Medicare Informa
División Medicare / Parte B

¡Qué Bueno Que Preguntó!

ANUNCIO ACERCA DEL PERÍODO DE PARTICIPACIÓN DE MEDICARE PARA EL 2003

Tenemos magníficas noticias para compartir con usted. Es de conocimiento público que CMS planificaba aplicar una reducción de 4.4 por ciento a las tarifas fijas a partir del 1 de marzo de 2003. CMS trabajó con el Congreso por muchos meses en un esfuerzo de corregir un error en la fórmula usada para computar las tarifas fijas. Dicho error se genera en parte por los cambios imprevistos en condiciones económicas. Nos complace anunciar que el Congreso ha actuado – este error se corregirá y, en vez de una reducción de 4.4 por ciento, efectivo el 1 de marzo de 2003, aplicaremos un incremento de 1.6 por ciento al factor de conversión.

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We Are Glad You Asked!

ANNOUNCEMENT ABOUT MEDICARE PARTICIPATION FOR 2003

We have great news to share with physicians and other practitioners throughout the country. As you know, CMS was scheduled to implement a negative 4.4 percent update effective March 1, 2003. CMS worked with Congress for many months in an effort to correct a defect in the formula generated in part by unanticipated changes in economic conditions. We are pleased to announce that Congress has acted – this flaw will be corrected and, instead of a negative 4.4 percent update, we implemented a positive 1.6 percent update effective March 1, 2003.

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

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

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http://www.cms.hhs.gov
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¡Qué Bueno Que Preguntó!

...Desde la Portada

El Programa Medicare es la cubierta de salud de millones de envejecientes y minusválidos y el compromiso de usted y su participación en el Programa Medicare hacen esto posible. Esperamos que mantenga esto en mente al tomar su decisión de participación en el 2003.

Usted ahora tiene hasta el 14 de abril de 2003, para hacer su decisión de la participación.

Conforme a lo antes expresado, el período de participación se extiende unos 45 días desde 1 de marzo de 2003 hasta 14 de abril de 2003, para permitirles hacer los cambios a su estatus de participación. El período de la participación es el momento en cual el proveedor de servicios de la salud puede elegir formar parte del Programa Medicare o para cambiar su condición de participación. Cualquier cambio en el estatus de participación realizado **durante este período (del 1 de marzo de 2003 al 14 de abril de 2003) será efectivo el 1 de marzo de 2003**. El cambio de participación solicitado **antes del 1 de marzo, será vigente al 1 de enero de 2003**.

Recordatorio: Reclamaciones sujetas a las tarifas fijas con fechas de servicio del 1 de enero al 28 de febrero de 2003, procesadas después del 1 de marzo, se pagarán conforme a las tarifas del 2003. No obstante, estas reclamaciones se ajustarán automáticamente en julio de 2003 para adjudicarles las tarifas de 2002. En algunos casos esto podrá significar un ajuste por sobrepago y procederemos conforme a los procedimientos usuales para recuperar estos dineros. Los servicios no sujetos a tarifas fijas se pagarán con sus respectivas tarifas cuya vigencia es el 1 de enero de 2003.

Si usted tiene cualquiera pregunta o necesita información adicional sobre este tema, favor de llamar a nuestro departamento de Relaciones con la Comunidad al 1-877-715-1921.

We Are Glad You Asked!

...From the Cover

Medicare remains a lifeline to millions of seniors and disabled Americans, and your commitment and participation in the Medicare program make this lifeline possible. We hope that you will keep this in mind as you make your decision regarding your participation in 2003.

All physicians and practitioners now have until April 14, 2003, to make their 2003 Medicare participation decisions.

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

Reminder: *Claims paid under the Medicare Physician Fee Schedule (MPFS) with dates of service January 1 through February 28, 2003, that are processed after March 1, will be paid at the new 2003 rate. However, these claims containing 2003 MPFS services will be automatically adjusted in July 2003 (January 1 through February 28, 2003, MPFS services are subject to the 2002 payment rate). Please note that some overpayments may result due to these adjustments and they will be recouped using normal procedures. Calendar year 2003 payment amounts for all services not under the MPFS are effective January 1, 2003.*

Please call 1-877-715-1921 if you have any questions or need further information on this matter.

Ref. CR# 2601/ PM-AB-03-27/ Feb. 24, 2003/dmg

Health Insurance Portability and Accountability Act (HIPAA)

PAID AMOUNTS IDENTIFICATION WHEN THERE ARE MULTIPLE PRIMARY PAYERS

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

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

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

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

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

Obligated to Accept as Payment in Full Amount: (OTAF): For line level services, physicians and suppliers must take the lowest OTAF amount for that service line, which must be greater than zero, and put the amount in loop 2400 CN102 CN 101 = 09. If only claim level information is sent to Medicare, take the lowest claim level OTAF amount, which must be greater than zero, and put this information in loop 2300 CN102 CN101 = 9.

Submission of Hardcopy MSP Claims With Multiple Primary Payers, but With More Than One Insurance Type Involvement

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

Health Insurance Portability and Accountability Act (HIPAA)

IMPLEMENTATION OF MODIFICATIONS (4010A1) TO TRANSACTIONS AND CODE SET STANDARDS FOR ELECTRONIC TRANSACTIONS ADOPTED UNDER HIPAA

The Designated Standards Maintenance Organizations (DSMOs) developed a process to address the changes to the X12N 4010 implementation guides that are required within the first year for compliance reasons. The addenda were posted at the Washington Publishing Company (WPC) website: http://wpc-edi.com/hipaa/HIPAAAddenda_40.asp

The changes apply to the following transactions:

X12N 837 Professional and Institutional

X12N 835 Remittance Advice

X12N 270/271 Eligibility Inquiry/Response

X12N 276/277 Claims Status Inquiry/Response

NCPDP

We will be ready to begin testing and transitioning EDI Trading Partners to version 4010A1 by May 1, 2003. EDI Submitters that have successfully tested with the 837 version 4010 do not need to be retested on 4010A1. Retesting for these submitters will be on a "by request" basis. Medicare plans to switch to exclusive use of the version 4010A1 by October 16, 2003. Providers must submit all of their electronic claims, claim status inquiries, and eligibility inquiries in compliance with the requirements in the X12N 837 version 4010A1, by October 16, 2003. Trading partners who have chosen to exchange COB, remittance, claim status response, and eligibility response electronically must accept version 4010A1 by October 16, 2003.

New submitters not using a current Medicare approved billing service, clearinghouse or software are encouraged to use the X12 4010A1 Format.

CR#2385/Nov. 26, 2002/js/els

ADDITIONAL INSTRUCTIONS REGARDING HIPAA COMPLIANT X12N 837 (4010) COORDINATION OF BENEFITS (COB) AND PROFESSIONAL TRANSACTION

Admission Date

The 4010 version of the ASC X12N 837 professional implementation guide states that the admission date is required for all inpatient medical visits claims/encounters. Since this data is not currently captured by the carrier standard system for paper and non-4010 claims the admission date will be reported using the earliest date of service at loop 2400 DTP03 for all inpatient medical visit claims.

Cont. on next page

NM109 – Identification Number

When building your outbound X12N 837 (4010) COB transaction, the value in all NM109 data elements are defined by the qualifier in NM108. In order to support standardization across all contractors, if the qualifier in NM108 is "34" and the value in NM109 is not a nine-digit numeric and/or begins with 7, 8, or 9, the standard system will replace the value in NM109 with "199999999". This will eliminate the possibility of creating a valid social security number if NM109 were gap-filled with "9's". If the qualifier in NM108 is "24", the value in NM109 will be nine digits. The standard system will gap fill any missing characters with "9's".

Certification Segments

Non-HIPAA claims may not have the ambulance and chiropractic certification information that is required on the outbound X12N 837 (4010) COB transaction. Since these segments are not being created as part of the gap filling process, outbound X12N 837 (4010) COB will not contain these segments when the incoming claim is paper or a non- HIPAA format.

Transmission Type Code

Until April 1, 2003, 837 transactions will be rejected unless data element REF02 contains the value "004010X098".

REMITTANCE ADVICE REMARK AND REASON CODE UPDATE

X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. Updates to the Remittance Advice Remark Codes may impact Medicare and can be updated every 4 months. The list of remark codes is available at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp and http://www.wpc-edi.com/hipaa/, and will be updated each March, July, and November. The updated list will be used starting April 1, 2003.

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at http://www.wpc-edi.com/hipaa/**.** Medicare Carriers will start using the updated Adjustment Reason Codes by April 1, 2003 and will use the latest Adjustment Reason Codes as they are updated every four months.

Ref. CR#2546/AB-03-12/02-03-03/JS/dmg

Health Insurance Portability and Accountability Act (HIPAA)

PROVEEDORES/VENDORS QUE PASARON PRUEBAS HIPAA FORMATO X12N (TRANSACCIÓN 837)

La siguiente tabla identifica a aquellos Proveedores y vendedores de programas de facturación electrónica que han completado exitosamente las pruebas "HIPAA X12N 837 Professional" realizadas por Triple-S, Inc. / División de Medicare. Sus programas pueden ser utilizados por los proveedores de Medicare para el envío de reclamaciones en formato X12N.

HIPAA TESTING FORMAT X12N FOR PROVIDERS/VENDORS (837 TRANSACTION)

The following table identifies those providers and billing software vendors that have successfully completed "HIPAA X12N 837 Professional" testing with Triple-S, Inc./ Medicare Division. Their programs may be used by Medicare providers to submit X12N electronic claims.

Vendor's Name / Program Name	Type of Claims Tested	Address / Phone Numbers	837 Production Version	HIPAA Testing Completion Date
MASS Medical Accounting Systems Software **VisualMass 7.0**	-Visit/Consultation -Laboratory Procedure -Surgery Procedure	PO Box 397 Manatí, PR 00674 787-854-8638 787-884-7214	004010X098	Sept. 12, 2002
Medical Computer System	-UPIN -Visit/Consultation -Diagnostic Tests -Laboratory Procedure	642 Greenwood Summitt Hills Rio Piedras, PR 00920 787-767-2981	004010X098	Oct. 25, 2002
Structured Systems Corp **Medical Practice 6.2**	-Visit/Consultation -Diagnostic Tests -Refering Provider/UPIN -Surgery Procedure	PO Box 50335 Levittown, PR 00950 787-795-5072	004010X098	Sept. 20, 2002
TurboMed, Inc. **TurboMed ver. 1.01**	-Visit/Consultation -Diagnostic Tests -Refering Provider/UPIN	Box 1811 Arecibo, PR 00613 787-898-1437	004010X098	Sept. 25, 2002
CompuSoft de Puerto Rico **LabSoft Ver. 2H15**	-Laboratory Services	Urb. Borinquen Calle 4H 18-C Cabo Rojo, PR 00623 787-851-2867 787-851-6320	004010X098	Oct. 09, 2002
Advance Data Support **MedOne Ver. 2.0**	-Visit/Consultation	PO Box 8512 Bayamón, PR 00960 787-269-3830 787-269-5620 787-841-0396	004010X098	Oct. 11, 2002
Blás Menendez y Assoc. **MedicMax v2.11.20**	-Surgery -Visit/Consultation -Purchase -Service -Reffering Provider	PO Box 3226 Guaynabo, PR 00970 787-751-2526 787-754-2294 787-763-5181	004010X098	Nov. 06, 2002

NON-PHYSICIAN PRACTITIONERS AND EVALUATION AND MANAGEMENT (E/M) CODES

A. As of October 25, 2002, Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner (NPP) in the State in which he/she practices. The Commonwealth of Puerto Rico does not allow the practice of NPP's in the Territory. NPP's are legal practitioners in the U.S. Virgin Islands.

   Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

   Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

   "Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met.

   Office/Clinic Setting - In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

   Hospital Inpatient/Outpatient/Emergency Department Setting - When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

   In the rare circumstance when a physician (or NPP) provides a service that does reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A

description of the service provided must accompany the claim. The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate. CPT modifier 52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier 52 for this purpose.

C. When counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

   The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

   In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

CR 2321/Trans.1776/October 25, 2002/GGL-1927

UPDATE TO THE MAMMOGRAPHY QUALITY STANDARD ACT (MQSA) FILE RECORD LAYOUT FOR THE FOOD AND DRUG ADMINISTRATION (FDA) CERTIFIED DIGITAL MAMMOGRAPHY CENTERS

Scope:

This article implements the use of an additional indicator on the MQSA file to identify the FDA approved mammography facilities for digital mammography.

Background:

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. The new digital mammography codes have a higher payment rate. In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, the FDA will send an updated file via CMS Mainframe Telecommunications System (CMSTS), formerly Network Data Mover, on a weekly basis.

CMS and the FDA decided upon on a method to annotate the mammography file that the facility also has a digital certification. Currently on the MQSA file, there is a 0 (header-record), a 1 (film facility) and a 9 (trailer record). Effective April 1, 2003, the new file will show:

- Name of facility,
- Certification number of the facility,
- Film certification obtained (Record-type = 1) or digital certification obtained (Record-type = 2), and
- Effective and Expiration dates of each certification

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

Policy:

Medicare pays for film mammography and digital mammography at different rates and pays for a service only if the provider or supplier is certified by the FDA to perform those types of mammogram for which payment is sought. If the FDA mammography file has an error, contact your Regional Office mammography coordinator. The coordinators will contact the FDA to research the error. The FDA file is transmitted weekly.

At the present time there are no certified digital mammography centers in Puerto Rico or Virgin Islands.

AB-02-149 (CR 1729)/October 25, 2002/GGL-1918

DEEP BRAIN STIMULATION FOR ESSENTIAL TREMOR AND PARKINSON'S DISEASE

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

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

Parkinson's disease (PD) is an age-related progressive neurodegenerative disorder involving the loss of dopaminergic cells in the substantia nigra of the midbrain. The disease is characterized by tremor, rigidity, bradykinesia and progressive postural instability. Dopaminergic medication is typically

used as a first line treatment for reducing the primary symptoms of PD. However, after prolonged use, medication can become less effective and can produce significant adverse events such as dyskinesias and other motor function complications. For patients who become unresponsive to medical treatments and/or have intolerable side effects from medications, DBS for symptom relief may be considered.

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

1. Medicare will only consider DBS devices to be reasonable and necessary if they are Food and Drug Administration (FDA) approved devices for DBS or devices used in accordance with FDA approved protocols governing Category B Investigational Device Exemption (IDE) DBS clinical trials.
2. For thalamic VIM DBS to be considered reasonable and necessary, patients must meet all of the following criteria:
    a. Diagnosis of essential tremor (ET) based on postural or kinetic tremors of hand(s) without other neurologic signs, or diagnosis of idiopathic PD (presence of at least 2 cardinal PD features (tremor, rigidity or bradykinesia)) which is of a tremor- dominant form.
    b. Marked disabling tremor of at least level 3 or 4 on the Fahn-Tolosa-Marin Clinical Tremor Rating Scale (or equivalent scale) in the extremity intended for treatment, causing significant limitation in daily activities despite optimal medical therapy.
    c. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.
3. For STN or GPi DBS to be considered reasonable and necessary, patients must meet all of the following criteria:
    a. Diagnosis of PD based on the presence of at least 2 cardinal PD features (tremor, rigidity or bradykinesia).
    b. Advanced idiopathic PD as determined by the use of Hoehn and Yahr stage or Unified Parkinson's Disease Rating Scale (UPDRS) part III motor subscale.
    c. L-dopa responsive with clearly defined "on" periods.
    d. Persistent disabling Parkinson's symptoms or drug side effects (e.g., dyskinesias, motor fluctuations, or disabling "off" periods) despite optimal medical therapy.
    e. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

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

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

6. Significant medical, surgical, neurological or orthopedic co-morbidities contraindicating DBS surgery or stimulation.

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

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

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

1. Neurosurgeons must: (a) be properly trained in the procedure; (b) have experience with the surgical management of movement disorders, including DBS therapy; and (c) have experience performing stereotactic neurosurgical procedures.
2. Operative teams must have training and experience with DBS systems, including knowledge of anatomical and neurophysiologic characteristics for localizing the targeted nucleus, surgical and/or implantation techniques for the DBS system, and operational and functional characteristics of the device.
3. Physicians specializing in movement disorders must be involved in both patient selection and post-procedure care.
4. Hospital medical centers must have: (a) brain imaging equipment (MRI and/or CT) for pre-operative stereotactic localization and targeting of the surgical site(s); (b) operating rooms with all necessary equipment for stereotactic surgery; and (c) support services necessary for care of patients undergoing this procedure and any potential complications arising intraoperatively or postoperatively.

Allowable Covered Diagnosis Codes

Deep Brain Stimulation is covered for the following ICD-9-CM diagnosis codes:

332.0 - Parkinson's disease, with paralysis agitans

333.1 – Essential and other specified forms of tremor

HCPCS Coding

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

E0752	Implantable Neurostimulator Electrode, Each
E0756	Implantable Neurostimulator Pulse Generator
61862	Twist drill, burr hole, craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)
61880	Revision or removal of intracranial neurostimulator electrodes
61885	Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays

61888 Revision or removal of cranial neurstimulator pulse generator or receiver

95961 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance

95962 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure) (Use 95962 in conjunction with code 95961)

95970 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple brain, spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95972 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

95973 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, additional 30 minutes after hour (List separately in addition to code for primary procedure) (Use 95973 in conjunction with code 95972)

Ambulatory Surgical Centers

The following HCPCS codes are approved for billing in Ambulatory Surgical Centers:

61885 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array - ASC Payment Group 02

61888 Revision or removal of cranial neurstimulator pulse generator or receiver - ASC Payment Group 01

NOTE: **Pulse generator is payable in an ASC; implantation of electrodes are not.**

GGL-1945/AB-03-023/CR 2553/February 14, 2003

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

REQUIREMENTS FOR PAYMENT OF MEDICARE CLAIMS FOR FOOT AND NAIL CARE SERVICES

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare nail debridement payments, which is the single largest paid podiatric service. The OIG found that about one in every four claims did not include documentation of medical need for nail debridement in beneficiaries' medical records and that more than half of these inappropriate payments included other related inappropriate payments. This article explains the requirements for payment of Medicare claims for foot and nail services including information about routine foot care exclusion, exceptions to routine foot care exclusion, Class Findings, billing instructions, required claim information, and documentation on file.

Routine Foot Care Exclusion

Except as noted in "Exceptions to Routine Foot Care Exclusion" section, routine foot care is excluded from coverage. Services that are normally considered routine and not covered by Medicare include:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care such as cleaning and soaking the foot, use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

Exceptions to Routine Foot Care Exclusion

- Services performed as a necessary and integral part of otherwise covered services such as diagnosis and treatment of ulcers, wounds, infections, and fractures.
- The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease that may require scrupulous foot care by a professional. Certain procedures that are otherwise considered routine may be covered when systemic condition(s), demonstrated through physical and/or clinical findings, result in severe circulatory embarrassment or areas of diminished sensation in the legs or feet and may pose a hazard if performed by a nonprofessional person on patients with such systemic conditions. In the case of patients with systemic conditions such as diabetes mellitus, chronic thrombophlebitis, and peripheral neuropathies involving the feet associated with malnutrition and vitamin deficiency, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, and uremia, they must also be under the active care of a doctor of medicine or doctor of osteopathy and who documents the condition in the patient's medical record.
- Services performed for diabetic patients with a documented diagnosis of peripheral neuropathy and loss of protective sensation (LOPS) and no other physical and/or clinical findings sufficient to allow a presumption of coverage as noted in the Medicare Carriers Manual. This class of patients can receive an evaluation and treatment of the feet no more often than every six months as long as they have not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) guidelines. Five sites should be tested on the plantar surface of each foot, according to NIDDK guidelines.
- Treatment of warts, including plantar warts, may be covered. Coverage is to the same extent as services provided for in treatment of warts located elsewhere on the body.

- Treatment of mycotic nails for an ambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

NOTE: Active care is defined as treatment and/or evaluation of the complicating disease process during the six-month period prior to rendition of the routine care or had come under such care shortly after the services were furnished, usually as a result of a referral.

Class Findings

A presumption of coverage may be made by Medicare where the claim or other evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, the following findings are pertinent:

- **Class A Findings**

  Nontraumatic amputation of foot or integral skeleton portion thereof

- **Class B Findings**

  Absent posterior tibial pulse

  Advanced trophic changes; three of the following are required: hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), skin color (rubor or redness)

  Absent dorsalis pedis pulse

- **Class C Findings**

  Claudication
  Temperature changes
  Edema
  Paresthesia
  Burning

Billing Instructions

The following are the main HCPCS/CPT codes for billing of foot and nail care services (additional codes can be found in the HCPCS/CPT code book):

11719 – Trimming of nondystrophic nails, any number

11720 – Debridement of nail(s) by any method(s); one to five

11721 – Debridement of nail(s) by any method(s); six or more

11730 – Avulsion of nail plate, partial or complete, simple; single

11732 – Avulsion of nail plate, partial or complete, simple; each additional nail plate (list separately in addition to code for primary procedure)

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

Required Claim Information

NOTE: Program Memorandums AB-02-096 dated July 17, 2002 and AB-02-109 dated July 31, 2002 contain claim and billing instructions for peripheral neuropathy. For information on completing the CMS-1500 form, see the "Medicare Resident & Physicians Training Manual", Chapter 3 at http://www.cms.hhs.gov/medlearn. You may also contact our Customer Service Department at 1-877-715-1921.

The following requirements are of particular importance to podiatrists:

Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. A referring physician is a physician who requests an item or service for the patient for which payment may be made under the Medicare program.

Item 17a. Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17.

Item 19. Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims.

Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 24d. Enter the procedures, services, or supplies using the HCPCS/CPT code. When applicable, show HCPCS modifiers with the HCPCS code. Enter the Q7 – One Class A finding; Q8 – Two Class B findings; or Q9 – One Class B and two Class C findings as appropriate.

Enter the specific procedure code without a narrative description.

Item 24e. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; enter either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses in item 21.

Documentation on File

Podiatrists may submit claims using the Q7, Q8, or Q9 modifiers to indicate to the carriers the findings they have made on the patient's condition. This does not relieve them of the responsibility of maintaining documentation on file. This documentation must be maintained and made available to the carriers at their request. Failure to produce appropriate documentation may result in denial of the claim. Podiatrists should consult their carriers to verify that they are meeting the documentation requirements for Medicare claims.

CR#2374/B-02-091-December 27, 2002/GGL

LEVOCARNITINE FOR USE IN THE TREATMENT OF CARNITINE DEFICIENCY IN ESRD PATIENTS

Carnitine is a naturally occurring substance that functions in the transport of long-chain fatty acids for energy production by the body. Deficiency can occur due to a congenital defect in synthesis or utilization, or from dialysis. The causes of carnitine deficiency in hemodialysis patients include dialytic loss, reduced renal synthesis and reduced dietary intake.

Intravenous levocarnitine will only be covered for those ESRD patients who have been on dialysis for a minimum of three months for one of the following indications.

Patients must have documented carnitine deficiency, defined as a plasma free carnitine level >40 micromol/L (determined by a professionally accepted method as recognized in current literature), along with signs and symptoms of:

1. Erythropoietin resistant anemia (persistent hematocrit <30 percent with treatment) that has not responded to standard erythropoietin dosage (that which is considered clinically appropriate to treat the particular patient) with iron replacement, and for which other causes have been investigated and adequately treated, or
2. Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g. fluid management). Such episodes of hypotension must have occurred during at least 2 dialysis treatments in a 30-day period.

Continued use of levocarnitine will not be covered if improvement has not been demonstrate within 6 months of initiation of treatment. All other indications for levocarnitine are non-covered in the ESRD population.

For a patient currently receiving intravenous levocarnitine, Medicare will cover continued treatment if:

1. Levocarnitine has been administered to treat erythropoietin-resistant anemia (persistent hematocrit <30 percent with treatment) that has not responded to standard erythropoietin dosage (that which is considered clinically appropriate to treat the particular patient) with iron replacement, and for which other causes have been investigated and adequately treated, or hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g. fluid management) and such episodes of hypotension occur during at least 2 dialysis treatments in a 30-day period; and
2. The patient's medical record documents a pre-dialysis plasma free carnitine level <40 micromo/L prior to the initiation of treatment; or
3. The treating physician certifies (documents in the medical record) that in his/her judgment, if treatment with levocarnitine is discontinued, the patient's pre-dialysis is carnitine level would fall below 40 micromo/L and the patient would have recurrent erythropoietin-resistant-anemia or intradialytic hypotension.

GGL-1946/Transmittal AB-02-165/CR 2438/November 8, 2002

From the Desk of the Medical Director...

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HYPERBARIC OXYGEN THERAPY

This article is a revision of the previously published material of HBO in the Coverage Issues Manual and is a national coverage decision (NCD). NCDs are binding on all Medicare contractors.

Hyperbaric Oxygen Therapy (HBO) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Based on evidence that we have reviewed, we are expanding coverage for the treatment of diabetic wounds of the lower extremities in patients who meet all of the following three criteria:

1. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
2. Patient has a wound classified as Wagner grade III or higher; and
3. Patient has failed an adequate course of standard wound therapy.

For the purposes of coverage under Medicare, hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmosphere pressure.

A. Covered Conditions – Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one man unit) and is limited to the following conditions:

1. Acute carbon monoxide intoxication (ICD-9 CM diagnosis 986).
2. Decompression illness (ICD-9 CM diagnosis 993.2, 993.3).
3. Gas embolism (ICD-9 CM diagnosis 958.0, 999.1).
4. Gas gangrene (ICD-9 CM diagnosis 0400).
5. Acute traumatic peripheral ischemia. HBO therapy is an adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened (ICD-9 CM diagnosis 902.53, 903.01, 903.1, 904.0, 904.41).
6. Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb or life is threatened. (ICD-9 CM diagnosis 927.00-927.03, 927.09-937.11, 927.20-927.21, 927.8-927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0, 996.90-996.99).
7. Progressive necrotizing infections (necrotizing fasciitis) (ICD-9 CM diagnosis 728.86).
8. Acute peripheral arterial insufficiency (ICD-9 CM diagnosis 444.21, 444.22, 444.81).
9. Preparation and preservation of compromised skin grafts (not for primary management of wounds (ICD-9 CM diagnosis 996.52; excludes artificial skin graft).
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management (ICD-9 CM diagnosis 730.10-730.19).
11. Osteoradionecrosis as an adjunct to conventional treatment (ICD-9 CM diagnosis 526.89).
12. Soft tissue radionecrosis as an adjunct to conventional treatment (ICD-9 CM diagnosis 990).
13. Cyanide poisoning (ICD-9 CM diagnosis 987.7, 989.0).
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment (ICD-9 diagnosis 039.0-039.4, 039.8, 039.9).
15. Diabetic wounds of the lower extremities in patients who meet the following three critirea:

a. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes:

b. Patient has a wound classified as a Wagner grade III or higher; and

c. Patient has failed an adequate course of standard wound therapy.

The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes: assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable sings of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

B. **Noncovered conditions** – All other indications not specified are not covered under the Medicare program. No program payment may be made for any conditions other than those listed.

No program payment may be made for HBO in the treatment of the following conditions:

1. Cutaneous, decubitus, and stasis ulcers
2. Chronic peripheral vascular insufficiency
3. Anaerobic septicemia and infection other than clostridial
4. Skin burns (thermal)
5. Senility
6. Myocardial infarction
7. Cardiogenic shock
8. Sickle cell anemia
9. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
10. Acute or chronic cerebral vascular insufficiency
11. Hepatic necrosis
12. Aerobic septicemia
13. Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)
14. Tetanus
15. Systemic aerobic infection
16. Organ transplantation
17. Organ storage
18. Pulmonary emphysema
19. Exceptional blood loss anemia
20. Multiple sclerosis
21. Arthritic diseases
22. Acute cerebral edema

C. **Topical Application of Oxygen** – This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

CIM Transmittal 164/CR 2388/December 27, 2002/GGL-1948

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

Section 15016 -Supervising Physicians in Teaching Settings- of the Medicare Carriers Manual, is revised to clarify the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. In addition, the revisions clarify policies for services involving students and other issues and update regulatory references.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

A. Definitions - For purposes of this section, the following definitions apply:

1. Resident means an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.
2. A student means an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student. See Section C. 2 for a discussion concerning E/M service documentation performed by students.
3. Teaching physician means a physician (other than another resident) who involves residents in the care of his or her patients.
4. Direct medical and surgical services mean services to individual patients that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the fiscal intermediary for the hospital.
5. Teaching hospital means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.
6. Teaching setting means any provider, hospital-based provider, or non provider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.
7. Critical or key portion means that part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
8. Documentation means notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in specific situations (section C) regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated, and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

9. Physically present means that the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

B. Payment for Teaching Physicians. - Pursuant to 42 CFR 415.170. Medicare will pay for physician services provided in teaching settings using the physician fee schedule only if:

1. Services are personally furnished by a physician who is not a resident;
2. A teaching physician was physically present during the critical or key portions of the service that a resident performs subject to the exceptions as provided below in Section C; or
3. A teaching physician provides care under the conditions contained in Section C. 3. which follows.

In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the fiscal intermediary.

C. General Documentation Instructions and Common Scenarios

1. Evaluation and Management (E/M) Services - For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and

b. The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1

The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.
- Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2

The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Scenario 3

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Following are examples of minimally acceptable documentation for each of these scenarios:

Scenario 1

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

(**NOTE:** In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2

Initial or Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Following are examples of unacceptable documentation:

- "Agree with above." followed by legible countersignature or identity;
- "Rounded, Reviewed, Agree." followed by legible countersignature or identity;
- "Discussed with resident. Agree." followed by legible countersignature or identity;
- "Seen and agree." followed by legible countersignature or identity;
- "Patient seen and evaluated." followed by legible countersignature or identity; and
- A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

2. E/M Service Documentation Provided By Students. - Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

   Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

3. Exception for E/M Services Furnished in Certain Primary Care Centers -Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in section B applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86(f)(4) (ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.86(i).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies) and
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and
- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

4. Procedures - In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

    a. Surgery (Including Endoscopic Operations) - The teaching surgeon is responsible for the preoperative, operative, and post-operative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which post-operative visits are considered key or critical and require his or her presence. If the post-operative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in §4824.B apply. During non-critical or non-key portions of the surgery,

if the teaching surgeon is not physically present, he or she must be immediately available to return to the procedure, i.e., he or she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

(1) Single Surgery - when the teaching surgeon is present for the entire surgery, notes in the medical records made by the physician, resident, or operating room nurse may demonstrate his or her presence. For purposes of this teaching physician policy, there is no required **2183** information that the teaching surgeon must enter into the medical records.

(2) Two Overlapping Surgeries - In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

(3) Minor Procedures - For procedures that take only a few minutes (5 minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

b. Anesthesia - Pay an unreduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or post-operative visits with the beneficiary is not sufficient to receive Medicare payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist, pay for the anesthesiologist's services as medical direction.

c. Endoscopy Procedures - To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection a), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

5. Interpretation of Diagnostic Radiology and Other Diagnostic Tests -Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a teaching physician.

If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he or she is indicating that he or she personally performed the interpretation. If a resident prepares and

signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

6. Psychiatry -The general teaching physician policy set forth in section B applies to psychiatric services. For certain psychiatric services, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service through the use of a one-way mirror or video equipment. Audio-only equipment does not satisfy to the physical presence requirement. In the case of time-based services, such as individual medical psychotherapy, see subsection 8 below.

Further, the teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

7. Time-Based Codes - For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

   - Individual medical psychotherapy (CPT codes 90804- 90829);
   - Critical care services (CPT codes 99291-99292);
   - Hospital discharge day management (CPT codes 99238-99239);
   - E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;
   - Prolonged services (CPT codes 99358-99359), and
   - Care plan oversight (HCPCS codes G0181 - G0182).

8. Other Complex or High-Risk Procedures - In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident. The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

9. Miscellaneous - In the case of maternity services furnished to Medicare eligible women, apply the physician presence requirement for both types of delivery as you would for surgery. In order to bill Medicare for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (prepartum, delivery, and postpartum) and for deliveries only.

In situations in which the teaching physician's only involvement was at the time of delivery, the teaching physician should bill the delivery only code. In order to bill for the global procedures, the teaching physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the teaching physician is not required to be present for a specified number of visits.

Do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

D. Election of Costs for Services of Physicians in Teaching Hospital - A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments for such services. A teaching hospital may make this election to receive cost payment only when all physicians who render covered Medicare services in the hospital agree in writing not to bill charges for such services or when all the physicians are employees of the hospital and, as a condition of employment, they are precluded from billing for such services. When this election is made, Medicare payments are made exclusively by the hospital's intermediary, and fee schedule payment is precluded.

When the cost election is made for a current or future period, each physician who provides services to Medicare beneficiaries must agree in writing (except when the employment restriction discussed above exists) not to bill charges for services provided to Medicare beneficiaries. However, when each physician agrees in writing to abide by all the rules and regulations of the medical staff of the hospital (or of the fund that is qualified to receive payment for the imputed cost of donated physician's services), such an agreement suffices if required as a condition of staff privileges and the rules and regulations of the hospital, medical staff, or fund clearly preclude physician billing for the services for which costs benefits are payable. The intermediary must advise the carrier when a hospital elects cost payment for physicians' direct medical and surgical services and supply the carrier with a list of all physicians who provide services in the facility.

E. Services of Assistants at Surgery Furnished in Teaching Hospitals

1. General - Medicare will not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of subsections 3, 4, or 5 are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed. There may be some teaching hospitals in which you can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. Process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82 which indicates that a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

"I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier."

Assistant at surgery claims denied on the basis of these instructions do not qualify for payment under the waiver of liability provision.

2. Definition - An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery.) The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

3. Exceptional Circumstances - Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, not withstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

4. Physicians Who Do Not Involve Residents in Patient Care -Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a nonteaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection 5 is met.

5. Multiple Physician Specialties Involved in Surgery - Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §15044 is not applied. If payment is made on the basis of a single team fee, deny additional claims. Determine which procedures performed in your service area require a team approach to surgery. Team surgery is paid for on a "By Report" basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require the cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

CR 2290/Transmittal 1780/November 22, 2002/GGL-1922

ADD-ON-CODES FOR ANESTHESIA

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

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

New Codes

The Current Procedural Terminology includes new add-on-codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia. The add-on code is billed in addition to the primary anesthesia code. In the burn area, code 01953 (1 base unit) is used in conjunction with code 01952 (5 base units). In the obstetrical area, code 01968 (2 base units) is used in conjunction with code 01967 (5 base units); code 01969 (5 base units) is used in conjunction with code 01967 (5 base units). The physician reports the add-on-code with the primary anesthesia code.

Pricing Claims

Effective July 1, 2003, anesthesia add-on-codes are priced differently than multiple anesthesia codes.

Generally, for an add-on code, allow only the base unit of the add-on code. All anesthesia time should be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia.

If the time of the add-on obstetrical codes, such as 01968 or 01969, the anesthesia time be separately reported with each of the primary and the add-on code based on the amount of time appropriately associated with either code

EXAMPLE:

Code 01967 is billed with 01968. Make two separate calculations. Price code 01967 using 5 base units and anesthesia time units and price code 01968 using 2 base units and anesthesia time units.

CR2539/Transmittal B-03-017/February 28, 2003/ICR

ELECTRICAL STIMULATION FOR THE TREATMENT OF WOUNDS
(EFFECTIVE FOR SERVICES ON AND AFTER APRIL 1, 2003)

Electrical stimulation (ES) has been used or studied for many different applications, one of which is accelerating wound healing. Electrical stimulation for the treatment of wounds is the application of electrical current through electrodes placed directly on the skin in close proximity to the wound. Electrical stimulation for the treatment of wounds will only be covered for chronic. Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers. All other uses of electrical stimulation for the treatment of wounds are noncovered. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. Electrical stimulation will not be covered as an initial treatment modality.

The electrical stimulation for the treatment of wounds is considered an adjunctive therapy. Electrical stimulation will be covered only after appropriate standard wound therapy has been tried for at least 30 days and there no measurable signs of healing. This 30-day period can begin while the wound is acute. Measurable signs of improved healing include a decrease in wound size, either surface area or volume, decrease in amount of exudates and decrease in amount of necrotic tissue. Standard wound care includes: optimization of nutritional status: debridement by any means to remove devitalized tissue; maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; and necessary treatment to resolve any infection that may be present. Standard wound care based on the specific type of wound includes: frequent repositioning of a patient with pressure ulcers (usually every 2 hours); off-loading of pressure and good glucose control for diabetic ulcers; establishment of adequate circulation for arterial ulcers; and the use of a compression system for patients with venous ulcers.

Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Electrical stimulation must be discontinued when the wound demonstrates 100 percent epithelialzed wound bed.

Any form of electromagnetic therapy for the treatment of chronic wounds will not be covered. This service can only be covered when performed by a physician, physical therapist or incident to a physician service. Evaluation of the wound is an integral part of wound therapy. When a physician, physical therapist, or a clinician incident to a physician, performs electrical stimulation, that practitioner must evaluate the wound and contact the treating physician if the wound worsens. If electrical stimulation is being used, wounds must be evaluated at least monthly by the treating physician.

Unsupervised use of electrical stimulation for wound therapy will not be covered, as this use has not been found to be medically reasonable and necessary.

Applicable HCPCS Codes

- **G0281 -** Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care.
- **G0282 -** Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
- **97032 -** Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes. **(Note: 97032 should NOT be reported for wound care of any sort because wound care does not require constant attendance)**

Trans. 161-CR 2313-11/08/02-GGL-1954

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

PROGRESSIVE ACTION PLAN

During a post payment review performed on home visit codes, we were able to identify services that were billed as home services when the patient is in a domiciliary, rest homes or custodial care facility. For that reason, we would like to clarify the difference between these places of services and to remind you that there are different evaluation and management codes that apply for each specific place of service.

Home Services versus Domiciliary, Rest Homes (Boarding Home) or Custodial Care Services: Two Very Different Places of Services

Home Services are defined as those provided to a beneficiary at his or her private home or place of residence. The CPT codes for these services are 99341-99345 for new patient and 99347-99350 for an established patient. The intensity and degree of complexity of each one of these codes are based on Evaluation and Management services guidelines. Home Services have been assigned substantially higher RVUs and therefore have greater fees than Domiciliary, Rest Home or Custodial Care Services. A physician providing home services will have to displace himself from his office or residence to the private residence of the patient.

On the other hand, Domiciliary, Rest Home or Custodial Care Services are provided in a facility which serves as a boarding home to multiple patients. Services at this location are remunerated to the physicians at the lower rate since more than one patient can be evaluated and treated on a single visit. These services include codes 99321-99323 for new patient and 99331-99333 for an established patient. This is one of the elements considered when determining the RVUs.

Billing Medicare for "Home Service" when the service rendered meets the definition of a domiciliary, rest home or custodial care service is not only an erroneous billing pattern, but if found to be persistent, can be interpreted as abusive or in some instances as a fraudulent practice.

The medical records we reviewed show an unusual frequency (five to six visits to different homes in a period of one or two hours) of home services billed to Medicare. From this preliminary evaluation, we concluded that most these services correspond to services given at domiciliary, rest home or custodial care areas and that these visits are billed to Medicare as home services.

Our interpretation is that there might be difficulties understanding these code families. Moreover, we are reluctant to believe that the aberrant billing pattern is the result of upcoding. For such reason a more extensive evaluation of these two code families will be carried out by this Carrier in an attempt to differentiate billing errors from abusive practices or even fraud.

We take this opportunity to remind all the providers that the services provided in either of these locations (Home or Domiciliary facilities) have to follow the guidelines previously published by this Carrier. For your benefit here are our guidelines:

1. Home visits or Custodial Care visits should have a clear defined justification. The medical necessity must justify the encounter of the physician and the patient at the private residence or at a custodial care. This visit should obey to the patients or her/his relative's request for a home visits. It should justify that the patient requires the visit because the patient is disable or bed ridden, etc. If the patient could stop at the doctor's office, the home visit or the custodial care visit is not justified. The home visit should not be for the doctor's nor the patient's convenience, but based on medical necessity. This encounter between doctor and patient and the justification should be implicit in the medical record. Follow-up visits will be justified if the patient could not go to the doctor's office.

Section 2051.1 of Coverage and Limitations Manual from the Medicare Program describes in detail the characteristics of the patient that is confined to its home. A copy of this Section could be obtained through the CMS website at http://cms.hhs.gov/manuals/14_car/3b2000.asp. If you do not have Internet access, you could contact us at 1-877-715-1921 for a copy.

2. "Gang visits" are not justified. Routine evaluations of patients that have not requested the medical services are considered routine or screening and are not covered by the Program.

If these requirements are not meet, the medical justification will be voided, and the visit should not be paid or recouped if previously paid.

The medical records must reflect the Evaluation and Management level according to what we publish on Volume 23 November-December 1994 - January 1995 of the Medicare Informa and the Local Medical Review Policies in November 1995.

A last word of caution: our reputation as physicians should be maintained to the highest level. Please do not allow errors in billing, or misunderstanding of the rules to be instrumental in the erroneous interpretation of our billing pattern, as abusive or even fraudulent practices.

Note: "Asilo de Ancianos" are Domiciliary, Rest Homes (e.g., Boarding Homes or Custodial Care Services). These "Asilos" are not the private residences. The "Asilos" provides room, board and other personal assistance services, generally on a long-term basis.

Medical Review/rg/3-03

NEUROMUSCULAR ELECTRICAL STIMULATION (NMES)

Neuromuscular electrical stimulation (NMES) involves the use of a device that transmits an electrical impulse to activate muscle groups by way of electrodes. There are two broad categories of NMES. One type of device stimulates the muscle when the patient is in a resting state to treat muscle atrophy. The second type is used to enhance functional activity of neurologically impaired patients.

Treatment of Muscle Atrophy

Coverage of NMES to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. Examples include casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).

Use for Walking in Patients with Spinal Cord Injury (SCI)

The type of NMES that is used to enhance the ability to walk of SCI patients in commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed of weak muscles in precise sequence. Coverage for the use of NMES/FES is limited to SCI patients, for walking, who have completed a training program, which consists of at least 32 physical therapy sessions with the device over a period of 3 months. The trial period of physical therapy will enable the physician treating the patient for his or her spinal cord injury to properly evaluate the person's ability to use these devices frequently and for the long term. Physical therapy sessions are only covered in the inpatient

hospital, outpatient hospital, comprehensive outpatient rehabilitation facilities, and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program; this service cannot be done unattended.

The goal of physical therapy must be to train SCI patients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

Coverage for NMES/FES for walking will be limited to SCI patients with all of the following characteristics:

1) Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);
2) Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;
3) Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction;
4) Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
5) Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
6) Persons that can demonstrate hand and finger function to manipulate controls;
7) Persons with at least 6-month post recovery spinal cord injury and restorative surgery;
8) Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
9) Persons who have demonstrated a willingness to use the device long-term.

NMES/FES for walking will not be covered in SCI patients with any of the following:

1) Persons with cardiac pacemakers;
2) Severe scoliosis or severe osteoporosis;
3) Skin disease or cancer at area of stimulation;
4) Irreversible contracture; or
5) Automatic dysreflexia

The only settings where therapists with the sufficient skills to provide these services are employed, are inpatient hospitals, outpatient hospitals, comprehensive outpatient rehabilitation facilities and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of one-on-one training program.

Additional therapy after the purchase of the DME would be limited by our general policies on coverage of skilled physical therapy.

All other uses of NMES remain non-covered.

Applicable HCPCS Code

- **97116 -** gait training (include stair climbing).

NOTE: This is the only code to be billed. It must be used for one-on-one face-to-face service provided by the physician or therapist.

Diagnosis code 344.1 must be present for payment to be made. However, while paraplegia of both lower limbs is a necessary condition for coverage, the nine criteria on the preceding page are also required.

ICD-9 codes that do not Support Medical Necessity:

1) presence of cardiac pacemakers (V45.89 & V53.31) or cardiac defibulators (V45.00, V45.01, V45.02 & V45.09);

2) severe scoliosis or severe osteoporosis (733.00-733.09, 736.89, 736.9, 737.30 -737.39, 7 37.40, 737.43, 738.4, 738.5 & 754.2);

3) irreversible contracture (736.00 – 736.09, 736.30 – 736.39, 736.6, 736.70 - 736.79, 736.81 & 736.89);

4) autonomic dysreflexia (337.3) or the following diagnosis:

5) skin disease or cancer at area of stimulation.

Trans. AB-02-156/CR 2314/11-01-02/GGL-1956

HEART TRANSPLANTS

A. General – Cardiac transplantation is covered under Medicare when performed in a facility, which is approved by Medicare as meeting institutional coverage criteria (See HCFA Ruling 87-1).

B. Exceptions – In certain limited cases, exceptions to the criteria may be warranted if there is justification and if the facility ensures our objectives of safety and efficacy. Under no circumstances will exceptions be made for facilities whose transplant programs have been in existence for less than two years, and applications from consortia will not be approved.

Although consortium arrangements will not be approved for payment of Medicare heart transplants, consideration will be given to applications from heart transplant facilities that consist of more than one hospital where all of the following conditions exist:

- The hospitals are under the common control or have a formal affiliation arrangement with each other under the auspices of an organization such as a university or a legally-constituted medical research institute; and
- The hospitals share resources by routinely using the same personnel or services in their transplant programs. The sharing of resources must be supported by the submission of operative notes or other information that documents the routine use of the same personnel and services in all of the individual hospitals. At a minimum, shared resources means:

- The individual members of the transplant team, consisting of the cardiac transplant surgeons, cardiologists and pathologists, must practice in all the hospitals and it can be documented that they otherwise function as members of the transplant team; and
- The same organ procurement organization, immunology, and tissue-typing services must be used by all the hospitals; and
- The hospitals submit, in the manner required (Kaplan-Meier method) their individual and pooled experience and survival data; and
- The hospitals otherwise meet the remaining Medicare criteria for heart transplant activities; that is, the criteria regarding patient selection; patient management, program commitment, etc.

C. Pediatric hospitals – Cardiac transplantation is covered for Medicare beneficiaries when performed in a pediatric hospital that performs pediatric heart transplants if the hospital submits an application which HCFA approves as documenting that:

- The hospital's pediatric heart transplant program is operated jointly by the hospital and another facility that has been found by HCFA to meet the institutional coverage criteria in HCFA Ruling 87-1;
- The unified program shares the same transplant surgeons and quality assurance program (including oversight committee, patient protocol, and patient selection criteria); and
- The hospital is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients.

D. Follow-up Care – Follow up care required as a result of a covered heart transplant is covered, provided such services are otherwise reasonable and necessary. Follow-up care is also covered for patients who have been discharged from a hospital after receiving a noncovered heart transplant. Coverage for follow-up care would be for items and services that are reasonable and necessary, as determined by Medicare guidelines. (See Intermediary Manual 3101.14 and Carriers Manual 2300.1).

E. Immunosuppressive Drugs – (See Intermediary Manual 3660.8 and Carriers Manual 2050.5, 4471 and 5249).

F. Artificial Hearts – Medicare does not cover the use of artificial hearts as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant (often referred to as a "bridge to transplant"). Medicare does cover a ventricular assist device (VAD) when used in conjunction with specific criteria listed in CIM 65-15.

CR 2481/CIM #165/12-27-2002/GGL-1963

CLARIFICATION ON NON-PHYSICIAN PRACTITIONERS BILLING ON BEHALF OF A DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES (DSMT) PROGRAM

The Centers for Medicare and Medicaid Services (CMS) has made the following clarifications on non-physician practitioners billing on behalf of diabetes outpatient self-management training:

- Medicare non-physician practitioners, such as nurse practitioners or registered dietitians who are eligible to render other Medicare services, may bill on behalf of a DSMT program. *****
- Payment to non-physician practitioners billing on behalf of a DSMT program (G0108 or G0109) should be made at the full fee schedule rate and should not be paid at 85 percent of the fee schedule like other non-physician practitioner services. This is because the payment is for the DSMT program and is not being made for the services of a single practitioner.
- Non-physician practitioners that bill on behalf of a DSMT program are subject to mandatory assignment.
- The beneficiary is liable for services denied over the limited number of hours with referrals for DSMT or MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable. An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their State but who have not obtained Medicare provider numbers.

In addition the following two new G codes have been created for MNT when there is a change in condition of the beneficiary:

- **G0270**: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
- **G0271**: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

The above new G codes for additional hours of coverage should be used after the completion of the 3 hours of basic coverage under 97802-97804 when a second referral is received during the same calendar year. No specific limit is set for the additional hours.

These new codes will be part of the annual 2003 HCPCS update. Therefore, the codes will be effective for dates of service on or after January 1, 2003.

***We remind you that in Puerto Rico, local laws do not authorize nurse practitioners and physician assistant to independently bill for their services**

CR2373/PM AB-02-151/October 24, 2002/ICR/dg

From the Desk of the Medical Director...

Gonzalo V. González-Liboy, MD FACP

CRITICAL CARE CODES

During year 2002, as part of the Progressive Corrective Action initiative, we selected a sample of claims billed with codes 99291 and 99292 for post payment review. For this effort, we requested medical record from a group of providers. Our Review Specialist evaluated these medical records with the purpose of validating the proper use of codes and that the documents included in the record justified the code billed.

We would like to share some of the findings with respect to the used of codes 99291 and 99292:

1. Services for patient who is not critically ill, but happens to be in a critical care unit.
2. Time engaged in treating a patient is not recorded in the patient's record.
3. Consultation visits to a patient that is in the critical care unit, but is not in critical condition at the moment that the service was provided.

Considering the results of the post payment review evaluation, we would like to remind physicians of a number of issues related to the interpretation, reporting and payment of American Medical Association's (AMA) Current Procedural Terminology (CPT) critical care codes 99291 and 99292.

1. Use of the critical care CPT codes 99291 and 99292.

(A) Definition of Critical Illness or Injury

The AMA's CPT has redefined a critical illness or injury as follows:

> "A critical illness or injury acutely impairs one or more vital organ systems such that the patient's survival is jeopardized."

Please note that the term "unstable" is no longer used in the CPT definition to describe critically ill or injured patients.

(B) Definition of Critical Care Services

> "Critical care is the direct delivery by a physician(s) of medical care for a critically ill or injured patient. The care of such patients involves decision making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vital system functions to treat single or multiple vital organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and the application of advanced technology to manage the patient.
>
> Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above."
>
> "Critical care services include but are not limited to, the treatment or prevention or further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post operative complications, or overwhelming infection. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility."

(C) Guidelines for Use Whenever Medical Review is performed in Relation to Critical Illness and Critical Care Service

A clarification of Medicare policy concerning both payment for and medical review of critical care services is warranted, given the CPT redefinition of both critical illness/injury and critical care services.

In order to reliably and consistently determine that delivery of critical care services rather than other evaluation and management services is medically necessary, both of the following medical review criteria must be met in addition to the CPT definitions:

Clinical Condition Criterion

There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition, which requires the highest level of physician preparedness to intervene urgently.

Treatment Criterion

Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

Claims for critical care services should be denied if the services are not reasonable and medically necessary. If the services are reasonable and medically necessary but they do not meet the criteria for critical care services, then the services should be re-coded as another appropriate E/M service (e.g., hospital visit).

Providing medical care to a critically ill patient should not be automatically determined to be a critical care service for the sole reason that the patient is critically ill. The physician service must be medically necessary and meet the definition of critical care services as described previously in order to be considered covered.

EXAMPLE: A dermatologist treating a rash on an ICU patient who is maintained on ventilator and nitroglycerine drips that are being managed by an intensivist should not bill for critical care.

When an entry in a patient's medical record indicates that a result or finding from a single test or procedure is "within normal limits", or indicates improvement in response to therapy, carriers may not automatically deny the claim on this basis.

Carriers are to look for other indications in the medical record supplied by the provider that all criteria (i.e., the CPT definition and medical review criteria) indicate that medical necessity and coverage are met. A patient with a designated status of "do not resuscitate" (e.g., organ donor) may qualify for critical care services when medical review criteria are met.

In summary, these criteria are consistent with the new CPT definitions of critical illness/injury and critical care services. Publication and application of these criteria will ensure:

(i) Appropriate billing for critical care services;

(ii) Reliable and consistent medical review of medical records documenting provision of critical care services; and

(iii) Correct payment for critical care and other evaluation and management services.

(D) "Full Attention" Requirement For Critical Care Service

CPT 2000 eliminated the requirement for "constant attention" as a prerequisite for use of critical care codes. The new language states: "The CPT critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time."

(E) Reporting of Physician Time Toward Critical Care Time

The CPT states the following: "Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the medical decision making."

"Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss other patients)."

(F) Medical Review Guidelines Regarding "Full Attention" and Physician Time in Critical Care Services.

(i) Since critical care is a time-based code, the physician's progress note must contain documentation of the total time involved providing critical care services. If the time is not legibly and unequivocally documented the claim will be subject to recoding or denial.

(ii) Time involved performing procedures that are not bundled into critical care (i.e., billed separately) may not be included and counted toward critical care time. The physician's progress note must document that time involved in the performance of separately billable procedures was not counted toward critical care time.

(iii) Time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT 2000), may be counted toward critical care time only when (a) the patient is unable or incompetent to participate in giving a history and/or making treatment decisions, (b) the discussion is absolutely necessary for treatment decisions under consideration that day, and (c) all of the following are documented in the physician's progress note for that day:

a. The patient was unable or incompetent to participate in giving history and/or making treatment decisions, as appropriate

b. The necessity of the discussion (e.g., no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to discuss treatment options with family immediately"),

c. The treatment decisions for which the discussion was needed, and

d. The substance of the discussion as related to the treatment decision.

We emphasize that the physician's progress note must link the family discussion to a specific treatment issue and explain why the discussion was necessary on that day. All other family discussions, no matter how lengthy, may not be counted towards critical care time. Examples of family discussions that do not meet the appropriate criteria include regular or periodic updates of the patient's condition, emotional support for the family, and answering questions regarding the patient's condition (only questions related to decision-making regarding treatment, as described above, may be counted toward critical care).

Telephone calls to family members and surrogate decision makers must meet the same conditions as face-to-face meetings.

(iv) Time involved in activities that do not directly contribute to the treatment of the patient, and therefore may not be counted towards critical care time, include teaching sessions with residents whether conducted on rounds or in other venues.

(G) Non Critically Ill or Injured Patients in a Critical Care Unit

The CPT states: "Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes."

This means that the care of a patient who receives medical care in a critical care, intensive care, or other specialized care unit should not be reported with critical care codes unless the services:

(i) meet the CPT definition of critical illness/injury,

(ii) meet the CPT definition of critical care services, and

(iii) meet the medical review criteria set forth in sections 1 (C) and (F) of this Program Memorandum.

Examples of patients who may not satisfy Medicare criteria for critical care payment include:

a. patients admitted to a critical care unit because no other hospital beds were available,

b. patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs,

c. patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin drips) to be administered in the critical care unit.

Care of patients which does not meet all these criteria should be reported using the appropriate evaluation and management codes (e.g., subsequent hospital visit codes 99231 - 99233, or inpatient consultation codes 99251 - 99255) depending on the level of service provided.

2. Hours And Days Of Critical Care That May Be Billed

Carriers shall not arbitrarily deny claims for critical care after a fixed number of hours of critical care or a fixed number of days on which critical care was billed. Critical care time may be continuous or interrupted.

The following national policies on the amount of critical care services that can be billed were first issued on May 29, 1992 in a memorandum from the Director, Office of Payment Policy to all Associate Regional Administrators for Medicare. These policies remain in effect.

(i) CPT code 99291 is used to report the first hour of critical care on a given date of service. CPT code 99292 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15-30 minutes of critical care on a given date.

Critical care time of less than 30 minutes is not reported separately. This should be reported using another appropriate E/M code.

(ii) Only one physician may bill for a given hour of critical care even if more than one physician is providing care to a critically ill patient.

3. Bundled Services

The following services, when performed on the day a physician bills for critical care, are included in the critical care service and should not be reported separately:

+ the interpretation of cardiac output measurements (CPT 93561, 93562)
+ chest x-rays (CPT 71010, 71015, 71020)
+ blood gases
+ blood draw for specimen (HCPCS G0001)
+ information data stored in computers (e.g., ECGs, blood pressures, hematologic data (CPT 99090)
+ gastric intubation (CPT 91105)
+ pulse oximetry (CPT 94760, 94762
+ temporary transvenous pacing (CPT 92953)
+ ventilator management (CPT 94656, 94657, 94660, 94662)
+ vascular access procedures (CPT 36000, 36410, 36600)
+ family medical psychotherapy (CPT 90846)

Any services performed that are not listed above may be reported separately. (See discussion under section C3, Reporting of Physician Time, for details.)

4. Global Surgery

Use of modifier "-25" to permit payment of critical care on the day of a procedure with a global fee period.

Critical care cannot be paid on the day the physician also bills a procedure code with a global surgical period unless the critical care is billed with the CPT modifier "-25" to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre- and post-operative care associated with the procedure that is performed. It appears that some carriers do not permit payment for the critical care on the same day as a procedure with a global surgical period even if it is billed with the CPT modifier "-25".

This issue was addressed in regard to evaluation and management services in our memorandum to all Associate Regional Administrators of August 27, 1993. Carriers are reminded that critical care codes are evaluation and management services and that the discussion of payment for services billed with CPT modifier "-25" also applies to critical care codes (CPT 99291 and 99292).

We believe that if denials for critical care are occurring, they may relate to a misunderstanding of what services are included or bundled into critical care. Prior to 1993, the CPT definition of critical care bundled a number of fairly significant procedures into the critical care codes, including endotracheal intubation and placement of catheters. At that time, it

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz, (CPT code 93503) are no longer bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier "-25". The time spent performing these unbundled services, e.g., endotracheal intubation, is excluded from the determination of the time spent providing critical care.

Please note this policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPT code 92950). CPR has a global period of 0 days and is not bundled into the critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier "-25". The time spent performing CPR is excluded from the determination of the time spent providing critical care.

When postoperative (for procedures with a global surgical period) critical care services are provided by a physician other than the surgeon, no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, modifiers "-54" and "-55" must be used by the surgeon and intensivist who are submitting claims. When modifiers "-54" and "-55" are used, notations in the medical record from the surgeon and intensivist clearly documenting the transfer of care from the surgeon to the intensivist are required.

5. Teaching Physician Rules for Critical Care Billing

For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the period of time for which the claim is made. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes.

Time spent teaching may not be counted towards critical care time. Time spent by the resident in the absence of the teaching physician cannot be billed by the teaching physician as critical care. Only time spent by the resident and teaching physician together with the beneficiary or the teaching physician alone with the beneficiary can be counted toward critical care time.

The teaching physician's progress note must meet all the requirements described in this Program Memorandum. Furthermore, the medical review criteria are the same for the teaching physician as for other physicians.

6. Ventilator Management

The Medicare Physician Fee Schedule final rule published on December 10, 1993, established national policy of paying for either an E/M service or ventilator management but not both. The final rule states, "We will continue to recognize the ventilator management codes (CPT codes 94656, 94657, 94660, and 94662) as physician services payable under the physician fee schedule. Physicians will no longer be paid for ventilation management in addition to an evaluation and management service, even if the evaluation and management service is billed with CPT modifier "-25".

Ref. Medical Review/ rg/3-03

ORDERING DIAGNOSTIC TESTS

A. Definitions

1. A "diagnostic test" includes all diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic tests furnished to a beneficiary.

2. A "treating physician" is a physician, as defined in 1861(r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem.

   NOTE: A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician.

3. A "treating practitioner" is a nurse practitioner, clinical nurse specialist, or physician assistant, as defined in §1861(s)(2)(K) of the Act, who furnishes, pursuant to State law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary's specific medical problem.

4. A "testing facility" is a Medicare provider or supplier that furnishes diagnostic tests. A testing facility may include a physician or a group of physicians (e.g., radiologist, pathologist), a laboratory, or an independent diagnostic testing facility (IDTF).

5. An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y). An order may include the following forms of communication:

   a. A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; **NOTE:** No signature is required on orders for clinical diagnostic tests paid on the basis of the physician fee schedule or for physician pathology services.

   b. A telephone call by the treating physician/practitioner or his/her office to the testing facility; and

   c. An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

   NOTE: If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

B. Treating Physician/Practitioner Ordering of Diagnostic Tests - The treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.

C. Different Diagnostic Test.—When an interpreting physician, e.g., radiologist, cardiologist, family practitioner, general internist, neurologist, obstetrician, gynecologist, ophthalmologist, thoracic surgeon, vascular surgeon, at a testing facility determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal, and that a different diagnostic test should be performed

(e.g., an MRI should be performed instead of a CT scan because of the clinical indication), the interpreting physician/testing facility may not perform the unordered test until a new order from the treating physician/practitioner has been received. Similarly, if the result of an ordered diagnostic test is normal and the interpreting physician believes that another diagnostic test should be performed (e.g., a renal sonogram was normal and based on the clinical indication, the interpreting physician believes an MRI will reveal the diagnosis), an order from the treating physician must be received prior to performing the unordered diagnostic test.

D. Additional Diagnostic Test Exception.—If the testing facility cannot reach the treating physician/practitioner to change the order or obtain a new order and documents this in the medical record, then the testing facility may furnish the additional diagnostic test if all of the following criteria apply:

1. The testing center performs the diagnostic test ordered by the treating physician/practitioner;
2. The interpreting physician at the testing facility determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;
3. Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary;
4. The result of the test is communicated to and is used by the treating physician/practitioner in the treatment of the beneficiary; and
5. The interpreting physician at the testing facility documents in his/her report why additional testing was done.

EXAMPLE: (a) The last cut of an abdominal CT scan with contrast shows a mass requiring a pelvic CT scan to further delineate the mass; (b) a bone scan reveals a lesion on the femur requiring plain films to make a diagnosis.

E. Interpreting Physician Exception.—This exception applies to an interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient. The interpreting physician must document accordingly in his/her report to the treating physician/practitioner.

1. Test Design.—Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).
2. Clear Error.—The interpreting physician may modify, without notifying the treating physician/practitioner, an order with clear and obvious errors that would be apparent to a reasonable layperson, such as the patient receiving the test (e.g., x-ray of wrong foot ordered).
3. Patient Condition.—The interpreting physician may cancel, without notifying the treating physician/practitioner, an order because the beneficiary's physical condition at the time of diagnostic testing will not permit performance of the test (e.g., a barium enema cannot be performed because of residual stool in colon on scout KUB; PA/LAT of the chest cannot be performed because the patient is unable to stand). When an ordered diagnostic test is cancelled, any medically necessary preliminary or scout testing performed is payable.

F. Surgical/Cytopathology Exception.—This exception applies to an independent laboratory's pathologist or a hospital pathologist who furnishes a pathology service to a beneficiary who is not a hospital inpatient or outpatient, and where the treating physician/practitioner does not specifically request additional tests the pathologist may need to perform. When a surgical or cytopathology specimen is sent to the pathology laboratory, it typically comes in a labeled container with a requisition form that reveals the patient demographics, the name of the physician/practitioner, and a clinical impression and/or brief history. There is no specific order from the surgeon or the treating physician/practitioner for a certain type of pathology service. While the pathologist will generally perform some type of examination or interpretation on the cells or tissue, there may be additional tests, such as special stains, that the pathologist may need to perform, even though they have not been specifically requested by the treating physician/practitioner. The pathologist may perform such additional tests under the following circumstances:

1. These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;
2. The results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and
3. The pathologist documents in his/her report why additional testing was done.

EXAMPLE: A lung biopsy is sent by the surgeon to the pathology department, and the pathologist finds a granuloma which is suspicious for tuberculosis. The pathologist cultures the granuloma, sends it to bacteriology, and requests smears for acid fast bacilli (tuberculosis). The pathologist is expected to determine the need for these studies so that the surgical pathology examination and interpretation can be completed and the definitive diagnosis reported to the treating physician for use in treating the beneficiary.

ICD-9-CM Coding for Diagnostic Tests

As required by the Health Insurance Portability and Accountability Act (HIPAA), the Secretary published a rule designating the ICD-9-CM and its Official ICD-9-CM Guidelines for Coding and Reporting as one of the approved code sets for use in reporting diagnoses and inpatient procedures. This final rule requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002. The Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 16, 2003. HHS anticipates that most plans and providers will obtain this extension.

The Official ICD-9-CM Guidelines for Coding and Reporting provides guidance on coding. The ICD-9-CM Coding Guidelines for Outpatient Services, which is part of the Official ICD-9-CM Guidelines for Coding and Reporting, provides guidance on diagnosis coding specific to outpatient facilities and physician offices.

The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline. CMS conforms with these longstanding official coding and reporting guidelines.

The following are instructions and examples for coding specialists, contractors, physicians, hospitals, and other health care providers to use in determining the use of ICD-9-CM codes for coding diagnostic test results. The instructions below provide guidance on the appropriate assignment of ICD-9-CM diagnosis codes to simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office). Note that physicians are responsible for the accuracy of the information submitted on a bill.

Additional examples of using ICD-9-CM codes consistently with ICD-9-CM Coding Guidelines for Outpatient Services are provided at the end of this section.

A. Determining the Appropriate Primary ICD-9-CM Diagnosis Code For Diagnostic Tests Ordered Due to Signs and/or Symptoms.

1. If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

   EXAMPLE 1: A surgical specimen is sent to a pathologist with a diagnosis of "mole." The pathologist personally reviews the slides made from the specimen and makes a diagnosis of "malignant melanoma". The pathologist should report a diagnosis of "malignant melanoma" as the primary diagnosis.

   EXAMPLE 2: A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of "intra-abdominal abscess."

   EXAMPLE 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "cough". The chest x-ray reveals a 3 cm peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

2. If the diagnostic test did not provide a definitive diagnosis or was normal, the testing facility or the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

   EXAMPLE 1: A patient is referred to a radiologist for a spine x-ray due to complaints of "back pain". The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray.

   EXAMPLE 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow-up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

4. Positron Emission Tomography (PET) Scans (HCPCS Codes G0030 -G0047).—For procedures furnished on or after March 14, 1995, pay for PET procedure of the heart under the limited coverage policy set forth in 50-36 of the Coverage Issues Manual (CMS Pub. 6) using the billing instructions in 4173 of the Medicare Carriers Manual.

D. Radiation Oncology (Therapeutic Radiology) (CPT 77261-77799)

1. Weekly Radiation Therapy Management (CPT 77427).—Pay for a physician's weekly treatment management services under code 77427. Instruct billing entities to indicate on each claim the number of fractions for which payment is sought.

   A weekly unit of treatment management is equal to five fractions or treatment sessions. A week for the purpose of making payments under these codes is comprised of five fractions regardless of the actual time period in which the services are furnished. It is not necessary that the radiation therapist personally examine the patient during each fraction for the weekly treatment management code to be payable. Multiple fractions representing two or more

treatment sessions furnished on the same day may be counted as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consist of: Review of port films; review of dosimetry, dose delivery, and treatment parameters; review of patient treatment set-ups; examination of patient for medical evaluation and management, (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results).

EXAMPLE: 18 fractions = 4 weekly services

62 fractions = 12 weekly services

8 fractions = 2 weekly services

6 fractions = 1 weekly service

If billings have occurred which indicate that the treatment course has ended (and, therefore, the number of residual fractions has been determined), but treatments resume, adjust your payments for the additional services consistent with the above policy.

EXAMPLE: 8 fractions = payment for 2 weeks

2 additional fractions are furnished by the same physician. No additional Medicare payment is made for the 2 additional fractions.

There are situations in which beneficiaries receive a mixture of simple (code 77420), intermediate (code 77425), and complex (code 77430) treatment management services during a course of treatment. In such cases, pay under the weekly treatment management code that represents the more frequent of the fractions furnished during the five-fraction week. For example, an intermediate weekly treatment management service is payable when, in a grouping of five fractions, a beneficiary receives three intermediate and two simple fractions.

2. Services Bundled Into Treatment Management Codes.—Make no separate payment for any of the following services rendered by the radiation oncologists or in conjunction with radiation therapy:

11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.0 sq. cm or less
11921	6.1 to 20.0 sq. cm
11922	each additional 20.0 sq. cm
16000	Initial treatment, first degree burn, when no more than local treatment is required
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small
16015	under anesthesia, medium or large, or with major debridement
16020	without anesthesia, office or hospital, small
16025	without anesthesia, medium (e.g., whole face or whole extremity)
16030	without anesthesia, large (e.g., more than one extremity)
36425	Venipuncture, cut down age 1 or over
53670	Catheterization, urethra; simple
53675	complicated (may include difficult removal of balloon catheter)
99211	Office or other outpatient visit, established patient; Level I
99212	Level II

99213	Level III
99214	Level IV
99215	Level V
99238	Hospital discharge day management
99281	Emergency department visit, new or established patient; Level I
99282	Level II
99283	Level III
99284	Level IV
99285	Level V
90780	IV infusion therapy, administered by physician or under direct supervision of physician; up to one hour
90781	each additional hour, up to eight (8) hours
90841	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; time un-specified
90843	approximately 20 to 30 minutes
90844	approximately 45 to 50 minutes
90847	Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
99050	Services requested after office hours in addition to basic service
99052	Services requested between 10:00 PM and 8:00 AM in addition to basic service
99054	Services requested on Sundays and holidays in addition to basic service
99058	Office services provided on an emergency basis
99071	Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician
99090	Analysis of information data stored in computers (e.g., ECG, blood pressures, hematologic data)
99150	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery, standby for newborn care following caesarean section); 30 minutes to one hour

CR 2410/MCM 1787/01/24/2003/GGL-1964

CARE PLAN OVERSIGHT

Care Plan Oversight (CPO) is physician supervision of patients under either the home health or hospice benefit where the patient requires complex or multi-disciplinary care modalities requiring ongoing physician involvement. Medicare has covered CPO since January 1, 1995.

For all claims for CPO services physicians must submit the 6-character Medicare Provider number for the HHA or hospice rendering covered Medicare services during the period in which the care planning was furnished. For hard copy claims, the 6-character Medicare Provider number of the HHA or hospice must be entered in block 23 of the HCFA-1500. For EMC claims submitted via the NSF, the HHA or Hospice Medicare provider number must be entered in Record EAO, field 49, positions 290 through 295. For EMC claims submitted in ANSI-837 format, the HHA or hospice Medicare provider number must be entered in 2-250-NM109, use qualifier MP for NM108 and FA for NM101. The physician is responsible for obtaining the Medicare Provider Number for the HHA or hospice, which is responsible for the plan of care (s) he has signed for the beneficiary, and which is rendering Medicare covered services to the beneficiary.

Claims for CPO services submitted with an invalid HHA or hospice Medicare provider number will be denied. Claims submitted for CPO services where the Medicare HHA or Hospice provider number is missing will be returned. Claims for CPO services will be denied when review of beneficiary claims history files fails to identify a covered physician service requiring a face-to-face encounter by the same physician during the six months preceding the provision of the first CPO service. The face-to-face encounter is defined as an Evaluation & Management Codes in the ranges 99201-99263 or 99281-99357.

Dates of service entered on the claim form must be the first and last date during which documented care planning services were actually provided during the calendar month, not just the first and last day 30 days of the calendar month for which the claim is submitted. Medical records for those dates must document that 30 minutes or more time have been spent by the physician for countable care planning activities as well as which services were furnished and the date and length of time associated with those services.

The physician must bill no other services than CPO services on the claim, must bill care planning only once per calendar month, must bill only one month's services per line item, and must not submit the claim until after the end of the month in which the service is performed.

The following outlines the HCPCS codes and policy concerning Care Plan Oversight:

HCPCS CODES:

1) Physicians must use HCPCS code G0179 for recertification services of Medicare covered home health service under a participating home health agency;

2) HCPCS G0180 for certification services for Medicare covered home health services under a participating home health agency;

3) G0181 for physician supervision of patient receiving Medicare covered services provided by a participating home health agency and

4) G0182 for physician supervision of a patient under a Medicare approved hospice services.

Conditions of Coverage

1. The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;
2. The beneficiary must be receiving Medicare covered home health or hospice services during the period in which the care plan oversight services are furnished;
3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care.
4. The physician must furnish at least 30 minutes of care plan oversight (see details of countable services below) within the calendar month for which payment is claimed and no other physician has been paid for care plan oversight within that calendar month;
5. The physician must have provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the provision of the first care plan oversight service (a face-to-face encounter does not include EKG, lab services or surgery);
6. The care plan oversight billed must not be routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;
7. For beneficiaries receiving Medicare covered home health services, the physician must not have a significant financial or contractual interest in the home health agency as defined in 42 CFR 424.22 (d);
8. For beneficiaries receiving Medicare covered hospice services, the physician must not be the Medical Director or an employee of the hospice or providing services under arrangements with the hospice;
9. The care plan oversight services must be personally furnished by the physician who bills them;
10. Services provided "incident to" a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.
11. The physician may not bill CPO during the same calendar month in which (s)he bills the Medicare monthly capitation payment (ESRD benefit) for the same beneficiary.
12. The physician billing for Care Plan Oversight must document in the patient's record which services were furnished and the date and length of time associated with those services.

Countable Services

The following activities are countable services toward the 30-minute minimum requirement for care plan oversight:

1. Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.

2. Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.
3. Team conferences (time spent per individual patient must be documented).
4. Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.
5. Medical decision making.
6. Activities to coordinate services are countable if the coordination activities require the skills of a physician.

Non-countable services

The following activities are services not countable toward the 30-minute minimum requirement:

1. Services furnished by nurse practitioners, physician assistants, and other non-physicians cannot be billed under the care plan oversight service. This includes the time spent by staff getting or filing charts, calling HHAs, patients, etc.
2. The physician's telephone call to patient or family, even to adjust medication or treatment. The physician's time spent telephoning prescriptions into the pharmacist is not countable since these activities do not require physician work or meaningfully contribute to the treatment of the illness or injury.
3. Travel time, time spent preparing claims and for claims processing.
4. Initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
5. Low intensity services included as part of other Evaluation and Management services.
6. Informal consults with health professionals not involved in the patient's care.
7. The physician's time spent discussing, with his/her nurse, conversations the nurse had with the HHA do not count toward this 30 minute requirement. However, the time spent by the physician working on the care plan after the nurse has conveyed the pertinent information to the physician is countable toward the 30 minutes.
8. Only one physician per month will be paid for CPO for a patient. Other physicians working with the physician who signed the plan of care are not permitted to bill for these services.
9. The work included in hospital discharge day management (99238-99239) and discharge from observation (99217) is not countable toward the 30 minute per month required for the billing of care plan oversight. Physicians may bill for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital.

Ref. Medical Review / March 25, 2003/rg/ic/dmg

HEARING AND EXCLUSION

Section 1862(a)(7) of the Social Security Act states that no payment may be made under Part A or Part B for any expenses incurred for items or services "where such expenses are for… hearing aids or examinations therefore…". This policy is further reiterated which specifically states that "hearing aids or examination for the purpose of prescribing, fitting, or changing hearing aids" are excluded from coverage.

At the time of passage of the hearing aid exclusion, all hearing aids utilized functional air and/or bone conduction pathways to facilitate hearing. We are clarifying that any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve is a hearing aid for the purposes of Medicare payment policy. Examples of hearing aids are devices that produce airconducted sound into the external auditory canal, devices that produce sound by mechanically vibrating bone, or devices that produce sound by vibrating the cochlear fluid through stimulation of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids for purposes of Medicare payment policy.

Medicare will deny payments for an item or service that is associated with any hearing aid as defined above. This clarification is not meant to change policy for the medically necessary removals of implantable hearing aids due to infection.

CR 2256/Transmittal 1781/November 22, 2002/GGL-1929

ADDITIONAL DIAGNOSTIC CODES

Several Local Medical Review Policies have been updated to include additional data pertaining to the amended Local Medical Review Policies. On pages 55 and 56 you will find Local Medical Review Policies amended. These are:

1. Abdominal Retroperitoneal and Pelvis Sonograms
2. Arthrocentesis
3. Basic Metabolic Panel
4. Cardiovascular Stress Testing
5. Comprehensive Metabolic Panel
6. Lipid Profile
7. Radiologic Examination of the Chest, and
8. Physical Therapy

PUBLICATION DATE	PROCEDURE CODES	DIAGNOSTIC CODES ADDED				
Vol. 38 (June 1996), Pag. 45	**76700-76705**	V1046	V711	1980	4419	5551
		591	5932	59389	5997	600-6001
		6003	6009	7832	78321-78322	7859
		7904	7910	7934		
	76770-76775	185	2395	25040-25043	2395	5800-5809
		5819	58381	59389	5939	5990
		5996	5997	7100	75310-75319	78909
		7910				
	76856-76857	V711	1533-1534	1540-1541	1543	185
		1990-1991	2365	44481	4538	4565
		5940-5954	59581-59589	5960	5964	59651-59659
		5966-5968	5996-5997	600	6000-6009	6010-6029
		60783	6258-6259	6279	71945	7388
		7535-7536	75611	78820-78221	78829	78903-78904
		78933-78934	7934	9025	9390	71536
		71596	8404			
Vol. 65 (June 2001), Pag. 6	**20610**	71536	71596	71916	8404	
Vol. 61 (October 2000), Pag. 14		2750-2759	49320	V658, V7281	V7281	
Vol. 63 (February 2001), Pag. 27	**93015**	043-0430	090-0900	0915-09155	09483-09484	11502
		1302	135	1360	1374	1398
		1905-1906	22455-2246	3600-3601	36021	36023-36024
		36050-36069	36081-3609	36100-36107	36110-36119	3612-36202
		36210-36218	36221-36237	36240-36243	36250-36257	36260-36266
		36270-36277	36281-3629	36300-36308	36310-36315	36320
		36322	36330-36335	36340-36343	36350-36357	36361-36363
		36370-3639	36500-36504	36510-36515	36520-36524	36531-36352
		36541-36544	36551-36559	37700-37704	37710-37716	37721-37724
		37730-37739	37741-37749	37921-37929	74352	8710-8719
	93016, 93017, 93018	40201	40210-40211	40400-40492	412	4149
		74685				
Vol. 63 (February 2001), Pag. 16		2724	4599	60784	V7281-V7284	
Vol. 59 (July 2000), Pag. 55		2721	4279	78659	7906	9879
		V7281-V7284	V658			
Vol. 43 (April-May 1997), Pag. 30		V011	V658	V7281-V7284	61172	78071
		78900	78321-7833			
Special Edition Medical Policies IV, May 1999	**97014**	34431	3510	43820-43822	43830-43832	43840-43842
		7071	7170	7172	7173	71741-71743
		7176	7177	71781-71789	81380-81383	8850-8877
		8980-8977	9515	95200-95290		
	97018	33720-3379	71113	71116	71123-71124	71126-71127
		71129-71134	71136-71137	71139	71143-71144	71149
		71153-71154	71156-71157	71159	71163-71164	71167
		71169	71173-71174	71176-71177	71179	71183-71184
		71186-71187	71189	71193-71194	71196-71197	71199
		71213	71216	71219	71223	71226
		71229	71233-71234	71236-71237	71281	71283-71284
		71286-71287	71293-71294	71296-71297	7137	71509
		71513	71516	71523	71526	71533-71534
		71536-71537	71593-71594	71596-71597	71613-71614	71616-71617

MEDICAL POLICIES	PUBLICATION DATE	PROCEDURE CODES	DIAGNOSTIC CODES ADDED				
Physical Therapy	Special Edition Medical Policies IV, May 1999	**97018**	71619	71623-71624	71626-71627	71629	9850
			9853	7014	7101	71010	71633-71634
			71636-71637	71639	71643-71644	71646-71647	71649
			71653-71654	71656-71657	71659	71663-71664	71666-71667
			71683-71684	71686-71687	71689	71693-71694	71696-71697
			71699	71803-71804	71807	71823-71824	71826-71827
			71829	71833-71834	71836-71837	71839	71843
			71846	71849	71933-71934	71936-71937	71939
			71941	71949	71953	71956	71959
			71963-71964	71966-71967	71969	721	72679
			72700	72701			
		97024	71500-71537				
		97026	3510, 9514				
		97028	72761				
		97032	34431	3510	43820-43822	43830-43832	7071
			7172-7173	71741-71743	7176-7177	71781-71789	81380-81383
			8850-8877	8950-8977	9514	95200-95290	
		97035	351-3518	3530	7170	7172-7173	71741-71743
			7176-7177	71781-71789	83819		
		97110	3400	36841	36845-36847	36901	36903-36904
			36906-36908	36912	36914	36916-36918	36922
			36924-36925	7170-7173	71740-71743	7175-71783	72782
			83819	8550-8877	8950-8977	94230-94259	94430-94458
			94530	94559	95920		
		97112	7170	7172-7173	71741-71743	7176-7177	71781-71789
			7812				
		97116	V4970	36841	36845-36847	36901	36903-36904
			36906-36908	36912-36914	36916-36918	36922	36924-36925
			7211				
		97124	3510	3530-3535	3540-3549	3550-3559	71946-71947
			71951-71957	7234	7243-7244	72704	72706
			72761	7291	9514	9530-9535	9550-9558
			9561-9563				

Contractors Policy Number
PR/VI-02-037

Contractor Name
Triple-S, Inc.

Contractor Number
00973 & 00974

Contractor type
Carrier

LMRP title
Electroencephalography (EEG)

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
Coverage Issues Manual, Sections 50-39, 50-39.1

Primary Geographic Jurisdiction
Puerto Rico & US Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
March 13, 2003

Original Policy Ending Date
N/A

Revision Effective Date
N/A

Revision Ending Date
N/A

LMRP description
Electroencephalography (EEG) can detect electrical brain alterations associated with epilepsy, sleep disturbances, and metabolic and structural encephalopathies.

The EEG is particularly useful in appraising altered consciousness that is episodic and of uncertain etiology. The record is examined for asymmetries between the two hemispheres suggesting structural disease, for excessive slowing as seen in depressed consciousness, encephalopathy, dementia, and abnormal wave patterns.

Indications and limitations of coverage and/or medical necessity
Electroencephalography (EEG) including recording awake and asleep (95819);

Medicare in our area will consider electroencephalography (EEG) including recording awake and asleep to be medically necessary for certain conditions (See ICD-9 Codes that Support Medical Necessity).

Electroencephalography (EEG) (Ambulatory/24 hour) Long -term (24 hour) Ambulatory EEG Monitoring (95950, 95951, 95953, 95956):

Ambulatory or 24-hour electroencephalographic (EEG) monitoring (95950-95951, 95953, 95956) is covered for patients in whom a seizure diathesis is suspected but not defined by history, physical or resting EEG. Ambulatory EEG can be utilized in the differential diagnosis of syncope and transient ischemic attacks if not elucidated by conventional studies. Ambulatory EEG should always be preceded by a awake and asleep resting EEG (95816, 95819, 95822, 95827). (Sleep and awake).

Digital EEG is an established substitute for recording, reviewing and storing a paper EEG record. It is a clear technical advance over previous paper methods. Although computer technology has revolutionized EEG recordings storage and analysis, analog EEG recording on paper is very adequate for clinical purpose.

Digital EEG interpretation EEG techniques are considered established in:
1. **Epilepsy:** For screening for possible epileptic spikes or seizures in long-term EEG monitoring recording to facilitate **subsequent expert visual** EEG interpretation.

2. OR and ICU monitoring: For continuous EEG monitoring by frequency-trending to detect early, acute intracranial complications in the OR or ICU, and for screening for possible epileptic seizures (convulsive or non convulsive) in high-risk ICU patients.

CPT code 95957 should be used only for digital analysis of electroencephalogram(s) in clinical situations where this is a necessity. It is described as not necessary or helpful for routine clinical records. It would usually be necessary only when an epileptology service is trying to localize foci for possible surgery, or where quantitative clinical research is undertaken.

Code 95957 refers to the analysis of EEG and not to the computer technology used to perform and record the EEG.

CPT/HCPCS Section and benefit category
Medicine/Neurology and Neuromuscular procedures

CPT/HCPCS codes

95816	Electroencephalogram (EEG) including recording awake and drowsy (including hyperventilation and/or photic stimulation when appropriate)
95819	Electroencephalogram (EEG) including recording awake and asleep (including hyperventilation and/or photic stimulation when appropriate)
95822	Electroencephalogram (EEG); sleep only
95827	Electroencephalogram (EEG); all night sleep only

95950	Monitoring for identification and lateralization of cerebral seizure focus; electroencephalographic (e.g., 8 channel EEG) recording and interpretation, each 24 hours
95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel (EEG), electroencephalographic (EEG) recording and interpretation, each 24 hours
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours.
95957	Digital analysis of electroencephalogram (EEG) (Eg, for epileptic spike analysis)

Not Otherwise Classified (NOC)
N/A

ICD-9 codes that Support Medical Necessity
For Procedure code 95819

291.0	Alcohol withdrawal delirium
293.0	Acute delirium
294.0	Amnestic syndrome
294.8	Other specified organic brain syndromes (chronic)
294.9	Organic brain syndrome, unspecified (chronic)
296.00-296.06	Manic disorder, single episode
296.10-296.16	Manic disorder, recurrent episode
296.20-296.26	Major depressive disorder, single episode
296.30-296.36	Major depressive disorder, recurrent episode
296.40-296.46	Bipolar affective disorder, manic
296.50-296.56	Bipolar affective disorder, depressed
296.60-296.66	Bipolar affective disorder, mixed
296.7	Bipolar affective disorder, unspecified
296.80-296.82	Manic depressive psychosis
296.89	Other manic depressive psychosis
296.90	Unspecified affective psychosis
296.99	Other specified affective psychoses
300.10-300.11	Hysteria, unspecified and conversion disorder
306.9	Psychophysiological malfunction, unspecified
310.1	Organic personality syndrome
310.2	Postconcussion syndrome
322.9	Meningitis, unspecified
323.0	Encephalitis in viral diseases classified elsewhere
324.0	Intracranial abscess
331.0	Alzheimer's disease
331.1	Pick's disease
331.2	Senile degeneration of brain
332.0	Paralysis agitans
333.6	Idiopathic torsion dystonia

342.00-342.02	Flaccid hemiplegia
342.10-342.12	Spastic hemiplegia
342.80-342.82	Other specified hemiplegia
342.90-342.92	Hemiplegia, unspecified
345.00-345.01	Generalized nonconvulsive epilepsy
345.10-345.11	Generalized convulsive epilepsy
345.2-345.3	Grand mal status and petit mal status
345.40-345.41	Partial epilepsy, with impairment of consciousness
345.60-345.61	Infantile spasms
345.70-345.71	Epilepsia partialis continua
345.80-345.81	Other forms of epilepsy
345.90-345.91	Epilepsy, unspecified
346.00-346.01	Classical migraine
346.10-346.11	Common migraine
346.20-346.21	Variants of migraine
346.80-346.81	Migraine, other forms
346.90-346.91	Migraine, unspecified
348.1	Anoxic brain damage
348.3	Encephalopathy, unspecified
349.0	Reaction to spinal or lumbar puncture
349.82	Toxic encephalopathy
379.40	Abnormal pupillary function, unspecified
379.50	Nystagmus, unspecified
386.2	Vertigo of central origin
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
433.20-433.21	Vertebral artery stenosis and occlusion
435.0-435.3	Transient cerebral ischemia
435.8-435.9	Other specified and unspecified transient cerebral ischemia
437.1-437.2	Other generalized ischemic cerebrovascular disease and hypertensive encephalopathy
780.1	Hallucinations
780.2	Syncope and collapse
780.31-780.39	Convulsions
780.4	Dizziness and giddiness
780.91-780.99	Other general symptoms
781.0	Abnormal involuntary movements
781.2	Abnormality of gait
784.3	Aphasia
852.00-852.09	Subarachnoid hemorrhage following injury without mention of open intracranial wound
852.10-852.19	Subarachnoid hemorrhage following injury with open intracranial wound
852.20-852.29	Subdural hemorrhage following injury without mention of open intracranial wound
852.30-852.39	Subdural hemorrhage following injury with open intracranial wound
852.40-852.49	Extradural hemorrhage following injury without mention of open intracranial wound
852.50-852.59	Extradural hemorrhage following injury with open intracranial wound
853.00-853.09	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound

853.10-853.19	Other and unspecified intracranial hemorrhage following injury with open intracranial wound
854.00-854.09	Intracranial injury of other and unspecified nature without mention of open intracranial wound
854.10-854.19	Intracranial injury

For procedure codes 95950, 95951, 95953, 95956)

006.5	Amebic brain abscess
013.00-013.06	Tuberculous meningitis
013.10-013.16	Tuberculoma of meninges
013.20-013.26	Tuberculoma of brain
013.30-013.36	Tuberculous abscess of brain
013.40-013.46	Tuberculoma of spinal cord
013.50-013.56	Tuberculous abscess of spinal cord
013.60-013.66	Tuberculous encephalitis or myelitis
013.80-013.86	Other specified tuberculosis of central nervous system
013.90-013.96	Unspecified tuberculosis of central nervous system
036.0-036.1	Meningococcal meningitis or encephalitis
045.00-045.03	Acute paralytic poliomyelitis specified as bulbar
045.10-045.13	Acute poliomyelitis with other paralysis
045.20-045.23	Acute nonparalytic poliomyelitis
045.90-045.93	Acute poliomyelitis, unspecified
053.0	Herpes zoster with meningitis
053.10-053.19	Herpes zoster with other nervous system complications
054.72	Herpes simplex meningitis
056.00-056.09	Rubella with neurological complications
062.0-062.9	Mosquito-borne viral encephalitis
063.0-063.9	Tick-borne viral encephalitis
064	Viral encephalitis transmitted by other and unspecified arthropods
071	Rabies
072.1	Mumps meningitis
072.2	Mumps encephalitis
191.0-191.9	Malignant neoplasm of brain
192.0	Malignant neoplasm of cranial nerves
192.1	Malignant neoplasm of cerebral meninges
225.0	Benign neoplasm of brain
225.2	Benign neoplasm of cerebral meninges
228.00-228.09	Hemangioma, any site
292.0	Drug withdrawal syndrome
292.11-292.12	Paranoid and/or hallucinatory states induced by drugs
292.81-292.89	Other specified drug-induced mental disorders
293.0-293.1	Delirium, acute or subacute
293.81-293.89	Other specified transient organic mental disorders
294.0-294.11	Other organic psychotic conditions (chronic)
295.20-295.24	Schizophrenic disorders, catatonic type
296.10-296.16	Manic disorder, recurrent episode
296.20-296.26	Major depressive disorder, single episode
296.30-296.36	Major depressive disorder, recurrent episode

296.40-296.46	Bipolar affective disorder, manic
296.50-296.56	Bipolar affective disorder, depressed
296.60-296.66	Bipolar affective disorder, mixed
296.7	Bipolar affective disorder, unspecified
296.80-296.89	Manic-depressive psychosis, other and unspecified
296.90-296.99	Other and unspecified affective psychoses
298.9	Unspecified psychosis
303.90-303.92	Other and unspecified alcohol dependence
310.0-310.9	Specific nonpsychotic mental disorders due to organic brain damage
326	Late effects of intracranial abscess or pyogenic infection
331.0-331.7	Other cerebral degenerations
332.0-332.1	Parkinson's disease
333.0-333.5	Other extrapyramidal disease
334.0-334.9	Spinocerebellar disease
335.10-335.19	Spinal muscle atrophy
335.20-335.29	Motor neuron disease
335.8-335.9	Other and unspecified anterior horn cell diseases
337.0-337.9	Disorders of the automatic nervous system
340	Multiple sclerosis
341.0-341.9	Other demyelinating diseases of central nervous system
343.0-343.9	Infantile cerebral palsy
345.00-345.01	Generalized nonconvulsive epilepsy
345.10-345.11	Generalized convulsive epilepsy
345.2-345.3	Petit mal status or grand mal status
345.40-345.41	Partial epilepsy, with impairment of consciousness
345.50-345.51	Partial epilepsy, without mention of impairment of consciousness
345.60-345.61	Infantile spasms
345.70-345.71	Epilepsia partials continua
345.80-345.81	Other forms of epilepsy
345.90-345.91	Epilepsy, unspecified
346.00-346.01	Classical migraine
346.10-346.11	Common migraine
346.20-346.21	Variants of migraine
346.80-346.81	Others forms of migraine
346.90-346.91	Migraine, unspecified
348.3	Encephalopathy, unspecified
349.0	Reaction to spinal or lumbar puncture
350.1-350.9	Trigeminal nerve disorders
352.0-352.9	Disorders of other cranial nerves
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.1	Subdural hemorrhage
433.00-433.01	Occlusion and stenosis of basilar artery
433.10-433.11	Occlusion and stenosis of carotid artery
433.20-433.21	Occlusion and stenosis of vertebral artery
433.30-433.31	Occlusion and stenosis of multiple and bilateral (precerebral) arteries
433.80-433.81	Other specified precerebral artery
433.90-433.91	Unspecified precerebral artery

434.00-434.11	Cerebral embolism
434.90-434.91	Cerebral artery occlusion, unspecified
435.0-435.9	Transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
437.1	Other generalized ischemic cerebrovascular disease
437.2	Hypertensive encephalopathy
572.2	Hepatic coma
767.0	Birth trauma, subdural and cerebral hemorrhage
780.2	Syncope and collapse
780.31-780.39	Convulsions
780.4	Dizziness and giddiness
780.50-780.59	Sleep disturbances
781.6	Meningismus
784.3	Aphasia
803.00-803.09	Closed skull fracture without mention of intracranial injury
803.10-803.19	Closed skull fracture with cerebral laceration and contusion
803.20-803.29	Closed skull fracture with subarachnoid, subdural, and extradural hemorrhage
803.30-803.39	Closed skull fracture with other and unspecified intracranial hemorrhage
803.40-803.49	Closed skull fracture with intracranial injury of other and unspecified nature
803.50-803.59	Open skull fracture without mention of intracranial injury
803.60-803.69	Open skull fracture with cerebral laceration and contusion
803.70-803.79	Open skull fracture with subarachnoid, subdural and extradural hemorrhage
803.80-803.89	Open skull fracture with other and unspecified intracranial hemorrhage
803.90-803.99	Open skull fracture with intracranial injury of other and unspecified nature
851.00-851.09	Cortex (cerebral) contusion without mention of intracranial wound
851.10-851.19	Cortex (cerebral) contusion with open intracranial wound
851.20-851.29	Cortex (cerebral) aceration without mention of open intracranial wound
851.30-851.39	Cortex (cerebral) laceration with open intracranial wound
851.40-851.49	Cerebellar or brain stem contusion without mention of open intracranial wound
851.50-851.59	Cerebellar or brain stem contusion with open intracranial wound
851.60-851.69	Cerebellar or brain stem laceration without mention of open intracranial wound
851.70-851.79	Cerebellar or brain stem laceration with open intracranial wound
851.80-851.89	Other and unspecified cerebral laceration and contusion without mention of open intracranial wound
851.90-851.99	Other and unspecified cerebral laceration and contusion with open intracranial wound
852.00-852.09	Subarachnoid hemorrhage following injury without mention of open intracranial wound
852.10-852.19	Subarachnoid hemorrhage following injury with open intracranial wound
852.20-852.29	Subdural hemorrhage following injury without mention of open intracranial wound
852.30-853.39	Subdural hemorrhage following injury with open intracranial wound
852.40-852.49	Extradural hemorrhage following injury without mention of open intracranial wound
852.50-852.59	Extradural hemorrhage following injury with open intracranial wound
853.00-853.09	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound

853.10-853.19	Other and unspecified intracranial hemorrhage following injury with open intracranial wound
854.00-854.09	Intracranial injury of other and unspecified nature without mention of open intracranial wound
854.10-854.19	Intracranial injury of other and unspecified nature with open intracranial wound
950.0-950.9	Injury to optic nerve and pathways
951.0-951.2	Injury to other cranial nerve(s) (oculomotor, trochlear, trigeminal)
951.3-951.9	Injury to other cranial nerves
997.00-997.09	Complications affecting the nervous system
V10.85	Personal history of malignant neoplasm of the brain
V12.40-V12.49	Personal history of disorders of nervous system and sense organs

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
Telephonically transmitted EEG's are not covered for determining electrical inactivity (e.g., brain death).

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

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

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
Use of technical component (TC) or professional component (26) modifier is appropriate in billing diagnostic procedures.

Documentation requirements
Appropriate diagnosis criteria is required.

The provider has a responsibility to ensure the medical necessity for these procedures and must maintain documentation for postpayment audit.

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

Other comments
Terms defined:

Consciousness: a state of awareness
Diathesis: predisposition to certain disease conditions
Electroencephalogram: recording of electrical activity of the brain

Sources of Information and basis for decision
Coverage Issues Manual 50-39, 50-39.1. Assessment of Digital EEG, Quantitative EEG, and EEG Brain Mapping: Report of the American Academy of Neurology and the American Clinical Neurophysiology Society, M. Nuwer.
Harrison's Principles of Internal Medicine 14th Edition: 2282
MKSAP 12; Neurology 10-11; 5-6; 112
Scientific American; Neurology XII; 3-5
Neurology July 1997(1) 277-92
J. Clin. Neurology 1998 November, 485-8

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
December 3, 2002

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Revision history
N/A

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Contractor name
Triple-S, Inc.

Contractor number
00973 & 00974

Contractor type
Carrier

LMRP title
Non-Invasive Vascular Diagnostic Studies

AMA CPT copyright statement

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)(1)(A)
  This section allows coverage and payment for only those services that are considered 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.
- Medicare Coverage issues Manual, Section 50-6
  This section covers payable procedures and indications for plethysmography.
- Medicare Coverage Issues Manual, Section 50-7
  This section covers payable procedures and indications for ultrasound diagnostic procedures.

Primary Geographic Jurisdiction
Puerto Rico & US Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
September 27, 1999

Original Policy Ending Date
March 12, 2003

Revision Effective Date
March 13, 2003

Revision Ending Date
N/A

LMRP Description

Non-invasive vascular diagnostic studies utilize ultrasonic Duplex and Doppler physiologic principles to assess irregularities in blood flow in arterial and venous systems. The display may be a two-dimensional image with spectral analysis and color flow or a plethysmographic recording that allows for quantitative analysis.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output or imaged when provided.

The accuracy of non-invasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and interpreter. Consequently, the providers of interpretations must be capable of demonstrating documented training and experience and maintain documentation for post-payment audit.

Effective September 27, 1999, all non-invasive vascular diagnostic studies must be either: (1) performed by or under the general supervision of persons who have demonstrated minimum entry level competency by being credentialed in vascular technology, or (2) performed in facilities with laboratories accredited in vascular technology. Examples of appropriate personnel certification include the Registered Vascular Technologist (RVT) credential and the Registered Cardiovascular Technologist (RCVT) credential in vascular technology. Appropriate laboratory accreditation includes the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL).

In general, non-invasive studies of the arterial system are to be utilized when invasive correction is contemplated, or when medical necessity rules apply.

Definitions:

- A duplex scan implies an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging.

- A physiologic study implies functional measurement procedures including Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurements or plethysmography.

- Plethysmography implies volume measurement procedures including air, impedance, or strain gauge methods.

- Transcranial Doppler uses ultrasound principles to emit high frequency soundwaves from a Doppler device to detect the flow of blood or pinpoint an arterial irregularity such as an obstruction in the arteries within the cranium (skull).

The following techniques are not covered:

Thermography, mechanical oscillometry, inductance plethysmography, capacitance plethysmography, photoelectric plethysmography, light reflection rheography, pulse delay ocutoplethysmography, periorbital photoplethysmography.

Indications and Limitations of Coverage and/or Medical Necessity

Non-invasive vascular studies *are* used for the evaluation of patients with either arterial or venous diseases. The studies are often used prior to invasive studies, or to define surgical intervention.

Non-invasive vascular studies are payable only in places of service: office (11) for the global or a component of the global service; inpatient hospital (21), outpatient hospital (22), and emergency room (23) for the professional component of the services; and independent diagnostic testing facility (IDTF) (99) for the technical component of the services, or for the global service if a physician is employed by the IDTF to interpret tests at the facility. (Note: the physician rendering this service may not be the ordering or referring physician).

It is seldom necessary to perform arterial and venous studies during the same encounter. Documentation should be available to support the medical necessity for both studies.

It is rarely necessary to perform cerebrovascular and upper extremity studies on the same day Documentation supporting the need for both studies should be available for review.

A referral must be on record for each non-invasive study performed. A referral for one type of study does not qualify as a referral for all tests.

CEREBROVASCULAR ARTERIAL STUDIES (codes 93875-93888)
Indications:

Cerebrovascular arterial studies are considered for Medicare payment when at least one of the following conditions is present:

- Cervical bruits
- Amaurosis fugax
- Focal cerebral or ocular transient ischemic attacks (i.e., localizing symptoms, weakness of one side of the face, slurred speech, weakness of a limb)
- Drop attacks or syncope are rare indications primarily seen with vertebrobasilar or bilateral carotid artery disease.
- Episodic dizziness with symptom characteristics typical of transient ischemic attacks, especially when other more common sources (e.g., postural hypotension or transiently decreased cardiac *output* as demonstrated by cardiac events monitoring) have been previously excluded.
- Severe stenosis or occlusion of the extracranial and major basal subarachnoid arteries
- Cerebral vasospasm complicating subarachnoid hemorrhage
- Impending invasive therapeutic interventions for cerebral arteriovenous malformations
- Intracranial hemodynamic abnormalities in patients with suspected brain death
- Intraoperative and perioperative monitoring of intracranial flow velocity and hemodynamic patterns during carotid endarterectomy (This is usually a Part A responsibility, unless the professional component is performed by a physician who is not a member of the operating team).
- Cerebral embolization

Limitations:

The following conditions would not meet medical necessity criteria for coverage:

- Headaches (including migraines)
- Dizziness, unless associated with other localizing symptoms
- Assessment of familial and degenerative diseases of the *cerebrum, brainstem,* cerebellum, basal ganglia and motor neurons
- Epilepsy
- Psychiatric disorders
- Brain tumors
- Evaluation of infectious and inflammatory conditions

The following conditions are considered investigational applications and are not covered:

- Migraine
- Monitoring during carotid endarterectomy, cardiopulmonary bypass and other cerebrovascular and cardiovascular interventions.
- Evaluation of patients with dilated vasculopathies such as fusiform aneurysms
- Assessing autoregulation, physiologic, and pharmacological responses of cerebral arteries

PERIPHERAL ARTERIAL EXAMINATIONS (codes 93922-93931)

Indications

Peripheral arterial studies are considered for Medicare coverage when there are significant signs and/ or symptoms of possible limb schemia in a patient who may be a candidate for invasive therapeutic procedures, as indicated by at least one of these conditions:

- Claudication of less than one block or of such severity that it interferes significantly with the patients occupation or lifestyle.
- Rest pain (typically including the forefoot), usually associated with absent pulses, 'which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position.
- Tissue loss defined as gangrene or pregangrenous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses.
- Aneurysmal disease
- Evidence of thromboembolic events
- Blunt or penetrating trauma (including complications *of diagnostic and/or* therapeutic procedures

Limitations:

The following conditions would not meet medical necessity criteria for coverage:

- Continuous burning of the feet is considered to be a neurologic symptom
- "Leg pain, nonspecific" and "Pain in limb" as single diagnoses are too general to warrant further investigation unless they are related to other signs and symptoms.
- Edema rarely occurs with arterial occlusive disease unless it is the immediate post-operative period, *in* association *with* another inflammatory process or in association with rest pain.
- Absence of relatively minor pulses (dorsalis pedis, posterior tibial) in the absence of symptoms is not an indication to proceed beyond the physical examination unless it is related to other signs or symptoms.

PERIPHERAL VENOUS EXAMINATIONS (codes 93965-93971)

Indications

These studies are medically necessary in patients who are candidates for anticoagulation, thrombolysis, or invasive therapeutic procedures and who have signs or symptoms of one of the following:

- Deep vein thrombosis (DVT) indicated by edema, tenderness, inflammation, and/or erythema
- Pulmonary embolism (RE) indicated by hemoptysis, chest pain, and/or dyspnea
- Unexplained lower extremity edema status-post major surgical procedures
- Chronic venous insufficiency indicated by secondary varicose veins
- Post-thrombotic (post-phlebitic) syndrome
- Ulceration suspected to be secondary to venous insufficiency

Limitations:

The following conditions would not meet medical necessity criteria for coverage:

- Bilateral limb edema in the presence of signs and/or symptoms of congestive heart failure, exogenous obesity and/or arthritis should rarely be an indication.
- It is not medically necessary to perform peripheral venous examinations to study primary varicose veins.

VISCERAL VASCULAR STUDIES (93975, 93976, 93978, 93979)

Indications

Visceral vascular studies are considered for Medicare payment when one of the following conditions is present:

- Arteriosclerosis of renal artery
- Aortic aneurysm and dissection
- Peripheral vascular disease
- Intestinal vascular insufficiency
- intestinal angiodysplasia

HEMODIALYSIS ACCESS EXAMINATION (code 93990)

Indications

This procedure will be considered for Medicare coverage for the following:

- Signs or symptoms in patients with ESRD of impending failure of the hemodialysis access site

Limitations to coverage:

- When services are performed by the ESRD physician of record, services are considered renal related (part of the monthly capitation fee) and are not separately payable.

- Services performed by a Medicare approved ESRD facility are included in the composite rate of the facility and are not separately payable.

CPT/HCPCS Section Benefit Category
Medicine/Vascular Studies

CPT/HCPCS codes
Cerebrovascular Arterial Studies

93875	Non-invasive physiologic studies of extracranial arteries, complete bilateral study (e.g., periorbital flow direction with arterial compression, ocular pneumoplethysmograph doppler ultrasound spectral analysis)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	; unilateral or limited study
93886	Transcranial doppler study of the intracranial arteries; complete study
93888	;limited study complete bilateral study compression, ocular analysis) study

Extremity Arterial Studies

93922	Non-invasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement).
93923	Non-invasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (e.g., segments blood pressure measurements, segmental *Doppler* waveform analysis. segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia)
93924	Non-invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, complete bilateral study
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	;unilateral or limited study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts: complete bilateral study
93931	unilateral or limited study

Extremity Venous Studies

93965	Non-invasive physiologic studies of extremity veins, complete bilateral study (e.g., Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	;unilateral or limited study

Visceral Vascular Studies

93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study limited study
93976	limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	;unilateral or limited study
93980	duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981	follow -up or limited study

Extremity Arterial-Venous Studies

93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

Not Otherwise Classified (NOC)

ICD-9 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 procedure to be paid.

CEREBROVASCULAR ARTERIAL STUDIES (93875.93880.93882. 93886.93888)

342.01-342.02	Flaccid hemiplegia
342.11-342.12	Spastic hemiplegia
342.81-342.82	Other specified hemiplegia
344.01-344.09	Quadriplegia and quadriparesis
344.1	Paraplegia
344.2	Diplegia of upper limbs
344.31-344.32	Monoplegia of lower limbs
344.41-344.42	Monoplegia of upper limbs
362.31-362.37	Retinal vascular occlusion
362.84	Retinal ischemia
368.10	Subjective visual disturbance
368.11-368.12	Sudden or transient visual loss
368.41-368.47	Visual field defects
433.00-433.81	Occlusion and stenosis of precerebral arteries
434.00-434.11	Occlusion of cerebral arteries
434.91	Cerebral artery occlusion, unspecified, with cerebral infarction
435.0-435.8	Transient cerebral ischemia
435.9	Unspecified transient cerebral ischemia
436	Acute, but ill-defined cerebrovascular disease
437.0	Cerebral atherosclerosis
437.1	Other generalized ischemic cerebrovascular disease
437,3	Cerebral aneurysm, nonrupted
437.4	Cerebral arteritis
437.7	Transient global amnesia
442.81	Aneurysm of artery of neck
442.82	Aneurysm of subclavian artery
447.1	Stricture of artery
780.2	Syncope and collapse
781.2	Abnormality of gait

781.3	Lack of coordination
781.4	Transient paralysis of limb
782.0	Disturbance of skin sensation
784.3	Aphasia
784.5	Other speech disturbance
785.9	Other symptoms involving cardiovascular system (bruit, arterial)
900.01 - 900.1	Injury to blood vessels of head and neck
901.1	Injury to innominate and subclavian arteries
996.1	Mechanical complication of other vascular device, implant, and graft
996.7	Other complications of internal (biological) (synthetic) prosthetic device, implant and graft)

EXTREMITY ARTERIAL STUDIES (93922, 93923, 93924, 93925, 93926, 93930 93931)

250.70-250.73	Diabetes with peripheral circulatory disorders
353.0	Brachial plexus lesions
440.0	Atherosclerosis of aorta
440.21	Atherosclerosis of the extremities with intermittent claudication
440.22	Atherosclerosis of the extremities with rest pain
440.23	Atherosclerosis of the extremities with ulceration
440.24	Atherosclerosis of the extremities with gangrene
440.30-440.32	Atherosclerosis of bypass graft of extremities
441.00-441.9	Aortic aneurysm and dissection
442.0	Aneurysm of artery of upper extremity
442.3	Aneurysm of artery of lower extremity
443.0-443.89	Other peripheral vascular diseases
443.9	Peripheral vascular disease; unspecified
444.21-444.22	Arterial embolism and thrombosis of arteries of extremities
447.1-447.2	Disorders of arteries
707.1	Chronic ulcer of skin of lower limbs, except decubitus
707.8	Chronic ulcer of skin of other specified sites
782.5	Cyanosis
785.4	Gangrene
903.00-903.8	Injury to blood vessels of upper extremity
904.0-904.7	Injury to blood vessels of lower extremity and unspecified sites
996.1	Mechanical complication of other vascular device, implant, and graft
996.70-996.79	Other complications of internal (biological)(synthetic) prosthetic device, implant and graft
997.2	Peripheral vascular complications
998.11-998.13	Hemorrhage or hematoma or seroma complicating a procedure
998.2	Accidental puncture or laceration during a procedure

EXTREMITY VENOUS STUDIES (93965, 93970, 93971)

415.11-415.19	Pulmonary embolism and infarction
451.0-451.9	Phlebitis and thrombophlebitis
454.0	Varicose veins of lower extremities with ulcer
454.2	Varicose veins of lower extremities with ulcer and inflammation

459.1	Postphlebitic syndrome
459.2	Compression of vein
459.81	Venous (peripheral) insufficiency, unspecified
671.20-671.24	Superficial thrombophlebitis
671.30-671.33	Deep phlebothrombosis, antepartum
671.40-671.44	Deep phlebothrombosis, postpartum
682.6	Cellulitis and abscess of leg, except foot
695.9	Unspecified erythematous condition
707.1	Chronic ulcer of skin of lower limbs, except decubitus
729.5	Pain in limb
729.81	Swelling of limb
747.63	Anomaly of the peripheral vascular system, upper limb
747.64	Anomaly of the peripheral vascular system, lower limb
747.69	Anomaly of the peripheral vascular system, other specified sites
782.2	Localized superficial swelling, mass or lump
782.3	Edema
785.4	Gangrene
786.09	Dyspnea and respiratory abnormalities
794.2	Nonspecific abnormal results of pulmonary function studies
903.00-903.8	Injury to blood vessels of upper extremity
904.0-904.9	Injury to blood vessels of lower extremity and unspecified, sites
996.1	Mechanical complication of other vascular device, implant, and graft
996.70-996.79	Other complications of internal (biological) (synthetic) prosthetic device, implant and graft
997.2	Peripheral vascular complications
998.2	Accidental puncture or laceration during a procedure
999.2	Other vascular complications
V12.51	History of venous thrombosis and embolism
V12.52	History of thrombophlebitis

VISCERAL VASCULAR STUDIES (93975, 93976, 93978, 93979)

V42.0	Kidney replaced by transplant
V82.8	Screening for other specified conditions
236.0	Neoplasm of uncertain behavior of uterus
236.2	Neoplasm of uncertain behavior of ovary
236.3	Neoplasm of uncertain behavior of other and unspecified
401.0	Malignant essential hypertension
415.19	Embolism and infarction, other
440.0	Atherosclerosis of aorta
440.1	Atherosclerosis of renal artery
440.21	Atherosclerosis of extremities with intermitent claudication
441.00-441.9	Dissection of aorta
443.1	Thromoangitis obliterans (Buerger's disease)
443.9	Peripheral vascular disease, unspecified
451.11	Phlebitis and thrombophlebitis, other
451.19	Phlebitis and thrombophlebitis, other
452	Portal vein thrombosis

453.2	Embolism and thrombosis of vena cava
453.3	Embolism and thrombosis of renal vein
456.1	Esophageal varices without mention of bleeding
456.2	Esophageal varices in diseases classified elsewhere
456.4	Scrotal varices
456.8	Varices of other sites
557.0	Acute vascular insufficiency of intestine; infarction of appendices
557.1	Chronic vascular insufficiency of intestine
569.84	Angiodysplasia of intestine, with or without mention of hemorrhage
569.85	Angiodysplasia of intestine with hemorrhage
571.2	Alcoholic cirrhosis of liver
571.3	Alcoholic liver damage, unspecified
571.4	Chronic hepatitis
571.5	Cirrhosis of liver without mention of alcohol
571.8	Other chronic nonalcoholic liver disease
571.9	Unspecified chronic liver disease without mention of alcohol
572.3	Portal hypertension
603.9	Hydrocele, unspecified
604.90	Orchitis and epididymitis, unspecified
620.8	Other noninflamatory disorders of ovary, fallopian
671.40	Deep phlebothrombosis, postpartum, unspecified as to
959.1	Other and unspecified injury to trunk
996.1	Mechanical complication of other vascular device implant

PENILE VASCULAR STUDIES (93980, 93981)

607.82	Vascular disorders of penis
607.83	Edema of penis
607.84	Impotence of organic origin

EXTREMITY ARTERIAL VENOUS STUDIES (93990)

V45.1	Postsurgical renal dialysis status
V67.0	Follow-up examination following surgery
447.0	Arteriovenous fistula, acquired
585	Chronic renal failure
996.73	Renal dialysis device, implant graft

Diagnosis that Support Medical Necessity
All of the above.

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

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

Reasons for Denial

- Claims for non-invasive vascular diagnostic studies with diagnoses or indications other than those listed as covered will be denied as not medically necessary. Claims for non-invasive vascular studies done for screening purposes will be denied.
- Claims for non-invasive vascular studies performed in any place of service other than those indicated as payable in the "Indications and Limitations" section of this policy will be denied.
- Claims submitted without a referring physician or qualified non-practitioner's name and UPIN will be returned as unprocessable.
- Claims submitted with a referring physician or qualified non-practitioner who is not independent of the facility performing the studies and the physician interpreting the studies will be denied.

Non-covered ICD-9 Codes

Any ICD-9 CM not included in this policy.

Noncovered diagnosis

Any diagnosis not included in this policy.

Coding Guidelines

1. A vascular study may be coded as a global study, reflecting all technical and professional components, or as separate technical (modifier TC) and professional (modifier 26) components.

2. The following services are by definition performed bilaterally and are programmed to reimburse as bilateral studies: 93875, 93880, 93922, 93923, 93924, 93925, 93930, 93965, 93970, 93975, 93978. They should never be billed with a bilateral modifier (50) or with a number of services greater than one (1).

3. The following services are by definition limited or unilateral studies and should also be billed only with a number of services of one (1): 93882, 93886, 93888, 93926, 93931, 93971, 93976, 93979 and 93990. A bilateral modifier (50) is not appropriate with these codes. Bilateral or complete studies should be reported with the appropriate codes.

4. The Correct Coding Initiative precludes billing a limited or follow up non-invasive vascular diagnostic study on the same day as a complete non-invasive vascular study.

5. Cerebrovascular studies are payable on the same day as extremity studies only in rare cases, and both must be documented as medically indicated.

6 Calculation of the ankle/brachial index is considered to be part of the peripheral vascular study, and is therefore not separately payable.

7. The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of the bi-directional vascular flow, and Doppler procedures performed with zero-crossers (i.e. analog [strip chart recorder] analysis) are not separately payable services.

8. The name and UPIN of the treating/ordering physician must be on the claim in boxes 17 and 1 7a, respectively. If submitting electronically, this information must be in the record, fields 22.0 and 20.0. Without this information, claims will be returned as unprocessable.

9. Payable places of service are: office (11) for global service or a component of the global service (modifier 25); inpatient (21), outpatient (22), and emergency room (23) for the professional

component (modifier 26) of the services; and IDTF (99) for the technical component (modifier TC) of the services or for the global service if a physician is employed by the IDTF to interpret tests at the facility.

Documentation Requirements

- Claims may be submitted electronically or on paper. Medical records will not be required, but must substantiate the medical necessity if records are requested. Requests for review must be accompanied by a copy of the report and the clinical summary from the primary physician.

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

- On request for the medical record, a clinical summary (evaluation) supporting the medical necessity for the study must be submitted. On medical review the simple order with the ICD-9 (diagnosis) alone will not be accepted.

- For medical review purpose, evidence must be demonstrated that the diagnostic study must either be: (1) performed by or under the general supervision of persons who have demonstrated minimum entry level competency by being credentialed in vascular technology, or (2) performed in facilities with laboratories accredited in vascular technology. Examples of appropriate personnel certification include the Registered Vascular Technologist (RVT) credential and the Registered Cardiovascular Technologist (RCVT) credential in vascular technology. Appropriate laboratory accreditation includes the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL).

- Evidence of this accreditation must be submitted when requested.

- Failure to comply with the above, will deem the study as not medically necessary.

- Records must demonstrate evidence of planned medical or surgical treatment contemplated.

- Also evidence of knowledge, skills and experience of the technologist and interpreter must be submitted on request for medical review.

- Each study performed must be ordered by the treating physician. A referral for one non-invasive study is not a blanket referral for all studies.

Utilization guidelines

N/A

Other comments

N/A

Sources of information and basis for decision

- Passman, M.D., et al, “Efficacy of color flow duplex imaging for proximal upper extremity venous outflow obstruction ‘iii hemodialysis patients”, Journal of Vascular Surgery, Volume 25, Number 5, November, 1998.

- Kerstein, M.D.,Ostomv~Wound-Manage: The non-healing leg ulcer; peripheral vascular disease, chronic venous insufficiency, and ischemic vasculitis, 1996
- Williams & Wilkins, M.D.'s, Guide to clinical preventative services, "Screening for asymptomatic carotid artery stenosis," 1996.
- Report of the American Academy of Neurology, Assessment: Transcranial Doppler, Neurology, April 1990.

Advisory Committee Notes
This policy does not reflect 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 vascular specialties.

Start date of comment period
December 3, 2002

Ending date of comment period
January 18, 2003

Start date of notice period
January 27, 2003

Revision history

Revision number	Effective date of the revision	Changes
R-13-02		A. Additional diagnostic codes (ICD-9) were added. B. Documentation requirements were extended to demonstrate specific medical necessity, diagnostic codes in a prescription are not sufficient for payment. Evaluation and management to substantiate medical necessity must be available on request. Also, evidence of proper trainings of the person performing the test as well as the person reading the test must be submitted on request.

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Contractors Policy Number
PR/VI-02-039

Contractor Name
Triple-S, Inc.

Contractor Number
00973 & 00974

Contractor type
Carrier

LMRP title
Electrodiagnostic Studies (EDX)

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

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

Program Memorandum B-01-28, CR #850 dated April 19, 2001, gives information on physician supervision of diagnostic tests.

Primary Geographic Jurisdiction
Puerto Rico & US Virgin Islands

Secondary Geographic Jurisdiction
N/A

CMS Region
New York, Region II

CMS Consortium
Northeastern

Original Policy Effective Date
January 15, 1998

Original Policy Ending Date
March 12, 2003

Revision Effective Date
March 13, 2003

Revision Ending Date
N/A

LMRP description
Nerve conduction studies (NCS) are used to measure action potentials resulting from peripheral nerve stimulation recordable over the nerve or from an innervated muscle. With this technique, nerve conduction velocities are measured between two sites of stimulation, or between a stimulus and a recording site. Nerve conduction studies are undertaken together with electromyography (EMG). Since EMG and NCS go hand in hand and one is rarely done without the other the term FDX is encompass the EMG and NCS. Nerve conduction velocity measurement (NCV) is one aspect of a nerve conduction study.

Results of NCV reflect on the integrity and function of the lower motor neuron and the axon (an extension of neuronal cell body) of a nerve. Diseases of the lower motor neuron, interruption of axon and dysfunction of myelin, will affect NCV results. Nerve conduction studies are of two broad types: sensory and motor. Either surface or needle electrodes can be used to stimulate the nerve. Axonal damage or dysfunction generally results in loss of nerve or muscle potential amplitude; whereas, demyelination leads to prolongation of conduction time. The following are a few prime examples where NCS are helpful: carpal tunnel syndrome, ulnar neuropathy at the elbow, metabolic and immune peripheral neuropathies or traumatic nerve damage.

It is often valuable to test conduction status in proximal segments of peripheral nerves. These segments include the first several centimeters of a compound nerve emerging from the spinal cord or brainstem. H-reflex, F-waves and Blink reflex testing (CPT 95934, 95936, 95903, 95933) accomplish this task better than distal NCS (CPT 95900, 95904).

Electromyography (EMG) is the study and recording of intrinsic electrical properties of skeletal muscles. This is carried out with a needle electrode, often, but not always, a disposable one. Generally the electrodes are of two types: monopolar or concentric. EMG is undertaken together with NCS. Unlike NCS, however, EMG testing relies on both auditory and visual feedback to the electromyographer. This testing is also invasive in that it requires needle insertion and adjustment at multiple sites, and at anatomically critical areas. In common with NCV, the electromyographer depends on ongoing real-time clinical diagnostic evaluation for deciding whether to continue, modify or conclude a test. This requires a knowledge base of anatomy, physiology and neuromuscular diseases.

EMG results reflect not only on the integrity of the functioning connection between a nerve and its innervated muscle, but also on the integrity of a muscle itself. The axon innervating a muscle is primarily responsible for the muscle's volitional contraction, survival and trophic functions. Thus, interruption of the axon will alter the EMG. A few prime examples are disc disease, advanced nerve compression, ALS, neuropathy and so on. Primary muscle disease such as polymyositis will also alter a normal EMG pattern. Myotonic disorders may show a pattern of spontaneous repetitive discharges on needle exploration. After an acute neurogenic lesion, EMG changes may not appear for several days to weeks in the innervated muscles. In summary, axonal and muscle involvement are best detected by EMGs and myelin and axonal involvement are best detected by NCV's.

Somatosensory Evoked Potentials (SSEPs)

SSEPs are an extension of the electrodiagnostic evaluation of the peripheral nervous system. SSEPs can define not only CNS dysfunction, but can also monitor conduction in the peripheral nervous system in a useful manner. Suggested criteria for using SSEPs include: (1) that the studies be performed in a technically accepted manner and (2) that the results could be expected to be clinically helpful.

Indications and limitations of coverage and/or medical necessity
Nerve Conduction Studies

The dichotomy into axonal and demyelinating neuropathies provides a practical means of correlating electrical abnormalities with major pathophysiologic changes in the nerve. Electrical studies can be of help in distinguishing one variety of neuropathy form another: for example, diffuse vs. multifocal; axonal vs. demyelinating. Such distinction has diagnostic value. Specific classification of nerve injuries into neuropraxia and axonotmesis can be made based on conduction studies and electromyography. Such classification has a bearing on prognosis and treatment.

Focal neuropathies or compressive lesions such as carpal tunnel syndrome, ulnar neuropathies or root lesions, for localization.

Traumatic nerve lesions, for diagnosis and prognosis.

Diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic, metabolic or immune.

Repetitive nerve stimulation in diagnosis of neuromuscular junction disorders such as myasthenia gravis, myasthenic syndrome.

There may be other instances, not detailed here, where NCS may be of use. Not all possible or potential indications are addressed here. The broad diagnostic scope of NCS is recognizable by the foregoing description. There may be instances where questions about an indication, or need for a study, will arise. The clinical history and examination carried out before the study, must always describe and document clearly and comprehensibly the need for the planned test. A “rule-out” diagnosis is not always acceptable. The Carrier is cognizant of the fact that patients are not always referred with a definite diagnosis in mind. Often, pain, paresthesia or weakness in an extremity is the reason for an EDX. These common symptoms result not only from axonal and myelin dysfunction but from systemic, non-neurological illnesses. EDX may help in making this distinction. Therefore, symptom-based diagnoses such as “pain in limb” (729.5), weakness (728.9), disturbance in skin sensation (782.0) or “paresthesia” are acceptable provided the clinical assessment unequivocally supports the need for a study. To cite, but one example of many, and EDX is irrelevant as a first order diagnostic test for limb pain resulting from immediate antecedent trauma or acute bone injury. Both EMGs and NCVs are required for a clinical diagnosis of peripheral nervous system disorders. EMG results reflect on the integrity of the functioning connection between a nerve and its innervated muscle and on the integrity of a muscle itself. Performance of one does not eliminate the need for the other. The intensity and extent of testing with EDX are matters of clinical judgment developed after the initial pre-test evaluation, and later modified during the testing procedure. The need for ongoing real-time clinical diagnostic evaluation, and the invasive nature of needle exploration are two, of several, reasons for requiring that trained physicians perform EMGs and interpret NCS and EMG. Decisions to continue, modify or conclude a test also rely on a knowledge base of anatomy, physiology and neuromuscular diseases. For this reason also, NCS, if performed by non-physicians, requires readily available direct (over the shoulders) physician’s supervision.

Electromyography

Neurogenic disorders are distinguishable from myopathic disorders by a carefully performed EMG. For example, both polymyositis and ALS (Amyotrophic Lateral Sclerosis) produce manifest weakness. The former carries a very different prognosis and treatment than the latter. An EMG is very valuable in making this distinction. Similarly, classification of nerve trauma into axonal vs. demyelinating categories, with corresponding differences in prognoses, are possible with EMG. Below is a list of common disorders where an EMG, in tandem with properly conducted NCS, will be helpful in diagnosis:

1. Nerve compression syndromes, including carpal tunnel syndrome and other focal compressions
2. Radiculopathy - cervical, lumbosacral
3. Mono/polyneuropathy - metabolic, degenerative, hereditary
4. Myopathy - including poly and dermatomyositis, myotonic and congenital myopathies
5. Plexopathy - idiopathic, trauma, infiltration
6. Neuromuscular junction disorders - myasthenia gravis. Single fiber EMG (95872) is of especial value here.
7. At times, before Botulinum A toxin injection, for localization.

There may be other instances, not detailed here, where EMG may be of use.

CPT/HCPCS Section and benefit category
Medicine

CPT/HCPCS codes
A. Nerve Conduction Studies (NCS)

95900	Nerve conduction, amplitude and latency/velocity study, each nerve any/all site(s) along the nerve; motor, without F-wave study
95903	motor, with F-wave
95904	sensory
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936	record muscle other than gastrocnemius/soleus muscle
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method)

B. Electromyography (EMG)

95860	Needle electromyography, one extremity and related paraspinal areas
95861	Needle electromyography, two extremities and related paraspinal areas
95863	Needle electromyography, three extremities and related paraspinal areas
95864	Needle electromyography, four extremities and related paraspinal areas
95867	Needle electromyography, cranial nerve supplied muscles, unilateral
95868	Needle electromyography, cranial nerve supplied muscles, bilateral
95869	Needle electromyography, limited study of specific muscles (e.g., thoracic spinal muscles)
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studies
51785	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes with interpretation and report

Not Otherwise Classified (NOC)
N/A

ICD-9 codes that Support Medical Necessity
005.1 Botulism

037	Tetanus
138	Late effects of acute poliomyelitis (post polio)
192.2	Malignant neoplasm of spinal cord
192.3	Malignant neoplasm of spinal meninges
250.60	Diabetes with neurological manifestations; type II (non-insulin dependent type)(NIDDM type) (adult-onset type) or unspecified type, not stated as uncontrolled
250.61	Type I (insulin dependent type) (IDDM) (juvenile type), not stated as uncontrolled
250.62	Type II (non-insulin dependent type) (NIDDM) (adult-onset type) or unspecified type, uncontrolled
250.63	Type I (insulin dependent type) (IDDM) (juvenile type), uncontrolled
265.1	Other and unspecified manifestations of thiamine deficiency
269.1	Deficiency of other vitamins
272.5	Lipoprotein deficiencies
332.0	Paralysis agitans
333.6	Idiopathic torsion dystonia
333.83	Spasmodic torticollis
333.90-333.99	Other unspecified extrapyramidal diseases and abnormal movement disorders
335.0	Werding - Hoffmann disease
335.10	Spinal muscular atrophy, unspecified
355.11	Kugelberg - Welander disease
335.19	Other spinal muscular atrophy
335.20-.29	Motor neuron disease
335.8	Other anterior horn cell diseases
335.9	Anterior horn cell disease, unspecified
336.0-336.9	Other diseases of spinal cord
337.0-337.9	Disorders of the automatic nervous system includes: disorders of peripheral autonomic, sympathetic, parasympathetic or vegetative system
340	Multiple sclerosis
341.0	Neuromyelitis optica
341.1	Schilder's disease
342.90-342.92	Hemiplegia, unspecified
344.0	Quadriplegia
344.1	Paraplegia
344.60	Cauda equina syndrome; without mention of neurogenic bladder
344.61	with neurogenic bladder
344.89	Other specified paralytic syndrome
344.9	Paralysis, unspecified
348.1	Anoxic brain damage
350.2	Atypical face pain
350.9	Trigeminal nerve disorder
351.0	Bell's palsy
351.8	Other facial nerve disorders
351.9	Facial nerve disorder, unspecified
352.3	Disorders of pneumogastric (10th) nerve
352.4	Disorders of accessory (11th) nerve
352.5	Disorders of hypoglossal (12th) nerve
352.6	Multiple cranial nerve palsies
353.0	Brachial plexus lesions

353.1	Lumbosacral plexus lesions
353.2	Cervical root lesions, not elsewhere classified
353.3	Thoracic root lesions, not elsewhere classified
353.4	Lumbosacral root lesions, not elsewhere classified
353.5	Neuralgic amyotrophy
353.8	Other nerve root and plexus disorders
353.9	Unspecified nerve root and plexus disorder
354.0-354.9	Mononeuritis of upper limb and mononeuritis multiplex
355.0-355.9	Mononeuritis of lower limb and unspecified site
356.0-356.9	Hereditary and idiopathic peripheral neuropathy
357.0-357.8	Inflammatory
358.0-358.9	Myoneural disorders
359.0-359.9	Myopathy, unspecified
478.75	Laryngeal spasm
710.3	Dermatomyositis
710.4	Polymyositis
710.5	Eosinophilia myalgia syndrome
721.0	Cervical spondylosis with myelopathy
721.1	Cervical spondylosis with myelopathy
721.2	Thoracic spondylosis without myelopathy
721.3	Lumbosacral spondylosis without myelopathy
721.41	Spondylosis with myelopathy, thoracic region
721.42	Spondylosis with myelopathy, lumbar region
722.0-722.11	Displacement or cervical, thoracic, or lumbar intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.4	Degeneration of cervical intervertebral disc
722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.6	Degeneration of intervertebral disc, site unspecified
722.70-73	Invertebral disc disorder with myelopathy
722.80-83	Postlaminectomy syndrome
722.91-93	Other specified disc disorder
723.0	Spinal stenosis in cervical region
723.1	Cervicalgia (neck Pain)
723.4	Brachial neuritis or radiculitis NOS
723.5	Torticollis, unspecified
724.00-09	Spinal stenosis, other than cervical
724.1	Pain thoracic spine
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Backache, unspecified
726.0-726.8	Peripheral enthesopathies and allied syndromes
727.9	Unspecified disorders of synovium, tendon and bursa (synovitis, bursitis)
728.0	Infective myositis
729.1	Myalgia and Myositis, unspecified
729.2	Neuralgia, neuritis and radiculitis, unspecified
729.5	Pain in limb

736.05	Wrist drop (acquired)
736.06	Claw hand (acquired)
736.09	Other acquired deformities of forearm, excluding fingers
736.79	Other acquired deformities of ankle and foot
738.4	Acquired spondylolisthesis
767.6	Injury to Brachial Plexus (birth Trauma)
780.7	Malaise and fatigue
780.9	Other general symptoms
781.2	Abnormality of gait
781.3	Lack of coordination
781.4	Transient paralysis of limb
781.7	Tetany
782.0	Disturbance of skin sensation
784.49	Other disturbance, including spasmodic dysphonia
952.00-09	Spinal cord injury without evidence of spinal bone injury-cervical
952.10-19	Spinal cord injury without evidence of spinal bone injury-dorsal (thoracic)
952.2	Lumbar spinal cord injury without spinal bone injury
952.3	Sacral spinal cord injury without spinal bone injury
952.4	Cauda equina spinal cord injury without spinal bone injury
952.8	Multiple sites of spinal cord injury without spinal bone injury
952.9	Unspecified site of spinal cord injury without spinal bone injury
953.0-9	Injury to nerve roots and spinal plexus
954.0-9	Injury to other nerve(s) of trunk, excluding shoulder and pelvic girdles
955.0-9	Injury to peripheral nerve(s) of shoulder girdle and upper limb
956.0-9	Injury to peripheral nerve(s) of pelvic girdle and lower limb
957.0-9	Injury to other and unspecified nerves
959.0	Trauma to face and neck
959.1	Trunk (musculoskeletal injury-back)
959.7	Knee, leg, ankle and foot (musculoskeletal injury L/E)
958.8	Other specified sites, including multiple

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
Nerve Conduction Studies
Examination using portable hand-held devices, which are incapable of waveform analysis, will be included in a visit. They will not be paid separately. Psychophysical measurements are not covered.

A clinical history from the referral source must clearly document the need for each test. Referral data containing pertinent clinical information must be available for review in instances where the need for a test may come under scrutiny. Absolute inclusive or exclusive criteria for performance of a diagnostic test are difficult to enumerate.

Consistent excessive use of units of testing (see table on suggested upper limits), repeated testing on the same patient or testing every patient referred for pain, weakness or paresthesia may become evident on review and a pattern of performing NCS without a concomitant EMG. In these cases, denial will be the invariable outcome. The EDX performing provider, in addition to the referring provider, is responsible for determination of the appropriateness of a study.

Generally, the following diagnoses may be established without exceeding the unit limits given below:

CONDITIONS	MOTOR NCV 95900	SENSORY NCV 95904
Carpal tunnel (unilateral)	3	3
Carpal tunnel (bilateral)	4	6
Radiculopathy (i.e., sciatica)	3	2
Mono/polyneuropathy	6	6
Myopathy	2	2
ALS	4	4
Plexopathy	6	6
Neuromuscular junction disorder	3	2

Segmental testing of a single nerve will not be reimbursed on a multiple unit basis. For instance, testing the ulnar nerve at wrist, forearm, below elbow, above elbow, axilla and supraclavicular regions will be considered as a one unit test of 95900 or 95904.

Certain less than optimal practices are discouraged and may invite reviews. They are: narrative reports alluding to "normal" or "abnormal" results without numerical data, descriptions of F-wave without reference to a corresponding motor conduction data; pattern-setting unilateral H-reflex measurements; separate E/M consultation charges without documentable request from the referral source.

Frequency of testing is a difficult issue to answer. Clinical justification, rather than an algorithm, should be the determinant in these instances. While this removes any recipe-style limits, it also calls for clear, responsible and evidence-based documentation for any repeat study. Such a guideline applies to all studies including those for patients (1) under medical, surgical or rehabilitative treatment, (ii) for patients with chronic renal failure and/or dialysis.

Screening testing for polyneuropathy (not mononeuropathies) of diabetes or end stage renal disease (ESRD) is NOT covered. Testing for the sole purpose of monitoring disease intensity or treatment efficacy in these two conditions is also not covered.

Electromyography

A clinical history from the referral source must clearly document the need for each test. Referral data containing pertinent clinical information must be available for review in instances where the need for a test may come under scrutiny. Absolute inclusive or exclusive criteria for performance of a diagnostic test are difficult to enumerate.

Surface and macro EMGs will not be paid.

Certain less than optimal practices are discouraged, and may invite review. They include: exclusive testing of intrinsic foot muscles in the diagnosis of proximal lesions; definitive diagnostic conclusions based on paraspinal EMG in regions bearing scar of past surgeries (e.g., previous laminectomies); pattern-setting limited limb muscle examinations, without paraspinal muscle testing for a diagnosis of

radiculopathies, narrative reports without data, and premature EMG testing after trauma when EMG changes may not have taken place.

Frequency of testing issue has been addressed in NCS policy (see NCS section on "Reasons for Non-coverage").

C. Regulations in Puerto Rico and Virgin Islands for NCSs and EMGs

The Puerto Rico Board of Medical Examiners has emended it's by laws based on the guidelines given by the American Academy of Electrodiagnostic Medicine. These studies are an integral part of the examination performed by a Neurologist or Physiatrist. These studies are tailored or designed according to the findings encountered during the examination. This is the reason why they have to be performed by the Neurologist or a Physiatrist. These studies are part of a Neurological Physical examination.

Article 7.5 clearly states that in the Commonwealth of Puerto Rico the only person authorized to perform and make an interpretation of these sophisticated studies, must have completed a formal training in Physical Medicine and Rehabilitation or Neurology. The Board of Medical Examiners recognizes that doctors with regular medical licenses that have completed the above stated training are the only medical doctors authorized by law to be involved in the performance, supervision and interpretation of this test.

Following the law, in Puerto Rico Medicare will only honor payments for performance, supervision and interpretation of this test to physicians licensed in Puerto Rico with the written evidence from the Puerto Rico Board of Medical Examiners certifying completion of training in the above stated specialties.

The bases for the above are the By Laws of the Board of Medical Examiners in Puerto Rico. In the Commonwealth of Puerto Rico, Article 7.5 prevails over any other regulations.

Evaluation of tests performed prior to this instruction and performed for providers not trained in the above stated specialties would be subject to evaluation for determination of medical necessity and accurateness in the test and its interpretation. Such an evaluation will be subject to recoupment by the Medicare Part B Program and evaluation for referral to the proper agencies if such tests are inappropriate or if no clinical indications for such tests are found.

In the Commonwealth of Puerto Rico EMGs must be performed by a neurologist or a physiatrist (or a physician with training equivalent to the one obtained during training of the above stated specialties). NCS if invasive (needles) must also be performed by a neurologist or physiatrist. If NCS are not invasive, the personal supervision of the neurologist or physiatrist must be clearly documented in the medical report.

Tests performed in the USVI require that the EMGs be performed by a specialist. Same principles apply to NCS, if invasive. For non-invasive NCS the personal (over the shoulder) supervision of the specialist is required.

In addition, in the USVI the performing physician, if not specialist in neurology or physiatrist, must demonstrate training in electrophysiology equivalent to the training received in a neurology or physiatrist residency.

Noncovered ICD-9 codes

Any ICD-9 CM not included in this policy.

Noncovered diagnosis
Any diagnosis not included in this policy.

Coding guidelines
Since and FDX is a direct extension of the physical examination, it is expected that an Evaluation/ Management (E/M) service should have been charged, a short period of time before executing the FDX in addition to EMG-NCS codes. Such a service, must abide by all required E/M criteria.

Codes 95900 and 95904 are billed by units. Code 95903 includes both F-waves and motor conductions. If nephrologists submit 95900, 95903, 95904, 95934 or 95936 for ESRD patients, these codes are not separately payable; they are part of the monthly capitation fee. These codes are payable if submitted by other specialties when the indications are appropriate.

Service can be performed in the office, hospital or nursing home. For 95860-96864, only one unit of service should be billed. (This covers all muscles tested including the related paraspinal muscles and recording of motor unit recruitment, amplitude and configuration both at rest and with muscle contraction). Code 95869 should be used to bill a limited EMG study of specific muscles (eg., thoracic, spinal muscles or less than five limb muscles.

Examinations confined to distal muscles only, such as intrinsic foot or hand muscles, will be reimbursed as code 95869 and not as 95860-95864.

Documentation requirements
The patient's medical records must clearly document the medical necessity for the test. It is not necessary to include documentation for routine claim submissions. Data gathered during NCS, however, should be available. They should reflect the actual members (latency, amplitude, etc.), preferably in a tabular (not narrative) format. The reason for referral and a clear diagnostic impression are required for each study. Hard copies of wave forms obtained will aid documentation requirements in cases where a review becomes necessary. If conditions are outside of listed guidelines, paper claims can be submitted accompanied by supportive medical data for review. If processing results in denial, it is appropriate to ask for a review.

Utilization guidelines
N/A

Other comments

Persons performing electrodiagnosis should be appropriately trained and qualified. They must have a detailed knowledge of neuromuscular diseases and awareness of the influence of age, temperature and body height on the results. Since these tests may produce anxiety and stress, an exquisite awareness of patient's comfort and sensitivity are essential. There are guidelines published by AAEM (American Association of Electrodiagnostic Medicine) and other medical organizations, including the AMA, The American Academy of Neurology, The American Academy of Physical Medicine and Rehabilitation, American Neurological Association and the Department of Veterans Affairs. These guidelines require that only trained physicians perform and interpret both EMG and NCS.

The person performing the electrodiagnosis should be appropriately trained and qualified. Attention is directed to the section on NCS for further details. Reference has been made to the invasive nature of EMG. The potential for discomfort in sensitive persons, bleeding and transmission of infectious diseases must be always kept in mind. EMG of certain muscles, such as the serratus anterior, iliopsoas,

sternomastoids, facial muscles and the recti require special care in view of the vital structures in their proximity.

Sources of Information and basis for decision

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Brown, W. F. and C. F. Bolton. Clinical Electromyography. 2nd ed. Boston: Butterworths, 1993.

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Dumitru, D. Electrodiagnostic Medicine. Philadelphia: Hanley & Belfus, 1995.

Oh, S. J. Clinical Electromyography; Nerve Conduction Studies. 2nd ed. Baltimore: Williams & Wilkins, 1993.

Kimura, J. Electrodiagnosis in Diseases of Nerve and Muscle: Principles and Practice. 2nd ed. Philadelphia FA Davis, 1989.

"Laboratory Tests in End-Stage Renal Disease Patients Undergoing Dialysis". AHCPR #94-053 Health Technology Assessment Publication number 2, May 1994.

Suggested Reference List available from American Association of Electrodiagnostic Medicine (AAEM) at 21 Second Street S. W., Suite 103 Rochester, MN 55902.

"Who is Qualified to Practice Electrodiagnostic Medicine?" American Association of Electrodiagnostic Medicine. Includes position statements from (A) American Medical Association. House of Delegates. Resolution: G2, I-83, 1983. (B) American Academy of Neurology. Minutes of Executive Board Meeting 11.9 (1) December 2, 1981. American Academy of Physical Medicine and Rehabilitation. Statement re: Clinical Diagnostic Electromyography, November 1983. (D) Veterans' Administration. Professional Services Letter: Professional Qualifications for Performing Electromyographic Examinations IL-11-80-1, January 4, 1980.

Ref. #8 and 9 are also available from AAEM Web site URL: <http://www.pitt.edu/-nab4/aaem.html>.

AAEM monographs. These provide detailed discussions with bibliography covering individual topics in the field of electrodiagnosis. They are available from the Web site cited above.

Nathan, D.M. 1996. "The pathophysiology of diabetic complications: How much does the glucose hypothesis explain?" Am Int Med 124: 86-89.

"Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and proression of long term complications in insulin dependent diabetes mellitus". 1993. New Eng J of Med 329: 977-986.

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 physiatrist.

Start date of comment period
December 3, 2002

Ending date of comment period
January 18, 2003

Start date of notice period
January 27, 2003

Revision history

Revision Number	Effective Date of the Revision	Changes
R-14-02		Clarification regarding the need for documentation of the medical necessity to perform the test was addressed. This medical necessity documentation must be available on request. Failure to provide such may result in a denial. The training of the specialist performing and reading the test must also be available and submitted if requested.

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GGL-1905

Reembolso

NUEVAS PRUEBAS AL CERTIFICADO DE DISPENSA

A continuación las pruebas que recientemente la Administración Federal de Drogas y Alimentos aprobó como pruebas de dispensa bajo el *Clinical Laboratory Improvement Amendments* (CLIA por sus siglas en inglés). A los códigos de procedimiento (*Current Procedural Terminology*) correspondientes a estas nuevas pruebas, se les debe añadir el modificador QW para que sean reconocidas como pruebas de dispensa.

Reimbursement

NEW TESTS TO THE WAIVED CERTIFICATE

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

TEST NAME	MANUFACTURER	CPT CODE(S)
*Polymer Technology Systems CardioChek PA Analyzer {PTS Panels Lipid Panel Test Strips},	Polymer Technology Systems, Inc.	82465QW, 83718QW, 84478QW, 80061QW
*Phamatech QuickScreen One Step Amphetamine Test	Phamatech	80101QW
*Phamatech QuickScreen One Step Cocaine Screening Test	Phamatech	80101QW
*Phamatech QuickScreen One Step Methamphetamine Test	Phamatech	80101QW
*Phamatech QuickScreen One Step Opiate Screening Test	Phamatech	80101QW
*Phamatech QuickScreen One Step PCP Screening Test	Phamatech	80101QW
*ThermoBiostar PocketChem UA	ThermoBiostar	81003QW
*Lifescan Harmony INR Monitoring System--Prescription Home Use and Professional Use	Lifescan, Inc.	85610QW
*Matritech, Inc. NMP22 BladderCheck Test for Professional and Prescription Home Use	Maritech, Inc.	86294QW
*Meridian BioScience ImmunoCard STAT! *H.pylori Whole Blood Test*	Applied Biotech, Inc.	86318QW
*DE Healthcare Products, TruView Strep A Test	DE Healthcare Products	87880QW
*Henry Schein Inc, One Step+Srep A Test	Henry Schein	87880QW

CR2533/Transmittal AB-03-013/02-03-2003/mm

Reembolso

ACTUALIZACIÓN TRIMESTRAL A LAS TARIFAS DMEPOS DEL 2003

Las tarifas fijas de Equipo Médico Duradero, Protésico, Ortótico y Suplidos (DMEPOS) por sus siglas en inglés, se actualizan trimestralmente. El propósito de la actualización es implementar las tarifas fijas para los nuevos códigos y revisar aquellas cantidades de las tarifas de los códigos existentes calculadas incorrectamente.

En vigencia el 1 de abril de 2003 el nuevo código HCPCS K0560 estará bajo la jurisdicción local.

> ***K0560** Metacarpal Phalangeal Joint Replacement, Two Pieces, Metal (E.G., Stainless Steel Or Cobalt Chrome), Ceramic-Like Material (E.G., Pyrocarbon), For Surgical Implantation (All Sizes, Includes Entire System)

***Este código está clasificado bajo la categoría de pago protésico y ortótico.**

Efectivo el 1 de abril de 2003 entra en vigor los siguientes nuevos códigos HCPCS bajo la jurisdicción regional de equipo médico duradero (DMERC), por sus siglas en inglés.

Reimbursement

APRIL QUARTERLY UPDATE FOR 2003 DMEPOS FEE SCHEDULE

The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule is updated on a quarterly basis in order to implement fee schedule amounts for new codes and revise any fee schedule amounts for existing codes that were erroneously calculated.

Effective April 1, 2003 new HCPCS code K0560 will be implemented for local carrier jurisdiction.

> ****K0560*** *Metacarpal Phalangeal Joint Replacement, Two Pieces, Metal (E.G., Stainless Steel Or Cobalt Chrome), Ceramic-Like Material (E.G., Pyrocarbon), For Surgical Implantation (All Sizes, Includes Entire System)*

****This code is located in the payment category for prosthetics and orthotics.***

Effective April 1, 2003 the following new HCPCS codes will be implemented for DMERC Jurisdiction.

K0600	Functional Neuromuscular Stimulator, Transcutaneous Stimulation Of Muscles Of Ambulation With Computer Control, Used For Walking By Spinal Cord Injured, Entire System, After Completion Of Training Program
K0601	Replacement Battery For External Infusion Pump Owned By Patient, Silver Oxide, 1.5 Volt, Each
K0602	Replacement Battery For External Infusion Pump Owned By Patient, Silver Oxide, 3 Volt, Each
K0603	Replacement Battery For External Infusion Pump Owned By Patient, Alkaline, 1.5 Volt, Each
K0604	Replacement Battery For External Infusion Pump Owned By Patient, Lithium, 3.6 Volt, Each
K0605	Replacement Battery For External Infusion Pump Owned By Patient, Lithium, 4.5 Volt, Each

CR2535/Transmittal AB-03-006/01-24-2003/mm

Reembolso

MÉTODO SIMPLE DE PRECIOS

La presencia o ausencia de un medicamento en la lista de Métodos Simple de Precios (SDP por sus siglas en inglés) no representa una determinación de cubierta o no-cubierta del medicamento por Medicare. Además, la tarifa que aparece en dicha lista corresponde al pago máximo permitido por medicamento sí el contratista determina que el mismo cumple con los requisitos de cubierta. Igualmente, la ausencia de un medicamento de la lista significa que si el contratista determina cubrir dicho medicamento tendrá que establecer la tarifa a reembolsar conforme a la política de estandarización de precios para medicamentos. Los contratistas determinan si cierto medicamento cumple con los requisitos de cubierta y si ése es el caso, determina si el reembolso por el medicamento se podrá realizar para la condición para la cual fue administrada. Los ejemplos de estas determinaciones incluyen, pero no están limitadas a aquellas que establecen que un medicamento o ruta de administración es razonable y necesario para el tratamiento de la condición del beneficiario, si el medicamento podrá ser excluido por ser auto-administrable y si existe una alternativa menos costosa del medicamento.

Reimbursement

SINGLE DRUG PRICER (SDP)

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

AB-03-014/CR2544/03-07-03/DG

TARIFAS PARA LA ADMINISTRACIÓN DE VACUNAS

El 1 de marzo de 2003 entra en vigor las tarifas para administración de las vacunas de influenza, neumocócica y hepatitis B. Estas son:

VACCINE ADMINISTRATION FEES

Effective March 1, 2003 the fees for the administration of the influenza, pneumococcal and hepatitis B vaccines are:

Código ***Code***	**Descripción** ***Description***	**Tarifas / *Fees***	
		Puerto Rico	***Virgin Islands***
G0008	Administration of influenza virus vaccine	$5.34	$7.89
G0009	Administration of pneumococcal vaccine	$5.34	$7.89
G0010	Administration of hepatitis B vaccine	$5.34	$7.89

CR2530-1/17/2003-MM

Reembolso

REVISIÓN DE LOS MENSAJES DE LAS REMESAS DE PAGO PARA LOS CENTROS DE ENFERMERÍA ESPECIALIZADA

Los mensajes para la facturación consolidada para los Centros de Enfermería Especializados (SNF, por sus siglas en inglés) fueron revisados y tendrán vigencia el 1 de abril de 2003. Los mensajes que se utilizarán para denegar estos servicios serán los siguientes:

> "Reason Code 109-"Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor".
>
> "Remark Code N73 –"A SNF is responsible for payment of outside providers who furnish these services/supplies under arrrangement to its residents."

Los servicios brindados por Trabajadores Sociales Clínicos a beneficiarios en una estadía SNF cubierta por Parte A no pueden ser facturados por separado. Estos servicios se incluyen en la Tarifa de Pago Prospectivo pagado a los SNFs. Para esta situación, se implementarán los siguientes editos por servicios prestados a beneficiarios en una estadía SNF Parte A:

Édito 1

Este nuevo edito será para reclamaciones con fecha de servicio a partir del 1 de abril de 2001 y se reciban a partir del 1 de abril de 2003. Si la especialidad del proveedor que prestó el servicio es 80 (Trabajador Social Clínico), la reclamación será rechazada con el mensaje que sigue:

> "Adjustment reason code 96–Non-covered charges

Remark code N121- Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing facility stay".

Édito 2

Comenzando el 1 de abril de 2003 si las reclamaciones por servicios prestados con fecha de servicio a partir del 1 de abril de 2001 fueron pagadas y la especialidad del proveedor que prestó el servicio es 80, estas se ajustarán y se recuperará el pago.

Reimbursement

REVISION TO MESSAGES IN THE REMITTANCE ADVICE FOR THE SKILLED NURSING FACILITIES

Effective April 1, 2003 the messages for Skilled Nursing Facility (SNF) Consolidated Billing in the Remittance Advice (RA) Notice have been revised. The messages that will be used to deny this type of service will be as follows:

> *Reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.*
>
> *Remark Code N73- A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.*

Services provided by Clinical Social Workers (CSWs) to beneficiaries in a Part A SNF stay may not be billed separately, payment for these services are included in the Prospective Payment Rate paid to the SNF. The following edits for services rendered beneficiaries in a Part A SNF stay have been implemented.

Edit 1

This new edit has been established for claims with dates of services rendered starting April 1, 2001 and received on April 1, 2003 and thereafter. If the performing provider specialty code is 80 CSWs, the claim will be rejected as follows:

> *Adjustment reason code 96 – Non-covered charges*

Remark code N121 – Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility stay.

Edit 2

As of April 1, 2003 for services rendered with dates of service starting April 1, 2001 and thereafter; an edit similar to Edit 1 has been installed. If claims for services that fall within the dates of the stay and the performing provider specialty code is 80 have already been paid, the claims will be adjusted and recouped.

CR2360/B-02-067/October 25, 2002/ ICR/els

Reembolso

ELIMINACIÓN DE CÓDIGOS DE VACUNA 90723 Y 90748

A partir del el 1 de enero de 2003 los siguientes códigos de vacuna no son válidos para propósitos de Medicare:

90723: Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B and poliovirus vaccine, inactivated (DTA-HEPB-UV), for intramuscular use

90748: Hepatitis B and hemophilus influenza B vaccine (HEPB- HIB) for intramuscular use

Se determinó que estos códigos de vacuna no eran apropiados para beneficio preventivo. A dichos códigos no le aplica el periodo de gracia de 90 días.

Los códigos 90740, 90743, 90744, 90746 y 90747 continuan válidos para propósitos de Medicare.

Reimbursement

DELETION OF 90723 AND 90748 VACCINES CODES

As of January 1, 2003 the following vaccine codes are no longer valid for Medicare purposes:

***90723**: Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B and poliovirus vaccine, inactivated (DTA-HEPB-UV), for intramuscular use*

***90748**: Hepatitis B and hemophilus influenza B vaccine (HEPB- HIB) for intramuscular use*

It has been determined that these vaccines codes were inappropriate for preventive benefit. These codes that are no longer applicable to Medicare will not have a 90-day grace period.

Codes 90740, 90743, 90744, 90746 and 90747 are still valid for Medicare purposes.

CR 2536/TRANS AB-02-185/12-31-2002/CR 2392/TRANS 1778/ 11-01-2002/MM/ CR2560/ TRANS 1778/02-03-2003/MM

TARIFAS PARA LA CÁPSULA ENDOSCÓPICA

En el volumen 70, página 44 de nuestro boletín Medicare Informa, se publicó la política médica para la cápsula endoscópica. A continuación las tarifas para dicho procedimiento:

WIRELESS CAPSULE ENDOSCOPY FEES

In volume 70, page 44 of our Medicare Informa bulletin, we published the Medical Policy for the Wireless Capsule. The following are the fees for this procedure:

CODIGO CODE	*TARIFA PAR PAR FEE*	*TARIFA NO-PAR NON-PAR FEE*	*CARGO LIMITE LIMITING CHARGE*
91299	$950.00	$902.50	$1,037.87

3/2003/MM

Reembolso

LISTA DE JURISDICCIÓN PARA CÓDIGOS DMEPOS

A continuación una lista actualizada de los códigos correspondientes a equipo médico duradero, protésico, ortótico y suministros (DMEPOS). Dicha lista también indica cuál es el contratista con jurisdicción para procesar las reclamaciones que contengan estos códigos.

Esta información es efectiva el 1 de abril de 2003.

Reimbursement

2003 DMEPOS JURISDICTION LIST

The following is an updated list of the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) codes. This list also indicates which carrier (local or regional) has jurisdiction for the processing of these codes.

The effective date for this information is April 1, 2003.

CR 2567/Trans. B-03-020/02-28-03/mm

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
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4253 - A4259	Diabetic Supplies	DME REGIONAL Carrier
A4260	Levonorgestrel Implant	Local Carrier
A4261	Cervical Cap for Contraceptive Use	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
A4266 - A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4281 - A4286	Accessory for Breast Pump	DME REGIONAL Carrier
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4310 - A4359	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4361 - A4422	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A4450 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4458	Enema Bage	DME REGIONAL Carrier
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4483	Moisture Exchanger	DME REGIONAL Carrier

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME REGIONAL Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4606	Oxygen Probe for Oximeter	DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4609 - A4610	Tracheal Suction Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME Regional Carrier
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4646	Imaging Agent; Contrast Material	Local Carrier
A4647	Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier
A4651 - A4932	Supplies for ESRD	DME REGIONAL Carrier
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier
A5500 - A5511	Therapeutic Shoes	DME REGIONAL Carrier
A6000	Non-Contact Wound Warming Cover	DME REGIONAL Carrier
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6025	Silicone Gel Sheet	DME REGIONAL Carrier
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6412	Eye Patch	DME REGIONAL Carrier
A6421 - A6512	Surgical Dressings	DME REGIONAL Carrier
A7000 - A7039	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044	Respiratory Accessory	DME REGIONAL Carrier
A7501-A7509	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier
A9270	Noncovered Items or Services	DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
A9901	Delivery	DME REGIONAL Carrier
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0117	Crutches	DME REGIONAL Carrier

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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 - E0484	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0590	Drug Dispensing Fee	DME REGIONAL Carrier
E0600	Suction Pump	DME REGIONAL Carrier
E0601	CPAP Device	DME REGIONAL Carrier
E0602 - E0604	Breast Pump	DME REGIONAL Carrier
E0605	Vaporizer	DME REGIONAL Carrier
E0606	Drainage Board	DME REGIONAL Carrier
E0607	Home Blood Glucose Monitor	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0618 - E0619	Apnea Monitor	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621 - E0636	Patient Lifts	DME REGIONAL Carrier
E0650 - E0673	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0691 - E0694	Ultraviolet Light Therapy Systems	DME REGIONAL Carrier
E0700	Safety Equipment	DME REGIONAL Carrier
E0701	Helmet	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulators	Local Carrier

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
E0754	Patient Programmer for use with IPG	Local Carrier
E0755	Reflex Stimulator	DME REGIONAL Carrier
E0756 - E0759	Implantable Nerve Stimulator	Local Carrier
E0760	Ultrasonic Osteogenic Stimulator	DME REGIONAL Carrier
E0761	Electromagnetic Treatment Device	DME REGIONAL Carrier
E0765	Nerve Stimulator	DME REGIONAL Carrier
E0776	IV Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier
E0830	Ambulatory Traction Device	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0930	Trapeze/Fracture Frame	DME REGIONAL Carrier
E0935	Passive Motion Exercise Device	DME REGIONAL Carrier
E0940	Trapeze Equipment	DME REGIONAL Carrier
E0941	Traction Equipment	DME REGIONAL Carrier
E0942 - E0945	Orthopedic Devices	DME REGIONAL Carrier
E0946 - E0948	Fracture Frame	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier
E1353 - E1390	Additional Oxygen Related Equipment	DME REGIONAL Carrier
E1399	Miscellaneous DME	Local Carrier if implanted DME. If other, DME REGIONAL Carrier
E1405 - E1406	Additional Oxygen Equipment	DME REGIONAL Carrier

Actualizado: Enero 2003 / *Revised: January 2003*

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1840	Dynamic Flexion Devices	DME REGIONAL Carrier
E1902	Communication Board	DME REGIONAL Carrier
E2000	Gastric Suction Pump	DME REGIONAL Carrier
E2100 - E2101	Blood Glucose Monitors with Special Features	DME REGIONAL Carrier
G0001 - G9016	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J3590	Unclassified Biologics	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7190 - J7192	Factor VIII	Local Carrier
J7193 - J7195	Factor IX	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7302	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7317 - J7320	Injection	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7340 - J7350	Dermal and Epidermal - Tissue of Human Origin	Local Carriers
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
J7608 - J7699	Inhalation Solutions	DME REGIONAL Carrier
J7799	NOC, Other than Inhalation Drugs through DME	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemotherapeutic	DME REGIONAL Carrier
J8510 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier

Actualizado: Enero 2003 / *Revised: January 2003*

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0112 - K0116	Spinal Orthotics	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0268	Humidifier	DME REGIONAL Carrier
K0415 - K0416	Antiemetic Drugs	DME REGIONAL Carrier
K0452	Wheelchair Bearings	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0460 - K0461	Power Add-on Converters for Wheelchairs	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0531	Accessory for Respiratory Assist Device	DME REGIONAL Carrier
K0532 - K0534	Respiratory Assist Device	DME REGIONAL Carrier
K0538 - K0540	Negative Pressure Wound Therapy Pump	DME REGIONAL Carrier
K0541 - K0547	Speech Generating Device	DME REGIONAL Carrier
K0548	Injection, Insulin Lispro	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
K0549 - K0550	Hospital Bed, Heavy Duty	DME REGIONAL Carrier
K0556 - K0559	Socket Inserts	DME REGIONAL Carrier
K0581 - K0597	Ostomy Devices and Supplies	DME REGIONA Carrier
L0100 - L2090	Orthotics	DME REGIONAL Carrier
L2102 - L2104	Casts	Local Carrier
L2106 - L2116	Orthotics	DME REGIONAL Carrier
L2122 - L2124	Casts	Local Carrier
L2126 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME REGIONAL Carrier
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8490	Prosthetics	DME REGIONAL Carrier
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier

Actualizado: Enero 2003 / *Revised: January 2003*

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
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; Cardio-kymography	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0136	Injection, Epoetin Alpha	Local Carrier
Q0144	azithromycin dihydrate	Local Carrier
Q0163 - Q0181	Anti-emetic	DME REGIONAL Carrier
Q0183	Artificial Skin	Local Carrier
Q0187	Factor VIIA	Local Carrier
Q1001 - Q1005	New Technology IOL	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3019 - Q3020	ALS Transport	Local Carrier
Q3021 - Q3026	Vaccines	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q9920 - Q9940	Injection of EPO	DME REGIONAL Carrier when self-administered or for Method II beneficiaries, otherwise Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier

Actualizado: Enero 2003 / *Revised: January 2003*

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HCPCS	DESCRIPCIÓN *DESCRIPTION*	JURISDICCIÓN *JURISDICTION*
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

Actualizado: Enero 2003 / *Revised: January 2003*

NO CUBIERTA PARA LA TERAPIA ELECTRO CONVULSIVA MÚLTIPLE (MECT)

Terapia Electro Convulsiva Múltiple (MECT, por sus siglas en inglés) no será cubierta por Medicare a partir del 1 de abril de 2003.

Según el Manual de Cubierta de Medicare, §35-103, la efectividad clínica de la Terapia Electro Convulsiva Múltiple no se ha comprobado con estudios científicos controlados. Así mismo, estudios demuestran un aumento en el riesgo de causar efectos adversos al provocar convulsiones múltiples. MECT no puede ser considerada razonable y necesaria por lo tanto, no estará cubierta para servicios efectuados a partir del 1 de abril de 2003.

Por lo tanto, el código 90871 [Electroconvulsive Therapy (includes necessary monitoring); multiple seizures, per day] no estará cubierto a partir del 1 de abril de 2003.

CR2499/Transmittal AB-03-003-10/01/03-ICR/els

NON-COVERAGE OF MULTIPLE ELECTROCONVULSIVE THERAPIES (MECT)

Effective for dates of service April 1, 2003 and thereafter, Multiple Electroconvulsive Therapies (MECT) will not be covered by Medicare.

As per § 35-103 of the Medicare Coverage Issues Manual, the clinical effectiveness of multiple-seizure electroconvulsive therapy has not been verified by scientifically controlled studies. In addition, studies have demonstrated an increased risk of adverse effect with multiple seizures. Accordingly, MECT cannot be considered reasonable and necessary and is non-covered.

Therefore, CPT code 90871 [Electroconvulsive Therapy (includes necessary monitoring); multiple seizures, per day] will be non-covered effective April 1, 2003.

Reembolso

CODIFICACIÓN DE ESPECIALIDADES

Los Centros para Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) revisó la Sección 2207 del **Medicare Carriers Manual** (MCM). Dicha sección añadió los siguientes códigos de especialidad y redefinió los códigos para Osteópatas y Plan de Pre-pagos Grupal (GPPP):

09 Intervención para el Manejo del Dolor

32 Asistente de Anestesiólogo – Anteriormente pertenecían al grupo de Enfermeras Anestesistas Certificadas. **La cubierta de esta especialidad para Puerto Rico está bajo consideración del Departamento de Salud Estatal**.

43 Enfermeras Anestesistas Certificadas –**Esta especialidad se cubre en las Islas Vírgenes pero en Puerto Rico no está autorizada.**

65 Terapista Físico en Practica Privada – se eliminó " en Práctica Independiente".

67 Terapista Ocupacional en Práctica Privada – se eliminó "en Práctica Independiente".

71 Dietista/Nutricionista Profesional Registrada

72 Manejo del Dolor

73 Inmunización en masa

74 Centros de Radioterapia - añadida para diferenciarlos de los Grupos de Diagnóstico Independiente (Independent Diagnostic Testing Facilities, IDTFs por sus siglas en inglés).

75 Instalaciones para la Preparación de Frotis - añadida para diferenciarlos de los IDTFs.

Si como resultado de estos cambios, desea actualizar la información de su especialidad que aparece en nuestros expedientes será necesario que complete un nuevo Formulario CMS 855. Debe incluir copia de las certificaciones donde se confirme que usted completó los requisitos de la especialidad que solicita.

Recuerde: El Formulario CMS 855I debe completarse por proveedores en práctica independiente y el Formulario CMS 855B para aquellos que ejercen dentro de un grupo. Usted puede acceder estos formularios en nuestra página de internet: www.triples-med.org.

Para su conveniencia, incluimos lista completa de códigos de especialidad.

Reimbursement

SPECIALTY CODES

*CMS has revised section 2207 of the **Medicare Carriers Manual** (MCM). Said section has added the following specialty codes and redefined Osteopathic and Group Practice Prepayment Plan (GPPP) codes:*

***09** Interventional Pain Management*

32** Anesthesiologist Assistant (AAs). AAs previously were grouped with Certified Registered Nurse Anesthetists (43). **The coverage of this specialty in Puerto Rico is under consideration by the State Department of Health.

***43** Certified Registered Nurse Anesthetists. **This specialty is covered in the U.S. Virgin Islands but not in Puerto Rico**.*

***65** Physical Therapist in Private Practice, removed "independently practicing".*

***67** Occupational Therapist in Private Practice; removed "independently practicing".*

***71** Registered Dietician/Nutrition Professional*

***72** Pain Management*

***73** Mass Immunization Roster Biller*

***74** Radiation Therapy Centers; added to differentiate from Independent Diagnostic Testing Facilities (IDTFs)*

***75** Slide preparation Facilities; added to differentiate from IDTFs*

If as a result of these changes an update to your specialty information is necessary, you must complete a new CMS 855 Form. The new form must include copy of the certification that validates your completion of requirements for the specialty for which you are applying.

Remember, Form CMS 855I is to be completed for independent practitioners and Form CMS 855B for those in group practices. The Forms are available at our Web Page: www.triples-med.org (Provider Enrollment/Form CMS 855).

For your convenience, we include a list of specialty codes.

CR2337/Transmittal 1779/1 de noviembre de 2002/ICR/els

Código Code	Especialidad / Specialty
1	General Practice
2	General Surgery
3	Allergy/Immunology
4	Otolaryngology
5	Anesthesiology
6	Cardiology
7	Dermatology
8	Family Practice
9	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Unassigned
16	Obstetrics/Gynecology
17	Unassigned
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Unassigned
22	Pathology
23	Unassigned
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Unassigned
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
31	Unassigned
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology

Código Code	Especialidad / Specialty
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty
32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical supply company with orthotic personnel certified by an accrediting organization
52	Medical supply company with prosthetic personnel certified by an accrediting organization
53	Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization
54	Medical supply company not included in 51, 52, or 53
55	Individual orthotic personnel certified by an accrediting organization
56	Individual prosthetic personnel certified by an accrediting organization
57	Individual prosthetic/orthotic personnel certified by an accrediting organization
58	Medical Supply Company with registered pharmacist
59	Ambulance Service Supplier (e.g., private ambulance companies, funeral homes)
60	Public Health or Welfare Agencies (Federal, State, and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice
67	Occupational Therapist in Private Practice
68	Clinical Psychologist
69	Clinical Laboratory (Billing Independently)
71	Registered Dietician/Nutrition Professional
73	Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)
74	Radiation Therapy Centers
75	Slide Preparation Facilities
80	Clinical Social Worker
87	All other suppliers, e.g., Drug Stores
88	Unknown Supplier/Provider
89	Clinical Nurse Specialist
95	Unassigned
96	Optician
97	Physician Assistant
A0	Hospital
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Nursing Facility, Other
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store

Reembolso

REVISIÓN A LA ACTUALIZACIÓN DE LOS CARGOS RAZONABLES PARA EL 2003 DE YESOS Y ENTABLILLADOS

Los Centros para Servicios de Medicare & Medicaid (CMS, por sus siglas en inglés) han notificado sobre problemas relacionados con la información necesaria para los cálculos de los cargos razonables de yesos y entablillados. Por lo tanto, estos servicios se continuarán pagando a base de "*gap-filled*" (proceso empírico para determinar la tarifa de pago en una localidad utilizando recursos de información disponibles).

Hasta nuevo aviso, se utilizarán las cantidades del "g*ap-filled* " para el pago de reclamaciones por suplidos suministrados desde el 1 de enero de 2003 en adelante. Estas cantidades fueron incluidas en el artículo; Actualización a los cargos razonables para el 2003 para entablillados, yesos y ciertos códigos de lente intraocular del **Medicare Informa** de octubre, noviembre y diciembre de 2002 y son las siguientes:

Reimbursement

REVISION TO THE REASONABLE CHARGE UPDATE OF 2003 SPLINTS AND CASTS

The Centers for Medicare & Medicaid Services (CMS) has informed Contractors that due to problems associated with the charge data necessary for the reasonable charge calculations of splints and casts these services will continue to be paid on a gap-filled basis.

Until further notice, gap-fill amounts will be used to pay claims for items supplied January 1, 2003 and thereafter. These amounts were included in our previous article "2003 Reasonable Charge Update for Splints, Casts and Certain Intraocular Lenses" published in our ***Medicare Informa****, October, November, and December 2002 edition and are as follows:*

CÓDIGO *CODE*	TARIFA *FEE*		CÓDIGO *CODE*	TARIFA *FEE*
A4565	$6.37		Q4025	$28.02
Q4001	$36.28		Q4026	$87.48
Q4002	$137.14		Q4027	$14.01
Q4003	$26.06		Q4028	$43.75
Q4004	$90.23		Q4029	$21.42
Q4005	$9.60		Q4030	$56.39
Q4006	$21.66		Q4031	$10.72
Q4007	$4.81		Q4032	$28.20
Q4008	$10.83		Q4033	$19.98
Q4009	$6.41		Q4034	$49.71
Q4010	$14.44		Q4035	$10.00
Q4011	$3.20		Q4036	$24.86
Q4012	$7.22		Q4037	$12.19
Q4013	$11.67		Q4038	$30.54
Q4014	$19.69		Q4039	$6.11
Q4015	$5.83		Q4040	$15.28
Q4016	$9.85		Q4041	$14.82
Q4017	$6.75		Q4042	$25.31
Q4018	$10.77		Q4043	$7.41
Q4019	$3.38		Q4044	$12.66
Q4020	$5.39		Q4045	$8.60
Q4021	$4.99		Q4046	$13.84
Q4022	$9.02		Q4047	$4.30
Q4023	$2.51		Q4048	$6.93
Q4024	$4.51		Q4049	$1.57

CR2510/B-02-089/20/12/02/MM/els

Reembolso

ACTUALIZACIÓN TRIMESTRAL DE LOS HCPCS USADOS EN LA FACTURACIÓN CONSOLIDADA PARA EL CUIDADO EN EL HOGAR

CMS estableció un proceso para actualizar la lista de HCPCS sujetos a la facturación consolidada para el Cuidado en el Hogar (HH PPS por sus siglas en inglés). Los servicios en dicha lista no deben facturarse al contratista porque Medicare pagará éstos directamente a la agencia de cuidado en el hogar que haya iniciado los episodios.

Esta actualización sólo incluye un código de material no rutinario. El nuevo código que se añadirá es A6440 : Zinc Paste >=3", 5"w/roll.

Usted puede obtener una lista actualizada de los códigos sujetos a Facturación Consolidada para el Cuidado en el Hogar a través de la siguiente dirección electrónica: http://www.cms.hhs.gov/medlearn/refhha.asp.

Reimbursement

QUARTERLY UPDATE OF HCPCS CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT

CMS have established the process to update the list of HCPCS codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). Services on this list should not be billed to the carrier since Medicare will pay the home health agencies that have opened the episodes.

This update will add a single non-routine supply code to the list. The new code to be added is A6440: Zinc Paste >=3", 5"w/roll.

An updated list of codes subject to HH consolidatedbilling is available at: http://www.cms.hhs.gov/medlearn/refhha.asp

CR2515/AB-03-002/01-10-03/ICR

SERVICIOS DIAGNÓSTICOS A PACIENTES RENALES EN CENTROS DE ENFERMERÍA ESPECIALIZADA (SNF)

La disposición de Facturación Consolidada en Centros de Enfermería Especializada (SNF CB, por sus siglas en inglés) requiere a estos centros incluir en la factura a la Parte A de Medicare casi todos los servicios que sus residentes reciben durante una estadía cubierta por la Parte A. No obstante, existen ciertas categorías de servicios que la ley (§1888(e)(2)(A)(ii) del Seguro Social excluye de esta disposición y pueden ser facturadas separadamente a la Parte B de Medicare por el suplidor externo que los provea. Una de las categorías excluidas abarca aquellos artículos y servicios incluidos en el del beneficio de la Parte B que cubre diálisis crónica para beneficiarios con Enfermedad Renal en Etapa Final (ESRD, por sus siglas en inglés).

DIAGNOSTIC SERVICES FOR ESRD PATIENTS AT SKILLED NURSING FACILITY (SNF)

The SNF CB provision requires a SNF to include in its Part A bill almost all of the services that its residents receive during the course of a Part A covered stay. However, there are several categories of services that the law (§1888(e)(2)(A)(ii) of the Social Security Act) specifically excludes from this provision and these excluded services remain separately billable under Part B by the outside supplier that provided them. One of the excluded categories is for those items and services that cover chronic dialysis for beneficiaries with ESRD.

Cont. on next page

Reembolso

Desde la implantación del SNF CB se han, las facturas por algunas pruebas diagnósticas provistas a beneficiarios ESRD que reciben diálisis en centros independientes o centros que son parte de un hospital.

A partir del 1 de abril de 2003, las pruebas diagnósticas que incluidas en el beneficio de la Parte B que cubre diálisis crónica para beneficiarios con ESRD que sean facturadas con el modificador **CB** y fechas de servicio del 1 de abril de 2001 en adelante, serán consideradas para pago.

Proveedores y suplidores deben utilizar modificador CB para los servicios ordenados por un médico del centro de diálisis como parte del ESRD del paciente con beneficios de diálisis y que no son parte de la tasa compuesta y son reembolsados separadamente. No es necesario incluir el modificador **CB** en todos los servicios; no obstante, los servicios que contengan el modificador se considerarán parte del SNF CB. Este modificador debe ser utilizado bajo las siguientes condiciones:

- El beneficiario tiene una cubierta ESRD
- La prueba está relacionada al tratamiento de diálisis para ESRD
- La prueba es ordenada por el centro de diálisis
- La prueba no está incluida en el pago al centro de diálisis
- El beneficiario recibe los servicios del SNF en una estadía de Parte A

Las reclamaciones por los servicios descritos que se le han denegado y que cumplan con las condiciones arriba mencionadas, pueden ser sometidas nuevamente utilizando el modificador **CB.**

Recuerde que el modificador **CB** debe ser usado solamente si el beneficiario reúne las condiciones indicadas previamente. Hasta que usted reciba la información del centro de diálisis; no es correcto someter la reclamación a Medicare con el modificador **CB**.

Reimbursement

Since the implementation of the SNFCB, certain diagnostic services furnished to ESRD beneficiaries receiving dialysis at an independent or provider-based dialysis facility have been denied.

*Beginning April 1, 2003, for dates of service April 1, 2001 and thereafter SNFCB edits for diagnosis services where modifier **CB** is present for the line item, will be bypassed.*

*Providers and suppliers should use Modifier **CB** for services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit that are not part of the composite rate and are reimbursable separately. It is not necessary to include modifier **CB** in every single service; however, the provider or supplier must be aware that SNF CB editing will be applied if the line item does not contain the modifier. This modifier should be used under the following conditions:*

- *The beneficiary has ESRD entitlement*
- *The test is related to the dialysis treatment for ESRD*
- *The test is ordered by a dialysis facility*
- *The test is not included in the dialysis facility composite rate payment*
- *The beneficiary is in a Part A stay*

*If your claims for services to a beneficiary who meets the above conditions have been denied, please resubmit them with modifier **CB**.*

*Remember that modifier **CB** should be used only if the beneficiary has the conditions indicated above. Unless you receive this information from the dialysis facility; it is improper to submit a claim to Medicare with modifier **CB**.*

CR2475/Trans. AB-02-175/12-13/02/ICR/lv/els

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 mesualmente. Los contratistas reciben mensualmente una lista de CMS, que incluye las exclusiones y reintegraciones efectuadas por la Oficina del Inspector General (OIG). Las exclusiones tienen vigencia a los 20 días de la fecha de notificación al proveedor. Estas exclusiones y reintegraciones serán vigentes en 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 del "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. Estas penalidades se aplicarán en los casos en los cuales una persona contrata un proveedor excluído, con el propósito de ofrecer 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, en la siguiente página encontrará las listas de los proveedores reintegrados y excluidos 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 in the "Medicare Carrier Manual" 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 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 on this page 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 on	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

Cont. en siguiente página
Cont. on next page

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*
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
Baco Cuebas, German A.	Urb. Ponce De Leon 11 Calla Granada Mayaguez, PR 00680	Indefinite	January 20, 2003
Vega Delgado, Marisol	Portal De Los Pinos B19 Calle 2 San Juan, PR 00936	Indefinite	January 20, 2003
Baez López, Roberto	Calle Victor Salaberry #32 Guanica, PR 00653	Indefinite	February 20, 2003
Cruz Baez, Edgar A	Hospital Dr. Pila Ave. Las Américas Ponce, PR 00731	Indefinite	February 20, 2003
Ortega Ortíz, Orlando	Bo. Cuevas Carretera 132 Peñuelas, PR 00624	Indefinite	February 20, 2003
Ortíz Vargas, Daniel	Hospital Area de Yauco Clinicas CASPRI Yauco, PR 00698	Indefinite	February 20, 2003
Perea Vicente, Miguel A.	Ctro. Salud San German Calle St. Javilla San German, PR 00683	Indefinite	February 20, 2003
Quiñones Acevedo, Pablo	Irurregui Plaza 201 Rio Piedra, PR 00925	Indefinite	February 20, 2003
Soto Santiago, Reynaldo	Res. Levisticos del Oeste J104 Cabo Rojo, PR 00623	Indefinite	February 20, 2003

ERRORES SIMPLES DE FACTURACIÓN
(SEGUNDO ARTÍCULO DE LA SERIE)

En nuestro primer artículo (boletín de oct. nov. y dic. de 2002, páginas 57-58) le identificamos los errores más comunes en facturación que ocasionan que sus reclamaciones sean devueltas. Para complementar esta información, ahora le presentamos copia de una remesa de pago en la cual le señalamos el área de código de rechazo y nota.

SIMPLE CLAIM SUBMISSION ERRORS
(SECOND ARTICLE OF A SERIES)

In our first article (Oct. Nov. & Dec. 2002 bulletin, pages 57-58) we identified common billing errors, which may cause your claims to be returned. To supplement this information and aid you find the remark code and note on the remittance advise, we are displaying copy of a remittance were these items are marked.

III

PO BOX
CHRISTIANSTED, VI 00823

PROVIDER #: 00
PAGE #: 1 OF 1
DATE: 12/27/02
CHECK/EFT #: 02
STATEMENT #: 30

*** Visit our WEB Page at: www.triples-med.org*** Our toll free phone number is: 1-877-715-1921****

"Visit our WEB page to obtain information regarding the Participation Enrollment Period and the 2003 Medicare Physician Fee Schedule ."

For dates of service January 1, 2003 to February 28,2003, you will be calculating the annual deductible and co-insurance using 2002 Fee Schedule amounts. Moreover, for services rendered March 1, 2003 to December 31, 2003, you will be using 2003 Fee Schedule amount to calculate the deductible and co-insurance.

NAME | HIC 0 | ACNT 0 | ICN 02 | ASG Y | MOA MA130/MA13

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
00	1202 120202	11	1	99204	25	125.00	0.00	0.00	0.00	CO-16	125.00	0.00
REM: M76												
00	1202 120202	11	1	73590	50	90.00	0.00	0.00	0.00	CO-16	90.00	0.00
REM: M76												
00	1202 120202	11	1	73590		90.00	0.00	0.00	0.00	CO-16	90.00	0.00
REM: M76												
00	1202 120202	11	1	29345	58	304.00	0.00	0.00	0.00	CO-16	304.00	0.00
REM: M76												
00	1202 120202	11	1	Q4034		49.17	0.00	0.00	0.00	CO-16	49.17	0.00
REM: M76												
PT RESP 0.00				CLAIM TOTALS		658.17	0.00	0.00	0.00		658.17	0.00

(A) (B) (C)

ADJ TO TOTALS: PREV PD 0.00 INTEREST 0.00 LATE FILING CHARGE 0.00 NET 0.00

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	1	658.17	0.00	0.00	0.00	658.17	0.00	0.00	0.00

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

CO	Contractual obligation. The patient may not be billed for this amount.
16	Claim/service lacks information which is needed for adjudication.
M76	Incomplete/invalid patient's diagnosis(es) and condition(s).
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (Patient Responsability) group code.
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

A) Detalla que su reclamación fue denegada o devuelta

B) Indica el razón por la denegación o devolución de su reclamación.

C) Instruye sobre cómo proceder para la adjudicación de dicha reclamación.

A) Details if your claim was denied or returned (rejected).

B) Indicates why your claim was denied or returned.

C) Instructs on the action to be take for the re-adjudication of a given claim.

Relaciones con la Comunidad

¡PRONTO EL SISTEMA "MULTI-CARRIER" EN MEDICARE PARA RETIRADOS FERROVIARIOS!

Palmetto GBA, el contratista para la Junta de Retiro Ferroviario (maneja las reclamaciones de equipo médico duradero) se encuentra actualmente en la transición de su sistema de procesamiento de reclamaciones. El trabajo continuará durante los próximos cinco meses hasta la fecha de cierre planificada para el 2 de junio de 2003.

Habrá una nueva línea de comunicación para que los proveedores sometan las reclamaciones de Medicare para Retirados Ferroviarios y reciban la remesa de pago electrónica (ERNs, por sus siglas en inglés). En febrero, aquellos proveedores que facturan electrónicamente recibieron un envío especial con información específica sobre la nueva línea de comunicación. Esto le concederá a los afectados por el cambio, tiempo suficiente para tomar aquellas medidas que garanticen que no tendrán interrupciones en sus procesos electrónicos.

Para cerciorarse que la comunicación a la comunidad médica es precisa, informativa y oportuna, Medicare para Retirados Ferroviarios utilizará las siguientes fuentes educativas:

- Palmetto GBA anunciará y mantendrá una nueva sección de facturación y reclamaciones para los Retirados Ferroviarios en su página de "Internet", www.palmettogba.com.
- Palmetto GBA distribuirá a todos los que facturan electrónicamente un envío especial con información específica relacionada a reclamaciones electrónicas.
- Proveedores pueden unirse gratuitamente a la lista de correo electrónico de Medicare para Retirados Ferroviarios y recibir notificaciones periódicas de mensajes publicados en la página "Internet" de Palmetto GBA. Esto incluye alertas al programa clave, consejos educativos y otros artículos de información crítica.

Community Relations

THE MULTI-CARRIER SYSTEM (MCS) IS COMING TO RAILROAD MEDICARE!

Palmetto GBA, the carrier for Railroad Retirement Board Medicare beneficiaries (handles durable medical equipment claims) is currently in the process of converting its claims processing system to MCS. Work will continue over the next five months until the planned cutover date of June 2, 2003.

There will be a new telecommunications gateway for providers to submit Railroad Medicare claims and receive electronic remittance notices (ERNs). In February, electronic submitters received a special mailing providing specific information about these gateway changes. This will provide ample time for affected submitters to take the necessary actions to ensure there is no interruption to their electronic processes.

To ensure accurate, informative and timely communication to the provider community, Railroad Medicare will keep providers informed through a variety of educational sources.

- *Palmetto GBA will post and maintain a new billing or claim filing requirements for Railroad Medicare on their Website, www.palmettogba.com.*
- *Palmetto GBA will issue a special mailing to electronic submitters with specific information related to electronic claim submission.*
- *Providers may join Railroad Medicare's free electronic mail list and receive periodic e-mail notification of messages posted to the Website, including key program alerts, educational tips, and other critical informational articles. This is an excellent way to stay informed on information related to the MCS conversion.*

Relaciones con la Comunidad

Para asegurarnos de una transición exitosa al sistema "multi-carrier" es imperativo que tanto proveedores como las agencias de facturación se mantengan informados sobre los nuevos requisitos de las reclamaciones. La página de "Internet" de Palmetto GBA (www.palmettogba.com) es fuente fidedigna de información sobre la transición de Medicare para Retirados Ferroviarios a MCS.

De tener alguna duda que no pueda ser contestada al visitar la página de "Internet" de Palmetto GBA Medicare, comuníquese con uno de los representantes de servicio al 1-877-288-7600.

JSM-1812/12/10/02/els

Community Relations

To ensure a successful move to the Multi-Carrier System, it is imperative that providers and billing agencies stay informed of new claim filing requirements. Palmetto GBA's Website will be a major source of information to keep providers informed about the Railroad Medicare transition to the MCS. Please visit the Palmetto GBA Website (www.palmettogba.com) often for updates regarding the Railroad Medicare MCS conversion.

If you have questions that cannot be answered by visiting the Palmetto GBA Medicare Website, please contact their Customer Service Department at 1-877-288-7600.

REQUISITO DE INFORMACIÓN ADICIONAL PARA PROVEEDORES QUE REFIEREN SERVICIOS DE LABORATORIO

Según la disposición del reglamento sobre cubiertas y políticas para Servicios de Pruebas de Laboratorio Clínico desarrollada bajo el "*Negotiated Rulemaking Act*", esta afirma lo siguiente: Si la documentación suministrada para un servicio determinado no demuestra que el servicio es razonable y necesario, el contratista solicitará información adicional al médico o al profesional de la salud que refirió el servicio.

Por consiguiente, le recordamos a los proveedores de servicios de laboratorios que deben suplir suficiente información que identifique al proveedor que refiere la prueba en la línea 17 y 17A del Formulario de Reclamación CMS 1500 o campo comparable en el formato electrónico. De faltar ésta información en la reclamación, nos veremos en la obligación de adjudicar la misma a base de la documentación recibida. O sea, que se podría denegar o disminuir el nivel facturado.

ADDITIONAL DOCUMENTATION REQUESTS REQUIREMENTS FOR ORDERING PROVIDERS OF LABORATORY SERVICES

A provision of the rule on coverage and policies for clinical diagnostic laboratory services, developed under the Negotiated Rulemaking Act, states that if documentation provided for a given service does not demonstrate that the service is reasonable and necessary, the contractor will request additional information from the ordering physician or nonphysician practitioner.

Therefore, laboratory providers are reminded that they supply sufficient information to identify the ordering provider on item 17 and 17A of the CMS-1500 form claim or its comparable fields on electronic claim formats. If this information is not provided, we would be forced to adjudicate the claim based only on the documentation received and deny or downcode as appropriate.

CR 2504/PM-AB-03-021/02-14-03/els

Relaciones con la Comunidad

FACTURACIÓN DE SERVICIOS QUE PUDIERAN SER PARTE DE SERVICIOS DE SALUD EN EL HOGAR

Antes de prestar servicios a un beneficiario de Medicare verifique si dicho beneficiario ha recibido algún episodio de servicios en el hogar y si existe o no una fecha de alta. Este artículo le proveerá información que le ayudará a determinar si Medicare pagará por separado sus servicios o si el pago por este tipo de servicio ya está incluido en el pago que se hace a la agencia que presta servicios de salud en el hogar.

Se continuarán denegando aquellas reclamaciones en las que el pago esté incluido en el pago de la agencia de Cuidado de Salud en el Hogar por lo tanto usted no recibirá el pago! Además, Medicare recobrará aquellas reclamaciones pagadas a partir del 1 de abril de 2003 en adelante en donde se incluyan servicios que hayan sido consolidados en el pago por servicios a las agencias que prestan servicios de Salud en el Hogar. En estas situaciones la remesa de pago que recibirá leerá de la siguiente forma:

> **"Reason Code B-15: "Claim denied/ reduced because this procedure/service is not paid separately" Remark Code N70: "Home health consolidated billing and payment applies."**

Para ayudarle a determinar si el beneficiario ha recibido servicios de cuidado en el hogar, CMS planifica tener la información de elegibilidad disponible electrónicamente a través del sistema de respuesta de elegibilidad (eligibility Benefit Inquiry/Reponse (270/271) Transaction System.) Hasta tanto este sistema no esté implantado será su responsabilidad como proveedor preguntar al beneficiario o su representante legal si al presente está recibiendo servicios de salud en el hogar. Usted podrá cobrarle al beneficiario por los servicios que Medicare deniegue pero deberá advertirle al beneficiario cual es su obligación antes de prestarle el servicio.

Community Relations

BILLING FOR SERVICES THAT MAY BE PART OF A HOME HEALTH STAY

Before you provide services to a Medicare beneficiary, you need to be certain whether or not a home health episode of care exists for that beneficiary, and whether or not an actual home health discharge date exists. This article provides information that will help you determine whether Medicare will pay separately for your service or whether payment for the services are consolidated into Medicare's payment to a home health agency (HHA).

Claims consolidated in the HHA's payment will continue to be denied and you will not receive payment! Additionally, Medicare will adjust claims paid on or after April 1, 2003 for services already consolidated into the HHA's payment and will recover your payment for these services. You will receive a remittance advice on any denied claim which will read as follows:

> ***"Reason code B15: "Claim denied/ reduced because this procedure/ service is not paid separately", and remark code N70: "Home health consolidated billing and payment applies."***

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

Relaciones con la Comunidad

Como último recurso si no puede obtener esta información de parte del beneficiario o su representante legal, tiene la alternativa de llamar al "carrier" para solicitar la información relacionada al servicio de salud en el hogar de un representante de servicio. La información no estará disponible a través del contestador automático de llamadas.

Recuerde, usted es responsable de determinar si el beneficiario al que usted le prestará los servicios es elegible para recibir servicios adicionales de Medicare. Los servicios que se presten a un beneficiario que no sea elegible no se pagarán.

CR#2619/ B-03-021/fmr

Community Relations

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

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

DETECCIÓN TEMPRANA DEL CÁNCER COLORRECTAL

El cáncer colorrectal, o cáncer del colon y del recto, es la segunda causa de muertes por cáncer en los Estados Unidos después del cáncer del pulmón. Se estima que en el 2003 habrá 147,500 nuevos casos y 57,100 muertes por esta causa.

Más de una tercera parte de las muertes causadas por el cáncer colorrectal pudieron haberse evitado si las personas sobre 50 años se hubiesen realizado pruebas para detectar esta condición. La mayoría de los casos de cáncer colorrectal comienzan como pólipos.

Las personas con pólipos o con cáncer colorrectal no siempre experimentan síntomas al principio. En ocasiones las personas pudieran tener pólipos o cáncer colorrectal y no tener conocimiento de ello. Los exámenes de detección son importantes porque pueden detectar el cáncer colorrectal en sus primeras etapas cuando la probabilidad de supervivencia es mayor del 90%. El cáncer colorrectal es uno de los más fáciles de prevenir. Mediante las pruebas de detección temprana se pueden encontrar pólipos pre-cancerosos de manera que se puedan remover antes de que se conviertan en cáncer.

EARLY DETECTION OF COLORECTAL CANCER

Colorectal cancer is the second leading cancer killer in the United States after lung cancer. Colorectal cancer (cancer of the colon or rectum) is second only to lung cancer in causing cancer-related deaths in the U.S. An estimated 147,500 new cases and 57,100 deaths from colorectal cancer are expected in 2003.

More than one-third of colorectal cancer deaths could be avoided if people over 50 had regular screening tests. Most colorectal cancers begin as polyps.

People who have polyps or colorectal cancer do not always have symptoms, especially at first. Someone could have polyps or colorectal cancer and not know it. Screening tests are so important because they can find colorectal cancer early, when treatment works best. When colorectal cancer is detected in the earliest stage of the disease (Stage 1), the survival rate is greater than 90 percent. Colorectal cancer is one of the most preventable cancers. Screening tests can help prevent colorectal cancer by finding pre-cancerous polyps so they can be removed before they turn into cancer.

Cont. on next page

Relaciones con la Comunidad

El riesgo de desarrollar este tipo de cáncer aumenta con la edad. De hecho, muchos casos (90%) ocurren en personas de 50 años o mayores.

Tanto hombres como mujeres corren riesgo de desarrollar cáncer colorrectal. Algunas personas piensan que las mujeres no están en riesgo de desarrollar esta enfermedad. Sin embargo, ambos sexos pudieran desarrollarla.

Si usted tiene 50 años o más y está cubierto por la parte B Medicare es elegible para recibir exámenes de detección de cáncer colorrectal. Sin embargo, en el caso de la colonoscopía no existe límite de edad. Las pruebas preventivas cubiertas por Medicare para detectar esta condición son:

Community Relations

Risk increases as we age. In fact, most cases (90%) occur in people 50 and older.

Both men and women are at risk. Some people think that women are not at risk for colorectal cancer. However, both sexes may develop this cancer.

Medicare helps pay for colorectal cancer screening tests. People with Medicare Part B coverage who are age 50 or older are eligible for colorectal cancer screenings. However, in the case of colonoscopy, there is no age limit. Several different screening tests can be used to test for polyps or colorectal cancer. Each can be used alone. Sometimes they are used in combination with each other. Medicare covers the following screening tests:

PRUEBAS *TESTS*	**FRECUENCIA** *FREQUENCY*	**CODIGO CPT** *CPT CODE*
COLONOSCOPÍA *COLONOSCOPY*	Cada 5 – 10 años *Every 5 – 10 years*	G0105 *G0105*
SANGRE OCULTA EN HECES FECALES *FECAL OCCULT BLOOD*	Anual *Annual*	G0107 *G0107*
SIGMOIDOSCOPIA FLEXIBLE *FLEXIBLE SIGMOIDOSCOPY*	Cada 5 años *Every 5 years*	G0104 *G0104*
ENEMA DE BARIO DE DOBLE CONTRASTE *BARIUM ENEMA*	Cada 5 – 10 años *Every 5 – 10 years*	G0106 *G0106*

Ref. PM- AB-03-033/CR2580/fmr

LÍMITE EN PAGO A SERVICIOS DE TERAPIA FÍSICA, OCUPACIONAL Y DEL HABLA

Recientemente CMS publicó instrucciones para todos sus contratistas relacionadas al nuevo límite anual para reembolso por gastos de servicios de terapia física, terapia del habla y terapia ocupacional. Próximamente CMS publicará más detalles relacionados con estos cambios. Las instrucciones serán efectivas el 1 de julio de 2003. Favor de referirse la siguiente dirección de Internet para más información: http://cms.hhs.gov/manuals/pm_trans/AB03018.pdf

Trans.AB-03-018/CR2183/02-07-03/FM

FINANCIAL LIMITATION FOR PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Recently CMS published instructions to all its contractors related to the new payment limitation for the reimbursement of costs related to Physical, Occupational and Speech therapy. CMS will publish more details related to these changes in the near future. The instructions related to this topic will be effective on July 1, 2003. You may access the following Internet address for more information: http://cms.hhs.gov/manuals/pm_trans/AB03018.pdf

Relaciones con la Comunidad

RECLAMACIONES DIRIGIDAS INCORRECTAMENTE

La Sección 3110 del Manual del Contratista de Medicare establece el procedimiento para disponer de aquellas reclamaciones dirigidas incorrectamente. Los Centros para Servicios de Medicare y Medicaid (CMS, por sus siglas en inglés) implementarán los siguientes cambios a dicha sección a partir del 1 de julio de 2003.

Cuando un contratista reciba reclamaciones por servicios pagaderos por otro contratista utilizará los siguientes mensajes:

Remesa de Pago (*Remittance Advice*)

"Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor".

"New remark code N104 – This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov."

Si un contratista recibe reclamaciones por servicios prestados a beneficiarios de Medicare para Retirados Ferroviarios, conforme a la Sección 3005, los servicios asignados serán devueltos como no procesables y los no asignados serán denegados. Así mismo, CMS requiere que cuando la Junta de Retiro Ferroviario reciba reclamaciones que no correspondan a servicios prestados a beneficiarios de Medicare para Retirados Ferroviarios, devuelvan las mismas. Estas serán devueltas al remitente notificándole que las envíe al Contratista Local o al Contratista Regional de Equipo Médico Duradero (DMERC, por sus siglas en inglés) correspondiente.

Al igual que otras reclamaciones dirigidas incorrectamente, reclamaciones pagaderas por la Unión de Trabajadores Mineros de América (UMWA, por sus siglas en inglés) se devolverán como no procesables aquellas en las que el proveedor aceptó la asignación de beneficio y se denegarán aquellas para las cuales no se ha

Community Relations

DISPOSITION OF MISDIRECTED CLAIMS

Section 3110 of the Medicare Carrier Manual establishes the procedure for handling misdirected claims. The Centers for Medicare and Medicaid Services (CMS) will implement the following changes to this section as of July 1, 2003.

When a Carrier receives claims for services that are in another Carrier's payment jurisdiction these will be returned with the following message:

Remittance Advice (RA)

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N104 – This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov.

If a Carrier receives claims for a Railroad Retirement Board (RRB) beneficiary, according to Section 3005, those for assigned services will be returned as "not able to process" and those for unassigned services will be denied. In like manner, CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notifies them that the claim must be submitted to the Carrier or Durable Medical Equipment Regional Carrier (DMERC) for processing.

As with other misdirected claims, those which are payable by the United Mine Workers of America (UMWA) will be returned as "not able to process" when services have been assigned and unassigned services will be denied. The Carrier will use the following messages:

Cont. on next page

aceptado asignación. En esta situación se utilizará los siguientes mensajes:

Remesa de Pago (*Remittance Advice)*

"Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor".

"New remark code N127 – This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission".

Resumen de Medicare *(Medicare Summary Notice)*

11.11 – Esta reclamación/servicio no se paga bajo nuestra jurisdicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación por estos servicios a la Unión de Trabajadores Mineros de América.

De recibir reclamaciones de una Organización para el Mantenimiento de la Salud (HMO, por sus siglas en inglés) el contratista denegará las mismas con el siguiente mensaje:

Remesa de Pago (*Remittance Advice)*

"Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor".

Remittance Advice

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N127 – This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.

Medicare Summary Notice (MSN)

11.11 – This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America for processing.

For Health Maintenance Organization (HMO) claims, the Carrier will deny these entirely with the following message:

Remittance Advice

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

CR2502/Transmittal 1789/LV/els

CONTRATISTA PARA BENEFICIARIOS RETIRADOS FERROVIARIOS

A partir del 1 de julio de 2003 Palmetto GBA manejará las reclamaciones por servicios prestados a beneficiarios que como Retirados Ferroviarios cualificaron para Medicare. Palmetto GBA inclusive tendrá la jurisdicción sobre reclamaciones por servicios a beneficiarios que tienen tanto beneficios del Seguridad Social y Retiro Ferroviario con las excepciones siguientes:

RAILROAD RETIREMENT BENEFICIARY CARRIER

Effective July 1, 2003 Palmetto GBA will handle claims for payment involving individuals who are qualified railroad retirement beneficiaries (QRRBs), including those who are entitled to both social security and railroad retirement benefits with the following exceptions:

Cont. on next page

Relaciones con la Comunidad

- Servicios prestados por un plan prepagado de práctica del grupo que recibe reembolso directamente de CMS conforme a una base de costos
- Que el beneficiario participe de un programa de una agencia estatal y que dicha agencia realice las funciones de un contratista con respecto a ese beneficiario
- Servicios médicos prestados fuera de los Estados Unidos.

Si una reclamación es por servicios prestados en y afuera de los Estados Unidos, Palmetto GBA procesará la porción correspondiente a los servicios ofrecidos dentro de los Estados Unidos. Si el beneficiario pregunta acerca de los servicios médicos proporcionados fuera de los Estados Unidos, Palmetto GBA orientará al beneficiario a contactar y enviar su reclamación a:

Railroad Retirement Board
Division of Disability and Health Insurance
844 Rush St.
Chicago, IL 60611

Community Relations

- *The services are furnished by a Group Practice Prepayment Plan (GPPP) which deals directly with CMS on a cost basis;*
- *The QRRB is enrolled under a buy-in agreement involving a state agency which has entered into an agreement to act as a carrier with respect to such individuals or*
- *The medical services were provided outside the United States.*

If a claim involves medical services provided both within and outside the United States, Palmetto GBA processes the claim for the medical services provided within the United States. If the claimant raises a question as to why he was not paid for the medical services provided outside the United States, Palmetto GBA directs the claimant to contact the RRB and forwards the claim to them at:

¡BUENAS NOTICIAS! AHORA PODRÁ REVISAR ALGUNAS DENEGACIONES POR ICD-9 A TRAVÉS DEL TELÉFONO

A partir del **1 de abril de 2003** podrá llamarnos para presentar solicitudes de revisión relacionadas a denegaciones por concepto de ICD-9 incorrectos en aquellos casos donde el diagnóstico que se corrige es parte de la política relacionada al código de procedimiento. Los casos particulares que podrán revisarse a través de este método serán los denegados con el indicador CO-B22.

Las reclamaciones rechazadas con código CO-16 Remark M-76 (diagnóstico incompleto o inválido) deberán resometerse como nuevas. Análisis recientes del volumen de reclamaciones denegadas por concepto de diagnósticos incorrectos nos han llevado a tomar varias acciones para mejorar esta situación. Como parte de nuestro plan para trabajar esta situación, haremos lo siguiente:

GOOD NEWS! NOW YOU CAN REVIEW SOME ICD-9 DENIALS BY TELEPHONE

*Beginning on **April 1, 2003** you will be able to submit requests for review of cases related to denials due to incorrect ICD-9s. This will only apply to cases where the ICD-9 to be corrected is part of a medical policy and have been denied with indicator CO-B22.*

On the other hand, claims that were rejected with code CO-16 remark M-76 (incomplete or invalid diagnosis) will have to be resubmitted as a new claim. Recent analysis of the volume of claims denied due to incorrect or missing ICD-9s have prompted us to take the following actions to improve this situation:

Cont. on next page

Relaciones con la Comunidad

1. Atender por teléfono situaciones de casos denegados por diagnósticos incorrectos. Sólo los casos en que usted cambie el diagnóstico y el mismo está en la política médica.
2. Llevar a cabo reuniones educativas con proveedores que tienen un número significativo de denegaciones por razón de diagnóstico incorrecto.
3. Desarrollar adiestramientos especializados en cómo facturar a Medicare debidamente.

Las revisiones por teléfono continúan teniendo una gran aceptación por parte de nuestros proveedores. Este servicio resulta mucho más conveniente en términos de rapidez y corrección de una factura a la vez que nos permite mayor eficiencia tanto al proveedor como al contratista.

Recuerde que estaremos atendiendo SOLO TRES REVISIONES POR LLAMADA. Esto es así para poder atender todas las llamadas que recibimos diariamente.

Por otra parte continuaremos revisando por teléfono las siguientes situaciones:

- reclamaciones denegadas como duplicado incorrectamente
- correcciones a fecha de servicio
- correcciones de lugar de servicio
- número de servicios / unidades
- reclamaciones denegadas por MSP (Medicare Pagador Secundario) cuando nuestro sistema ha sido actualizado
- corrección en el cargo sometido
- cambio en código de procedimiento
- código inválido y lo sustituye

Nuevamente agradecemos el gran apoyo que le han dado a nuestro servicio de Revisiones por Teléfono. Y si usted es uno de los que aún no ha llamado, le invitamos a que lo haga. Verá que cómodo y rápido resulta solicitar una revisión por teléfono.

Para más información y para comenzar a beneficiarse de este nuevo servicio, puede comunicarse a través del 1-877-715-1921 Opción Tres (3), uno de nuestros Representantes de Servicio Medicare gustosamente le ayudará.

Community Relations

1. *Include ICD-9 denials as one of the situations that can be reviewed over the telephone. (This will only apply to cases where the ICD-9 to be corrected is part of a medical policy and have been denied with indicator CO-B22.)*
2. *Conduct educational meetings with providers that have demonstrated a significant number of denials due to this reason.*
3. *Develop specialized trainings that focus on how to bill Medicare correctly.*

Our providers are very excited about the telephone reviews service. They are taking advantage of this service that is very convenient in terms of timeliness and efficiency for both the provider and the Carrier, avoiding unnecessary paperwork.

Remember that we can only handle THREE REVIEWS PER CALL. This is so, to be able to handle all the calls that we receive every day.

We will also continue reviewing the following situations through our telephone review services:

- *incorrect duplicate*
- *claims denied as duplicates*
- *corrections to the date of service*
- *corrections to the place of service*
- *number of services/units*
- *claims denied for MSP (Medicare Secondary Payer) when our system has been updated*
- *corrections to the submitted charge*
- *change of CPT code*
- *substitution of invalid CPT*

Once again we want to thank all providers who have used the Telephone Reviews Service. If you have not called yet, we invite you to do so. You will see how convenient and easy is to request a telephone review.

For more information and to begin to enjoy the service, you can call 1-877-715-1921, and select Option (3); one of our Medicare Service Representatives will gladly assist you.

FMR/3-13-03

Fechas Límites HIPAA / HIPAA Deadlines

FECHAS LÍMITES	*DEADLINES*
14 de abril de 2003	***April 14, 2003***
Regla de Privacidad	*Privacy Rule*
16 de abril de 2003	***April 16, 2003***
Pruebas Técnicas	*Testing*
Usted debe empezar a realizar pruebas técnicas de sus programas no más tarde del 16 de abril de 2003.	*You should start testing your software no later than April 16, 2003*
16 de octubre de 2003	***October 16, 2003***
Transacciones Electrónicas y Códigos Estándares	*Electronic Transactions & Code Sets*
Nota: Las reclamaciones de Medicare se someterán de forma electrónica con excepción (bajo unas circunstancias limitadas) de aquellas que provengan de médicos, profesionales de la salud, instalaciones y proveedores no hospitalarios con menos de diez (10) empleados a tiempo completo.	*Note: Medicare will require that all Medicare claims be submitted electronically, with the exception (under certain limited circumstances) of those from physicians, health practitioners, facilities or suppliers (other than provider of services) with fewer than ten (10) full-time equivalent employees.*
21 de abril de 2005	***April 21, 2005***
Regla de Seguridad	*Security Rule*

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