Medicare Informa

División Medicare / Parte B

¡Qué Bueno Que Preguntó!

NOTA IMPORTANTE

Los Centros para Servicios de Medicare y Medicaid (CMS) han revisado el Proceso Apelativo para Reclamaciones de Medicare. Según la revisión realizada a la Sección 1869(a)(3)(C) del Acta del Seguro Social, el nuevo tiempo límite para solicitar una revisión será de 120 días a partir de la fecha de la determinación inicial. Anteriormente, el tiempo límite establecido para solicitar una revisión por servicios procesados era de 6 meses a partir de la fecha de la determinación inicial.

Este nuevo tiempo límite de 120 días aplicará a toda notificación (Remesa de Pago y Resumen de Medicare) con fecha de 1 de octubre de 2002, en adelante.

Continua en la página 4

We Are Glad You Asked!

IMPORTANT NOTICE

The Centers for Medicare and Medicaid Services have revised the Medicare Claim Appeals Process. According to the revision made to Section 1869(a)(3)(C) of the Social Security Act, there is a new 120 day time limit for filing requests for appeal of initial determinations. Formerly, the time limit for filing requests for appeal for all initial determinations was six months.

The new 120-day time limit will apply to all notifications (Remittance Advice and Medicare Summary Notice) dated October 1, 2002 and there-after.

Continued on page 4

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:

This Edition of the bulletin will be available only electronically on this website, print copies will not be available or mailed.

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

Volume 71 / July, Aug., Sept., 2002

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¡Qué Bueno Que Preguntó!

Alertamos a todo proveedor/suplidor de Medicare a realizar los ajustes administrativos necesarios para cumplir con este requerimiento.

Por otro lado, todo beneficiario, proveedor y suplidor de Medicare que desee solicitar una audiencia ante un Juez Administrativo (ALJ) debe cumplir con el nuevo requisito de cantidad en controversia. Anteriormente, la cantidad en controversia para un ALJ era de $500.00. Ahora, el requisito de cantidad en controversia para un ALJ será de $100.00, si la determinación inicial se realizó a partir del 1 de octubre de 2002 en adelante.

We Are Glad You Asked!

We alert our Medicare provider and supplier community to make the necessary administrative changes to comply with this requirement.

CMS has also revised the amount in controversy (AIC) for all Part B Administrative Law Judge (ALJ) hearings. Previously, the AIC requirement for Part B ALJ request was $500.00. The new AIC requirement for Part B ALJ requests will be $100.00 for initial determinations made October 1, 2002 and later. Any beneficiary, provider and supplier wishing to file a Part B ALJ hearing must meet the new AIC requirement.

OPEN DOOR FORUMS

CMS has launched a series of public listening sessions in Washington and, with their regional offices, around the country to hear what it is like to work under the rules they develop and to listen to the various individual suggestions for improvement. They want to hear from local seniors, Medicaid enrollees, large and small providers, health workers, state workers, and others. They will meet with providers in rural offices and inner city clinics, with people in suburban health centers and in urban hospitals. In addition they will also talk to people in large hospital systems, in small practices and to solo providers. Individual input from group practice managers, physician assistants, nurses, and individuals will also be appreciated.

A schedule of upcoming CMS Open Door Forums can be found at: www.cms.hhs.gov/opendoor/schedule.asp

We recommend that you check this Web site monthly for updates and to verify call dates and times.

9/5/2002/Communications Office

Health Insurance Portability and Accountability Act (HIPAA)

¡ESTA CORDIALMENTE INVITADO!

Los Centros para Servicios de Medicare y Medicaid invitan a la comunidad médica hispanohablante a participar de una Conferencia Telefónica sobre la implantación de HIPAA.

Los temas a cubrir son:

A. Trasfondo de HIPAA

B. Códigos universales y transacciones estándares

C. Extensión al Cumplimiento de Transacciones y Códigos

D. Plan de Trabajo de Medicare Parte A&B

Contará con la participación de recursos de CMS, Triple-S, Inc. (Corporativo y Medicare Parte B) y COSVI (Medicare Parte A) quienes contestarán sus preguntas sobre este tan importante tema.

La conferencia se ofrecerá el 27 de septiembre de 2002 de 2:00 a 3:00 PM a través del **1-877-357-7851** el número de conferencia es **5209111**. Les esperamos.

DGE/08-30-02

YOU ARE CORDIALLY INVITED!

The Centers for Medicare and Medicaid invite the Hispanic medical community to participate of the Roundtable Conference Call on HIPAA Implementation.

The topics to be covered are:

A) Background on HIPAA

B) Code Sets and Standard Transactions

C) Compliance Extension for Transactions and Code Sets

D) Medicare Part A&B Workplan

Personnel from CMS, Triple-S, Inc. (Corporate & Medicare Part B) and COSVI (Medicare Part A) will answer to your questions on such an important subject.

*The conference call will be held on September 27, 2002 from 2:00 to 3:00 PM at **1-877-357-7851,** the conference identification number is **5209111**. We look forward to your participation.*

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA GLOSARY

We offer the following excerpt of CMS' glossary on HIPAA terms to aid your understanding of the subject.

— — — — — — — —

Administrative Code Sets: Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, sometimes referred to as non-clinical or non-medical code sets.

Administrative Services Only (ASO): An arrangement whereby a self-insured entity contracts with a third party administrator (TPA) to administer a health plan.

Administrative Simplification (AS): Title II, Subtitle F, of HIPAA which authorizes HHS to: (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.

Administrative Simplification Compliance Act (ASCA): Signed into law on December 27, 2001 as Public Law 107-105, this Act provides a one-year extension to HIPAA "covered entities" (except small health plans, which already have until October 16, 2003) to meet HIPAA electronic and code set transaction requirements. Also, allows the Secretary of HHS to exclude providers from Medicare if they are not compliant with the HIPAA electronic and code set transaction requirements and to prohibit Medicare payment of paper claims received after October 16, 2003, except under certain situations.

Business Relationships:

- **Business Associate (BA)** - Person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce (formerly referred to as an agent or business partner). A business associate can also be a covered entity in its own right. Also see Part II, 45 CFR 160.103

- **Chain of Trust Agreement (COT***)* -Contract needed to extend the responsibility to protect health care data across a series of sub-contractual relationships.

- **Third Party Administrator (TPA)** - Business associate that performs claims administration and related business functions for a self-insured entity.

- **Trading Partne**r - External entity with whom business is conducted, i.e. customer. This relationship can be formalized via a **trading partner agreement**. (Note: a trading partner of an entity for some purposes, may be a business associate of that same entity for other purposes.)

Centers for Medicare & Medicaid Services (CMS): The agency within HHS that administers the Medicare and Medicaid programs and is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards.

CFR: Code of Federal Regulations, the official compilation of federal rules and requirements. (http://www.access.gpo.gov/su_docs/aces/aces140.html).

Claim Adjustment Reason Codes: National administrative code set identifying reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment and is used in the X12N 835 Claim Payment & Remittance Advice and the X12N 837 Claims transactions.

Claim Attachment: Any of a variety of paper forms or electronic records needed to process a claim in addition to the claim itself.

This Glossary was largely compiled by WEDI-SNIP
For a more detailed version, please visit the WEDI/SNIP web site at
http://wedi.org/public/articles/HIPAA_GLOSSARY.pdf.
For official definitions, please reference the HIPAA Regulations.

Health Insurance Portability and Accountability Act (HIPAA)

Claim Status Category Codes: A national administrative code set indicating the general category of the status of health care claims.

Claim Status Codes: National administrative code set that identifies the status of health care claims and is used in the X12N 277 Claim Status Inquiry and Response transaction.

CMS-1450 (formerly HCFA-1450): The uniform institutional claim form.

CMS-1500 (formerly HCFA-1500): The uniform professional claim form.

Code Set: Any set of codes used to encode data elements (i.e., tables of terms, diagnostic or procedure codes), including both the codes and their descriptors. Also see Part II, 45 CFR 162.103.

Compliance Date: Date by which a covered entity must comply with a standard or a modification to a standard. This is generally 24 months after the effective date for all covered entities except small health plans, which have 36 months.

Coordination of Benefits (COB): Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Covered Entity (CE): A health plan, health care clearinghouse, or health care provider who transmits any health information in electronic form in connection with an adopted HIPAA standard transaction.

Current Dental Terminology (CDT): A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

Current Procedural Terminology (CPT): A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

Data Condition: A description of the circumstances in which certain data is required.

Data Content: All the data elements and code sets inherent to a transaction, and not related to the format of the transaction.

Data Element: Under HIPAA, this is the smallest named unit of information in a transaction.

Data Mapping: The process of matching one set of data elements or individual code values to their closest equivalents in another set of them, sometimes called a cross-walk.

D-Codes: Subset of the HCPCS Level II medical codes identifying certain dental procedures. It replicates many of the CDT codes and will be replaced by the CDT.

Descriptor: The text defining a code in a code set.

Designated Code Set: A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.

Designated Standard: A standard that the Secretary of HHS has adopted under the authority provided by HIPAA.

Designated Standard Maintenance Organization (DSMO): An organization, designated by the Secretary of the U.S. Department of Health & Human Services, to maintain standards adopted under Subpart I of 45 CFR Part 162. A DSMO may receive and process requests for adopting a new standard or modifying an adopted standard.

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Health Insurance Portability and Accountability Act (HIPAA)

Direct Data Entry (DDE): Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer.

EDI Translator: A software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

Effective Date: Date a final rule is effective, usually 60 days after it is published in the Federal Register (FR).

EIN: Employer Identification Number issued by the IRS.

Electronic Data Interchange (EDI): Electronic exchange of formatted data.

Electronic Media Claims (EMC): A flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.

Electronic Remittance Advice (ERA): Any of several electronic formats for explaining the payments of health care claims.

Employer Identifier: A standard adopted by the Secretary of HHS to identify employers in standard transactions. The IRS' EIN is the adopted standard.

Group Health Plan: An employee benefit plan that provides for medical care and that either has 50 or more participants or is administered by another business entity. Also see Part II, 45 CFR 160.103.

Health Care Clearinghouse: A public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches are health care clearinghouses if they perform these functions): 1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; 2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Healthcare Common Procedure Coding System (formerly known as the HCFA Common Procedure Coding System) (HCPCS): A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. It was adopted by the Secretary of HHS as the standard for reporting procedures, equipment, and supplies on standard transactions.

Healthcare Provider Taxonomy Codes: An administrative code set that classifies health care providers by type and area of specialization. The code set will be used in certain adopted transactions. (Note: A given provider may have more than one Healthcare Provider Taxonomy Code.)

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Federal law allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships, and requiring the adoption of Administrative Simplification and privacy standards.

Health Plan: An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or *HMO*.

HHS: The U.S. Department of Health & Human Services

Hybrid Entity: A covered entity whose covered functions are not its primary functions.

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http://wedi.org/public/articles/HIPAA_GLOSSARY.pdf.
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ICD, ICD-n-CM, & ICD-n-PCS: International Classification of Diseases with U.S. modifications identifying morbidity factors or diagnoses. (ICD-9-CM codes were adopted by the Secretary of HHS for use on standard transactions.)

- "n" = "9" for Revision 9 or "10" for Revision 10
- "CM" = "Clinical Modification"
- "PCS" = "Procedure Coding System".

Implementation Guide (IG): A document explaining the proper use of a standard for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions, and are incorporated into the CFR by reference.

J-Codes: A subset of the HCPCS Level II code set used to identify certain drugs and other items. The Secretary of HHS adopted a different code set—the NDC—as the standard for reporting drugs and biologics on standard transactions.

Local Code(s): A generic term for code values that are defined for a State or other local division or for a specific payer. Commonly used to describe HCPCS Level III Codes.

Maximum Defined Data Set: Under HIPAA, this represents all of the required data elements for a particular standard based on a specific implementation specification. An entity creating a transaction is free to include additional data any receiver might want or need.

Medical Code Sets: Codes that characterize a medical condition or treatment.

Medicare Contractor: A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

Medicare Remittance Advice Remark Codes: A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12N 835 Claim Payment & Remittance Advice transaction.

National Drug Code (NDC): A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. The Secretary of HHS adopted this code set as the standard for reporting drugs and biologics on standard transactions.

NplanID: A term used by CMS for a proposed standard identifier for health plans. CMS had previously used the terms PayerID and PlanID for the health plan identifier.

National Council for Prescription Drug Programs (NCPDP): An ANSI-accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which have been adopted as HIPAA standards.
NCPDP Batch Standard: An NCPDP format for use by low-volume dispensers of pharmaceuticals, such as nursing homes. The Secretary of HHS adopted Version 1.0 of this format as a standard transaction.

NCPDP Telecommunication Standard: An NCPDP format designed for use by high-volume dispensers of pharmaceuticals, such as retail pharmacies. The Secretary of HHS adopted Version 5.1 of this format as a standard transaction.

National Provider Identifier (NPI): A term proposed by the Secretary of HHS as the standard identifier for health care providers.

National Standard Format (NSF): Generically, any nationally standardized data format, although specifically used to designate the Professional EMC NSF developed by CMS, a 320-byte flat file record format used to submit professional claims.

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Health Insurance Portability and Accountability Act (HIPAA)

Notice of Proposed Rulemaking (NPRM): A document, published in the Federal Register, explaining regulations the Federal Government proposes to adopt, possibly inviting interested parties to submit comments to be used in developing a final regulation.

Office for Civil Rights: This Office is part of HHS. Its HIPAA responsibilities include oversight of the privacy requirements.

Plan Sponsor: An employer, union, or other entity that sponsors a health plan.

Pricer or Repricer: A person, organization, or software package that reviews procedures, diagnoses, fee schedules, and other data to determine the eligible amount for a given health care service or supply. Additional criteria can be applied to determine the actual allowance, or payment amount.

Segment: Under HIPAA, this is a group of related data elements in a transaction.

Self-Insured: An individual or organization that assumes the financial risk of paying for health care.

Small Health Plan: A health plan with annual receipts of $5 million or less.

Strategic National Implementation Process (SNIP): A national WEDI effort for helping the health care industry identify and resolve HIPAA implementation issues.

Third Party Administrator (TPA): An entity that processes health care claims and performs related business functions for a health plan.

Transaction: Under HIPAA, this is the electronic exchange of information between two parties to carry out financial or administrative activities related to health care.

Transaction Change Request System: A system established under HIPAA for accepting and tracking change requests for any of the adopted HIPAA transaction standards via a single web site. See www.hipaa-dsmo.org.

UB-92: An electronic format of the CMS-1450 paper claim form that has been in general use since 1993.

United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport *(UN/EDIFACT)*: An international EDI format. Interactive X12 transactions that use the EDIFACT message syntax.

Value-Added Network (VAN): A vendor of EDI data communications and translation services.

Virtual Private Network (VPN): A technical strategy for creating secure connections, or tunnels, over the Internet.

Washington Publishing Company (WPC): The company that publishes the X12N HIPAA Implementation Guides and the X12N HIPAA Data Dictionary. It developed the X12 Data Dictionary and hosts the EHNAC STFCS testing program.

WEDI: See the Workgroup for Electronic Data Interchange.

Workforce: Under HIPAA, employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity. Also see Part II, 45 CFR 160.103.

Workgroup for Electronic Data Interchange (WEDI): A health care industry group that has a formal consultative role under the HIPAA legislation *(*also sponsors SNIP).

HIPAA HOTLINE - 1-410-786-4232

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Health Insurance Portability and Accountability Act (HIPAA)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

ADMINISTRACIÓN SIMPLIFICADA

A todos los profesionales de la salud:

Le brindamos la siguiente información sobre cómo solicitar extensión para el cumplimiento de HIPAA. Esta extensión es para el cumplimiento con las transacciones electrónicas de facturación y códigos estándar y le ofrecerá un año para completar estos requisitos :

- ✓ Fecha límite de radicación: 15 de octubre de 2002
- ✓ Formas de radicar:
  - ¨ **Correo Postal:**

ATTENTION: Model Compliance Plans
Centers for Medicare & Medicaid Services
PO Box 8040
Baltimore, MD 21244-8040

Sugerencias:

- Enviar con acuse de recibo. CMS no le dará recibo.
- El matasellos debe tener fecha no más tarde del 15 de octubre de 2002.

¨ **Correo Electrónico:**

www.cms.hhs.gov/hipaa/hipaa2/ascaform.asp

—Recibirá un número de confirmación luego de oprimir el botón de "submit". Este número es evidencia de su radicación.

Se retransmitirá el video de CMS *"Meeting the HIPAA Challenge: Implementing the Administrative Simplifications of HIPAA"* el 10 de septiembre de 2002 de 2:00 a 3:30 PM EST. Para más información debe ir a: **www.cms.hhs.gov/medlearn/broadcst.asp**. Allí deberán registrarse para la retransmisión y seleccionar "webcast" como lugar para ver la retransmisión del video.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

ADMINISTRATIVE SIMPLIFICATION

To all Health Care Providers:

We offer the following information on how to request an extension in order to comply with HIPAA. This extension allows a one year grace period in order to comply with the requirements for standard electronic transactions and code sets:

- ✓ *Last date to request an extension: October 15, 2002*
- ✓ *How to send the request for an extension:*
  - ¨ **Postal Service:**

Suggestions:

- *Send with a Receipt Return Requested form. CMS will not send a receipt.*
- *The stamped date must not be later than October 15, 2002.*

¨ ***E-Mail:***

www.cms.hhs.gov/hipaa/hipaa2/ascaform.asp

—*You will receive a numbered confirmation after pressing the "submit" button. This number will be your submittal evidence.*

*CMS will re-air their video "*Meeting the HIPAA Challenge: Implementing the Administrative Simplifications of HIPAA" *on September 10, 2002 from 2:00 to 3:30 PM EST. For more information on this go to:* ***www.cms.hhs.gov/medlearn/broadcst.asp****. You must register in order to view the broadcast. Select "webcast" as the site to view the retransmission of the video.*

LOCAL MEDICAL REVIEW POLICY (LMRP) RECONSIDERATION PROCESS

The LMRP Reconsideration Process is a mechanism by which interested parties can request a revision to an LMRP. The LMRP Reconsideration Process is available only for final LMRPs. The whole LMRP or any part of the LMRP may be reconsidered, i.e., Benefit Category Provisions, Utilization Guidelines, Covered ICD-9 codes, etc. Contractors must respond timely to requests for LMRP reconsideration. In addition, contractors may revise or retire their LMRPs at any time on their own initiatives.

When a contractor receives a request for policy review in accordance with regulations he may choose to initiate an LMRP reconsideration following the specific process.

Requests for LMRP reconsideration:

- Requests for reconsideration must be submitted in writing and must identify the language that the requestor wants added to or deleted from an LMRP. The request must include a justification supported by new evidence, which may materially affect the LMRP's content or basis. Copies of published evidence must be included.
- The level of evidence required for LMRP reconsideration is the same as that is required for new/revised LMRP development.
- Any LMRP reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.
- Contractors may consolidate valid requests if similar requests are received.

Reconsideration requests will be accepted only for LMRP's published in final form. Requests will not be accepted for other documents including:

- National Coverage Decisions (NCD);
- Coverage provisions in interpretive manuals;
- Draft LMRPs;
- Template LMRPs, unless or until they are adopted by the contractor;
- Retired LMRPs;
- Individual claim determinations;
- Bulletins, articles, training materials; and
- Any instance in which no LMRP exists, i.e., requests for development of an LMRP.

If modification of the LMRP would conflict with an NCD, the request would not be valid. The contractor should refer the requestor to the NCD reconsideration process (www.cms.hhs.gov/coverage/Bal.htm).

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

Valid LMRP Reconsideration Request Requirements

This contractor will consider LMRP's reconsideration request from:

- Beneficiaries residing or receiving care in a contractor's jurisdiction; and
- Providers doing business in a contractor's jurisdiction.
- Contractor may consider LMRP's reconsideration requests from any interested party doing business in a contractor's jurisdiction.

Process

1. The requestor should submit a valid LMRP reconsideration request to the appropriate contractor, following instructions on the contractor's web site.
2. Within 30 days of the day the request is received, the contractor must determine whether the request is valid or invalid. If the request is invalid, the contractor must respond, in writing, to the requester explaining why the request was invalid. If the request is valid, the contractor should follow the requirements below.
3. Within 90 days of the day the request was received, the contractor must make a final LMRP reconsideration decision on the valid request and notify the requestor of the decision with its rationale. Decision options include retiring the policy, no revision, revision to a more restrictive policy, or revision to a less restrictive policy.
4. If the decision is either to retire the LMRP or to make no revision to the LMRP, then within 90 days of the day the request was received, the contractor must inform the requestor of that decision with its rationale.
5. If the decision is to revise the LMRP, follow the normal process for LMRP development.
6. Contractors must keep an internal list of the LMRP Reconsideration Requests received and the relevant dates, subject and disposition of each one.

CR 2196/PIM Transmittal 28/GGL-1844

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

COVERAGE AND RELATED CLAIMS PROCESSING REQUIREMENTS FOR POSITRON EMISSION TOMOGRAPHY (PET) SCANS – FOR BREAST CANCER AND REVISED COVERAGE CONDITIONS FOR MYOCARDIAL VIABILITY

Introduction

This is a summary of the revisions to §50-36 of the Coverage Issues Manual (CIM) for PET Scan services performed on **October 1, 2002** and thereafter for Breast Cancer and Myocardial Viability. Refer to §50-36 of the CIM for details of coverage. New and revised HCPCS codes are provided for proper claims submission.

General Description

Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the [human] body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as 2 [F 18] Fluoro-D-Glucose (FDG), that are administered intravenously to the patient.

Coverage of FDG PET for Breast Cancer

Effective for dates of service on October 1, 2002 and thereafter, Medicare will cover FDG PET as an adjunct to other imaging modalities for staging and restaging for locoregional, recurrence or metastasis. Monitoring treatment of a locally advanced breast cancer tumor and metastatic breast cancer when a change in therapy is contemplated is also covered as an adjunct to other imaging modalities. The baseline PET study for monitoring should be done under the code for staging or restaging.

Limitations: Effective for dates of service on October 1, 2002 and thereafter, Medicare continues to have a national non-coverage determination for initial diagnosis of breast cancer and initial staging of axillary lymph nodes. Medicare coverage now includes PET as an adjunct to standard imaging modalities for staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring for women with locally advanced and metastatic breast cancer when a change in therapy is contemplated.

Frequency: In the absence of national frequency limitations, contractors can, if necessary, develop reasonable frequency limitations for breast cancer.

Coverage for Myocardial Viability

FDG PET is covered for the determination of myocardial viability following an inconclusive single photon computed tomography test (SPECT) from July 1, 2001through September 30, 2002. Only full ring scanners are covered as the scanning medium for this service from July 1, 2001 through December 31, 2001. However, as of January 1, 2002 full and partial ring scanners are covered for myocardial viability following an inconclusive SPECT.

Beginning October 1, 2002, Medicare will cover FDG PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization, and will continue to cover FDG PET when used as a follow-up to an inconclusive SPECT. However, if a patient received a FDG PET study with inconclusive results, a follow-up SPECT is not covered. FDA full and partial ring PET scanners are covered.

Limitations: In the event that a patient receives a SPECT with inconclusive results, a PET scan may be performed and covered by Medicare. However, a SPECT is not covered following a FDG PET with inconclusive results. Refer to CIM §50-58 for specific frequency limitations for Myocardial Viability following an inconclusive SPECT.

Frequency: In the absence of national frequency limitations, contractors can, if necessary develop reasonable frequency limitations for myocardial viability.

Documentation that these conditions are met should be maintained by the referring physician as part of the beneficiary's medical record.

Conditions and coverage guidelines for both conditions are summarized in the table below.

Clinical Condition	Effective Date	Coverage
*Breast Cancer	October 1, 2002	As an adjunct to standard imaging modalities, staging distant metastasis or restaging patients with locoregional recurrence or metastasis; and as an adjunct to standard imaging modalities for monitoring response to treatment for locally advanced and metastatic disease to determine if therapy should be changed.
Myocardial Viability	July 1, 2001 to September 30, 2002	Covered only following inconclusive SPECT
Myocardial Viability	October 1, 2002	Primary or initial diagnosis prior to revascularization, or following an inconclusive SPECT.

***NOTE**: For Breast Cancer monitoring is allowed when a change in treatment is contemplated.

General Conditions of Coverage by Allowable Type of FDG PET Scanner

	Allowable Type of FDG PET System		
Covered Clinical Condition	**Prior to July 1, 2001**	**July 1, 2001 through December 31, 2001**	**January 1, 2002 and thereafter**
Breast Cancer	Not covered	Not covered	Effective October 1, 2002, Full and partial ring
Myocardial Viability Primary or initial diagnosis prior to revascularization (Continued coverage following an inconclusive SPECT is also allowed)	Not covered	Not covered	Effective October 1, 2002, Full and partial ring

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

HCPCS Codes for Breast Cancer PET Scans Performed on October 1, 2002 and thereafter

G0252: PET imaging, *full and partial-ring PET scanners only,* for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes), not covered by Medicare

Short Description: PET Imaging Initial dx

G0253: PET imaging for Breast cancer, *full and partial-ring PET scanners only,* staging/ restaging of local regional recurrence or distant metastases, i.e., Staging/restaging after or prior to course of treatment

Short Description: PET Image Brst Dection Recur

G0254: PET imaging for Breast cancer, *full and partial-ring PET scanners only,* evaluation of response to treatment, performed during course of treatment

Short Description: PET Image Brst Eval to Tx

HCPCS Codes for Myocardial Viability PET Scans performed on October 1, 2002 and thereafter

G0230: (PET imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study; *full- and partial-ring PET scanners only*) should continue to be billed following an inconclusive SPECT.

Short Description: PET myocard viability ring

78459: (Myocardial imaging, positron emission tomography (PET), metabolic evaluation) should be used for determination of myocardial viability as a primary or initial diagnostic study prior to revascularization.

Short Description: Heart muscle imaging (PET)

NOTE: [CIM reference §50-36 and §50-56 detail coverage indications. FDG Positron Emission Tomography is a minimally invasive diagnostic procedure using positron camera (tomograph) to measure the decay of radioisotopes such as FDG. The CMS determined that the benefit category for the requested indications fell under §1861(s)(3) of the Social Security Act diagnostic service.]

GGL-1815/CR #2138/PM AB-02-065

INTRAVENOUS IMMUNE GLOBULIN FOR THE TREATMENT OF AUTOIMMUNE MUCOCUTANEOUS BLISTERING DISEASES

Intravenous immune globulin (IVIg) is a blood product prepared from the pooled plasma of donors. It has been used to treat a variety of autoimmune diseases, including mucocutaneous blistering diseases. It has fewer side effects than steroids or immunosuppressive agents.

Effective October 1, 2002, IVIg is covered for the treatment of biopsy-proven (1) Pemphigus Vulgaris, (2) Pemphigus Foliaceus, (3) Bullous Pemphigoid, (4) Mucous Membrane Pemphigoid (a.k.a., Cicatricial Pemphigoid) and (5) Epidermolysis Bullosa Acquisita for the following patient subpopulations:

1. Patients who have failed conventional therapy. Contractors have the discretion to define what constitutes failure of conventional therapy;
2. Patients in whom conventional therapy is otherwise contraindicated. Contractors have the discretion to define what constitutes contraindications to conventional therapy; or
3. Patients with rapidly progressive disease in whom a clinical response could not be affected quickly enough using conventional agents. In such situations IVIg therapy would be given along with conventional treatment(s) and the IVIg would be used only until the conventional therapy could take effect.

In addition, IVIg for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short-term therapy and not as a maintenance therapy. Contractors have the discretion to decide what constitutes short-term therapy.

Use J1563 to bill for IVIg for the treatment of biopsy-proven (1) Pemphigus Vulgaris, (2) Pemphigus Foliases, (3) Bullous Pemhigoid, (4) Mucous Membrane Pemphigoid, and (5) Epidermolysis Bullosa Acquisita.

This revision to the Coverage Issues Manual is a national coverage decision (NCD). The NCDs are binding on all Medicare carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 CFR 422.256(b) and NCD that expands coverage is also binding on a Medicare + Choice Organization. In addition, an administrative law judge may not review an NCD. (See 1869(f)(1)(A)(i) of the Social Security Act).

GGL-1823/CR #2149/PM AB-02-060

CODING INSTRUCTIONS FOR IN-111 ZEVALIN AND Y-90 ZEVALIN

This article provides coding instructions on how to bill for IN-111 Zevalin (Indium -111 Ibritumomab Tiuxetan), and Y-90 Zevalin (Yttrium-90 Ibritumomab Tiuxetan), which are used for the treatment of patients with relapsed or refractory low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.

These coding instructions only indicate the method by which the drug is paid, if it is covered by the Medicare Program. These instructions do not represent a determination that the Medicare Program covers the drug. Contractors must determine whether the drug meets all program requirements for coverage; for example, that the drug is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment because it is usually self-administered.

The CMS has undertaken a national coverage determination for Zevalin to assure that this biologic is appropriately used in the Medicare population. We expect to issue a decision this Fall. Further information can be found on the- CMS Medicare coverage policy tracking sheet at http://www.cms.gov/coverage/8b3.asp.

Payment for infusion is packaged into the imaging scans and should not be billed separately.

Only one of the three imaging codes should be used, with the units of service of one (1) that would include all the imaging studies performed, regardless of the number of images or number of days required to perform the imaging.

No codes other than the ones described below should be reported on claims for Zevalin.

This instruction applies to hospital outpatient departments paid under the OPPS and to physician offices. Critical access hospitals and other outpatient departments not paid under OPPS are to continue to utilize their current billing practices.

Physicians are to continue using HCPCS codes A4641 and 79900 for Zevalin after October 1, 2002, or until a more specific Level II HCPCS codes is available.

For services furnished on or after the effective date of this document, Zevalin should be reported as follows:

Diagnostic

For IN-111 Zevalin, pre treatment imaging/dosimetry diagnostic dose, report the following codes:

- 78800 - radiopharmaceutical localization of tumor, limited area, or
- 78801 - radiopharmaceutical localization of tumor, multiple areas, or
- 78802 - radiopharmaceutical localization of tumor, whole body and
- A4641 -diagnostic radiopharmaceutical, not otherwise classified

Therapeutic

For Y-90 Zevalin therapeutic dose, report the following code:

- 79400 - radiopharmaceutical therapy, nonthyroid, nonhematologic and
- 79900 - provision of therapeutic radiopharmaceutical(s)

PM AB-02-120/CR 2273/08-21-02/GGL-1867

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

PHOTODYNAMIC THERAPY

Photodynamic therapy is a medical procedure which involves the infusion of a photosensitive (light- activated) drug with a very specific absorption peak. This drug is chemically designed to have a unique affinity for the diseased tissue intended for treatment. Once introduced to the body, the drug accumulates and is retained in diseased tissue to a greater degree than in normal tissue. Infusion is followed by the targeted irradiation of the tissue with a non-thermal laser, calibrated to emit light at a wavelength that corresponds to the drug's absorption peak. The drug then becomes active and locally treats the diseased tissue.

Ocular photodynamic therapy (OPT)

OPT is used in the treatment of ophthalmologic diseases. OPT is only covered when used in conjunction with verteporfin.

A. Classic Subfoveal Choroidal Neovascular (CNV) Lesions.- OPT is covered with a diagnosis of neovascular age-related macular degeneration (AMD) with predominately classic subfoveal choroidal neovascular (CNV) lesions (where the area of classic CNV occupies $\geq$ 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram. Subsequent follow-up visits will require a fluorescein angiogram prior to treatment. There are no requirements regarding visual acuity, lesion size, and number of re-treatments.

B. Occult Subfoveal Choroidal Neovascular (CNV) Lesions.- OPT is noncovered for patients with a diagnosis of age-related macular degeneration (AMD) with occult and no classic CNV lesions.

C. Other Conditions - Use of OPT with verteporfin for other types of AMD (e.g., patients with minimally CNV lesions, atrophic, or dry AMD) is noncovered. OPT with verteporfin for other ocular indications such as pathologic myopia or presumed ocular histoplasmosis syndrome, is eligible for coverage through individual contractor discretion.

Photodynamic Therapy, regarding ocular photodynamic therapy (OPT) the policy for the use of OPT for age related macular degeneration (AMD) will remain noncovered for patients with occult and no classic lesions. Effective July 1, 2001 OPT was only covered when used in conjunction with verteporfin (see 45-30 PHOTOSENSITIVE DRUGS). Also effective July 1, 2001, OPT was covered with a diagnosis of neovascular age-related macular degeneration (AMD) with predominately classic subfoveal choroidal neovascular (CNV) lesions (where the area of classic CNV occupies $\geq$ 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram.

Photosensitive Drugs, regarding Verteporfin when used with OPT for the treatment of patients with AMD with occult and no classic lesions will remain noncovered.

Providers must use the GA modifier (Waiver of liability statement on file) when billing for OPT with verteporfin for patients with a diagnosis of AMD with occult and no classic CNV lesions where the beneficiary has signed an advanced beneficiary notice (ABN). Providers must use the GZ modifier (item or service expected to be denied as not reasonable and necessary) when billing for OPT with verteporfin for patients with a diagnosis of AMD with

occult and no classic CNV lesions where the beneficiary has NOT signed an ABN. Such claims will be denied by the contractor because the service is noncovered due to the national coverage determination. Critical access hospitals are to continue billing for these services as they do today until further instructions are issued.

This revision to the Coverage Issues Manual is a national coverage decision (NCD). NCDs are binding on all Medicare carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. An NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not review an NCD.

GGL-1864/CIM Transmittal 157/CR 2335/08-2-02

POLICY CLARIFICATION FOR PERIPHERAL NEUROPATHY WITH LOSS OF PROTECTIVE SENSATION (LOPS) IN PEOPLE WITH DIABETES

Effective for claims with dates of service on January 1, 2003 and thereafter, each physician or physician group of which that physician is a member may receive reimbursement only once for G0245 for each beneficiary. However, should that beneficiary need to see a new physician, that new physician may also be reimbursed once for G0245 for that beneficiary as long as it has been at least 6 months from the last time G0245 or G0246 was paid for the beneficiary, regardless of who provided the service. This same policy also applies to providers that bill the FI, e.g., hospitals, comprehensive outpatient rehabilitation facilities, and outpatient rehabilitation facilities, etc.

Clarification of Billing Requirement for G0247

In order for Common Working File (CWF) to process and edit LOPS claims correctly, G0247 must be billed on the same claim with the same date of service as either G0245 or G0246 in order to be considered for payment.

Code definitions

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

1. The diagnosis of LOPS;
2. A patient history;
3. A physical examination that consists of at least the following elements:
   (a) Visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) Evaluation of a protective sensation,
   (c) Evaluation of foot structure and biomechanics,
   (d) Evaluation of vascular status and skin integrity,

(e) Evaluation and recommendation of footwear, and

4. Patient education

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

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

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

1. Local care of superficial wounds,
2. Debridement of corns and calluses, and
3. Trimming and debridement of nails.

PM AB-02-109/CR 2150/07-31-02/GGL-1866

COVERAGE AND BILLING FOR HOME PROTHROMBIN TIME INTERNATIONAL NORMALIZED RATIO (INR) MONITORING FOR ANTICOAGULATION MANAGEMENT

Coverage

Use of the INR allows physicians to determine the level of anticoagulation in a patient independent of the laboratory reagents used. The INR is the ratio of the patient's prothrombin time compared to the mean prothrombin time for a group of normal individuals.

For services furnished on July 1, 2002 and thereafter, Medicare will cover the use of home prothrombin time INR monitoring for anticoagulation management for patients with mechanical heart valves on warfarin. The monitor and the home testing must be prescribed by a physician and the following patient requirements must be met:

- Must have been anticoagulated for at least three months prior to use of the home INR device;
- Must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
- Self testing with the device is limited to a frequency of once per week.

Applicable HCPCS Codes for Home Prothrombin Time INR Monitoring

G0248 (Type of Service 1): Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstration use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results and documentation of a patient ability to perform testing.

Short description: Demonstrate use home INR mon

G0249 (Type of Service S): Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests.

Short description: Provide test material, equipm

G0250 (Type of Service 1): Physician review; interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service).

Short description: MD review interpret of test

Applicable ICD-9 CM Code for Home Prothrombin Time INR Monitoring

ICD-9 V43.3, Organ or tissue replaced by other means; heart valve, applies.

Note: Porcine valves are not covered so Medicare will not make payment on Home INR Monitoring for patients with porcine valves.

Claims Requirements

Note that this is a CLIA waived diagnostic test and it is not covered as durable medical equipment. Therefore, claims submitted to DMERCs will not be paid. It is covered under the physician fee schedule. Also note that the cost of the device and supplies are included in the payment for G0249 and therefore not separately billed to Medicare. Additionally, for G0250, since this code descriptor is per 4 tests, this code should only be billed no more than once every 4 weeks.

GGL-1824/CR #2071/PM AB-02-064

MEDICARE COVERAGE OF REHABILITATION SERVICES FOR BENEFICIARIES WITH VISION IMPAIRMENT

Background

A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self-care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical and should be performed by an occupational or physical therapist. (Physical Therapy and Occupational Therapy assistants cannot perform such evaluations.)

Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).

Coverage and Limitations

In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare physician, and implemented by approved Medicare providers (occupational or physical therapists) or incident to physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services:

- Mobility;
- Activities of Daily Living; and
- Other rehabilitation goals that are medically necessary.

The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning – are not covered. For example, a person with an ICD-9 diagnosis 369.08 *(profound impairment in both eyes, i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less)* would generally be eligible for, and may be provided, rehabilitation services under HCPCS code 97535, *(self care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).*

Services may be provided by a physician as defined in §1861(r)(1) and (4) of the Social Security Act, a qualified occupational therapist, or a qualified physical therapist. Services furnished by an employee of the physician may only be provided incident to the physician's professional services, must be furnished under the physician's direct personal supervision, and must meet other incident to requirements provided in §2050 of the Medicare Carriers Manual. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as other therapy services.

Applicable HCPCS Therapeutic Procedures

The following list contains examples that are not meant to limit the provision of other medically necessary services:

97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility;
97116	Gait training (includes stair climbing);
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes;
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes;
97535	Self-care/home management training, e.g., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in use of adaptive equipment, direct one-on-one contact by provider, each 15 minutes; and
97537	Community/work reintegration (e.g., shopping, transportation, money management, avocational activities and/or work environment modification analysis, work task analysis, direct one on one contact by provider, each 15 minutes.

ICD-9-CM Codes for Vision Impairment that Support Medical Necessity

The following are appropriate diagnoses to use for the therapeutic procedures specified above:

BE = Better Eye LE = Lesser Eye

368.41	Scotoma central area	369.12	BE – severe impairment LE – total impairment
368.45	Generalized contraction or constriction	369.13	BE – severe impairment LE – near-total impairment
368.46	Homonymous bilateral field defects	369.14	BE – severe impairment LE – profound impairment
368.47	Heteronymous bilateral field defects	369.16	BE – moderate impairment LE – total impairment
369.01	BE – total impairment LE – total impairment	369.17	BE – moderate impairment LE – near-total impairment
369.03	BE – near-total impairment LE – total impairment	369.18	BE – moderate impairment LE – profound impairment
369.04	BE – near-total impairment LE – near-total impairment	369.22	BE – severe impairment LE – severe impairment
369.06	BE – profound impairment LE – total impairment	369.24	BE – moderate impairment LE – severe impairment
369.07	BE – profound impairment LE – near-total impairment	369.25	BE – moderate impairment LE – moderate impairment
369.08	BE – profound impairment LE – profound impairment		

Definition of Levels of Vision Impairment:

moderate = best corrected visual acuity is less than 20/60

severe = best corrected visual acuity is less than 20/160, or *(legal blindness)* visual field is 20 degrees or less

profound = best corrected visual acuity is less than 20/400, or *(moderate blindness)* visual field is 10 degrees or less

near-total = best corrected visual acuity is less than 20/1000, or (*severe blindness)* visual field is 5 degrees or less

total = no light perception *(total blindness)*

Ref. CR2083/Transmittal AB-02-078

Contractor's Policy Number
PR/USVI-02-028

Contractor Name
Triple-S, Inc.

Contractor Number
00973 & 00974

Contractor Type
Carrier

LMRP Title
Sentinel Lymph Node Biopsy

AMA CPT Copyright Statement

CMS National Coverage Policy
- Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical examinations.
- Title XVIH of the Social Security Act, Section 1862 (a)(1)(A). This section allows coverage and payment for only those services considered medically reasonable and necessary.
- Title XVIII of the Social Security Act, Section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

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
September 20, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Sentinel lymph node biopsy (SLNB) is a technique that allows sampling of the lymph node or nodes that receive drainage directly from a tumor or an area of carcinoma. The advantage of this technique is that if the sentinel lymph node(s) is negative for metastases, a lymph node dissection is usually not performed, sparing the patient morbidity and complications associated with that procedure. The sentinel lymph node is identified by injection of a radioactive tracer and/or vital dye that drains to the sentinel node.

Indications and Limitations of Coverage and/or Medical Necessity
Sentinel lymph node biopsy may be indicated in malignant melanoma. Cutaneous melanomas often spread through lymph channels to regional lymph nodes. The sentinel node is the first node that the dermal lymphatics around a tumor drain to. If the sentinel node biopsy is negative, lymphadenectomy is usually not performed.

Sentinel lymph node biopsy for malignant melanoma is eligible for reimbursement unless a regional lymphadenectomy is planned, regardless of the findings of the SLNB.

Sentinel lymph biopsy may be indicated in breast carcinoma and is eligible for reimbursement when the following conditions are met:

1. Clinical Stage I and II carcinoma of the breast with no palpable lymph nodes in the axilla and,
2. If the sentinel lymph node biopsy is negative, an axillary lymphadenectomy is not previously planned.

Limitations
The procedures is not done currently if:

1. clinically suspicious axillary nodes are present,
2. the tumor is greater than 5.0 CM,
3. the patient is pregnant and a radioactive tracer is used (may be performed with a vital dye) or
4. there are multifocal lesions.

CPT/HCPCS Section & Benefit Category
Surgery/Hemic and Lymphatic Systems
Nuclear Medicine

CPT/HCPCS Codes

38500	Biopsy or excision of lymph node(s); open, superficial
38510	open, deep cervical node(s)
38525	open, deep axillary node(s)
38530	open, internal mammary node(s) (separate procedure)
38792	Injection procedure; for identification of sentinel node
78195	Lymphatics and lymph glands imaging

Not Otherwise Classified (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
Truncated Diagnosis Codes are not Acceptable
ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest specificity and selected from the ICD-9-CM book appropriate to the year in which the claim submitted.

It is not enough to.link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

Further, these ICD-9-CM codes can be used only with the conditions listed in the Indications and Limitations sections of this policy.

172.0-172.9 Malignant melanoma of skin
174.0-174.9 Malignant neoplasm of female breast
175.0-175.9 Malignant neoplasm of male breast

Diagnoses that Support Medical Necessity
Same as above.

ICD-9-CM Codes that do not Support Medical Necessity
Use of any ICD-9-CM diagnosis code not listed in the "ICD-9-CM Diagnosis Codes that Support Medical Necessity" section of this policy will be denied.

Reasons for Denial
- A claim submitted without a valid ICD-9-CM diagnosis code will be returned as an incomplete claim under 1833(e).
- A claim submitted without one of the ICD-9-CM diagnosis codes listed in the "ICD-9-CM Diagnosis Codes that Support Medical Necessity" section of this policy will be denied under 1862 (a)(1)(A).
- A claim for services rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.
- It is planned therapy for the patient to have a lymphadenectomy regardless of the findings of the sentinel lymph node biopsy.
- The injection of vital dye to visualize the sentinel node is reported as code 38792. This code will be paid only once, regardless of the number of injections made around the lesion. When code 38792 is reported with NOS larger than one, only one service will be allowed while any services in excess of one will be denied.

The sentinel node excision is reported using the appropriate code from among the following: 38500, 38510, 38525, or 38530 with the NOS of 001 only. When one of these codes is reported with NOS larger than one, only one service (each code) will be allowed while any services in excess of one will be denied.

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

Coding Guidelines

1. This policy does not take precedence over the Correct Coding Initiative (CCI) and not interfere with the Indications and Limitations within this policy.
2. When lymphoscintigraphy is performed in advance of the surgical procedure to locate and mark the sentinel node(s), the injection and the lymphoscintigraphy procedures should be coded and reported separately by the physician performing these procedures. CPT code 38792 should be used for the injection procedure and code 78195 should be used for the lymphoscintigraphy.
3. The injection of the radioactive tracer should be billed with unit of service one (1) regardless of the number of injections around the lesion.
4. The injection of vital dye to visualize the sentinel node in the operating room should be reported by the surgeon/physician who performs the injection using code 38792. This code should be reported with units of service one (1), regardless of the number of injections made around the lesion.
5. When both a radioactive tracer and vital dye are used, reimbursement of CPT code 38792 will be made for- both the injection of the radioactive tracer and the injection of the vital dye.
6. The injection code (38792) may be billed with unit of service one (1) each for the injection of the radioactive tracer and the injection of the vital dye, regardless of the number of actual injections for etch substance. If one physician injects both the radioactive tracer and the vital dye, then the services may be billed on one line on the claim, with units of service two (2).
7. The sentinel node excision is reported using the appropriate code from among 38500-38542, and may only be billed with units of service one (1) regardless of the number of nodes excised.
8. Sentinel node biopsy is payable in the following places of service:

	OFFICE (11)	HOSPITAL INPATIENT (21)	HOSPITAL OUTPATIENT (22)	AMBULATORY SURGERY CENTER (24)
38500		X	X	X
38510		X	X	X
38525		X	X	X
38530		X	X	X
38792	X	X	X	X
78195	X			
78195-26	X	X	X	X
78195-TC	X			

9. Scintigraphy performed intraoperatively using a hand-held device is not separately reimbursable, and is included in the fee for the surgical procedure.
10. If the sentinel node is not identified at the time of surgery, and lymphadenectomy is performed, then the same CPT codes (38500, 38510, 38525 or 38530) should still be billed, regardless of the number of nodes excised. The injection and scintigraphy codes may still be billed, regardless of the results.

Documentation Requirements

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

Documentation must be available to Medicare upon request.

Documentation must clearly support the medical necessity for the procedures reported on the claims and must be legible.

Utilization Guidelines
N/A
Other Comments

- For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an acceptable advance notice of Medicare's possible denial of payment. An advance beneficiary notice (ABN) should be signed when a provider/supplier does not want to accept financial responsibility for the service.
- It is also expected by Medicare that the procedure will be done using either an injection of vital dye or an injection of a radiopharmaceutical tracer, or both, to allow visual and/or scintigraphic identification of the sentinel node(s).

Sources of Information and Basis for Decision

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Advisory Committee Notes
This policy does not reflect 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.

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GGL-1706

Contractor's policy number
PR/USVI-02-031

Contractor name
Triple-S, Inc.

Contractor number
00973 & 00974

Contractor type
Carrier

LMRP title
Acute Pain Management

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
N/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

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Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP Description
Acute pain may be produced by:

1. Surgery
2. Injuries
3. Certain disease conditions, particularly carcinoma, radiculopathies, herpes zoster, etc.
4. Labor and delivery

Duration of such pain varies with the cause of the pain, for example, the post-surgical/postrauma pain is immediate and usually of short duration, whereas pain caused by a radiculopahty may have been present for some time.

Usually acute pain responds to oral or injected analgesics, including narcotics, but sometimes it may need to be treated with procedures such as, intravenous analgesics (Patient controlled analgesia" PCA), regional blocks, epidural blocks, etc.

Post-surgical
Postoperative pain management services are generally provided by the operating surgeon and the global surgical allowance includes reimbursement for these services. Other services of the nursing staff in administering medications are routine hospital expenses and covered under Medicare Part A. However, under special circumstances, acute postoperative pain may be so severe that its treatment requires the services of a specialist (anesthesiologist or pain specialist). The surgeon should document the medical necessity for these special services in the patient's medical record.

Post-surgical analgesia may be accomplished by:

A. Nerve blocks (peripheral nerve block, intercostal nerve block)
Peripheral nerve blocks can provide excellent analgesia in the immediate post-operative period for some patients. To prolong the period of analgesia, catheters can be placed near many peripheral nerves for infusion of local anesthetics. This type of analgesia can be used after major reconstruction of the extremities and provides very efficient pain control without the sedation of systemic narcotic agents. Intercostal nerve blockade remains an excellent alternative for patients who have undergone thoracotomy. However, since repeated intermittent percutaneous injections of local anesthetics are usually not given, effectiveness is limited by the length of action of the local anesthetic. Interpleural analgesia offers an alternative way to block the intercostal nerves, which avoids this problem by using a catheter access. Because of the risk of pneumothorax and the unpredictability of plasma levels, the role of interpleural analgesia in acute pain management needs further definition.

B. Epidural infusion
Continuous epidural analgesia is rapidly becoming a primary method of pain management in the post-operative period, especially for major abdominal, urologic, orthopedic, thoracic, and vascular surgical procedures. However, risks and side effects do exist for epidural analgesia, and its use should be reserved for patients in whom simple techniques cannot provide adequate analgesia.

C. Intrathecal injection
The intrathecal injection of morphine and a local anesthetic into the subarachnoid space has been consistently found to be effective in reducing post-operative pain. However, the procedure is usually limited to a one-time administration, providing analgesia for no longer than 12 to 16 hours.

Indications and Limitations of Coverage and/or Medical Necessity
Indications

Major surgery, trauma, severe intractable pain due to cancer, persistent back pain due to acute rupture of herniation of Intervertebral disc, sickle cell disc and persistent radiculopathy.

Limitations
Medical necessity for providing the service must be clearly documented in the patient's medical record.

Reimbursement will be allowed for acute post-operative pain management for all types of surgical procedures. Non-surgical pain management services may be required for patients with severe trauma, extensive burns, multiple rib fractures or for patients with carcinoma.

Medicare Part B does not cover charges for daily visits or medical management for patient controlled analgesia (PCA) utilizing a device that delivers narcotics or other intravenous analgesics through an ongoing IV line. The surgeon should manage post-operative pain because payment for these services is included in the global fee paid to the surgeon.

CPT/HCPCS Section & Benefit Category
Anesthesia, Surgery

CPT/HCPCS Codes

01996	Daily management of epidural or subarachnoidal drug administration
62274	Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; subarachnoid or subdural, single
62279	Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, continuous
64420	Injection, anesthetic agent; intercostal nerve, single
64421	Intercostal nerves, multiple, regional block
64450	Other peripheral nerve or branch
J codes	For anesthetic agent used

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
Surgery for joint replacement and extensive orthopedic surgery V43.60-V43.66

History of surgery on major organs V15.2 (includes open cholecystectomy, thoracic surgery, peripherovascular disease surgery, abdominal surgery, pancreatectomy, small or large bowel surgery, splenectomy, nephrectomy, hysterectomy) gastrectomy, surgery on small/large intestines and in labor and delivery.

History of burns 948.3-948.9 (ICD-9 CM codes for specified sites of 2nd and 3rd degree burns may also be used).

History of severe trauma (ICD-9 959.01-959.9);
History of fracture (ICD-9 800-829)

Sickle cell disease (282.60-282.62-282.63-282.69)

Diagnosis that Support Medical Necessity
Post operative pain and others 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
No compliance with this policy.

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

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding Guidelines
When the services of a specialist (anesthesiologist or pain specialist) is necessary to accomplish post-operative analgesia, the pain specialist may:

--- provide a consultation (99251)
--- insert an epidural catheter under anesthesia (62279 - this code includes the catheter and the injection of the anesthetic substance), and provide daily management after the day on which the catheter was introduced (under code 01996), for a maximum of three days. Codes 62279 and 01996 are not payable on the same day.
--- advise intravenous analgesia. Follow-up care for intravenous analgesia is allowed (under code 99231
--- subsequent hospital care, per day), for a maximum of three days. Code 01996 may not be paid with 99231.
--- advise that regional anesthesia which was given during surgery be prolonged for postoperative pain management. Follow-up hospital visits (under code 99231 - subsequent hospital care, per day), are allowed for a maximum of three days.
--- may insert an intrapleural catheter (code 32002), and provide follow-up care as noted above.
Codes 62279 and 01996 are NOT appropriate to use for patient controlled analgesia (PCA). Claims received for this service will be denied as part of the global surgical service. Because this is a part of global surgery, the patient cannot be billed for this service.

Documentation Requirements
The patient's medical record should document the medical necessity for the pain management services and must be available if requested. There are no electronic claim media (EMC) restrictions.

Utilization guidelines
Correct ICD-9 and CPT codes must be reported.

Other comments
Post-operative pain management services: These are generally provided by the operating surgeon, the global surgery fee includes reimbursement for this service. However, after certain surgical procedures (see covered ICD-9 CM codes) pain is more severe and it's management requires specialized care. Such a specialist (usually an anesthetist) may provide the following services:

1. A problem focused consultation CPT code 99251-99255 (if one has been requested by the surgeon).
2. Epidural block - CPT code 62272, 62273, 62311, 62310, 62318 or 62319 - "Injection of anesthetic substance (including narcotics) diagnostic or therapeutic, epidural, lumbar or caudal; continous".

Note:
(a) The above code includes the reimbursement for insertion of the epidural catheter in those cases in which the catheter is inserted for post-operative pain management and not for the administration of the anesthesia during the surgical procedure or inserted after the surgical procedure for the post op pain management purposes. This should be billed utilizing CPT 62318-59 cervical/thoracic or 62319-59, lumbar/sacral.
(b) Do not bill CPT code 63780, "Insertion or replacement, subarachnoid or epidural catheter with reservoir and/or pump for drug infusion without laminectomy". This code will only be paid when the claim is submitted with a report detailing the medical necessity of the permanent insertion of pump/ reservoir and catheter.
3. Follow-up services, for monitoring the dosage of analgesia, etc. If provided will be covered for a maximum period of 3 days under CPT code 01996; "Daily management of epidural or subarachnoid drug administration". If this service is required for more than 3 days the claim must be submitted with a special report documenting the medical necessity.
4. Intravenous analgesia (patient controlled or otherwise) may be advised instead of epidural analgesia. Follow-up care for monitoring IV analgesia will be reimbursed for up to 3 days under CPT code 99231, 99232, 99233.
5. Prolonged regional analgesia (the regional block is usually provided during surgery) may be advised for post-operative pain management. Follow-up care for this service will be covered under CPT code 99231, 99232, 99233.
6. To control pleural pain after sclerosing solution has been used, analgesics may be used through a chest tube. Follow-up care for this service will also be covered under CPT code 99231, 99232, 99233.
7. Many surgeons request a nerve block be administered immediately following surgery Eg. shoulder or limb surgery. This reduces postoperative pain and is usually just a one time block. In this case the particular regional block should be billed using the appropriate code appended with modifier 59 indicating that it is separate from anesthesia administration.

Non-surgical acute pain management services: Pain management services are also required for patients with severe trauma, extensive burns, multiple fractures, carcinomas and those with acute radiculopathy. The following services will be covered for such situations:

1. Problem focused consultations, CPT code 99241-99245 in the out-patient setting and CPT code 99251-99255 in the in-patient setting.

2. Epidural blocks, CPT codes 62272, 62273, 62311, 62310, 62318, 62319, which ever has been provided after documenting the medical necessity. These codes include reimbursement for the insertion of the epidural catheter.

Note:
CPT code 63780 can only be billed if the epidural catheter is inserted along with the insertion of the implantable pump/reservoir and should be submitted with a special report documenting the medical necessity of the procedure. Follow-up care for CPT code 62279 is required and provided and such may be billed under CPT code 01996.

3. Follow-up care for monitoring intravenous analgesia/intrapleural analgesia may be provided under CPT codes 99211, 99212, 99213, 99214, 99215 or 99231, 99232, 99233 depending upon the location of where the service was provided and complexity of the case.

Sources of Information and basis for decision
HCFA National Carrier Medical Directors Conference, 1992

Advisory Committee Notes
This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from anesthesia and pain management specialties.

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August 5, 2002

Revision history
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GGL-1794

Contractor's policy number
PR/USVI-02-032

Contractor Name
Triple-S, Inc.

Contractor Number
00973 & 00974

Contractor Type
Carrier

LMRP Title
Debridement of Mycotic Nails

AMA CPT Copyright Statement

CMS National Coverage Policy
- Title XVIII of the Social Security Act, Section 1862 (a)(13)(C).
  This section excludes payment where such expenses are for routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care).
- 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 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.
- Medicare Carriers Manual, Section 2323. This section addresses foot care services excluded from Medicare coverage.
- Medicare Carriers Manual, Section 4120.2. This section addresses the application of the "reasonable and necessary" limitation to foot care services.
- Code of Federal Regulations (CFR) Part 411.15, subpart A. This section addresses general exclusions and the exclusion of particular services.

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

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

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Revision Ending Date
N/A

LMRP description
The debridement of nails is the removal of nail substance, partial or complete, when the presence of such structures is causing local pathology. It is a temporary reduction in the size or girth of an abnormal nail plate, short of avulsion. It is performed most commonly without anesthesia to accomplish any or all of the following objectives: (1) relief of pain; (2) treatment of infection (bacterial, fungal, and viral); (3) temporary removal of an anatomic deformity such as onychauxis (thickened nail), or certain types of onychocryptosis (ingrown nail); (4) exposure of subungual conditions for the purpose of treatment as well as diagnosis (biopsy, culture, etc); (5) as a prophylactic measure to prevent further problems, such as a subungual ulceration in an insensate patient with onychauxis. Debridement of mycotic nails is considered to be routine foot care.

Indications and Limitations of Coverage and/or Medical Necessity
Indications

Whether by manual method or by electrical grinder, debridement is a modality used as part of a definitive antifungal treatment of onychomycosis (ICD-9 CM code 110.1).

Limitations
Payment may be made for the debridement of mycotic nails only when the physician attending the mycotic condition documents that the following criteria are met:

1. In the absence of a systemic condition, the following criteria must be met:
   - In the case of ambulatory patients there exists:
     a. Clinical evidence of mycosis of the toenail, (110.1) and
     b. Marked limitation of ambulation (719.77, 781.2), pain (729.5), and/or secondary infection (681.10, 681.11) resulting from the thickening and dystrophy of the infected toenail plate.
   - In the case of non-ambulatory patients there exists:
     a. Clinical evidence of mycosis of the toenail (110.1), and
     b. The patient suffers from pain (729.5) and/or secondary infection (681.10, 681.11) resulting from the thickening and dystrophy of the infected toenail plate.

2. For patients with a systemic conditions and clinical evidence of mycosis of the toenail, but who do not meet the above criteria, refer to policy on Routine Foot Care.

CPT/HCPCS Section & Benefit Category
Integumentary System/Surgery

CPT/HCPCS Codes

11720	Debridement of nail(s) by any method(s); one to five
11721	six or more

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
Truncated Diagnosis Codes are not acceptable.

ICD-9-CM code listings may cover a range and exclude truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the claim is submitted.

It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedure to be paid.
Further, these ICD-9-CM codes can be used only with the conditions listed in the Indications and Limitations sections of this policy.

110.1	Dermatophytosis of nail
681.10	Cellulitis and abcess of toe, unspecified
681.11	Onychia and paronychia of toe
719.77	Difficulty in walking involving ankle and foot joint
729.5	Pain in limb
781.2	Abnormality of gait

Diagnoses that Support Medical Necessity
Same as above and with the conditions specified in Indications and Limitations section.

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.

Reasons for Denial
- Any claim submitted without a valid ICD-9-CM diagnosis code will be returned as an incomplete claim under 1833(e).
- Any claim submitted without ICD-9 CM code 110.1 will be denied as noncovered by Medicare for routine foot care services.
- Any claim submitted with ICD-9 CM code 110.1 as the sole diagnosis will be denied as noncovered by Medicare for routine foot care services.
- Any claim submitted with ICD-9 CM code 110.1 AND an ICD-9 CM code other than one of those listed in the "ICD-9 CM Codes that Support Medical Necessity" section of this policy or in Medical Policy for Routine Foot Care will be denied as noncovered by Medicare for routine foot care services.

- Any claim for services rendered in a place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.

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

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
1. This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with the Indications and Limitations within this policy.
2. Codes 11720 and 11721 should be reported with a unit of "1" regardless of the number of nails treated.
3. For dates of service on after January 1, 2002, when reporting nail debridement services performed in the absence of secondary infection, pain, or marked limitation of ambulation if there are no class findings, a modifier GY should be appended to code 11720 and/or 11721.
4. Services may be provided in the office (11), home (12), inpatient hospital (21), outpatient hospital (22), ambulatory surgical center (24), skilled nursing facility (31), nursing home (32), custodial care facility (33), hospice (34), inpatient psychiatric facility (51), psychiatric facility partial hospitalization (52), community mental health center (53), intermediate care facility (54), residential substance abuse treatment facility (55), psychiatric residential treatment center (56) comprehensive inpatient rehabilitation facility (61), comprehensive outpatient rehabilitation facility (62), end stage renal disease treatment facility (65), and public health clinic (71).

Documentation requirements
- For each service encounter, the medical record should contain a description of each nail, which requires debridement. This should include, but is not limited to, the size (including thickness) and color of each affected nail. In addition, the local pathology caused by each affected nail resulting in the need for debridement must be documented. For procedure code 11720 documentation of at least one nail will be accepted. For code 11721 complete documentation must be provided for at least 6 nails.
- Documentation must be available to Medicare upon request.

Utilization guidelines
- Claims for an unusually large number of services will be denied as not medically necessary in the absence of supportive documentation.

Other comments
N/A

Sources of Information and Basis for Decision
Copyright 2001, Physicians' Current Procedural Terminology, American Medical Association

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

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Ending Date of Comment Period
7/29/02

Start Date of Notice Period
August 5, 2002

Revision history

Revision Number	Effective Date of the Revision	Changes
1-R011-02	September 20, 2002	This policy replaces the section on Mycotic Nails from the policy published in Volume 38 (June 1996), Medicare Informa Medical Policies III.

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GGL-1795

Contractor's policy number
PR/USVI-02-033

Contractor name
Triple-S, Inc.

Contractor number
00973 & 00974

Contractor type
Carrier

LMRP title
Routine Foot Care

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)(7). This section excludes routine physical checkups.

Title XVIII of the Social Security Act, section 1862 (a)(13)(C). This section defines the exclusion for payment of routine foot care services

Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis and treatment of illness or injury.

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.

Medicare Carriers Manual (MCM), section 2323. This section addresses foot care services which are exceptions to the Medicare coverage exclusion.

Medicare Carriers Manual (MCM), section 4120.2. This section addresses coverage of routine foot care services.

Code of Federal Regulations (CFR) Part 411.15, subpart A. This section addresses general exclusions and exclusion of particular services.

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

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

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N/A

LMRP Description
The Medicare program generally does not cover routine foot care. However, this policy outlines the specific conditions for which coverage may be present.
The following services are considered to be components of routine foot care, regardless of the provider rendering the service:

- Cutting or removal of corns and calluses
- Clipping, trimming, or debridement of nails
- Shaving, paring, cutting or removal of keratoma, tyloma, and heloma
- Non-definitive simple, palliative treatments like shaving or paring of plantar warts which do not require thermal or chemical cautery and curettage;
- Other hygienic and preventive maintenance care in the realm of self care, such as cleaning and soaking the feet and the use of skin creams to maintain skin tone of both ambulatory and bedridden patients
- Any services performed in the absence of localized illness, injury, or symptoms involving the foot.

Indications and Limitations of Coverage and/or Medical Necessity
Indications

While the Medicare program generally excludes routine foot care services from coverage, there are specific indications or exceptions under which there are program benefits.

1. Medicare payment may be made for routine foot care when the patient has a systemic disease of sufficient severity that performance of such services by a nonprofessional person would put the patient at risk (for example, a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization).
2. Services normally considered routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.
3. Treatment of mycotic nails may be covered in the absence of a systemic condition, if there is clinical evidence of mycosis of the toenail, and the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected nail plate.

The following physical and clinical findings, which are indicative of severe peripheral involvement, must be documented and maintained in the patient record, in order for routine foot care services to be reimbursable.

Class A findings:
- Non-traumatic amputation of foot or integral skeletal portion thereof

Class B findings:
- Absent posterior tibial pulse
- Advanced trophic changes as evidenced by any three of the following:
  1. hair growth (decrease or increase)
  2. nail changes (thickening)
  3. pigmentary changes (discoloring)
  4. skin texture (thin, shiny)
  5. skin color (rubor or redness)
  6. Absent dorsalis pedis pulse

Class C findings:
- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning

Note: Patients with diabetes or other peripheral neuropathy but with no vascular impairment may not meet the above stated class findings. In such circumstances, claims for medically necessary services should be submitted without the Q7, Q8, or Q9 modifiers that indicate class findings.

Limitations:

When the patient's condition is designated by an ICD-9-CM diagnosis code with an asterisk (see ICD-9-CM Codes That Support Medical Necessity) routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) for such conditions.

Claims submitted for more than five services in one day for the same beneficiary may be subject to special review.

Services may be provided in the office (11), home (12), inpatient hospital (21) outpatient hospital (22), ambulatory surgery center (24), skilled nursing facility (31), nursing home (32), custodial care facility (33), hospice (34), inpatient psychiatric facility (51), psychiatric facility partial hospitalization (52), intermediate care facility (54), residential substance abuse treatment facility (55), psychiatric residential treatment center (56), comprehensive inpatient rehabilitation facility (61), comprehensive outpatient rehabilitation facility (62), endstage renal disease treatment facility (65), and state or local public health clinic, (71).

CPT/HCPCS Section Benefit Category
Integumentary/Surgery
Procedures/professional services (temporary)

CPT/HCPCS codes

11055	paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
11056	two to four lesions
11057	more than four lesions
11719	trimming of nondystrophic nails, any number
11720	debridement of nail(s) by any method; one to five
11721	six or more
G0127	trimming of dystrophic nails, any number (effective January 1, 1998)

Not Otherwise Classified (NOC)
N/A

ICD-9-CM Codes that Support Medical Necessity
Truncated Diagnosis Codes are not Acceptable.

ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the claim is submitted.

It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedures to be considered medically necessary.

Diabetes with complications

*250.40-250.43	Diabetes with renal manifestations
*250.50-250.53	Diabetes with ophthalmic manifestations
*250.60-250.63	Diabetes with neurological manifestations
*250.70-250.73	Diabetes with peripheral circulatory disorders

Atherosclerosis

440.20- 440.24	Atherosclerosis of native arteries of the extremities
440.9	Generalized and unspecified atherosclerosis

Other Peripheral Vascular Disease

443.0	Raynaud's syndrome
443.1	Thromboangiitis obliterans (Buerger's disease)
443.81- 443.89	Other specified peripheral vascular diseases

Chronic Thrombophlebitis

*451.11	Femoral vein (deep) (superficial)
*451.19	Other (femoralpopliteal vein, tibial vein, popliteal vein)

Peripheral neuropathies involving the feet, associated with:

030.1	Tuberculoid leprosy
090.40- 090.42	Juvenile neurosyphilis
094.0	Tabesdorsalis
094.1	General paresis
094.2	Syphilitic meningitis
094.81	Syphilitic encephalitis

094.82	Syphilitic parkinsonism
094.9	Neurosyphilis, unspecified
*265.2	Pellagra
*266.2	Other B-complex deficiencies
272.7	Lipidoses
277.3	Amyloidosis
*281.0	Pernicious anemia
*340	Multiple sclerosis
356.2	Hereditary sensory neuropathy
*357.2	Polyneuropathy in diabetes
*357.3	Polyneuropathy in malignant disease
357.4	Polyneuropathy in other disease classified elsewhere
*357.5	Alcoholic polyneuropathy
*357.6	Polyneuropathy due to drugs
579.0	Celiac disease
579.1	Tropical sprue
*585	Chronic renal failure

For treatment of Mycotic Nails, this additional diagnosis must be present:

110.1	Dermatophytosis of nail

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
A claim submitted without a valid ICD-9-CM diagnosis code will be returned as an incomplete claim under 1833(e).

A claim submitted without a diagnosis code listed in the "ICD-9-CM Diagnosis Codes That Support Medical Necessity" section of this policy will be denied under 1862(a)(1)(A).

A claim submitted without any of the required information, such as modifiers, class findings, etc., as outlined in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy will be denied for missing information.

A claim submitted in any other place of service other than those listed in this policy will be denied as non-covered.

A claim submitted with an ICD-9-CM diagnosis code not coded to its highest level of specificity will be returned as an incomplete claim under Section 1833(e).

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

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding Guidelines

1. Effective January 1, 1998, CPT code M0101 (cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care [excludes debridement of toenails with onychogryposis or onychauxis], is no longer valid for Medicare purposes. To report covered services, use CPT codes 11055-11057, 11719, 11720, 11721, or G0127.
2. Appropriate modifiers must be used to indicate class findings.
   a. Modifier Q7: One class A finding
   b. Modifier Q8: Two class B findings
   c. Modifier Q9: Two class C findings, and one class B finding.

NOTE: If the patient has evidence of diabetes with peripheral neuropathy, but no vascular impairment, the use of class findings modifiers is not necessary.

3. All diagnoses must be coded to the highest specificity.
4. Services may be provided in the office (11), home (12), inpatient hospital (21) outpatient hospital (22), ambulatory surgery center (24), skilled nursing facility (31), nursing home (32), custodial care facility (33), hospice (34, inpatient psychiatric facility (51), psychiatric facility partial hospitalization (52), intermediate care (54), residential substance abuse treatment facility (55), psychiatric residential treatment center (56), comprehensive inpatient rehabilitation facility (61), comprehensive outpatient rehabilitation facility (62), endstage renal disease treatment facility (65), and state or local public health clinic, (71).
5. Providers must submit appropriate modifiers, UPIN number of attending physician, and date last seen by that physician as follows:

   Modifiers:
   Instructions for paper claims
   Providers should enter modifiers in Box 24D of the HCFA-1500 form.
   Date last seen by attending physician:
   Instructions for paper claims
   The date the beneficiary was last seen by MD or DO who diagnosed the complicating condition (attending physician) must be in box 19 of the HCFA-1500 form.
   UPIN name and number (attending physician)
6. When reporting debridement of mycotic nails, the primary diagnosis representing the patient's systemic condition must be listed, as well as the secondary diagnosis representing dermatophytosis of the nail.

Documentation Requirements
Documentation supporting the medical necessity, such as ICD-9-CM codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.
Documentation supporting the medical necessity, such as physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement must be maintained in the patient record.

Physical findings and services must be precise and specific (e.g., left great toe, or right foot, 4th digit.) Documentation of co-existing systemic illness should be maintained.

Utilization guidelines
N/A

Other Comments
For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an acceptable advance notice of Medicare's possible denial of payment and a Waiver of Liability should be signed when a provider/ supplier does not want to accept the financial responsibility of the service.

Sources of Information and basis for decision
- Other Medicare carriers medical policy: Group Health Incorporated, United HealthCare Medicare Part B
- Triple-S podiatry/foot care

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

Start Date of Comment Period
06-14-02

Ending Date of Comment Period
07/29/02

Start Date of Notice Period
August 5, 2002

Revision history

Revision Number	Effective Date of the Revision	Changes
1-R12-02	September 20, 2002	This policy replaces the section on Routine Foot Care from policy of Podiatry Foot Care, Volume 38 (June 1996), Medical Policies III, pages 5-14.

GGI-1796

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Contractor's Policy Number
PR/USVI-02-034

Contractor Name
Triple-S, Inc.

Contractor Number
00973 & 00974

Contractor Type
Carrier

LMRP Title
Luteinizing Hormone-Releasing Hormone Analogues in the Treatment of Prostate Cancer

AMA CPT Copyright Statement

CMS National Coverage Policy
Medicare Program Integrity Manual (PIM), section, 2.3.3.C. This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

*Medicare Carriers Manua*l, Sections 2049, 2050.5D (Drugs and Biologicals), 7501.1C (Least Costly Alternative).

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
November 30, 2000

Original Policy Ending Date
September 19, 2002

Revision Effective Date
September 20, 2002

Revision Ending Date
N/A

LMRP Description
This policy explains how luteinizing hormone-release hormone (LHRH) analogues are reimbursed under Medicare. Goserelin acetate (HCPCS code J9202), leuprolide acetate (HCPCS code J9217) and leuprolide acetate implant 65 mg (HCPCS code J9219) are synthetic luteinizing hormone-releasing hormone (LHRH) analogues indicated in the palliative treatment of advanced carcinoma of the prostate. These drugs offer an alternative treatment of prostatic cancer when orchiectomy or estrogen administration are either not indicated or are unacceptable to the patient.

Indications and Limitations of Coverage and/or Medical Necessity
To be considered for coverage by Medicare, a drug or biological must be safe and effective and otherwise reasonable and medically necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for approved indications as specified on the labeling. Medical necessity is, however, determined by the Carrier at the local level.

The underlying issue in the application of 7501.1 of the *Medicare Carriers Manual* is that if two or more services are clinically equivalent, then Medicare does not cover the additional expense of the more costly one, because this additional expense is not attributable to an item or service that is medically reasonable and necessary.

A review of the literature and of FDA data indicates that goserelin acetate and leuprolide acetate are equivalent in their capacity to suppress testosterone production. There is no demonstrable difference in clinical effectiveness.

Leuprolide acetate may be used for treatment of prostate cancer when administered every 12 months in implant form (65 mg). Coverage of the implant is restricted to patients having a reasonable expectation of surviving at least 12 months.

If the patient expresses a preference for the more costly drug, he will be charged up to the price difference between the least costly and more costly medication. The patient indicates acceptance of the additional payment by signing an advanced beneficiary notice for each injection. Individual consideration for the payment of the difference in cost may be given in cases where the provider documents the medical necessity of administering the more costly agent. If there are true medical indications require the use of Leuprolide acetate (Eg., cachexia, infection, allergy to grocerelin). Medicare will consider payment for the difference in cost if an acquisition invoice and documentation of the medical necessity accompanies the claim.

CPT/HCPCS Section and Benefit Category
HCPCS section
Drugs and Biologicals

CPT section
Surgery/Integumentary

Benefit Category
Physician services

CPT/HCPCS Codes

CPT codes

17999 Skin tissue procedure (For services performed prior to 01/01/2002)
11981 Insertion, non-biodegradable drug delivery implant (For services performed on and after 01/01/2002)
11982 Removable, non-biodegradable drug delivery implant (For services performed on and after 01/01/2002)
11983 Removable with insertion, non-biodegradable drug delivery implant (For services performed on and after 01/01/2002)

HCPCS codes

J9202 Goserelin acetate implant, per 3.6 mg
J9217 Leuprolide acetate (for depot suspension), 7.5 mg
J9219 Leuprolide acetate implant 65 mg

Not Otherwise Classified (NOC)
N/A

ICD-9 Codes that Support Medical Necessity
Use of this code does not guarantee reimbursement. The patient's medical record must document that the coverage criteria in this policy have been met.

185 Malignant neoplasm of prostate
198.1 Secondary malignant neoplasm of other urinary organs
198.82 Secondary malignant neoplasm of genital organs
233.4 Carcinoma in situ of prostate
236.5 Neoplasm of uncertain behavior of prostate

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

Reasons for Denial
Medicare does not cover the additional expense of the more costly drug because this additional expense is not attributable to an item or service that is medically reasonable and necessary.

All other ICD-9 codes not listed under "ICD-9 Codes that Support Medical Necessity" will be denied as not medically necessary.

Services performed for conditions not listed as covered in this policy will be denied as not medically necessary.

Services performed for excessive frequency will be denied as not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and the reason for additional services is not justified by documentation.

Services considered:

- Experimental; or
- Cosmetic; or
- Routine screening; or
- A program exclusion; or
- Never medically necessary; or
- Otherwise not covered

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

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding Guidelines
When submitting a claim for HCPCS codes J9202 (goserelin acetate implant, per 3.6 mg.) or J9217 (leuprolide acetate for depot suspension, 7.5 mg,) for a one, three, or four-month injection, the quantity billed must be number of one, three, or four respectively, utilizing the date the analogue was administered.

When submitting a claim for HCPCS code J9219 (Leuprolide acetate implant 65 mg) a quantity billed of one must be used.

Providers using the more costly drug must use HCPCS modifier GA to indicate that the advance Beneficiary Notice is on file for the difference in cost of the two drugs. In addition to the normal co-payment on the Medicare allowed price, the provider is responsible for only charging up to 95% of the average wholesale price (AWP) of the more costly drug.

To submit a claim for the insertion or removal of leuprolide acetate implant (HCPCS code J9219), CPT code 17999 must be used for services prior to 01/01/2002. For services on and after 01/01/2002, CPT codes 11981, 11982, or 11983 must be used.

Rebundling combinations are listed in the latest version of Correct Coding Initiative (CCI).

Documentation Requirements
Documentation with the claim
For unspecified CPT procedure code 17999, a narrative description of the service provided, e.g., insertion of HCPCS code J9219 or removal of HCPCS code J9219, must be indicated in the appropriate Documentation Record for claims submitted electronically. If paper claims are submitted, the required documentation must be in Item 19 or on an attachment to the HCFA-1500 form.

Documentation in the medical record
In cases where the provider indicates the more costly agent is medically necessary, the medical record must indicate why it was medically necessary to administer the more costly drug.

The patient's medical record must document the medical necessity of services for each date of service submitted on a claim, and documentation must be available to Medicare upon request.

Sample Advance Notice for Beneficiaries Accepting Responsibility for Price Difference

Physician Notice
Medicare will only pay for services that it determines to be "reasonable and necessary" under section 2.3.3.C of the *Medicare Program Integrity Manual.* If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will not pay for the service.

I believe that in your case, Medicare will not pay for the extra expense of leuprolide acetate over and above the Medicare allowance for goserelin acetate because there is no difference in clinical effects.

Beneficiary Agreement
I have been notified by my physician that in my case, Medicare will not pay for the difference in cost between leuprolide acetate and goserelin acetate.

I agree to be personally and fully responsible for a payment not to exceed the difference in Medicare allowance for the 2 medications of $_____.

Signed (Beneficiary signature)
Date (Date of signature)

Utilization guidelines
N/A

Other Comments
Limitation of liability and refund requirements apply to denials for frequency and/or medical necessity for drugs submitted on assigned claims and for drug administration codes submitted on assigned and non-assigned claims. When the advance notice is given, the service must be submitted with the HCPCS modifier GA (advance notice has been given to the beneficiary).

Sources of Information and Basis for Decision
Goldspiel, B.R., Kohler, D.R. et al: Goserelin acetate implant, DCIP. The Annals of Pharmacotherapy; 25: 796-804, 1991.

Kaisary, A.V.,Tyrrell, C.J. et al: Comparison of LHRH analogue (zoladex) with orchiectomy in patients with metastatic prostatic carcinoma. J Urology, 67:502-508, 1991.

Cassileth, B.R., Soloway, M.S. et al: Patients' choice of treatment in stage D prostate cancer. Urology, Vol XXXIII; 5:57-62, 1989.

Polsker, G.L., Brodgen, R.N.: Leuprorelin. A review of its pharmacology and therapeutic use in prostatic cancer, endometriosis and other sex hormone-related disorders. Drugs, 48:930-67, 1994.

Oefelein, M.G. and Cornum, R.: Failure to achieve castrate levels of testosterone during luteinizing hormone releasing hormone agonist therapy: the case for monitoring serum testosterone and a treatment decision algorithm. J Urology: 164: 726-729, 2000.

Fowler, J.E., Gottesman, J.E. et al: Safety and efficiency of an implantable leuprolide delivery system in patients with advanced prostate cancer. J Urology: 164: 730-734, 2000.

Advisory Committee Notes
This policy does not represent the sole opinion of the Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from oncology, urology and internal medicine.

Start Date of Comment Period
6/14/02

Ending Date of Comment Period
7/29/02

Start Date of Notice Period
August 5, 2002

Revision History

Revision number	Effective Date of the Revision	Changes
1R010-02	September 20, 2002	Codes 17999-11981-11982-11983-J9219 added.

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GGL-1803

Contractors Policy Number
PR/USVI-02-036

Contractor Name
Triple-S, Inc.

Contractor Number
00973 & 00974

Contractor type
Carrier

LMRP title
Electroconvulsive Therapy, ECT

AMA's CPT copyright statement
"CPT codes, descriptions and other data only are copyright 2001American 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.

-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 U.S. Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
September 20, 2002

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Electroconvulsive Therapy (ECT) is a modality of treatment for certain mental illnesses in which a brief electrical impulse is used to produce a generalized seizure. This therapy is given under general anesthesia. ECT administration is limited to psychiatrists that are duly trained and certified on ECT.

The first ECT treatments date back to the early 1940's and were called also "Electro Shock Treatment". During the seventies, ECT was an issue of great controversy and the manner of administering it, without neither analgesia nor anesthesia, was considered cruel or even as punishment to patients. After an APA Report that appeared during the late 1980's, the effectiveness of this procedure was recognized again regaining acceptance in the medical community.

According to the current medical literature, the only *absolute contraindication* for ECT is the presence of an intracranial lesion/mass. In geriatric patients, a cardiac evaluation before ECT is recommended. It is not uncommon for patients that have been submitted to ECT to present transient memory problems. Usually, this disappears within days to weeks.

Indications and limitations of coverage and/or medical necessity
Clear-cut indications for ECT have always been a matter of debate. According to the American Psychiatric Association Task Force Report on ECT, the decision to use it should be based on the patient's diagnosis, the nature and severity of symptoms, the treatment history, consideration of risks vs. benefits and patient's preference.

The diagnostic indicators for ECT include mayor depressive disorder, bipolar disorder, schizoaffective disorder and other psychoses including catatonia. Also useful when affective symptomatology is prominent and when there is a history of previous positive response to ECT as well as for psychiatric conditions on which standard conventional treatment has failed such as status epilepticus.

CPT/HCPCS Section and benefit category
Medicine/Psychiatry

CPT/HCPCS codes
90870 Electroconvulsive therapy (includes necessary monitoring); single seizure

Not Otherwise Classified (NOC)
N/A

ICD-9 codes that Support Medical Necessity

293.39	Catatonic disorder, other
295.00-295.90	Schizophrenic disorders
296.00-296.99	Affective psychoses
297.00-297.90	Delusional disorders
333.82	Tardive Dyskinesia

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 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 a ICD-9 code(s) other than those listed above
- 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).
- Documentation not supporting medical necessity
- Inadequate or incomplete medical record documentation.
- Documentation not meeting the APA Task Force Report Recommendations as for the clinical setup, equipment and staff

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

Noncovered diagnosis
Any diagnosis not included in this policy.

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

Documentation requirements
On every case, an explanation of why is ECT being used is needed. This explanation must include failure with other modalities of treatment as well as positive response in the past to ECT, on the applicable cases. Similarly, when there is a medical condition that prevents the patient from using medications or when the patient is pregnant and medication use may be potentially dangerous to the fetus/conceptus, it has to be well documented in order to justify the therapy.

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 basis for decision
- OIG's Report on Medicare Reimbursement for Electroconvulsive Therapy, 2001.
- Kaplan & Sadock, Comprehensive Textbook of Psychiatry, 6th edition 1998.

- National Institute of Mental Health, *Consensus Study on ECT*, 1997
- American Psychiatric Association, *Task Force Report on ECT*, 1996
- Brattleboro Retreat Psychiatry Review, *ECT During Pregnancy*, 1996
- Health and Safety Code, *Electroconvulsive and other therapies*, 1993
- Diagnostic and Statistics Manual, 4th edition, 1994
- ICD-9-CM, 2002 and CPT-2002

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

Start date of comment period
06-14-02

Ending date of comment period
07-29-02

Start date of notice period
August 5, 2002

Revision history
N/A

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GGL-1809

Reembolso

CAMBIO EN EL CÓDIGO PARA *SODIUM HYALURONATE*

Los Centros de Servicios para Medicare y Medicaid implantaron el nuevo código de procedimiento *Q3030-SODIUM HYALURONATE, PER 20 TO 25 MG DOSE, FOR INTRA ARTICULAR INJECTION* efectivo a partir del 1 de julio de 2002 para reclamaciones con fecha de servicio. El código actual (J7316) para este medicamento se eliminó el 1 de julio de 2002 con un periodo de gracia de 90 días. Los proveedores deben someter la reclamación con uno de los dos códigos, no ambos a la misma vez.

Debido a limitaciones en el sistema, CMS no aceptará el nuevo código para pago hasta el 1 de octubre de 2002. Por tal razón, las reclamaciones por servicio sometidas con el código Q3030 serán denegadas hasta el 1 de octubre de 2002. Los proveedores podrán retener sus reclamaciones y someterlas utilizando el código Q3030 comenzando el 1 de octubre de 2002, o, pueden continuar sometiendo las reclamaciones con el código J7316 hasta el 30 de septiembre de 2002. De haber alguna diferencia en el pago de los códigos J7316 y Q3030, comenzando el 1 de octubre de 2002 los proveedores podrán comunicarse con el "carrier" y solicitar un ajuste para las reclamaciones con fechas de servicio desde el 1 de julio de 2002 hasta el 30 de septiembre de 2002.

Reimbursement

CODING CHANGES FOR SODIUM HYALURONATE

The Centers for Medicare & Medicaid Services (CMS) established a new payment code Q3030-SODIUM HYALURONATE, PER 20 TO 25 MG DOSE, FOR INTRA ARTICULAR INJECTION. *This code was effective July 1, 2002, for claims with dates of service on and after that date. The current code (J7316) for this drug was discontinued as of July 1, 2002 with a 90 day grace period. Providers should submit a claim with one code or the other, but not both.*

Due to system limitations, CMS will not be able to accept the new code for payment until October 1, 2002. Therefore, services submitted with the Q3030 will be denied until October 1, 2002. Providers may hold their claims and submit them using the Q3030 starting October 1, 2002. Or, they may continue to submit them using the J7316 through September 30, 2002. Should there be a payment differential between J7316 and Q3030, starting October 1, 2002, providers may contact their carrier and request that an adjustment be made for claims with dates of service from July 1, 2002, through September 30, 2002.

CR 2230/Transmittal AB-02-082/June 11, 2002/MM

Reembolso

ACTUALIZACION TRIMESTRAL PRECIOS DE MEDICAMENTOS

A continuación detallamos el procedimiento utilizado para la actualización trimestral de los precios de medicamentos. Incluimos además, una lista de códigos actualizados para este trimestre. Estas tarifas serán vigentes para facturas recibidas 30 días después de la fecha de emisión de este boletín.

Instrucciones para el Cómputo de Precios

Los medicamentos y productos biológicos se pagan a base del 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 productos biológicos se calculan de la siguiente manera:

- Para medicamentos o productos biológicos de una sola fuente, el AWP será igual al AWP del único producto existente.
- Para medicamentos o productos 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 producto 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 producto biológico.

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

Reimbursement

QUARTERLY PRICING UPDATE FOR DRUGS

The following is the procedure used for the drug pricing quarterly update. In addition, we include an updated list of codes for this quarter. These new fees will become effective for claims received 30 days after the emission date of this bulletin.

Methodology Used to Determine the Fees

Drugs and biological products 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 the Federal Register (63 FR 58849). Fees for drugs and biological products are calculated as follows:

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

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

Reembolso | Reimbursement

CÓDIGO *CODE*	TARIFA *FEE*	NO-PART *NON-PART*	CÓDIGO *CODE*	TARIFA *FEE*	NO-PART *NON-PART*
J0207	$427.33	$405.96	J2770	$105.10	$99.85
J0290	$1.84	$1.75	J2995	$126.67	$120.34
J0295	$8.21	$7.80	J3305	$142.50	$135.38
J0456	$24.68	$23.45	J3480	$0.21	$0.20
J0692	$8.13	$7.72	J7190	$0.96	$0.91
J0690	$3.06	$2.91	J9031	$174.62	$165.89
J0698	$10.45	$9.93	J9045	$135.97	$129.17
J0694	$9.91	$9.41	J9185	$311.12	$295.56
J0696	$14.91	$14.16	J9208	$161.34	$153.27
J0743	$15.86	$15.07	J9268	$1,926.60	$1,830.27
J0835	$16.74	$15.90	J9320	$120.46	$114.44
J0895	$14.81	$14.07	J9355	$54.93	$52.18
J1190	$199.22	$189.26	Q2019	$1,538.42	$1,461.50
J1438	$160.38	$152.36	Q2021	$131.95	$125.35
J2352	$145.82	$138.53	J9170	$328.34	$311.92
J2355	$256.63	$243.80	J9390	$99.28	$94.32
J2700	$3.18	$3.02	J9219	$5,399.80	$5,129.81
J2720	$1.00	$0.95			

CR 745/Transmittal AB-00-110/November 14, 2000/MM
Data Source: Red Book CD ROM/ July 2002

Reembolso

TARIFAS PARA VACUNAS CONTRA LA INFLUENZA

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

CÓDIGO *CODE*	DESCRIPCIÓN *DESCRIPTION*	TARIFA *FEE*
90657	Influenza virus vaccine, split virus, 6-35 months dosage for intramuscular or jet injection use	$4.15
90658	Influenza virus vaccine, split virus, 3 years and above dosage for intramuscular or jet injection use	$8.31

CÓDIGO *CODE*	DESCRIPCIÓN *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
CR 2190/TRANSMITTAL AB-02-084/June 20, 2002
Data Source: Red Book CD ROM/July, 2002

Reimbursement

INFLUENZA VACCINES FEES

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

ICD-9-CM DIAGNOSTIC CODES UPDATE

In accordance with instructions issued by the Centers for Medicare & Medicaid Services (CMS) physicians may begin using the updated ICD-9-CM codes for claims submitted on October 1, 2002 and thereafter. The new, revised and deleted ICD-9-CM codes have been posted at the Centers for Medicare and Medicaid Services (CMS) Web site at the following address: http://www.cms.hhs.gov/medlearn/icd9code.asp.

The update of the ICD-9-CM codes may be obtained at:

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

The old or new ICD-9-CM codes will be accepted from October 1, 2002 through December 31, 2002. Starting January 1, 2003, the updated codes must be used.

It is important that you use the most recent version of the ICD-9-CM coding book and code the highest level of specificity.

CR 2194/Transmittal AB-02-085/June 20, 2002/MM

Reembolso

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

Las siguientes pruebas de dispensa fueron aprobadas por la Administración Federal de Drogas y Alimentos bajo el *Clinical Laboratory Improvement Amendments (CLIA).* Los códigos CPT (Current Procedural Terminology) deben tener el modificador QW para que sean reconocidos como pruebas de dispensa.

Reimbursement

NEW TESTS TO THE WAIVED CERTIFICATE

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

NOMBRE DE LA PRUEBA ***TEST NAME***	**FECHA DE EFECTIVIDAD** ***EFFECTIVE DATE***	**CODIGO(S) CPT** ***CPT CODE(S)***
Enterix Insure Fecal Occult Blood Test	1-Jan-02	82274QW
Alatex Scientific Peace of Mind Multiple	21-Feb-02	80101QW
Metrika A 1c Now for Prescription Home Use (K020234)	8-Mar-02	83036QW
Metrika A 1c Now for Professional Use (K020235)	8-Mar-02	83036QW

CAMBIOS EN CÓDIGOS

Efectivo el 3 de junio de 2002, el código CPT para la prueba *Diagnostic Chemicals ImmunoDip Urinary Albumin Screen (Urine Dipstick)* cambió del código 82044QW al 83518QW.

Efectivo el 17 de junio de 2002 el código CPT para las pruebas *Boehringer Mannheim Chemstrip Micral* y *Roche Diagnostics Chemstrip Micral (Urine Dipstick)* cambió del código 82044QW al 83518QW ya que ambas pruebas utilizan metodología similar a la de Diagnostic Chemicals ImmunoDip Urinary Albumin Screen (Urine Dipstick).

CR 2263/Transmittal AB-02-091/July 2,2002/MM

CODING CHANGES

Effective June 3, 2002, the CPT code for the Diagnostic Chemicals ImmunoDip Urinary Albumin Screen (Urine Dipstick) has been changed from 82044QW to 83518QW.

Effective June 17, 2002, the CPT code for Boehringer Mannheim Chemstrip Micral and the Roche Diagnostics Chemstrip Micral (Urine Dipstick) has also been changed from 82044QW to 83518QW since both tests use methodology that is similar to the Diagnostic Chemicals ImmunoDip Urinary Albumin Screen (Urine Dipstick).

Reembolso

LISTA DE JURISDICCIÓN DE CÓDIGOS PARA EL 2002

A continuación la tabla A que incluye los códigos HCPCS que fueron añadidos o eliminados para el año 2002. La tabla B incluye todos los códigos correspondientes a equipo médico duradero, protésico, ortótico y suministros (DMEPOS) e indica el "carrier" que tiene la jurisdicción del procesamiento de los códigos. La tabla B indica, además, el "carrier" (local o regional) al cual se deberá facturar cada uno de los códigos y bajo qué circunstancias.

Reimbursement

2002 JURISDICTION LIST

The following Table A includes the HCPCS codes that have been added or deleted for the year 2002. Table B includes all codes for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and indicates which carrier (local or regional) has jurisdiction on the processing of the codes. Table B also indicates which carrier (local or regional) should be billed for each code and under what circumstances.

TABLA A / *TABLE A*

Nuevos Códigos / *New Codes*				
A4929	G0217	L0561	Q4017	V5255
A5509	G0218	L0986	Q4018	V5256
A5510	G0219	L1005	Q4019	V5257
A5511	G0220	L2768	Q4020	V5258
A6000	G0221	L3677	Q4021	V5259
A6010	G0222	L5301	Q4022	V5260
A9511	G0223	L5311	Q4023	V5261
B4086	G0224	L5321	Q4024	V5262
E0169	G0225	L5331	Q4025	V5263
E0221	G0226	L5341	Q4026	V5264
E0231	G0227	L5671	Q4027	V5265
E0232	G0228	L5847	Q4028	V5266
E0316	G0229	L5989	Q4029	V5267
E0481	G0230	L5990	Q4030	V5268
E0482	J0587	L6881	Q4031	V5269
E0603	J0692	L6882	Q4032	V5270
E0604	J0706	L8001	Q4033	V5271
E0620	J0744	L8002	Q4034	V5272
E0752	J1056	L8505	Q4035	V5273
E0754	J1270	L8507	Q4036	V5274
E0759	J1590	L8509	Q4037	V5275
E1500	J1655	L8510	Q4038	
E1637	J1755	P9045	Q4039	
E1638	J1835	P9046	Q4040	

Nuevos Códigos / *New Codes*				
A4929	G0217	L0561	Q4017	V5255
A5509	G0218	L0986	Q4018	V5256
A5510	G0219	L1005	Q4019	V5257
A5511	G0220	L2768	Q4020	V5258
A6000	G0221	L3677	Q4021	V5259
A6010	G0222	L5301	Q4022	V5260
A9511	G0223	L5311	Q4023	V5261
B4086	G0224	L5321	Q4024	V5262
E0169	G0225	L5331	Q4025	V5263
E0221	G0226	L5341	Q4026	V5264
E0231	G0227	L5671	Q4027	V5265
E0232	G0228	L5847	Q4028	V5266
E0316	G0229	L5989	Q4029	V5267
E0481	G0230	L5990	Q4030	V5268
E0482	J0587	L6881	Q4031	V5269
E0603	J0692	L6882	Q4032	V5270
E0604	J0706	L8001	Q4033	V5271
E0620	J0744	L8002	Q4034	V5272
E0752	J1056	L8505	Q4035	V5273
E0754	J1270	L8507	Q4036	V5274
E0759	J1590	L8509	Q4037	V5275
E1500	J1655	L8510	Q4038	
E1637	J1755	P9045	Q4039	
E1638	J1835	P9046	Q4040	

TABLA A / *TABLE A*

Códigos Eliminados / *Deleted Codes*				
A4329	A4919	E1592	J1930	L5300
A4650	A4920	E1594	J1970	L5310
A4655	A4921	E1630	J2240	L5320
A4700	A5064	E1635	J2330	L5330
A4705	A5074	E1640	J2350	L5340
A4735	A5075	E1900	J2480	L5667
A4780	A5502	J0340	J2512	L5669
A4790	A9160	J0400	J2640	P9018
A4800	A9170	J0510	J2675	P9042
A4820	A9190	J0590	J2860	Q0144
A4850	B4084	J0695	J2970	Q0156
A4880	B4085	J0730	J3080	Q0157
A4900	E0298	J0810	J3270	Q0160
A4901	E0609	J1090	J3390	Q0161
A4905	E0753	J1362	J3450	Q0185
A4910	E1510	J1690	J7315	Q2015
A4912	E1570	J1739	K0008	Q2016
A4914	E1590	J1741	K0013	Q3013

TABLA B / *TABLE B*

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

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

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4572	Rib Belt	DME REGIONAL Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	Local Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME Regional Carrier
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4646	Imaging Agent; Contrast Material	Local Carrier
A4647	Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4651 - A4929	Supplies for ESRD	DME REGIONAL Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosth
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosth
A5500 - A5511	Therapeutic Shoes	DME REGIONAL Carrier
A6000	Non-Contact Wound Warming Cover	DME REGIONAL Carrier
A6010 - A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A6025	Silicone Gel Sheet	DME REGIONAL Carrier
A6154 - A6406	Surgical Dressing	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
A7000 - A7020	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7501 - A7509	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier
A9270	Noncovered Items or Services	DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
A9901	Delivery	DME REGIONAL Carrier
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0116	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
E0176 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0241 - E0246	Bath and Toliet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0297	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier
E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heel Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0480	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0481	Intra-Pulmonary Percussive Ventilation System	DME REGIONAL Carrier
E0482	Cough Stimulating Device	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier
E0600	Suction Pump	DME REGIONAL Carrier
E0601	CPAP Device	DME REGIONAL Carrier
E0602 - E0604	Breast Pump	DME REGIONAL Carrier
E0605	Vaporizer	DME REGIONAL Carrier
E0606	Drainage Board	DME REGIONAL Carrier
E0607	Home Blood Glucose Monitor	DME REGIONAL Carrier
E0608	Apnea Monitor	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621 - E0635	Patient Lifts	DME REGIONAL Carrier
E0650 - E0673	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0690	Ultraviolet Cabinet	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0752	Implantable Nerve Stimulator Electrodes	Local Carrier
E0754	Patient Programmer for use with IPG	Local Carrier
E0755	Reflex Stimulator	DME REGIONAL Carrier
E0756 - E0759	Implantable Nerve Stimulator	Local Carrier
E0760	Ultrasonic Osteogenic Stimulator	DME REGIONAL Carrier
E0765	Nerve Stimulator	DME REGIONAL Carrier
E0776	IV Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier
E0830	Ambulatory Traction Device	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0930	Trapeze/Fracture Frame	DME REGIONAL Carrier
E0935	Passive Motion Exercise Device	DME REGIONAL Carrier
E0940	Trapeze Equipment	DME REGIONAL Carrier
E0941	Traction Equipment	DME REGIONAL Carrier
E0942 - E0945	Orthopedic Devices	DME REGIONAL Carrier
E0946 - E0948	Fracture Frame	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
E1353 - E1390	Additional Oxygen Related Equipment	DME REGIONAL Carrier
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier
E1405 - E1406	Additional Oxygen Equipment	DME REGIONAL Carrier
E1500 - E1699	Artificial Kidney Machines and Accessories	DME REGIONAL Carrier
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1840	Dynamic Flexion Devices	DME REGIONAL Carrier
E1902	Communication Board	DME REGIONAL Carrier
E2000	Gastric Suction Pump	DME REGIONAL Carrier
E2100 - E2101	Blood Glucose Monitors with Special Features	DME REGIONAL Carrier
G0001 - G9016	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7190 - J7192	Factor VIII	Local Carrier
J7193 - J7195	Factor IX	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7302	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7316 - J7320	Injection	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7340	Dermal and Epidermal - Tissue of Human Origin	Local Carriers
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
J7608 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7799	NOC, Other than Inhalation Drugs through DME	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemotherapeutic	DME REGIONAL Carrier
J8510 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0112 - K0116	Spinal Orthotics	DME REGIONAL Carrier
K0183 - K0189	Accessories for Positive Airway Pressure Devices	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0268	Humidifier	DME REGIONAL Carrier
K0415 - K0416	Antiemetic Drugs	DME REGIONAL Carrier
K0452	Wheelchair Bearings	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0460 - K0461	Power Add-on Converters for Wheelchairs	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0531	Accessory for Respiratory Assist Device	DME REGIONAL Carrier
K0532 - K0534	Respiratory Assist Device	DME REGIONAL Carrier
K0538 - K0540	Negative Pressure Wound Therapy Pump	DME REGIONAL Carrier
K0541 - K0547	Speech Generating Device	DME REGIONAL Carrier
K0548	Injection, Insulin Lispro	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
K0549 - K0550	Hospital Bed, Heavy Duty	DME REGIONAL Carrier
K0551	Risidual Limb Support System	DME REGIONAL Carrier
K0561 - K0580	Ostomy Devices and Supplies	DME REGIONAL Carrier
L0100 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME REGIONAL Carrier
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8490	Prosthetics	DME REGIONAL Carrier
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME REGIONAL Carrier
L8505	Artificial Larynx Accessory	DME REGIONAL Carrier
L8507 - L8510	Voice Prosthesis	DME REGIONAL Carrier
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted prosthetic device. If other, DME REGIONAL Carrier
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardiokymography	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0136	Injection, Epoetin Alpha	Local Carrier
Q0163 - Q0181	Anti-emetic	DME REGIONAL Carrier
Q0183 - Q0184	Artificial Skin	Local Carrier
Q0187	Factor VIIA	Local Carrier
Q1001 - Q1005	New Technology IOL	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3017	ALS Assessment	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q9920 - Q9940	Injection of EPO	DME REGIONAL Carrier when self-administered or for Method II beneficiaries, otherwise Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier

HCPCS	DESCRIPCIÓN / *DESCRIPTION*	JURISDICCIÓN / *JURISDICTION*
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME REGIONAL Carrier
V2781	Progressive Lens	DME REGIONAL Carrier
V2785	Processing--Corneal Tissue	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2799	Miscellaneous Vision Service	DME REGIONAL Carrier
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME REGIONAL Carrier
V5362 - V5364	Speech Screening	Local Carrier
Revised: February 2002		

CR 2051/Transmittal B-02-015/03-22-2002/MM

Reembolso

CLASIFICACIÓN PARA SERVICIOS DE TERAPIA NUTRICIONAL MÉDICA (MNT)

Este artículo aclara información publicada en el Medicare Informa, Volumen 69, página 48 sobre "Servicios de Terapia Nutricional Médica (MNT) Prestados por Dietistas Registrados o Profesionales de la Nutrición". La nueva información está identificada de la siguiente manera: los incisos/oraciones en letras*itálicas* en este artículo se fundamentan en la regulación final con fecha de efectividad al 1 de enero de 2002. Los incisos/oraciones en **letras negrillas** se fundamentan en la Determinación de la Cubierta Nacional y su fecha de efectividad será el 1 de octubre de 2002. El pago, Instrucciones para la Codificación de los Servicios, Información General sobre el Procesamiento de Reclamaciones y la Inscripción de Dietistas y Nutricionistas indicados en el artículo del Medicare Informa, volumen 69, página 48 continúan vigentes.

Trasfondo

La sección 105 de BIPA permite la cubierta por parte de Medicare de los servicios de terapia nutricional médica cuando estos son prestados por un dietista registrado o por un profesional de la nutrición siempre y cuando cumplan con ciertos requisitos. Este servicio es 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 referido para este servicio tendrá que hacerlo un médico certificado.* También permitirá, por primera vez, que Medicare reembolse directamente al dietista registrado o profesional de nutrición.

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 **es definido como el máximo de 3**

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ADDITIONAL CLARIFICATION FOR MEDICAL NUTRITION THERAPY (MNT) SERVICES

This article clarifies information published in the "Medicare Informa" Volume 69, page 48 on the "Medical Nutrition Therapy (MNT) Services Rendered by Registered Dietitians or Nutrition Professionals". The new information is identified as follows: the *italicized* items in this article are based on the final regulation that was effective January 1, 2002**.** The items in **bold** are from the National Coverage Determination (NCD) and are effective October 1, 2002. The Payment, Instruction for Use of the Medical Nutrition Codes, General Claims Processing Information and Enrollment of Dietitians and Nutritionists mentioned in the Medicare Informa, volume 69, page 48 are in effect.

Background

Section 105 of BIPA permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional who meet certain requirements. This service is available to 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). *Non-physician practitioners cannot make referrals for this service*. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time.

The benefit consists 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 **is defined as a maximum of 3 hours that may be reimbursed in the initial episode of care. In subsequent years, beneficiaries may**

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horas que pueden ser reembolsadas en el episodio de cuidado inicial. En los años subsiguientes, los beneficiarios podrán recibir 2 horas de MNT con el referido de un médico. El número de horas cubiertas para diabetes es igual al número de horas cubiertas para la condición renal.

Para propósitos de este servicio, condición renal significa: insuficiencia renal crónica; *enfermedad renal terminal donde el paciente no está recibiendo diálisis; y la condición médica de un beneficiario por 36 meses después de un trasplante de riñón*. Insuficiencia renal crónica significa una reducción en la función renal no tan severa que requiera diálisis o trasplante (velocidad de filtración glomerular, GFR, por sus siglas en ingles 13-50 ml/min/1.73m²). Diabetes se define como: diabetes mellitus Tipo 1 (condición de autoinmunidad que destruye las células beta del páncreas, causando una deficiencia de insulina), Tipo 2 (hipoglucemia familiar) *y diabetes del embarazo. Diabetes del embarazo es cualquier grado de intolerancia a glucosa con el comienzo del embarazo o durante el mismo.* 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's 2000 Report, The Role of Nutrition in Maintaining Health in the Nation's Elderly."

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 según descrito en este artículo. *El médico de cabecera es el médico de cuidado primario o el especialista de cuidado coordinado para el beneficiario con diabetes o condición renal.*
- El número de horas cubiertas en un episodio de cuidado no puede sobrepasar el límite permitido excepto si el médico de cabecera envía un segundo referido.
- Los servicios pueden prestarse individualmente o en grupo sin restricciones;

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receive 2 hours of MNT with a physician referral. The number of hours covered for diabetes is the same as the number of hours covered for renal disease.

For purposes of this service, renal disease means chronic renal insufficiency, *end-stage renal disease when the patient is not receiving dialysis; and the medical condition of a beneficiary for 36 months after a kidney transplant*. 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/1.73m²). Diabetes is defined as: diabetes mellitus Type 1 (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency), Type 2 (familial hyperglycemia), *and gestational diabetes. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy*. 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's 2000 Report, The Role of Nutrition in Maintaining Health in the Nation's Elderly.

General Conditions of Coverage

The general conditions for coverage are the following:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease as described in this article. *A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease*.
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;
- Services may be provided either on an individual or group basis without restrictions;

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- **Para los beneficiarios con un diagnóstico de diabetes, los servicios de Adiestramientos de Automanejo de la Diabetes (DSMT por sus siglas en inglés) y Terapia Nutricional Médica (MNT por sus siglas en inglés) pueden prestarse dentro de un mismo período. El número máximo de horas permitidas bajo la cubierta de cada servicio se reembolsará. La única excepción es que el DSMT y el MNT no pueden prestarse el mismo día al mismo beneficiario. Un beneficiario con un diagnóstico de diabetes que ha recibido DSMT y se le diagnostica una condición renal durante el mismo episodio de cuidado, puede recibir los servicios MNT con un cambio de la condición médica, diagnóstico o tratamiento según establecido en el 42 CFR 410.132(b)(5).**
- Sólo un dietista registrado o un profesional de la nutrición podrá prestar los servicios de MNT.

Limitaciones de Cubierta

Las siguientes limitaciones aplican:

- Los servicios de MNT para beneficiarios que reciben tratamiento de diálisis, para los cuales se paga según la §1881 del Acta, no están cubiertos.
- **Un beneficiario no puede recibir MNT y DSMT el mismo día.**

Referidos

Sólo el médico que ofrece los servicios al beneficiario con un diagnóstico de diabetes o condición renal, según definido en este artículo y con documentación existente en el récord médico del beneficiario, puede hacer el referido. 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 número de UPIN del médico que refiere debe aparecer en la forma HCFA-1500 sometida por el dietista registrado o el profesional de nutrición. Las reclamaciones que no tengan el número de UPIN del médico que refiere serán devueltas.

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- **For a beneficiary with a diagnosis of diabetes, Diabetes Self-management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit is covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment as stated in 42 CFR 410.132(b)(5).**
- MNT services must be provided by a registered dietitian or nutrition professional.

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.
- **A beneficiary may not receive MNT and DSMT on the same day.**

Referrals

Referrals may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease as defined in this PM with documentation maintained by the referring physician 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 UPIN number of the referring physician must be on the HCFA-1500 claim form (Items 17 & 17a) submitted by a registered dietitian or nutrition professional. Claims that do not have the UPIN number of the referring physician will be returned.

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Horas Adicionales Cubiertas para Servicios MNT

Horas adicionales para servicios de MNT pueden ser cubiertas más allá del límite de horas típicamente cubiertas bajo un episodio de cuidado cuando el médico de cabecera determina que hay un cambio en diagnóstico o condición médica dentro del episodio de cuidado que requiere un cambio en la dieta. Las revisiones médicas se realizarán durante el periodo de postpago. Servicios fuera de lo antes establecido, pueden ser evaluados con los protocolos dietéticos y nutricionales aceptados nacionalmente de acuerdo con la Sección 42 CFR 410.132(a).

Estándares Profesionales para Dietistas y Nutricionistas

Para cubierta de MNT bajo Medicare Parte B, sólo un dietista registrado o profesional de nutrición podrá proveer los servicios. "Dietista registrados o profesional de nutrición" significa un dietista o nutricionista licenciado al 21 de diciembre de 2000. Deberá someter junto a la forma CMS 855I los siguientes documentos:

- Diploma
- Certificado de "Good Standing" del Departamento de Salud
- Licencia
- Certificado negativo de Antecedentes Penales

Aquel individuo licenciado después del 21 de diciembre de 2000 deberá, además, someter la siguiente evidencia:

- Grado de bachillerato o un grado mayor otorgado por un colegio acreditado o universidad del estado (o un grado extranjero equivalente) que indique que ha completado los requisitos académicos de un programa de nutrición o dietética, acreditado por la organización nacional que se reconozca para estos propósitos. *Los requisitos académicos del programa de nutrición o dietética pueden ser completados después de terminar el grado.*

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Additional Covered Hours for MNT Services

Additional hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a postpayment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

Professional Standards for Dietitians and Nutritionists

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional," means a dietitian or nutritionist licensed or certified as of December 21, 2000 who should submit along with Form CMS 855I the following information:

- Diploma
- Certificate of Good Standing of the Department of Health
- License
- Certificate of a Non-Previous Criminal Record

Those individuals licensed after December 21, 2000 should submit in addition to the above-mentioned requirements 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. *The academic requirements of a nutrition or dietetics program may be concluded after the completion of the degree.*

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- Documentación de haber completado por lo menos 900 horas de práctica dietética supervisada por un dietista registrado o profesional de nutrición. La documentación de la práctica supervisada puede ser un documento firmado por el profesional/facilidad que ha supervisado al individuo.

CR 2142/Transmittal AB-02-059/May 1, 2002/MM/els

Reimbursement

- Documentation of having finished at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual.

AJUSTE A LOS ÉDITOS PARA LA FACTURACIÓN CONSOLIDADA DE ENFERMERIA ESPECIALIZADA (SNF CB POR SUS SIGLAS EN INGLÉS)

Efectivo el 1 de abril de 2002 se implantaron éditos para identificar los códigos HCPCS de ambulancia que están sujetos o excluídos de la Facturación Consolidada para la Facilidad de Enfermería Especializada (SNFCB por sus siglas en inglés). En esa ocasión se establecieron éditos para denegar los servicios de ambulancia facturados por separado de la facturación consolidada para beneficiarios cuya estadía en la Facilidad de Enfermería Especializada estaba cubierta por la Parte A. Desde la implantación de estos nuevos éditos se identificaron más códigos HCPCS de ambulancia y servicios auxiliares que fueron inadvertidamente omitidos de esta directríz.

Desde el 22 de agosto de 2002, los siguientes códigos HCPCS están sujetos a los éditos para el SNFCB: A0999, A0382, A0384, A0392, A0394, A0396, A0398, A0420, A0422, A0424, Q3019 y Q3020. Estos códigos serán denegados con el ANSI Code 109 cuando sean sometidos con modificador 'NN' y el beneficiario se encuentre en una estadía de SNF cubierta por la Parte A. Además, los éditos

ADJUSTMENT TO EDITS FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

Edits were implemented effective April 1, 2002 to identify HCPCS codes for ambulance services that were either subject to or excluded from SNF CB. This coding change added SNF CB edits to deny payment of some separately billed ambulance services for beneficiaries in a SNF Part A covered stay. Since the implementation of the edits for the separately billed codes, CMS has identified additional HCPCS codes for ambulance and ancillary services that were inadvertently omitted from this update.

On August 22, 2002, the HCPCS codes A0999, A0382, A0384, A0392, A0394, A0396, A0398, A0420, A0422, A0424, Q3019, and Q3020 were added to the list of codes subject to SNF CB. These codes will be denied with ANSI Code 109 when submitted with an "NN" modifier for a beneficiary in a Part A covered stay. Nonetheless, payment for claims with modifiers other than "NN" when a beneficiary is in a Part A stay and, for claims submitted with an "NN" modifier when the beneficiary is not in a Part A stay will be properly processed.

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permitirán el pago de reclamaciones por transporte en ambulancia que tengan un modificador distinto a "NN" y que la estadía del beneficiario esté cubierta por la Parte A o reclamaciones sometidas con modificador 'NN' y que la estadía del beneficiario no esté cubierta por la Parte A.

Es posible que algunas reclamaciones con un modificador distinto a 'NN' para el beneficiario en estadía cubierta por la Parte A o con el modificador 'NN' para un beneficiario en una estadía no cubierta por la Parte A se hayan procesado incorrectamente. Las reclamaciones posiblemente afectadas son: aquellas con las fechas de servi cio del 1 de abril de 2001 al 22 de agosto de 2002 con los códigos 'A' previamente indicados o las reclamaciones procesadas con fechas de servicio del 1 de abril de 2002 al 22 de agosto de 2002 para los códigos Q3019 o Q3020.

Si conforme a lo antes expuesto, usted entiende que sus reclamaciones fueron procesadas incorrectamente, deberá proceder a resometer las mismas. Las reclamaciones enviadas posterior al 23 de agosto de 2002 se procesarán correctamente.

JSM (CI-1688, 8-23-2002) IC/els/dg

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There is a possibility of incorrect processing of claims submitted with these HCPCS codes for beneficiaries in a Part A covered SNF stay, and for claims submitted with the "NN" modifier when the beneficiary is not in a Part A stay. The claims that might be affected include those submitted with the "A" HCPCS codes listed in this article with dates of service between April 1, 2001 and August 22, 2002, and claims submitted with HCPCS codes Q3019 or Q3020 with dates of service between April 1, 2002 and August 22, 2002.

If you feel that your claims were incorrectly processed you should proceed to resubmit them. New claims submitted August 23, 2002 and thereafter, will be processed correctly.

FACTURACIÓN CONSOLIDADA PARA FACILIDADES DE ENFERMERIA ESPECIALIZADA:
ACTUALIZACIÓN DE CÓDIGOS

Los archivos de codificación de la Facturación Consolidada para Facilidades de Enfermería Especializada en el "website" de CMS www.hcfa.gov/medlearn.refsnf.htm se actualizaron para reflejar correcciones y cambios en la política. En la siguiente tabla le proveemos los cambios que están en vigor desde abril de 2002.

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB):
UPDATE TO CODING FILES

The SNF CB coding files on the CMS Web site at www.hcfa.gov/medlearn/refsnf.htm were updated to reflect a number of corrections and policy changes. The following table reflects these code changes which are in effect since April 2002.

UPDATE TO CODING FILES					
Added to file: Part A Stay, Always Submit to Carrier/DMERC					
A4651	A4709	A4725	A4911	G0124	
A4652	A4719	A4726	A4928	G0141	
A4656	A4720	A4736	A4929	G0245	
A4657	A4721	A4737	E1500	G0246	
A4706	A4722	A4766	E1637	G0247	
A4707	A4723	A4801	E1638	P3001	
A4708	A4724	A4802	E1639	V5299	
Removed from file: Part A Stay, Always Submit to Carrier/DMERC					
G0117	G0197	83020	86255	87207	96003
G0118	G0198	83912	86256	88371	97601
G0121	G0199	84165	86320	88372	
G0193	G0200	84181	86325	89060	
G0194	G0201	84182	86327	95833	
G0195	J3370	85390	86334	95834	
G0196	L5669	85576	87164	96002	
Added to file: Part A Stay, Only Submit to Carrier with a 26 Modifier					
G0131	83912	86256	88371		
G0132	84165	86320	88372		
76075	84181	86325	89060		
76977	84182	86327	93770		
78890	85390	86334	94150		
78891	85576	87164			
83020	86255	87207			
Added to file: Part B stay only, Always Consolidated					
G0193	G0200	96003			
G0194	G0201	97601			
G0195	95833				
G0196	95834				
G0197	96000				
G0198	96001				
G0199	96002				

CR2085/Transmittal AB-02-035/March 21, 2002/IC

Reembolso

CÓDIGO DE MEDICAMENTOS NO CLASIFICADOS – J3490

Los siguientes medicamentos inyectables no tienen un código establecido por CMS. Sin embargo, se podrán facturar a Medicare utilizando el código J3490 (Unclassified Drugs).

Para facturar estos medicamentos es necesario que se indique en la reclamación, en el encasillado 19 del formulario CMS 1500 (antes conocido como HCFA 1500) o su equivalente en el formato NSF de facturación electrónica, la siguiente información:

a. Nombre del Medicamento

b. Concentración y dosis administrada

Rev. 07/2002/mm

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UNCLASIFIED DRUGS CODE J3490

The following injectable medications do not have a billing code established by the CMS. Nevertheless, Medicare can be billed for these medications using code J3490 (Unclassified Drugs).

Drug/Medicamento	Dosage/Dósis	Fee/Tarifa
Cimetidine(Tagamet)	300mg/ml	$ 2.85
Famotidine (Pepcid)	10mg/ml	$ 1.95
Verapamil HCL (Isoptin)	5mg/2ml	$ 2.13
Nitroglycerin (Tridil)	5mg/ml	$ 1.52
Aranesp	25mcg	$ 118.46
Aranesp	40mcg	$ 189.53
Aranesp	60mcg	$ 284.29
Aranesp	100mcg	$ 473.81
Aranesp	200mcg	$ 947.63
Zometa (Zoledronic Acid)	4 mg	$ 813.56

When you submit a claim for any of these drugs, it is necessary that you specify on claim form CMS1500 (previously known as HCFA 1500) in Block 19 or the equivalent in the NSF format for electronic claims the following information:

a. Name of the drug

b. Concentration and administered dosage

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ÚLTIMA ACTUALIZACIÓN DE LAS TARIFAS FIJAS PARA MÉDICOS EN EL 2002

Los Centros para Servicios de Medicare y Medicaid notificó sobre la actualización final de las tarifas fijas para médicos (MPFSD por sus siglas en inglés) en el 2002.

Conforme a la Parte 3, §15902 del Manual de Medicare los cambios serán efectivos para reclamaciones con fechas de servicio del 1 de enero de 2002 a menos que se indique otra fecha en el artículo. La implantación de los cambios será efectiva el 7 de octubre de 2002.

Los cambios incluidos en la última actualización del MPFSDB son los siguientes:

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FINAL UPDATE TO THE 2002 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

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

In accordance with the Medicare Carriers Manual Part 3 §15902, unless otherwise stated in this article, changes will be effective for claims with dates of service January 1, 2002, or later. The implementation of these changes will be October 7, 2002.

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

A4206	Procedure Status = B
A4207	Procedure Status = B
A4208	Procedure Status = B
A4209	Procedure Status = B
A4213	Procedure Status = B
A4214	Procedure Status = B
A4215	Procedure Status = B
A9502	Procedure Status = E
A9504	Procedure Status = E
A9507	Procedure Status = E
A9508	Procedure Status = E
A9510	Procedure Status = E
A9511	Procedure Status = E
A9600	Procedure Status = E
A9605	Procedure Status = E
A9700	Procedure Status = E

G0245 FYI – The corrected long descriptor of HCPCS code G0245 will read:

Initial physician evaluation *and management* of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) that must include:

1. The diagnosis of LOPS.
2. A patient's history.
3. A physical examination that consists of at least the following elements:

    (a) Visual inspection of the forefoot, hind foot, and toe web spaces,

    (b) Evaluation of protective sensation,

    (c) Evaluation of foot structure and biomechanics,

    (d) Evaluation of vascular status and skin integrity, and

    (e) Evaluation and recommendation of footwear,

4. Patient education.

G0246 FYI – The corrected long descriptor of HCPCS code G0246 will read:

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

1. A patient's history
2. A physical examination that includes:

    (a) Visual inspection of the forefoot, hind foot, and toe web spaces,

    (b) Evaluation of protective sensation,

    (c) Evaluation of foot structure and biomechanics,

    (d) Evaluation of vascular status and skin integrity, and

    (e) Evaluation and recommendation of footwear,

3. Patient education.

G0247 Global Period = ZZZ

Effective Date: Effective for services performed on or after July 1, 2002

G0248	Facility PE RVU = 3.06
G0248	Non-Facility PE RVU = 3.06
G0249	Facility PE RVU = 3.28
G0249	Non-Facility PE RVU = 3.28
G0250	Facility PE RVU = 0.06
G0250	Non-Facility PE RVU = 0.06

CPT Code:	G0252	G0252	G0252
Short Desc:	PET Imaging Initial dx		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	1.50	0.00
Fac PE RVU:	0.00	0.60	0.00
Non-Fac PE RVU:	0.00	0.60	0.00
MP RVU:	0.00	0.04	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	09
No Rel Code:	0	0	0
TOS:	4	4	4

Effective Date: Effective for services performed on or after October 1, 2002

CPT Code:	G0253	G0253	G0253
Short Desc:	PET image brst dection recur		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	1.50	0.00
Fac PE RVU:	0.00	0.60	0.00
Non-Fac PE RVU:	0.00	0.60	0.00
MP RVU:	0.00	0.04	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	09
No Rel Code:	0	0	0
TOS:	4	4	4

Effective Date: Effective for services performed on or after October 1, 2002

CPT Code:	G0254	G0254	G0254
Short Desc:	PET image brst eval to tx		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	1.50	0.00
Fac PE RVU:	0.00	0.60	0.00
Non-Fac PE RVU:	0.00	0.60	0.00
MP RVU:	0.00	0.04	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	09
No Rel Code:	0	0	0
TOS:	4	4	4

Effective Date: Effective for services performed on or after October 1, 2002

CPT Code:	G0255	G0255	G0255
Short Desc:	Sensory nerve conduct test		
Mod:		26	TC
ProcStat:	N	N	N
RVU Work:	0.00	1.50	0.00
Fac PE RVU:	0.00	0.60	0.00
Non-Fac PE RVU:	0.00	0.60	0.00
MP RVU:	0.00	0.04	0.00
PC/TC:	1	1	1
SOS:	9	9	9
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	9	9	9
Bilt Surg:	9	9	9
Asst Surg:	9	9	9
Co Surg:	9	9	9
Team Surg:	9	9	9
Bill Med:	9	9	9
Diag Supv:	09	09	01
No Rel Code:	9	9	9
TOS	4	4	4

Effective Date: Effective for services performed on or after October 1, 2002

J7316	Procedure Status = G
CPT Code:	Q3030
Short Desc:	Sodium hyaluronate injection
Mod:	
ProcStat:	E
RVU Work:	0.00
Fac PE RVU:	0.00
Non-Fac PE RVU:	0.00
MP RVU:	0.00
PC/TC:	9
SOS:	9
Global:	XXX
Pre-Op:	0.00
Intra-Op:	0.00
Post-Op:	0.00
Mult Surg:	9
Bilt Surg:	9
Asst Surg:	9
Co Surg:	9
Team Surg:	9
Bill Med:	9
Diag Supv:	09
No Rel Code:	9
TOS:	1, P

Bilateral Surgery Indicator Changes

20526	Bilateral Surgery Indicator = 1
24300	Bilateral Surgery Indicator = 1
24332	Bilateral Surgery Indicator = 1
25259	Bilateral Surgery Indicator = 1
25275	Bilateral Surgery Indicator = 1
25430	Bilateral Surgery Indicator = 1
25651	Bilateral Surgery Indicator = 1
25652	Bilateral Surgery Indicator = 1
25671	Bilateral Surgery Indicator = 1
26340	Bilateral Surgery Indicator = 1
29824	Bilateral Surgery Indicator = 1
36002	Bilateral Surgery Indicator = 1
36533	Bilateral Surgery Indicator = 1
36534	Bilateral Surgery Indicator = 1
36535	Bilateral Surgery Indicator = 1
36820	Bilateral Surgery Indicator = 1
37208	Bilateral Surgery Indicator = 1
38220	Bilateral Surgery Indicator = 1
38221	Bilateral Surgery Indicator = 1
61862	Bilateral Surgery Indicator = 1
61880	Bilateral Surgery Indicator = 1
61885	Bilateral Surgery Indicator = 1
61888	Bilateral Surgery Indicator = 1
63043	Bilateral Surgery Indicator = 1
63044	Bilateral Surgery Indicator = 1
64821	Bilateral Surgery Indicator = 1
64822	Bilateral Surgery Indicator = 1
64823	Bilateral Surgery Indicator = 1
69300	Bilateral Surgery Indicator = 1
75685	Bilateral Surgery Indicator = 3
75685 – TC	Bilateral Surgery Indicator = 3
75685 – 26	Bilateral Surgery Indicator = 3

0005T	Bilateral Surgery Indicator = 1
0006T	Bilateral Surgery Indicator = 1
0007T	Bilateral Surgery Indicator = 1
0012T	Bilateral Surgery Indicator = 1
0013T	Bilateral Surgery Indicator = 1
0014T	Bilateral Surgery Indicator = 1
0016T	Bilateral Surgery Indicator = 1
0017T	Bilateral Surgery Indicator = 1
0020T	Bilateral Surgery Indicator = 1

76012 FYI—In the 2001 Medicare Physician Fee Schedule Database the PC/TC indicator was inadvertently changed from a '1' to a '2' for CPT code 76012, and the related professional and technical portions of this service were deleted. The PC/TC indicator has subsequently been changed back to a '1' and the professional and technical portions of CPT code 76012 have been reinstated effective January 1, 2002.

CPT Code:	76012	76012	76012
Short Desc:	Percut vertebroplasty fluor		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	1.31	0.00
Fac PE RVU:	0.00	0.49	0.00
Non-Fac PE RVU:	0.00	0.49	0.00
MP RVU:	0.00	0.23	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	03
No Rel Code:	0	0	0

76013 FYI—In the 2001 Medicare Physician Fee Schedule Database the PC/TC indicator was inadvertently changed from a '1' to a '2' for CPT code 76013, and the related professional and technical portions of this service were deleted. The PC/TC indicator has subsequently been changed back to a '1' and the professional and technical portions of CPT code 76013 have been reinstated effective January 1, 2002.

CPT Code:	76013	76013	76013
Short Desc:	Percut vertebroplasty, ct		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	1.38	0.00
Fac PE RVU:	0.00	0.52	0.00
Non-Fac PE RVU	0.00	0.52	0.00
MP RVU:	0.00	0.48	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	03
No Rel Code:	0	0	0

75952 FYI—In the 2001 Medicare Physician Fee Schedule Database the PC/TC indicator was inadvertently changed from a '1' to a '2' for CPT code 75952, and the related professional and technical portions of this service were deleted. The PC/TC indicator has subsequently been changed back to a '1' and the professional and technical portions of CPT code 75952 have been reinstated effective January 1, 2002.

CPT Code:	75952	75952	75952
Short Desc:	Endovasc repair abdom aorta		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	4.00	0.00
Fac PE RVU:	0.00	1.60	0.00
Non-Fac PE RVU:	0.00	1.60	0.00
MP RVU:	0.00	0.68	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	03
No Rel Code:	0	0	0

75953 FYI—In the 2001 Medicare Physician Fee Schedule Da the PC/TC indicator was inadvertently changed from a '1' to a CPT code 75953, and the related professional and technical port this service were deleted. The PC/TC indicator has subsequentl changed back to a '1' and the professional and technical porti CPT code 75953 have been reinstated effective January 1, 2002.

CPT Code:	75953	75953	75953
Short Desc:	Abdom aneurysm endovas rpr		
Mod:		26	TC
ProcStat:	C	A	C
RVU Work:	0.00	1.36	0.00
Fac PE RVU:	0.00	0.54	0.00
Non-Fac PE RVU:	0.00	0.54	0.00
MP RVU:	0.00	0.68	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	03
No Rel Code:	0	0	0

76075	Short Descriptor: Dual energy x-ray study
76075 – TC	Short Descriptor: Dual energy x-ray study
76075 – 26	Short Descriptor: Dual energy x-ray study

CPT Code:	78459	78459	78459
Short Desc:	Heart muscle imaging (PET)		
Mod:		26	TC
ProcStat:	C	R	C
RVU Work:	0.00	1.50	0.00
Fac PE RVU:	0.00	0.60	0.00
Non-Fac PE RVU:	0.00	0.60	0.00
MP RVU:	0.00	0.04	0.00
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	01
No Rel Code:	0	0	0

Effective Date: Effective for services performed on or after October 1, 2002

78478	Global Period = XXX
78478 – TC	Global Period = XXX
78478 – 26	Global Period = XXX

78480	Global Period = XXX
78480 – TC	Global Period = XXX
78480 – 26	Global Period = XXX

92270	Diagnostic Supervision = 01
92270 – TC	Diagnostic Supervision = 01
92275	Diagnostic Supervision = 01
92275 – TC	Diagnostic Supervision = 01
92285	Diagnostic Supervision = 01
92285 – TC	Diagnostic Supervision = 01
92286	Diagnostic Supervision = 01
92286 – TC	Diagnostic Supervision = 01

PROCESSING INDICATORS DEFINITIONS

Procedure Status

A = ACTIVE CODE

B = BUNDLED

C = CARRIER PRICE

E = EXCLUDED FROM PHYSICIAN FEE SCHEDULE BY REGULATION

R = RESTRICTED COVERAGE. SPECIAL COVERAGE INSTRUCTIONS APPLY.

N = NON COVERED SERVICE

G = CODE IS NOT VALID FOR MEDICARE PURPOSES

BILATERAL SURGERY INDICATOR

1= 150% PAYMENT ADJUSTMENT FOR BILATERAL

GLOBAL PERIOD

ZZZ = THE CODE IS BILLED WITH ANOTHER CODE WHICH HAS BEEN ASSIGNED A NUMERICAL GLOBAL VALUE.

XXX = GLOBAL CONCEPT DOES NOT APPLY

DIAGNOSTIC SUPERVISION

01 = PROCEDURE MUST BE PERFORMED UNDER THE GENERAL SUPERVISION OF A PHYSICIAN

PC/TC INDICATOR

1 = DIAGNOSTICS TESTS OR RADIOLOGY SERVICES. THE CODES GENERALLY HAVE BOTH A PROFESSIONAL AND TECHNICAL COMPONENT.

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 incluye 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 los 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" como "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 la lista de los proveedores reintegrados al Programa Medicare y en la siguiente página la lista de los proveedores que han sido excluídos del 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 en el programa Medicare
Providers Reinstated in the Medicare Program

NOMBRE *NAME*	DIRECCION *ADDRESS*	FECHA EFECTIVIDAD *EFFECTIVE DATE*
Capó Fernández, Yolanda	Plaza Vega Baja Pearl Vission Express Vega Baja, PR 00693	January 15, 2002
Rosado Montalvo, Héctor	Ponce Plaza Alfonso XII - Int. Isabel St. Ponce, PR 00731	August 23, 2002

Proveedores Excluídos del Programa Medicare

Providers Excluded from the Medicare Program

NOMBRE *NAME*	DIRECCION *ADDRESS*	PERIODO DE EXCLUSION *PERIOD OF EXCLUSION*	FECHA EFECTIVIDAD *EFFECTIVE DATE*
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
Stella, Edgar	513 Street Tintillo Hills Bayamón, PR 00966	20 years	January 29, 1986
Rivera Cruz, Carlos	205 Lauro Piñero Ave. Ceiba, PR 00735	Indefinite	December 20, 1999
Moreno Torres, Edwin	134 Calle José I. Quinton Coamo, PR 00769	5 years	December 20, 1998
Mercado Franci, José A.	Villa Clarita 2 6 St. # 46 Fajardo, PR 00738	Indefinite	August 20, 2000
Texidor Sánchez, Carmen I.	25 St. - Z-19 Rio Verde Caguas, PR 00725	Indefinite	August 20, 2000
Rutkowski Whitehead, Morris E.	371 San Jorge St. Santurce, PR 00912	Indefinite	July 14, 1993
Arce Forestier, Nestor	3 Muñoz Rivera St. Camuy, PR 00627	Indefinite	August 20, 1998
Francis Ambulance	99 Manolo Flores St. Fajardo, PR 00738	Indefinite	August 20, 2000
Rivera López, Aixa	Pearl Vision 52-E José De Diego St. Cayey, PR 00736	Indefinite	September 20, 2000
Pérez Cuevas, Reynaldo	Centro Visual de Florida Florida, PR 00650	Indefinite	October 19, 2000
Arrillaga, Abenamar	Ext. Hermanas Davila 23 - J St. Bayamón, PR 00959	20 years	May 18, 2000
Kutcher Olivo, Roberto	Calle Betances 80 Canóvanas, PR 00629	Indefinite	March 20, 2001
Grana Díaz, Roberto	Urb Sagrado Corazón 1616 Calle Sta Eduviges San Juan, PR 00926	Indefinite	May 20, 2001
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
Caro Acevedo, Eduardo	Santa Rosa Mall Suite 201 Segundo Nivel Bayamon, PR 00959	Indefinite	March 20, 2002
Montañez López, Carlos W.	Optica Marbella Carr. 107 Km 1 Aguadilla, PR 00603	Indefinite	March 20, 2002
Olivari Milan, Jose A.	Bo. Miradero Carr. 102 Km 19 HM 2 Cabo Rojo, PR 00623	Indefinite	April 18, 2002
Vigo Sierra, Myrna L.	Bo. Miradero Carr. 102 Km 19 HM 2 Cabo Rojo, PR 00623	Indefinite	April 18, 2002
Santini Olivieri, Francisco A.	4 Calle Hostos Juana Diaz, PR 00795	Indefinite	April 18, 2002
Davila Aponte, Wanda E	63 Calle Nogal Monte Casino Toa Alta, PR 00953	Indefinite	May 20, 2002
Yemat Perez, Alex A.	Barrio Obrero 2041 Calle Borinquen Santurce, PR 00907	Indefinite	May 20, 2002
Alvarez Valentin, Mario	Urb. Valencia 1 52 Calle Pedro Cruz-Marg Juncos, PR 00777	Indefinite	July 18, 2002

Relaciones con la Comunidad

PROCEDIMIENTOS SUJETOS A FACTURACIÓN CONSOLIDADA DE SERVICIOS DE SALUD EN EL HOGAR

CMS determinó como necesaria actualizar trimestrales a las listas de códigos HCPCS sujetos a facturación consolidada para servicios de salud en el hogar. Estas actualizaciones incluyen los códigos HCPCS temporeramente (códigos de 'K') creados durante el transcurso del año, que puedan describir servicios sujetos a la facturación consolidada. Por ejemplo, códigos creados a petición de los "carriers" regionales del equipo médico duradero (DMERCs) para reflejar nuevas tecnologías o para clarificar la codificación de sus políticas de revisión.

Actualización Actual

Esta actualización refleja un nuevo sistema de los códigos de ' K ' para los suplidos de ostomía que fueron publicadas en nuestro boletín Medicare Informa de abril a junio de de 2001. Los siguientes nuevos códigos ' K ' substituyen códigos actualmente en la lista de códigos sujetos a facturación consolidada para servicios salud en el hogar. Observe que cada dos nuevos códigos en la lista siguiente substituyen el mismo código eliminado.

Community Relations

PROCEDURES SUBJECT TO HOME HEALTH CONSOLIDATED BILLING

CMS has determined the need for quarterly updates to the list of HCPCS codes subject to Home Health Consolidated Billing. These updates include temporary HCPCS codes ('K' codes) created throughout the course of a year, which may describe services subject to consolidated billing. For example, such codes may be created at the request of Durable Medical Equipment Regional Carriers (DMERCs) to reflect new technologies or clarify coding in support of local medical review policies.

Current Update

The current update reflects a new set of 'K' codes for ostomy supplies, which were published in our April to June 2001 Medicare Informa bulletin. The following new 'K' codes replace codes currently on the HH consolidated billing code list. The deleted code is replaced by two new codes.

TABLA 1 / *TABLE 1*

New Code and Description	Deleted Code and Description
K0561: Non-pectin based ostomy paste	A4370: Skin barrier paste per oz
K0562: Pectin based ostomy paste	A4370: Skin barrier paste per oz
K0563: Ext wear ost skn barr <4sq"	A4374: Skin barrier extended wear
K0564: Ext wear ost skn barr >4sq"	A4374: Skin barrier extended wear
K0565: Ost skn barr w flng <4sq"	A4386: Ost skn barrier w flng ex wr
K0566: Ost skn barr w flng >4sq"	A4386: Ost skn barrier w flng ex wr
K0567: 1 pc drainable ost pouch	A5061: Pouch drainable w barrier at
K0568: 1 pc cnvx drainabl ost pouch	A5061: Pouch drainable w barrier at
K0570: Ostomy skn barr w flng <4sq"	A5123: Skin barrier with flange
K0571: Ostomy skn barr w flng >4sq"	A5123: Skin barrier with flange

Los siguientes nuevos códigos ' K ' se añaden a la lista de código sujetos a facturación consolidada para servicios de salud en el hogar.

The following new 'K' codes are added to the HH consolidated billing code list, without a replacement.

TABLA 2 / *TABLE 2*

New Codes without Placement	
K0569: 2 pc drainable ost pouch	K0577: Ostomy pouch odor barrier
K0574: Ostomy pouch filter	K0578: Urinary pouch faucet/drain
K0575: Ost pouch rustle free mat	K0579: Ost pouch absorbent material
K0576: Ostomy pouch comfort panel	K0580: Ost pouch locking flange

Relaciones con la Comunidad

CMS determinó que los siguientes códigos **no** están sujetos a facturación consolidada para servicios de salud en el hogar

K0572- Cinta No-impermeable

K0573- Cinta impermeable

La siguiente tabla incluye la actualización a los códigos de suplidos no-rutinarios que publicamos en el Medicare Informa de abril, mayo y junio de 2001. La lista de códigos de terapia que están sujetos a facturación consolidada por servicios de salud en el hogar también publicados en el boletín antes indicado no se afectan con esta actualización.

Community Relations

*CMS has determined that the following codes are **not** subject to HH consolidated billing.*

K0572- Non-waterproof tape

K0573- Waterproof tape

The following table contains the update to the non-routine supplies codes which we published in our April, May and June 2001 Medicare Informa. The list of therapy codes that are subject to HH consolidated billing also published in the above mentioned bulletin are unaffected by this update.

TABLA 3 / *TABLE 3*

Non-Routine Supply Codes	
A4212 Non coring needle or stylet	A4379 Urinary plastic pouch w fcpl
A4310 Insert tray w/o bag/cath	A4380 Urinary rubber pouch w fcplt
A4311 Catheter w/o bag 2-way latex	A4381 Urinary plastic pouch w/o fp
A4312 Cath w/o bag 2-way silicone	A4382 Urinary hvy plstc pch w/o fp
A4313 Catheter w/bag 3-way	A4383 Urinary rubber pouch w/o fp
A4314 Cath w/drainage 2-way latex	A4384 Ostomy faceplt/silicone ring
A4315 Cath w/drainage 2-way silcne	A4385 Ost skn barrier sld ext wear
A4316 Cath w/drainage 3-way	A4387 Ost clsd pouch w att st barr
A4319 Sterile H2O irrigation solut	A4388 Drainable pch w ex wear barr
A4320 Irrigation tray	A4389 Drainable pch w st wear barr
A4321 Cath therapeutic irrig agent	A4390 Drainable pch ex wear convex
A4322 Irrigation syringe	A4391 Urinary pouch w ex wear barr
A4323 Saline irrigation solution	A4392 Urinary pouch w st wear barr
A4324 Male ext cath w/adh coating	A4393 Urine pch w ex wear bar conv
A4325 Male ext cath w/adh strip	A4394 Ostomy pouch liq deodorant
A4326 Male external catheter	A4395 Ostomy pouch solid deodorant
A4327 Fem urinary collect dev cup	A4396 Peristomal hernia supprt blt
A4328 Fem urinary collect pouch	A4397 Irrigation supply sleeve
A4330 Stool collection pouch	A4398 Ostomy irrigation bag
A4331 Extension drainage tubing	A4399 Ostomy irrig cone/cath w brs
A4332 Lubricant for cath insertion	A4400 Ostomy irrigation set
A4333 Urinary cath anchor device	A4402 Lubricant per ounce
A4334 Urinary cath leg strap	A4404 Ostomy ring each
A4335 Incontinence supply	A4421 Ostomy supply misc
A4338 Indwelling catheter latex	A4455 Adhesive remover per ounce
A4340 Indwelling catheter special	A4460 Elastic compression bandage
A4344 Cath indw foley 2 way silicn	A4462 Abdmnl drssng holder/binder
A4346 Cath indw foley 3 way	A4481 Tracheostoma filter
A4347 Male external catheter	A4622 Tracheostomy or larngectomy
A4348 Male ext cath extended wear	A4623 Tracheostomy inner cannula
A4351 Straight tip urine catheter	A4625 Trach care kit for new trach
A4352 Coude tip urinary catheter	A4626 Tracheostomy cleaning brush
A4353 Intermittent urinary cath	A4649 Surgical supplies
A4354 Cath insertion tray w/bag	A5051 Pouch clsd w barr attached
A4355 Bladder irrigation tubing	A5052 Clsd ostomy pouch w/o barr

CONT. TABLA 3 / *CONT. TABLE 3*

Non-Routine Supply Codes	
A4356 Ext ureth clmp or compr dvc	A5053 Clsd ostomy pouch faceplate
A4357 Bedside drainage bag	A5054 Clsd ostomy pouch w/flange
A4358 Urinary leg bag	A5055 Stoma cap
A4359 Urinary suspensory w/o leg b	A5062 Drnble ostomy pouch w/o barr
A4361 Ostomy face plate	A5063 Drain ostomy pouch w/flange
A4362 Solid skin barrier	A5071 Urinary pouch w/barrier
A4364 Liq adhes for facial prosth	A5072 Urinary pouch w/o barrier
A4365 Adhesive remover wipes	A5073 Urinary pouch on barr w/flng
A4367 Ostomy belt	A5081 Continent stoma plug
A4368 Ostomy filter	A5082 Continent stoma catheter
A4369 Skin barrier liquid per oz	A5093 Ostomy accessory convex inse
A4371 Skin barrier powder per oz	A5102 Bedside drain btl w/wo tube
A4372 Skin barrier solid 4x4 equiv	A5105 Urinary suspensory
A4373 Skin barrier with flange	A5112 Urinary leg bag
A4375 Drainable plastic pch w fcpl	A5113 Latex leg strap
A4376 Drainable rubber pch w fcplt	A5114 Foam/fabric leg strap
A4377 Drainable plstic pch w/o fp	A5119 Skin barrier wipes box pr 50
A4378 Drainable rubber pch w/o fp	A5121 Solid skin barrier 6x6
A5122 Solid skin barrier 8x8	A6243 Hydrogel drg >16<=48 w/o bdr
A5126 Disk/foam pad +or- adhesive	A6244 Hydrogel drg >48 in w/o bdr
A5131 Appliance cleaner	A6245 Hydrogel drg <= 16 in w/bdr
A6010 Collagen based wound filler, dry foam	A6246 Hydrogel drg >16<=48 in w/b
A6020 Collage wound dressing	A6247 Hydrogel drg > 48 sq in w/b
A6021 Collagen dressing <=16 sq in	A6248 Hydrogel drsg gel filler
A6022 Collagen drsg>6<=48 sq in	A6251 Absorpt drg <=16 sq in w/o b
A6023 Collagen dressing >48 sq in	A6252 Absorpt drg >16 <=48 w/o bdr
A6024 Collagen dsg wound filler	A6253 Absorpt drg > 48 sq in w/o b
A6154 Wound pouch each	A6254 Absorpt drg <=16 sq in w/bdr
A6196 Alginate dressing <=16 sq in	A6255 Absorpt drg >16<=48 in w/bdr
A6197 Alginate drsg >16 <=48 sq in	A6256 Absorpt drg > 48 sq in w/bdr
A6198 alginate dressing > 48 sq in	A6257 Transparent film <= 16 sq in
A6199 Alginate drsg wound filler	A6258 Transparent film >16<=48 in
A6200 Compos drsg <=16 no border	A6259 Transparent film > 48 sq in
A6201 Compos drsg >16<=48 no bdr	A6261 Wound filler gel/paste /oz
A6202 Compos drsg >48 no border	A6262 Wound filler dry form / gram
A6203 Composite drsg <= 16 sq in	A6266 Impreg gauze no h20/sal/yard
A6204 Composite drsg >16<=48 sq in	A6402 Sterile gauze <= 16 sq in
A6205 Composite drsg > 48 sq in	A6403 Sterile gauze>16 <= 48 sq in
A6206 Contact layer <= 16 sq in	A6404 Sterile gauze > 48 sq in
A6207 Contact layer >16<= 48 sq in	A6405 Sterile elastic gauze /yd
A6208 Contact layer > 48 sq in	A6406 Sterile non-elastic gauze/yd
A6209 Foam drsg <=16 sq in w/o bdr	A7501 Tracheostoma valve w diaphra
A6210 Foam drg >16<=48 sq in w/o b	A7502 Replacement diaphragm/fplate
A6211 Foam drg > 48 sq in w/o brdr	A7503 HMES filter holder or cap
A6212 Foam drg <=16 sq in w/border	A7504 Tracheostoma HMES filter
A6213 Foam drg >16<=48 sq in w/bdr	A7505 HMES or trach valve housing
A6214 Foam drg > 48 sq in w/border	A7506 HMES/trachvalve adhesivedisk

CONT. TABLA 3 / *CONT. TABLE 3*

Non-Routine Supply Codes	
A6215 Foam dressing wound filler	A7507 Integrated filter & holder
A6219 Gauze <= 16 sq in w/border	A7508 Housing & Integrated Adhesiv
A6220 Gauze >16 <=48 sq in w/bordr	A7509 Heat & moisture exchange sys
A6221 Gauze > 48 sq in w/border	K0561: Non-pectin based ostomy paste
A6222 Gauze <=16 in no w/sal w/o b	K0562: Pectin based ostomy paste
A6223 Gauze >16<=48 no w/sal w/o b	K0563: Ext wear ost skn barr <4sq"
A6224 Gauze > 48 in no w/sal w/o b	K0564: Ext wear ost skn barr >4sq"
A6228 Gauze <= 16 sq in water/sal	K0565: Ost skn barr w flng <4sq"
A6229 Gauze >16<=48 sq in watr/sal	K0566: Ost skn barr w flng >4sq"
A6230 Gauze > 48 sq in water/salne	K0567: 1 pc drainable ost pouch
A6231 Hydrogel dsg<=16 sq in	K0568: 1 pc cnvx drainabl ost pouch
A6232 Hydrogel dsg>16<=48 sq in	K0569: 2 pc drainable ost pouch
A6233 Hydrogel dressing >48 sq in	K0570: Ostomy skn barr w flng <4sq"
A6234 Hydrocolld drg <=16 w/o bdr	K0571: Ostomy skn barr w flng >4sq"
A6235 Hydrocolld drg >16<=48 w/o b	K0574: Ostomy pouch filter
A6236 Hydrocolld drg > 48 in w/o b	K0575: Ost pouch rustle free mat
A6237 Hydrocolld drg <=16 in w/bdr	K0576: Ostomy pouch comfort panel
A6238 Hydrocolld drg >16<=48 w/bdr	K0577: Ostomy pouch odor barrier
A6239 Hydrocolld drg > 48 in w/bdr	K0578: Urinary pouch faucet/drain
A6240 Hydrocolld drg filler paste	K0579: Ost pouch absorbent material
A6241 Hydrocolloid drg filler dry	K0580: Ost pouch locking flange
A6242 Hydrogel drg <=16 in w/o bdr	

CR#2247/ dmg

FACTURACION DE EQUIPO MEDICO DURADERO (DME) ARTICULOS PROTÉSICOS, PIEZAS DE REEMPLAZO, ACCESORIOS Y SUPLIDO

Efectivo al 26 de julio de 2002, los proveedores de equipo médico de implantes, artículos protésicos, piezas de reemplazo, accesorios y suplidos de implantes deberán facturar directamente al "Carrier" local y no al DMERC.

Los suplidos y accesorios deben facturarse con el código L9900 y las piezas de reemplazo con el código L7510. Se debe indicar en el encasillado 19 de la forma CMS 1500 (antes conocida como HCFA 1500) o su equivalente en el formato NSF de facturación electrónica una descripción detallada al facturar las piezas de reemplazo, accesorios o suplidos de implantes. Las reclamaciones que no tengan una descripción detallada pueden resultar en una denegación del servicio.

BILLING FOR IMPLANTED DURABLE MEDICAL EQUIPMENT (DME) PROSTHETIC SERVICES, REPLACEMENT PARTS, ACCESSORIES AND SUPPLIES

As of July 26, 2002, providers of implanted DME, prosthetic devices and their replacement parts, accessories and supplies for the implanted DME should bill their local Carrier directly and not the DMERC.

Supplies and accessories should be billed under code L9900, and the replacement parts should be billed under code L7510. Please provide a detailed description of the replacement part, accessories or supply being provided in line 19 of CMS Form 1500 (previously known as HCFA 1500) or its equivalent in the NSF Electronic Billing Format. Claims without a detailed description could result in denial of the service.

CR 2227/FR/ JR/MM

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