicos, proveedores y entidades que cometen fraude o abuso contra el Programa Medicare.

Procesos y Sanciones Criminales

Un individuo que defrauda al Gobierno de Estados Unidos o alguno de sus programas puede ser encarcelado, multado o ambos. Las sentencias criminales usualmente incluyen restitución y multas significativas y los proveedores y/u organizaciones de salud pueden perder sus licencias. Estas sentencias mandatoriamente resultan en la exclusión de Medicare y otros programas de salud federales por periodos de tiempo de duración específicos.

Algunas leyes que la Fiscalía de Estados Unidos puede usar para demandar y procesar legalmente individuos y/o entidades por casos de fraude son:

- 18 U.S.C. Sección 1347: Fraude en el cuidado de la salud

Benefit Integrity

FROM THE BENEFIT INTEGRITY UNIT

Abuse** is defined as billing Medicare for **services that are not covered or are not correctly coded.** **Fraud** is the intentional **deception or misrepresentation** that the individual knows to be false or does not believe to be true and the individual makes knowing that the deception **could result in some unauthorized benefit to himself/herself or some other person.

*The Medicare Benefit Integrity (**BI**) Unit is responsible for preventing, detecting and deterring Medicare fraud. Among other responsibilities, the BI unit identifies incidents of fraud that exist within its service area and takes appropriate action in each case; determines the factual basis of allegations of fraud made by beneficiaries, providers, the Centers for Medicare Medicaid (CMS), Office of Inspector General (OIG) and other sources; and develops cases and refers them to the OIG Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions. This article is a summary and a reminder of the actions that may be taken against physicians, providers or entities who commit fraud or abuse against the Medicare program.*

Criminal Prosecutions and Penalties

An individual who defrauds the United States Government or any of its programs may be sent to prison, fined or both. Criminal convictions usually include restitution, and significant fines and the providers and/or healthcare organizations may lose their state licenses. Convictions mandatorily result in exclusion from Medicare and other federal health care programs for a specific length of time.

Some statutes that may be used by the U.S. Attorney's Office to indict and prosecute the individuals and/or entities involved are:

- *18 U.S.C. Section 1347: Health care fraud*

Integridad al Programa

- 18 U.S.C. Sección 669: Robo o hurto en conexión con el cuidado de la salud
- 18 U.S.C. Sección 1035: Declaraciones falsas relativas al cuidado de la salud
- 18 U.S.C. Sección 1518: Obstrucción de una investigación federal de fraude en el cuidado de la salud
- 18 U.S.C. Sección 371: Conspiración para cometer fraude
- 18 U.S.C. Sección 287: Reclamaciones falsas
- 18 U.S.C. Sección 1001: Declaraciones falsas
- 18 U.S.C. Sección 201: Soborno
- 18 U.S.C. Sección 1320: Retribuciones ("Kickbacks")
- 18 U.S.C. Sección 1956-57: Lavado de dinero
- 18 U.S.C. Sección 1962: "RICO Act"
- 18 U.S.C. Sección 1343: Fraude "telegráfico"
- 18 U.S.C. Sección 1341; Fraude postal

Procesos y Sanciones Civiles

Además de, o en lugar de, procesos criminales, la Fiscalía de Estados Unidos puede presentar una demanda civil o puede decidir que el interés del programa se satisface mejor mediante el ajuste de cuentas en el caso. En estas situaciones, el gobierno recobra la cantidad de los daños más dinero adicional mediante sanciones y multas. Las sanciones pueden incluir la exclusión de Medicare y/o Medicaid del proveedor o entidad por un período definido de años.

Sanciones Monetarias Civiles

La Ley de Protección del Programa y Paciente de Medicare y Medicaid del 1987 autoriza la imposición de sanciones monetarias civiles cuando se ha determinado que una persona o entidad ha violado las leyes de Medicare al someter reclamaciones que causan violaciones específicas como violaciones de las disposiciones de los acuerdos de asignación de Medicare y otras.

Benefit Integrity

- *18 U.S.C. Section 669: Theft or embezzlement in connection with health care*
- *18 U.S.C. Section 1035: False statements relating to health care*
- *18 U.S.C. Section 1518: Obstruction of a federal health care fraud investigation*
- *18 U.S.C. Section 371: Conspiracy to commit fraud*
- *18 U.S.C. Section 287: False claims*
- *18 U.S.C. Section 1001: False statements*
- *18 U.S.C. Section 201: Bribery*
- *18 U.S.C. Section 1320: Kickbacks*
- *18 U.S.C. Section 1956-57: Money laundering*
- *18 U.S.C. Section 1962: RICO Act*
- *18 U.S.C. Section 1343: Wire fraud*
- *18 U.S.C. Section 1341; Mail fraud*

Civil Prosecutions & Penalties

In addition to or in lieu of criminal prosecutions, the U.S. Attorney may file a civil suit or may decide that the interest of the program is best served by settling the case. In these situations, the amount of damages plus additional money is paid to the government in the form of penalties and fines. These penalties may also include a permissive exclusion, which means that the provider and/or entity not being permitted to bill Medicare and Medicaid for a specified number of years.

Civil Monetary Penalties

The Medicare and Medicaid Patient and Program Protection Act of 1987 authorizes the imposition of civil monetary penalties when it is determined that a person or entity has violated Medicare laws by submitting claims that cause very specific violations like: Violation of the Medicare assignment provisions; a Medicare physician or supplier agreement violation and others. Typically,

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Típicamente, las penalidades conllevan la imposición de daños significativos tales como penalidades monetarias civiles de hasta **$10,000** por violación y exclusión del programa Medicare por un período mínimo **de cinco años o más**.

Acciones Resultantes de "Kickbacks", Sobornos, Declaraciones Falsas y Descuentos

Cualquiera que…

- A sabiendas e intencionadamente hace o causa que sea hecha una declaración falsa o representación de hecho material en una solicitud para un beneficio o pago de Medicare o para determinar el derecho a tal beneficio o pago;
- Conoce de algún hecho que afecte su derecho a recibir un beneficio o que afecte el derecho de otro individuo en nombre de quien él/ella recibe tal beneficio y no divulga tal hecho con el intento de asegurar fraudulentamente una suma o cantidad mayor que la debida o cuando ninguna es debida;
- Recibe beneficios a nombre de otra persona y a sabiendas y voluntariamente los utiliza para otro uso que no sea para el beneficio de esa persona; o
- Provee artículos o servicios y solicita ofrece o recibe una retribución, "kickback", soborno o descuento de tarifa…

…**será culpable de una delito grave y luego del fallo condenatorio será multado no más de $50,000 por violación o encarcelado por no más de 5 años por violación, o ambos.**

Autoridad de Exclusion

OIG tiene la autoridad para excluir proveedores que hallan sido convictos por un delito relacionado con el cuidado de la salud. Ser excluido significa que por un número determinado de años Medicare, Medicaid y otros programas federales no pagarán al proveedor o por servicios realizados o por servicios ordenados por el individuo excluido. Una exclusión mandatoria existe si hay una condena por fraude. En ausencia de una condena, OIG puede excluir

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*penalties involve assessments of significant damages such as civil monetary penalties up to **$10,000** per violation and exclusion from the Medicare program for a minimum of **five years or more**.*

Actions Resulting from Kickbacks, Bribes, False Statements and Rebates

***Whoever**…*

- *Knowingly and willfully makes or causes to be made any false statement or representation of material fact in an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;*
- *Has knowledge of any event affecting his/her right to receive a benefit or affecting the right of another individual in whose behalf he/she receives such benefit, and fails to disclose such event with the intent to fraudulently secure greater amount or quantity than is due or when none is due;*
- *Receives benefits on behalf of another person and knowingly and willfully puts them to a use other than for the benefit of that person; or*
- *Furnishes items or services and solicits, offers, or receives a kickback, bribe or rebate of a fee…*

*…**shall be guilty of a felony and upon conviction, shall be fined not more than $50,000 per violation or imprisoned for not more than five years per violation, or both.***

Exclusion Authority

*The **OIG** has the authority to exclude providers who have been convicted of a health care related offense. Exclusion means that for a designated number of years, Medicare, Medicaid and other government programs will not pay the provider for services performed or for services ordered by the excluded party. A mandatory exclusion exists if there is a conviction of fraud. In the absence of a conviction, the OIG may permissively exclude providers if certain*

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proveedores si ciertas condiciones y requisitos se han cumplido. OIG puede tomar acción para excluir al proveedor aun cuando la Oficina de la Fiscalía de Estados Unidos decline procesar un caso.

Sobre Referidos Médicos

Los proveedores algunas veces necesitan referir sus pacientes para un cuidado médico más especializado o para recibir determinados estudios diagnósticos o surtidos. Para evitar violaciones al programa, los proveedores deben:

- Asegurarse de que solamente los estudios o servicios ordenados fueron rendidos.
- Especificar la razón por la cual los servicios se ordenaron. No deje el poder de determinar el por qué los estudios fueron necesarios, al proveedor que los presta y es quien somete la reclamación a Medicare.
- Nunca firme formularios de certificación en blanco utilizados por los suministradores para justificar el pago por oxígeno en el hogar, equipo médico duradero (camas, sillones de ruedas…). Complete personalmente toda información médica, nombre y dirección del paciente antes de firmar el formulario.
- Sea extremadamente precavido al ordenar surtidos médicos y aparatos como "TENS" y "scooters" operados con motor. Tales artículos algunas veces son mercadeados a los beneficiarios con poca consideración por la condición médica del beneficiario. Donde sea aplicable, especifique la cantidad de surtidos médicos que usted cree son necesarios para su paciente. Certificaciones abiertas han llevado a que los surtidos hayan sido repartidos en cantidades asombrosas. Nunca certifique la necesidad de surtidos médicos para pacientes que usted no haya visto y examinado.
- Sea receloso si una entidad le ofrece descuentos, servicios gratis o dinero en efectivo para usted ordenar sus servicios. Algunos arreglos de negocios pueden ponerlo a usted en riesgo. Las penalidades por violar las leyes de "anti-kickback" de Medicare pueden ser muy severas.

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conditions and requirements have been met. Even when the U.S. Attorney's Office declines to prosecute a case, the OIG may take action to exclude the provider from the Medicare program.

About Physician Referrals

Providers sometimes need to refer patients for more specialized medical care or to receive certain diagnostic tests or supplies. To avoid program violations, providers should:

- *Ensure that only the tests or services ordered were rendered.*
- *Specify the reason the services are being ordered. Do not empower the rendering provider, who files the Medicare claim, to determine why the tests were needed.*
- *Never sign blank certification forms used by suppliers to justify Medicare payment for home oxygen, durable medical equipment (beds, wheelchairs…). Personally fully complete all medical information, the patient's name and address before signing the form.*
- *Use extreme caution when prescribing medical supplies and devices, like TENS and power operated scooters. Such items are sometimes aggressively marketed to beneficiaries with little regard for the beneficiary's medical condition. Where applicable, specify the quantity of medical supplies you believe are needed for your patients. Open-ended certifications have led to supplies being delivered in staggering quantities. Never certify the need for medical supplies for patients you have not seen and examined.*
- *Be suspicious if an entity offers you discounts, free services or cash to order services. Some business arrangements may put you at risk. The penalties for violating Medicare's anti-kickback laws can be severe.*

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Arreglos de Médicos y Proveedores

La ley de "Anti-kickback" de Medicare y Medicaid, 42 U.S.C. Sección 1320a-7b(b) es muy amplia. Entre otras cosas, este estatuto **penaliza a cualquiera que a sabiendas e intencionadamente solicita, recibe, ofrece o paga algo de valor para inducir o a cambio de**

(a)referir un individuo a otra persona para surtir o para hacer arreglos para surtir algún artículo o servicio pagadero bajo el programa Medicare o Medicaid, o

(b)comprar, alquilar u ordenar, o hacer arreglos para o recomendar comprar, alquilar u ordenar cualquier bien, comodidad, servicio o artículo pagadero bajo el programa Medicare o Medicaid.

La Unidad de Integridad de Beneficios y OIG han sido alertadas acerca de la proliferación de ciertos acuerdos o convenios entre aquéllos en posición de hacer referidos (como los médicos) y aquéllos que proveen artículos o servicios pagaderos bajo el Programa Medicare o Medicaid. Ejemplos de los artículos o servicios provistos mediante estos acuerdos incluyen servicios diagnósticos de laboratorios clínicos, equipo médico duradero (DME), estudios diagnósticos vasculares no invasivos como estudios arteriales cerebrovasculares y otros procedimientos de diagnóstico sofisticados. Puede que hayan razones legítimas para estos convenios o arreglos; sin embargo, creemos que algunos de estos acuerdos pueden estar violando el estatuto de "anti-kickback" del Medicare y Medicaid. Ya que los médicos se pueden beneficiar económicamente por sus referidos, se podrían ordenar o realizar procedimientos y pruebas innecesarios, lo que resulta en gastos innecesarios para el programa.

Los perfiles de laboratorios clínicos merecen cuidado especial. Algunos médicos que ordenan perfiles de laboratorios clínicos han recibido listas de cotejo para ordenar los perfiles o paneles. Los médicos deben asegurarse de que cada servicio ordenado es médicamente necesario, adecuado para el cuidado y tratamiento del paciente y está debidamente documentado en el expediente médico del paciente. Los médicos no deben

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Physicians and Providers Arrangements

The Medicare and Medicaid anti-kickback statute, 42 U.S.C. Section 1320a-7b(b) is very broad. Among other things, this statute ***penalizes anyone who knowingly and willfully solicits, receives, offers or pays anything of value to induce or in return for***

(a)referring an individual to a person for the furnishing or arrangement for the furnishing of any item or service payable under the Medicare or Medicaid program, or

(b)purchasing, leasing or ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item payable under the Medicare or Medicaid program.

The Benefit Integrity unit and the OIG have been aware of a proliferation of arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays. Examples of the items or services provided in these arrangements include clinical diagnostic laboratory services, durable medical equipment (DME), non-invasive vascular diagnostic studies, like cerebrovascular arterial studies and other diagnostic services. There may be legitimate reasons for these arrangements, however, we believe that some of these arrangements may violate the Medicare and Medicaid anti-kickback statute. Because the physicians can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures.

Special care must be taken with clinical laboratory profiles. Some physicians who order clinical laboratory profiles are supplied with check lists to order profiles or panels. Physicians must ensure that each service ordered is medically necessary, appropriate for the care and treatment of the patient, and clearly documented in the patient's medical record. Physicians should not check the profile box if the laboratory does not give an

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marcar el encasillado del panel si el laboratorio no da una opción para los estudios individuales incluidos en el perfil, a menos que todos los exámenes en el panel sean médicamente necesarios. En estos casos, los proveedores deben indicar cada prueba que se va realizar. Sólo aquellos exámenes que fueron médicamente apropiados y ordenados pueden ser facturados y reembolsados. Medicare paga únicamente por aquellos servicios los cuales son médicamente necesarios para el paciente y usualmente no cubre pruebas de cernimiento. Los proveedores deben ordenar solamente aquellas pruebas relacionadas con enfermedades o síntomas específicos.

Es necesario aclarar que un referido en sí mismo no puede considerarse ilegal o en violación de las leyes de Medicare. Sin embargo, el médico que los ordena ("referring / ordering physician") debe asegurarse de que existe necesidad médica para los servicios. Entendemos que quizás estos arreglos de prestar los servicios en la misma oficina del médico que los ordena se hacen pensando en la comodidad del paciente; pero el paciente siempre debe tener la oportunidad de escoger libremente al proveedor que le efectuará las pruebas requeridas. De lo contrario estos servicios podrían considerarse como servicios solicitados ("soliciting"). Además, es muy importante que se cumplan las leyes locales y los reglamentos establecidos por el Departamento de Salud de Puerto Rico.

El punto esencial es el siguiente: **el solicitar, ofrecer o recibir una retribución ("kickback"), soborno, rebaja o descuento** por referir pacientes a cambio de ordenar pruebas diagnósticas y otros servicios o equipo médico duradero viola los estatutos establecidos. **Los violadores están sujetos a penalidades criminales o a la exclusión de participar en los programas Medicare y Medicaid o ambos**.

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option for the individual tests included in the profile, unless all tests in the profile are medically necessary. In these cases, providers should list each test that is to be performed. Only those tests that were medically appropriate and ordered by the physician may be billed and reimbursed. Medicare pays only for those services which are medically necessary for the patient and usually does not cover tests for screening purposes. Providers should target their orders to only those tests that are related to specific symptomatology or disease conditions.

It is necessary to clarify that a referral itself could not be considered illegal or in violation of the Medicare statutes. Nonetheless, the referring physician must insure that there is medical necessity for the services. We understand that maybe those arrangements of providing the services at the same office of the referring physician are agreed upon thinking in the patient's comfort; but the patient must always have the opportunity to freely choose the provider who will render the services ordered. On the contrary, such services could be considered as soliciting. Besides, it is very important to comply with local laws and the Puerto Rico Department of Health regulations.

The bottom line is: ***soliciting, offering or receiving a kickback, bribe or rebate****, such as paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or DME is in violation of the established regulations.* ***Violators are subject to criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both.***

Be Aware!! Be Alert!!

Help Us To Fight Fraud!!

BI UNIT/EM/01/28/02

Relaciones con la Comunidad

SERVICIOS DEL MÉDICO DE CABECERA A PACIENTES DE HOSPICIO

Efectivo al 1 de abril de 2002, las secciones 4175.1- 4175.2 de la Parte 3 del *Medicare Carriers Manual* y la sección 2010.2 de la Parte 4, han sido revisadas para eliminar el requisito a los médicos de cabecera de los pacientes de hospicio, de incluir una declaración escrita en el encasillado 19 de la factura CMS 1500 o en el récord de la narrativa en el caso de facturas electrónicas. La declaración escrita será sustituida por el recientemente creado modificador GV. Otro nuevo modificador, el GW, se utilizará para facturar al carrier servicios no relacionados a la condición terminal del paciente. Estas revisiones consisten de lo siguiente:

Cuando un beneficiario de Medicare elige la cubierta de hospicio, éste puede designar un médico de cabecera no empleado por el hospicio, además del cuidado de salud que reciba de médicos empleados del hospicio. Los servicios profesionales para el tratamiento y manejo de la condición terminal de un paciente por parte de un médico de cabecera no empleado por el hospicio, no son considerados servicios de hospicio. Si dichos servicios se prestan sin que medie un acuerdo de pago con el hospicio, los mismos deben ser facturados al carrier por el médico de cabecera, utilizando el correspondiente código de servicio, acompañado del modificador GV: "Médico de cabecera no empleado o pagado bajo acuerdo con el proveedor de servicios de hospicio del paciente". El pago se basará en la reglamentación de pago y deducible que aplique a cada servicio cubierto.

En el caso de que otro médico sustituya al médico de cabecera designado, los servicios del médico sustituto serán facturados por el médico de cabecera designado, de acuerdo a las instrucciones de facturación recíproca o "locum tenens" (Véase MCM 3060.6 y 3060.7). En tales instancias, el médico de cabecera al

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ATTENDING PHYSICIANS SERVICES FURNISHED TO HOSPICE PATIENTS

Effective April 1, 2002, sections 4175.1-4175.2 of the Medicare Carriers Manual, Part 3 and 2010.2 of Part 4 have been revised to delete the hospice attending physician attestation statement requirement, intended to be used in box 19 of the CMS 1500 claim form or in the record for narrative for those providers who use electronic billing. The attestation statement has been replaced by a newly created GV modifier. Another new modifier, GW, will be used for billing services not related to a hospice patient's terminal condition. These revisions consist of the following:

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered "hospice services". These attending physician's services are not furnished under a payment arrangement with the hospice, therefore, the attending physician will code services with the GV modifier "Attending physician not employed or paid under agreement by the patient's hospice provider", when billing the carrier his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. Payment will be based on the payment and deductible rules applicable to each covered service.

If another physician covers for the designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. (See MCM 3060.6 and 3060.7). In such instances, the attending physician bills using

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facturar, deberá utilizar junto al correspondiente código de procedimiento, el modificador GV conjuntamente con el modificador Q5: "Servicio provisto por un médico sustituto" , o Q6: "Servicio provisto por un locum tenens ".

Cuando los servicios relacionados a la condición terminal de un paciente son prestados por el médico de cabecera designado bajo un acuerdo de pago con el hospicio, el médico debe solicitar el pago a dicho hospicio. En esta situación, los servicios del médico se consideran servicios de hospicio y serán facturados por el hospicio a su intermediario.

Por otro lado, las facturas de médicos y suplidores por servicios no relacionados a la condición terminal del paciente, deberán ser sometidas al carrier con el código correspondiente al servicio prestado, añadiéndole el modificador GW: "Servicio no relacionado a la condición terminal del paciente de hospicio"

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the GV modifier in conjunction with either the Q5 modifier: "Service furnished by a substitute physician under a reciprocal billing arrangement" or Q6 modifier: "Service furnished by a locum tenens physician" .

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician, the physician must look to the hospice for payment. In this situation the physicians' services are hospice services and are billed by the hospice to its intermediary.

On the other hand, claims from physicians and suppliers for services not related to the hospice patient's terminal condition, should be submitted to the carrier properly coded with the GW modifier: "Service not related to the hospice patient's condition".

Trans. 1728/CR1910/11-01-01/LV Trans. 25/CR1910/11-01-01/LV

Relaciones con la Comunidad

DIRECCIONES ELECTRÓNICAS DE LOS PROVEEDORES

Los Centros para Servicios de Medicare y Medicaid (CMS, antes HCFA) solicitó de sus contratistas el establecer y mantener listas de las direcciones de correo electrónico (e-mail) de los proveedores y suplidores. Estas listas se utilizarán para notificar información importante de Medicare a las personas registradas. También se les podrá comunicar futuros adiestramientos y eventos educativos y otros anuncios o mensajes que necesiten atención inmediata. Los contratistas también utilizarán esta lista de direcciones electrónicas para notificar la disponibilidad de los boletines informativos en su página de Internet.

Para someter su dirección electrónica a la Parte B de Medicare deberá completar los encasillados 1, 2 y 15 del Formulario CMS 855-I para individuos, o el CMS 855-B para grupos u organizaciones. Para obtener copia de cualquiera de estos formularios puede accesar la siguiente dirección electrónica: http://www.hcfa.gov/medicare/enrollment/forms/ **,** o puede comunicarse con Relaciones Profesionales Medicare al (787) 749-4232 o al 1-877-715-1921 para recibirlo a vuelta de correo. Una vez lo complete deberá enviarlo por correo a la siguiente dirección postal:

Medicare Parte B
Sección de Contratos
PO Box 71391
San Juan, PR 00936-1391

No se aceptará esta información a través de facsímil ya que los formularios deben contener la firma original autorizada del proveedor o del suplidor.

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PROVIDERS' ELECTRONIC MAILING ADDRESSES

The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) had instructed all Medicare contractors to establish and maintain electronic mailing lists for providers and suppliers. These lists will be used to notify important Medicare information. Upcoming education and training events, and other announcements or messages necessitating immediate attention. Contractors will also use the electronic mailing lists to notify registrants of the availability of contractor Bulletins on the web-site.

To submit your electronic mailing address to the Medicare Part B Carrier, you may complete items 1, 2, and 15 on form CMS 855-I for individuals or CMS 855-B for groups or organizations. To obtain a copy of either of the forms, you may access the following electronic address: http://www.hcfa.gov/medicare/enrollment/forms/ , or you may call Medicare Professional Relations at (787) 749-4232 or 1-877-715-1921 in order to receive it by mail. Once completed, the form must be mail to:

Medicare Part B
Contracts Section
PO Box 71391
San Juan, PR 00936-1391

Since the CMS 855 forms must contain the provider's or supplier's original authorized signature, this information will not be accepted if sent by fax.

BPRs2002/Feb. 2002/LV

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AUDIO SISTEMA INTERACTIVO DE MEDICARE 1-877-715-1921

El Sistema de Respuesta Automática de Medicare, está disponible de lunes a viernes de 6:00 a.m. a 10:00 p.m. excepto los días feriados federales. Incluso está disponible sábado, domingo y días feriados locales de 6:00 a.m. a 6:00 p.m

Durante los meses de febrero y marzo, muchos de nuestros proveedores y beneficiarios accesan el sistema para verificar el estatus del deducible anual. Esto causa congestión en nuestras líneas del Contestador Automático. Le exhortamos, que aproveche al máximo el horario del Contestador Automático de 6:00 a.m. a 10:00 p.m. o el horario de mayor accesibilidad de nuestros Representantes de Servicio que es de 8:00am a 9:00 a.m. y de 3:00 p.m. a 4:30 p.m.

De tener alguna pregunta en relación al uso de este sistema, llame por favor al **1-877-715-1921** y un Representante de Servicio le informará como lograr una comunicación efectiva a través del mismo.

Próximamente el número de teléfono 749-4232 no estará disponible. En su lugar se usará el número libre de cargo antes mencionado.

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AUTOMATIC RESPONSE SYSTEM 1-877-715-1921

Medicare's Automatic Response System is available from 6:00 a.m. to 10:00 p.m. from Monday to Friday, except on federal holidays. It is also available from 6:00 a.m. to 6:00 p.m. on Saturday, Sunday and local holidays.

Due to the high volume of calls received during the months of February and March, we suggest you to benefit from the low calls traffic hours of the day which are: from 8:00 a.m. to 9:00 a.m. and from 3:00 p.m. to 4:30 p.m.

*If you have any question related to the use of this system please call our Toll Free number **1-877-715-1921** and one of our Service Representatives will assist you on how to obtain an effective communication through the system.*

In the near future, our telephone number (749-4232) would not be available. The number to contact is the Toll Free number mentioned above.

Rel. Com./ASI/M.Meléndez/I.Piñeyro\02-28-02

Relaciones con la Comunidad

TARJETA DE IDENTIFICACIÓN DE MIEMBROS DE LOS MODELOS DE CUIDADO COORDINADO

Al entrar en Puerto Rico los modelos de prestación de servicios bajo *Medicare Plus Choice Plans*, instamos a todos los proveedores de servicios médicos, que antes de prestar algún servicio a sus pacientes de Medicare, le pregunten si poseen el plan tradicional de Medicare, o si pertenecen a un Modelo de Cuidado Coordinado.

Al presente el único Modelo de Cuidado Coordinado que opera en Puerto Rico es MMM Healthcare, Inc. , conocido también como Medicare y Mucho Más.

Cuando un beneficiario de Medicare decide acogerse a un Modelo de Cuidado Coordinado, opta por recibir todos los servicios a que tiene derecho a través de los proveedores pertenecientes a la red de dicho modelo. El cuidado de emergencia y el cuidado necesario de urgencia siempre estarán cubiertos por el Modelo de Cuidado Coordinado, aunque sean atendidos por proveedores que no pertenecen a la red.

Además de su tarjeta regular de Medicare, los miembros de un Modelo de Cuidado Coordinado poseen una tarjeta que los identifica como tal. Cuando algún afiliado a un Modelo de Cuidado Coordinado acude a recibir servicios de un proveedor, debe presentar al proveedor la tarjeta que lo identifica como miembro de dicho modelo y no la tarjeta del plan tradicional de Medicare. Esto se debe a que un proveedor de servicio puede también recibir otros pacientes que no pertenecen al Modelo de Cuidado Coordinado. Le recomendamos que coteje la elegibilidad con el beneficiario, para que pueda canalizar sus facturas correctamente, facilitando así el rápido proceso de las mismas.

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MANAGED CARE MODEL MEMBERS' IDENTIFICATION CARD

Now that Medicare Plus Choice Plans have entered in Puerto Rico, we urge all medical services providers to ask patients at the visit if they are enrolled in the traditional Medicare Plan, or if they are members of a managed care model. At the present time, the only managed care model that operates in Puerto Rico is MMM Healthcare, Inc. , known also as "Medicare y Mucho Más".

When a Medicare beneficiary selects a managed care model, is choosing to receive all the services that he or she has the right to from those providers that are participant of that model providers' net. Emergency care services and necessary urgent care services will always be covered by the managed care model, even if the patient receives the service outside the models providers' net.

Besides their regular Medicare identification card, manage care model members have another card that identifies them as such. When a managed care model member goes to receive services, he must present to the provider his or her member ID card, not the traditional Medicare card. This is necessary, due to the fact that a provider can also accept other patients that are not managed care models members.

We suggest you to verify with the beneficiary his or her eligibility, so that your claims be correctly canalized, allowing their prompt process.

E-mails C. Ayala-G. Lebrón/CMS/01-31-02 & 02- 26-02/LV

Relaciones con la Comunidad

DETENCIÓN DE PAGOS DE CHEQUES MEDICARE

Recuerde cuando necesite solicitar la detención del pago de un cheque de Medicare tiene que incluir la siguiente información en su solicitud:

- Nombre
- Número de Identificación del Proveedor
- Número de Cheque
- Fecha del Cheque
- Cantidad del Cheque (si la sabe)
- Copia de la licencia de conducir

Puede enviar su solicitud a la siguiente dirección:

MEDICARE

Depto. de Relaciones con la Comunidad

PO Box 71391

San Juan, Puerto Rico 00936-1391

También puede visitar nuestras oficinas en la Ave. F.D. Roosevelt 1441, San Juan, Puerto Rico. Nuestro horario de Oficina es de 8:00 a.m. a 4:30 p.m. de lunes a viernes.

Si envía un representante a someter la petición por usted a nuestras oficinas, recuerde que dicha persona tendrá que traer una carta original con su firma (como proveedor) autorizándole a completar esa gestión por usted y mostrar una identificación con foto. No se aceptarán documentos recibidos por fax. Sólo se aceptarán solicitudes en original.

Recuerde considerar la Transferencia Electrónica de Fondos (Depósito Directo). Esta opción elimina la posibilidad de que los cheques se extravíen. Para mayor información referente a la Transferencia Electrónica de Fondos se puede comunicar al teléfono 1-877-715-1921.

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MEDICARE CHECKS STOP PAYMENTS

Please remember that whenever you have the need to request a stop payment from Medicare you must include the following information in your request.

- *Name*
- *Provider Identification Number*
- *Check Number*
- *Date of Check*
- *Amount of Check (if known)*
- *Copy of the Provider's drivers license*

You may send your request to the following address:

MEDICARE

Community Relations Department

PO Box 71391

San Juan, Puerto Rico 00936-1391

You may also visit our offices at 1441 F. D. Roosevelt Ave., San Juan, Puerto Rico. Our Office hours are from 8:00 am to 4:30 p.m. from Monday through Friday.

If you are sending someone to submit a request in person on your behalf, he/she must bring an original authorization letter signed by the provider. The provider representative should also bring identification with picture. Documentation received through fax is not accepted. Only original request.

Remember always to consider enter in the Electronic Funds Transfer (Direct Deposit). It virtually eliminates the possibility of check loss. For further information in regard to the EFT, please call at 1-877-715-1921.

FMR/CF/MCU-002

Notas

NOTES

MEDICARE INFORMA
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