

Medicare Bulletin

A SERVICE OF CIGNA HEALTHCARE MEDICARE ADMINISTRATION



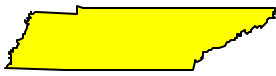
TENNESSEE GENERAL RELEASE 99-2

MARCH/APRIL 1999

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REACHING OUT TO THE MEDICARE COMMUNITY



Tennessee

Tennessee Health Professional Shortage Areas (HPSAs) (Effective for services performed on or after January 1, 1992)

<u>COUNTY</u>	<u>AREA NAME/PARTS</u>	<u>RURAL/URBAN</u>
Anderson	Briceville -Lake City Lake City West CCD New River CCD Lake City East CCD	Urban
Benton	All	Rural
Bledsoe ⁶	Dayton/Pikeville/Decatur	Rural
Blount	Tallassee Lanier CCD	Urban
Campbell ⁴	All	Rural
Carter	Roan Mountain Laurel Fork CCD, Roan Mountain CCD, Tiger Valley CCD	Urban
Cheatham ⁸	All	Rural
Chester ²	All	Rural
Claiborne ⁴	All	Rural
Clay ²	All	Rural
Crockett ⁴	All	Rural
Cumberland	All	Rural
Decatur ⁴	All	Rural
Dickson	Vanleer/Shiloh Vanleer CCD	Urban
Fayette	All	Rural
Giles ⁹	All	Rural
Grainger	All	Urban
Greene	Baileyton Baileyton CCD	Rural
Grundy	All	Rural
Hamilton ¹⁰	Middle Valley Soddy Daisy Division Middle Valley Division Sale Creek Division	Urban
Hancock	All	Rural
Hardeman	All	Rural
Hardin ⁴	All	Rural
Hawkins	All	Urban
Haywood	All	Rural
Henderson	All	Rural
Hickman	All	Rural
Jackson ⁵	All	Rural
Johnson	All	Rural
Knox ³	Mechanicsville Census Tracts 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 14, 20, 28	Urban
Lake	All	Rural
Lauderdale ⁶	All	Rural
Lewis	All	Rural

Tennessee



<u>COUNTY</u>	<u>AREA NAME/PARTS</u>	<u>RURAL/URBAN</u>
Lincoln	Cash Point - Blanche Cash Point/Blanche CCD	Rural
Madison ¹	East Jackson Census Tracts 5 and 8-12	Rural
McNairy ⁴	All	Rural
Meigs	Dayton/Pikeville/Decatur	Rural
Montgomery	Vanleer/Shiloh Palmyra/Shiloh CCD	Urban
Moore	All	Rural
Morgan	All	Rural
Obion	Hornbeak/Samburg Hornbeak/Samburg CCD	Rural
Pickett	All	Rural
Polk ⁴	All	Rural
Rhea ⁶	Dayton/Pikeville/Decatur	Rural
Roane ⁷	All	Rural
Rutherford	Eagleville Eagleville CCD	Urban
Scott ⁴	All	Rural
Sevier	All	Urban
Stewart ⁴	All	Rural
Trousdale ¹¹	All	Rural
Union	All	Urban
Van Buren ⁴	All	Rural
Wayne	All	Rural
Weakley	Dresden Chestnut Glade-Dukedom Palmer'sville CCD Dresden CCD Gleason CCD	Rural
White	All	Rural

¹ Classified as a HPSA, effective June 1, 1996.

² No longer classified as a HPSA, effective March 1, 1997.

³ Classified as a HPSA, effective July 1, 1997.

⁴ No longer classified as a HPSA, effective October 1, 1997.

⁵ No longer classified as a HPSA, effective February 1, 1997.

⁶ Classified as a HPSA, effective October 1, 1997.

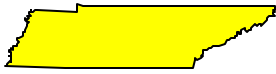
⁷ No longer classified as a HPSA, effective March 1, 1998.

⁸ Classified as a HPSA, effective May 1, 1998

⁹ No longer classified as a HPSA, effective May 1, 1998.

¹⁰ Classified as a HPSA, effective January 1, 1999.

¹¹ No longer classified as a HPSA, effective March 1, 1999.



Spring Workshops

Rx for Success...

with your Medicare transactions. Whether it's filing claims error-free, adding a new physician to your practice, preparing for the millennium, or ensuring full compliance with guidelines, the prescription for your success is registering to attend the 1999 CIGNA Medicare Spring Workshop. Plan to attend this historic event - the last Spring Workshop in the 20th century!

This workshop series, which is being offered in 20 locations to ensure maximum availability to Tennessee's approximately 12,000 providers, will emphasize cleaning up problem areas as we prepare to enter the new century. This workshop will provide instruction in important Medicare fundamentals for new billers and offer veteran billers tips and tools for resolving common problems. We will provide you the solutions for nipping new problems in the bud and the clarification necessary to end chronic problems.

Locations and dates are as follows:

Manchester	April 6, 1999
Kingsport	April 7, 1999
Chapel Hill	April 8, 1999
Athens	April 14, 1999
Nashville	April 14, 1999
Clarksville	April 15, 1999
Chattanooga	April 20, 1999
Memphis	April 20, 1999
Monteagle	April 22, 1999
Jackson	April 27, 1999
Johnson City	April 27, 1999
Jackson	May 4, 1999
Knoxville	May 5, 1999
Hendersonville	May 11, 1999
Nashville	May 13, 1999
Murfreesboro	May 18, 1999
Greeneville	May 19, 1999
Cookeville	May 20, 1999
Oak Ridge	May 25, 1999
Buchanan	May 26, 1999
Oneida	June 2, 1999
Alcoa	June 8, 1999
Memphis	June 10, 1999
Knoxville	June 10, 1999

If you have not received an announcement in the mail, call 615.782.4510 for more details or check us out on the Web at: www.cignamedicare.com.



Medicare Part B - TN Local Medical Review Policy

SUBJECT:

Diagnostic and Therapeutic Esophagogastroduodenoscopy (EGD)

POLICY NUMBER:

9901

DESCRIPTION:

Diagnostic and therapeutic EGD is a common endoscopic procedure performed for suspected and proven lesions of the upper gastrointestinal tract.

HCPCS SECTION BENEFIT CATEGORY:

Digestive System – Endoscopy

HCPCS CODES ©:

43234 Upper gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible endoscope)
43235 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43239 ...with biopsy, single or multiple
43241 ...with transendoscopic tube or catheter placement
43243 ...with injection sclerosis of esophageal and/or gastric varices
43244 ...with band ligation of esophageal and/or gastric varices
43245 ...with dilation of gastric outlet for obstruction, any method
43246 ...with directed placement of percutaneous gastrostomy tube
43247 ...with removal of foreign body
43248 ...with insertion of guide wire followed by dilation of esophagus over guide wire
43249 ...with balloon dilation of esophagus (less than 30 mm diameter)
43250 ...with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43251 ...with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43255 ...with control of bleeding, any method
43258 ...with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43259 ...with endoscopic ultrasound examination

HCFA'S NATIONAL POLICY:

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

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

INDICATIONS AND LIMITATIONS OF COVERAGE:

The following conditions are generally accepted as indication(s) for the performance of EGD(s):

Indications which support EGD(s) for diagnostic purpose(s) are as follows:

- upper abdominal distress which persists despite an appropriate trial of therapy;
- upper abdominal distress associated with symptoms and/or signs suggesting serious organic disease (e.g., anorexia and weight loss);
- dysphagia or odynophagia;



- esophageal reflux symptoms which are persistent or recurrent despite appropriate therapy;
- persistent vomiting of unknown cause;
- other system disease in which the presence of upper GI pathology might modify other planned management. Examples include patients with a history of GI bleeding who are scheduled for organ transplantation, long-term anticoagulation, and chronic non-steroidal therapy for arthritis;
- X-ray findings of:
 - a suspected neoplastic lesion, for confirmation and specific histologic diagnosis;
 - gastric or esophageal stricture or obstruction
- gastrointestinal bleeding
 - in most actively bleeding patients;
 - when surgical therapy is contemplated;
 - when rebleeding occurs after acute self-limited blood loss;
 - when portal hypertension or aorto-enteric fistula is suspected; or,
 - for presumed chronic blood loss and for iron deficiency anemia when colonoscopy is negative;
- when sampling of duodenal or jejunal tissue or is indicated;
- to assess acute injury after caustic agent ingestion; or,
- intraoperative EGD when necessary to clarify location or pathology of a lesion

Indications which support EGD(s) for therapeutic purpose(s) are as follows:

- treatment of bleeding from lesions such as ulcers, tumors, vascular malformations (e.g., electrocoagulation or injection therapy);
- sclerotherapy and/or band ligation for bleeding from esophageal or proximal gastric varices;
- foreign body removal;
- removal of selected polypoid lesions;
- placement of feeding tubes (per oral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy);
- dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilating systems employing guidewires); or,
- palliative therapy of stenosing neoplasms (e.g., laser, bipolar electrocoagulation, stent placement).

Sequential or periodic diagnostic EGD may be indicated:

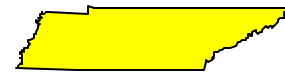
- for follow-up of selected esophageal, gastric or stomal ulcers to demonstrate healing (frequency of follow-up EGD is variable, but every two to four months until healing is demonstrated is reasonable);
- for follow-up in patients with prior adenomatous gastric polyps (approximate frequency of follow-up EGDs would be every one to four years depending on the clinical circumstances, with occasional patients with sessile polyps requiring every six months surveillance initially);
- for follow-up for adequacy of prior sclerotherapy and/or band ligation of esophageal varices (approximate frequency of follow-up EGDs is variable depending on the state of the patient but every six to 24 months is reasonable after the initial sclerotherapy sessions are completed);
- for follow-up of Barrett’s esophagus (approximate frequency of follow-up EGDs is one to two years with biopsies, unless dysplasia is demonstrated, in which case, a repeat biopsy in two to three months might be indicated); or,
- follow-up in patients with familial adenomatous polyposis (approximate frequency of , follow-up EGDs would be every two to four years, but might be more frequent such as every six to 12 months, if gastric adenomas or adenomas of the duodenum were demonstrated).

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

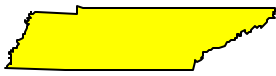
Medicare is establishing the following limited coverage for codes 43234-43235, 43239, 43241, 43243-43251, 43255 and 43258:

Covered for:

041.86	Helicobacter pylori
150.0 - 150.5	Malignant neoplasm of esophagus
150.8 - 150.9	Malignant neoplasm of stomach
151.0 - 151.6	Malignant neoplasm of duodenum
151.8 - 151.9	Malignant neoplasm of other sites of stomach, unspecified
152.0	Malignant neoplasm of duodenum
211.0 - 211.2	Benign neoplasm of other parts of digestive system
230.1 - 230.2	Carcinoma in situ of digestive organs



235.2 - 235.3	Neoplasm of uncertain behavior, stomach, intestines, rectum, liver and biliary system
235.5	Neoplasm of uncertain behavior of other and unspecified digestive organs
239.0	Neoplasms of unspecified nature, digestive system
261	Nutritional marasmus
263.0	Malnutrition of moderate degree
263.8 - 263.9	Other and unspecified protein-calorie malnutrition
280.0	Iron deficiency anemia, secondary to blood loss (chronic)
280.9	Iron deficiency anemia, unspecified
285.1	Acute posthemorrhagic anemia
447.2	Rupture of artery
456.0 - 456.1	Varicose veins of other sites
456.20 - 456.21	Esophageal varices in diseases classified elsewhere
530.0	Achalasia and cardiospasm
530.10 - 530.11	Esophagitis
530.19	Other esophagitis
530.2 - 530.7	Diseases of the esophagus
530.81 - 530.84	Other specified disorders of esophagus
531.00 - 531.01	Gastric ulcer, acute with hemorrhage, with or without mention of obstruction
531.30 - 531.31	Gastric ulcer, acute without mention of hemorrhage or perforation, with or without mention of obstruction
531.40 - 531.41	Gastric ulcer, chronic or unspecified with hemorrhage, with or without mention of obstruction
531.70 - 531.71	Gastric ulcer, chronic without mention of hemorrhage or perforation, without mention of hemorrhage or perforation, with or without mention of obstruction
531.90 - 531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with or without mention of obstruction
532.00 - 532.01	Duodenal ulcer, acute with hemorrhage, with or without mention of obstruction
532.30 - 532.31	Duodenal ulcer, acute without mention of hemorrhage or perforation, with or without mention of obstruction
532.40 - 532.41	Duodenal ulcer, chronic or unspecified with hemorrhage, with or without mention of obstruction
532.70 - 532.71	Duodenal ulcer, chronic without mention of hemorrhage or perforation, with or without mention of obstruction
532.90 - 532.91	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with or without mention of obstruction
533.00 - 533.01	Peptic ulcer, site unspecified, acute with hemorrhage, with or without mention of obstruction
533.30 - 533.31	Peptic ulcer, site unspecified, acute without mention of hemorrhage or perforation, with or without mention of obstruction
533.40 - 533.41	Peptic ulcer, site unspecified, chronic or unspecified with hemorrhage, with or without mention of obstruction
533.70 - 533.71	Peptic ulcer, site unspecified, chronic without mention of hemorrhage or perforation, with or without mention of obstruction
533.90 - 533.91	Peptic ulcer, site unspecified, unspecified as acute or chronic, without mention of hemorrhage or perforation, with or without mention of obstruction
534.00 - 534.01	Gastrojejunal ulcer, acute with hemorrhage, with or without mention of obstruction
534.30 - 534.31	Gastrojejunal ulcer, acute with hemorrhage, with or without mention of obstruction
534.40 - 534.41	Gastrojejunal ulcer, chronic or unspecified with hemorrhage, with or without mention of obstruction
534.70 - 534.71	Gastrojejunal ulcer, chronic without mention of obstruction
534.90 - 534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with or without mention of obstruction
535.00 - 535.01	Acute gastritis, with or without mention of hemorrhage
535.10 - 535.11	Atrophic gastritis, with or without mention of hemorrhage
535.20 - 535.21	Gastric mucosal hypertrophy, with or without mention of hemorrhage
535.30 - 535.31	Alcoholic gastritis, with or without mention of hemorrhage
535.40 - 535.41	Other specified gastritis, with or without mention of hemorrhage
535.50 - 535.51	Unspecified gastritis and gastroduodenitis, with or without mention of hemorrhage
535.60 - 535.61	Duodenitis, with or without mention of hemorrhage



536.2	Persistent vomiting
536.3	Gastroparesis
536.8	Dyspepsia
537.0 - 537.4	Other disorders of stomach and duodenum
537.6	Hourglass stricture or stenosis of stomach
537.81 - 537.83	Other specified disorders of stomach and intestines, pylorospasm, angiodysplasia of stomach and duodenum with or without mention of hemorrhage
537.89	Other specified disorders of stomach and duodenum
537.9	Unspecified disorder of stomach and duodenum
552.3	Diaphragmatic hernia with obstruction
553.3	Diaphragmatic hernia
555.0	Regional enteritis - small intestine
569.84	Angiodysplasia of intestine
578.0 - 578.1	Gastrointestinal hemorrhage
578.9	Hemorrhage of gastrointestinal tract, unspecified
579.0 - 579.4	Intestinal malabsorption
579.8 - 579.9	Other specified and unspecified intestinal malabsorption
747.20	Other anomalies of aorta, unspecified
747.61	Gastrointestinal vessel anomaly
750.3 - 750.4	Other congenital anomalies of upper alimentary tract
750.7	Other specified anomalies of stomach
783.2	Abnormal loss of weight
786.50	Chest Pain
787.1 - 787.2	Symptoms involving digestive system
789.01 - 789.02	Abdominal pain, right upper quadrant, left upper quadrant
789.05 - 789.06	Abdominal pain, periumbilic, epigastric
792.1	Occult GI Blood Loss
793.4	Non-specific abnormal findings on radiological or other examination, gastrointestinal tract
935.1 - 935.2	Foreign body in esophagus, stomach
936	Foreign body in intestine and colon
947.0	Burn of mouth and pharynx
947.2 - 947.3	Burn of internal organs, esophagus and gastrointestinal tract
V10.03 - V10.04	Personal history of malignant neoplasm of esophagus or stomach
V12.72	Colonic polyps
(Note: Use V12.72 to indicate familial adenomatous polyposis)	
V47.3	Other digestive problems
V58.61	Long-term (current) use of anticoagulants
V58.69	Long-term (current) use of other medications

Medicare is establishing the following limited coverage for code 43259:

Covered for:

150.0 - 150.5	Malignant neoplasm of esophagus
150.8 - 150.9	Malignant neoplasm of stomach
151.0 - 151.6	Malignant neoplasm of duodenum
151.8 - 151.9	Malignant neoplasm of other sites of stomach, unspecified
152.0	Malignant neoplasm of duodenum
153.0 - 153.9	Malignant neoplasm of colon
157.0 - 157.4	Malignant neoplasm of pancreas
157.8 - 157.9	Malignant neoplasm of other sites of pancreas, part unspecified
200.03	Reticulosarcoma, intra-abdominal lymph nodes
200.13	Lymphosarcoma, intra-abdominal lymph nodes
211.0 - 211.2	Benign neoplasm of other parts of digestive system
211.5	Benign neoplasm of liver and biliary passages
214.3	Lipoma, intra-abdominal organs



230.1 - 230.2	Carcinoma in situ of digestive organs
230.7	Carcinoma in situ of other and unspecified parts of intestine
230.8	Carcinoma in situ, liver and biliary system
235.2 - 235.3	Neoplasm of uncertain behavior, stomach, intestines, rectum, liver and biliary system
235.5	Neoplasm of uncertain behavior of other and unspecified digestive organs
456.1	Esophageal varices without mention of bleeding
530.0	Achalasia and cardiospasm
530.2 - 530.3	Diseases of esophagus
530.9	Unspecified disorder of esophagus
531.70 - 531.71	Gastric ulcer, chronic without mention of hemorrhage or perforation, with or without mention of obstruction
534.90 - 534.91	Gastrojejunal ulcer unspecified as acute or chronic, with or without mention of hemorrhage or perforation, with or without mention of obstruction
577.1 - 577.2	Diseases of pancreas
793.4	Non-specific abnormal findings on radiological and other examination of gastrointestinal tract
793.6	Non-specific abnormal findings on radiological and other examination of abdominal area, including retroperitoneum

REASONS FOR DENIAL:

Indications for which EGD(s) **are generally not covered** by Medicare are:

- distress which is chronic, non-progressive, atypical for known organic disease, and is considered functional in origin (there are occasional exceptions in which an endoscopic examination may be performed to rule out organic disease, especially if symptoms are unresponsive to therapy);
- uncomplicated heartburn responding to medical therapy;
- metastatic adenocarcinoma of unknown primary site when the results will not alter management;
- X-ray findings of:
 - asymptomatic or uncomplicated sliding hiatus hernia;
 - uncomplicated duodenal bulb ulcer which has responded to therapy; or,
 - deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy;
 - routine screening of the upper gastrointestinal tract; or,
 - patients without current gastrointestinal symptoms about to undergo elective surgery for non-upper gastrointestinal disease.

Sequential or periodic diagnostic EGD is **not** indicated for:

- surveillance for malignancy in patients with gastric atrophy, pernicious anemia, treated achalasia, or prior gastric operation;
- surveillance of healed benign disease such as esophagitis, gastric or duodenal ulcer; or,
- surveillance during chronic repeated dilations of benign strictures unless there is a change in status.

NONCOVERED ICD-9 CODES:

All diagnoses not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this policy

SOURCES OF INFORMATION:

- Carrier Medical Director (CMD) Endoscopy Workgroup, American Society for Gastrointestinal Endoscopy, "Appropriate Use of Gastrointestinal Endoscopy, Consensus Statement." Section on esophagogastroduodenoscopy (EGD)

CODING GUIDELINES:

DOCUMENTATION REQUIREMENTS:

OTHER COMMENTS:



CAC NOTES:

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee.

START DATE OF COMMENT PERIOD:

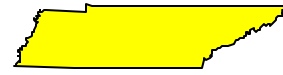
October 28, 1998

START DATE OF NOTICE PERIOD:

March 15, 1999

EFFECTIVE DATE:

May 1, 1999



Medicare Part B - TN Local Medical Review Policy

SUBJECT:

Positron Emission Tomography Scans

POLICY NUMBER:

9902

DESCRIPTION:

1. Positron emission tomography (PET), also known as positron emission transverse tomography (PET), is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A position camera (tomography) is used to produce cross-sectional tomographic images by detecting radioactivity from a radioactive tracer substance (radiopharmaceutical) that is injected into the patient.
2. In the past, Medicare considered these scans experimental and therefore not covered. HCFA concluded that one use of the PET scans, that is imaging of the perfusion of the heart using a specific radiopharmaceutical (Rubidium 82), was no longer experimental and could be covered if the conditions outlined in this policy were met and the testing was medically necessary, for dates of service on or after March 14, 1995. Sensitivity and specificity are very high in the diagnosis of coronary artery disease using this scan. PET scanning is important in identifying poorly perfused myocardium that is viable and potentially salvageable by revascularization. PET use in other types of heart disease or for other non-cardiac conditions is still considered investigational and not covered by Medicare.
3. Medicare has been continuously reviewing the scientific literature regarding PET scans. As with other new or evolving technologies, Medicare continued to review the progress of this technology, with a view toward modifying policy, based upon the best evidence available as to the medical effectiveness of such scans. This revised policy adds coverage of PET for the characterization of solitary pulmonary nodules (SPNs) and for the initial staging of lung cancer, conditioned upon its ability to provide useful information for the management and treatment of patients with either suspected or demonstrated lung cancer. All other uses of PET scans remain not covered by Medicare.
4. This coverage is predicated upon the use of PET scans with FDG to develop proper treatment plans for patients with SPNs and the initial staging of lung cancer. HCFA will evaluate both the data produced by claims for this service, as well as data obtained from other sources, to determine whether, and to what extent, it should make modifications in this coverage policy to assure that the services covered are medically effective for the treatment of Medicare beneficiaries.

HCPCS CODES®:

- | | |
|-------|---|
| G0030 | PET myocardial perfusion imaging, (following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic) |
| G0031 | PET myocardial perfusion imaging, (following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0032 | PET myocardial perfusion imaging, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic) |
| G0033 | PET myocardial perfusion imaging, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0034 | PET myocardial perfusion imaging, (following rest SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic) |
| G0035 | PET myocardial perfusion imaging, (following rest SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic) |
| G0036 | PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic) |



- G0037 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0038 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460); single study, rest or stress (exercise and/or pharmacologic)
- G0039 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0040 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic)
- G0041 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0042 PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)
- G0043 PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0044 PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)
- G0045 PET myocardial perfusion imaging, (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0046 PET myocardial perfusion imaging, (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic)
- G0047 PET myocardial perfusion imaging, (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0125 PET lung imaging of solitary pulmonary nodules using 2-(fluorine-18)-fluor-2-deoxy-D-glucose (FDG), following CT (71250/71260 or 71270)
- G0126 PET lung imaging of solitary pulmonary nodules using 2-(fluorine-18)-fluor-2-deoxy-D-glucose (FDG), following CT (71250/71260 or 71270); for initial staging of pathologically diagnosed NSCLC.

HCFA'S NATIONAL POLICY:

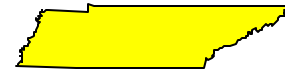
- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

INDICATIONS AND LIMITATIONS OF COVERAGE:

- A. Conditions Applicable to All Covered Uses of PET Scans:
Regardless of any other terms or conditions, all uses of PET scans, in order to be covered by the Medicare program, must meet the following conditions:
 - 1. Such scans must be performed using a camera that has either been approved or cleared for marketing by FDA to image radionuclides in the body.
 - 2. Submission of claims for payment must include any information Medicare requires to assure that the PET scan performed were: (a) medically necessary; (b) did not unnecessarily duplicate other covered diagnostic test, and (c.) did not involve investigational drugs, or procedures using investigational drugs, as determined by the Food and Drug Administration (FDA).
 - 3. The PET scan entity submitting claims of for payment must keep such patient records as Medicare requires on file for each patient for whom a PET scan claim is made.

- B. Coverage of PET scans using Rubidium 82 (Rb 82) and Related Tests - Effective for Services performed on or after March 14, 1995:

PET scans done at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb 82) are covered, provided such scans meet the following conditions:
 - 1. The PET scan, whether rest alone, or rest with stress, is used in place of, but not in addition to, a single photon emission computed tomography (SPECT); or



2. The PET scan, whether rest alone or rest with stress, is used following a SPECT that was found inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data).
 3. PET scans may be covered only at PET imaging centers with PET scanners that have been approved by the FDA. By submitting a claim(s), the provider is certifying that this is the case and must be able to produce a copy of this approval upon request. (Submission of claims by unapproved centers will result in an appropriate overpayment penalty).
 4. PET scans using Rubidium 82, whether rest or stress, are not covered by Medicare for routine screening or asymptomatic patients, regardless of the level of risk factors applicable to such patients.
- C. Coverage of PET Scans Using FDG in Characterization of Solitary Pulmonary Nodules (SPNs)-Effective for Services Performed on or after January 1, 1998.

Background: HCFA had carefully examined a wide range of uses of PET with FDG in detecting, staging and monitoring non-central nervous system (CNS) cancers. Currently, these uses do not appear to be sufficiently developed to allow HCFA to determine their medical effectiveness to a degree sufficient to make conclusive coverage determination under the Medicare program. However, there is some research data indicating that, in the case of characterization of single pulmonary nodules, (SPNs), regional PET chest scans may offer, at least for some patients, an effective method of determining the proper course of management for their disease. It is not yet clear how effective this procedure will be in everyday use. Therefore, Medicare will begin paying for PET scans on an interim basis in accord with terms of this policy. During the period of this interim coverage, Medicare will continue to seek and review information on the clinical effectiveness of this procedure. Researchers will be encouraged to continue to refine and expand the knowledge base necessary to assure that such scans are fully and properly utilized.

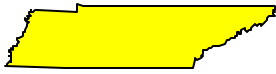
HCFA intends to closely monitor not only the provision of services furnished under this coverage, but also the development of additional information developed by non-HCFA studies. It is believed that a full understanding of the clinical effectiveness of PET for the characterization of SPNs will be found after additional clinical research. Medicare will collect and analyze claims data on this service, expects and encourages others to continue their study of the use of PET for characterization of SPNs, including randomized clinical trails. HCFA will continue to review the medical literature, as well as studies, assessment, and other information developed by the medical and scientific community to assure that its coverage of these scans is appropriate.

Coverage of PET scans for characterization of solitary pulmonary nodules (SPNs)-PET scan using the glucose analog 2-(fluorine-18)-fluoro-2-deoxy-D-glucose (FDG) are covered, subject to the conditions and limitations described below, when used for the characterization of suspected solitary pulmonary nodules (SPNs). The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient.

The procedure consists of the glucose analog FDG being injected into the patient intravenously, with image acquisition usually beginning 30-60 minutes later, and continuing for a period of 10-20 minutes. The FDG is metabolized by both normal and cancerous tissue in proportion to the rate of glucolysis.

Since tumor cells have shown an increased utilization of glucose, those regions observed to have an increased FDG uptake relative to background indicate areas of cancerous tissue.

The coverage of PET scans using FDG for the purpose of characterizing SPCs is limited to situations in which the patient has been tested and evaluated in accordance with the provisions outlined below. These provisions were developed using models for clinical practice developed in collaboration with the PET community as well as professional opinions from several sources familiar with the proper use of PET scans. These provisions are designed to limit coverage of this service to those situations in which it is effective in determining the course of future patient treatment. This criterion, the medical effectiveness of a service based on its utility in determining the course of treatment, is generally applied by Medicare to diagnostic modalities that substitute for, or are intended to replace other diagnostic modalities for the same medical purpose. As with any other Medicare claim, claims for PET scans may be reviewed to determine whether the provisions below were followed, and contractors may request additional information and clarification prior to making payment, or on post-payment review of claims.



In addition, PET scan facilities must maintain sufficient documentation on-site to answer inquiries from contractors as to the performance of PET scans for which they make claims for payment.

Requirements for Payment of Claims for Characterizing Solitary Pulmonary Nodules (SPNs) with PET using FDG.

1. Evidence of primary - Claims for regional PET chest scans for characterizing SPNs should include evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other detection methods, indicating an indeterminate or possibly malignant lesion, not exceeding four centimeters (cm.) in diameter. Such report should be included with the claim for payment, along with the result of PET scan, using the appropriate code.

NOTE: PET scans are not covered by Medicare for screening of asymptomatic patients, regardless of the number and severity of risk factors applicable to such patients.

2. PET scan results and results of concurrent computed tomography (CT) - In order to ensure that the PET scan is properly coordinated with other diagnostic modalities, PET scan claims must include the results of concurrent thoracic CT (as noted above), which is necessary for anatomic information.

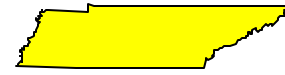
NOTE: A Tissue Sampling Procedure (TSP) should not be routinely covered in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. Claims for a TSP after a negative PET must be submitted with documentation for review by the Medicare contractor to determine if the TSP is reasonable and necessary in spite of a negative PET. Physicians should discuss with their patients the implications of this decision, both with respect to the patient's responsibility for payment for such a biopsy if desired, as well as the confidence the physician has in the results of such PET scans, prior to ordering such scans for this purpose. This physician-patient decision should occur with a clear discussion and understanding of the sensitivity and specificity trade-offs between CT and PET scans. In cases where a TSP is performed, it is the responsibility of the physician ordering the TSP to provide sufficient documentation of the medical necessity for such procedure or procedures. Such documentation should include, but is not necessarily limited to, a description of the features of the PET scan that call into question whether it is an accurate representation of the patient's condition, the existence of other factors in the patient's condition that call into question the accuracy of the PET scan, and such information as the contractor processing the claim deems necessary to determine whether the claim for the TSP should be covered and paid.

In case of serial evaluation of SPCs using both CT and regional PET chest screening, such PET scans will not be covered if repeated within 90 days following a negative PET scan.

- D. Coverage of PET Scans Using FDG to Initially Stage Lung Cancer-Effective for Services Performed on or after January 1,1998:

Background: HCFA has carefully examined a wide range of uses of PET with FDG in detecting, staging and monitoring non-central nervous system (CNS) cancers. Currently, these uses do not appear to be sufficiently developed to allow HCFA to determine their medical effectiveness to a degree sufficient to make a conclusive coverage determination under the Medicare program. However, there is some research data indicating that, in the case of the initial staging of non-small-cell lung carcinoma (NSCLC), whole body PET scan may offer, at least for some patients, an effective method of determining the proper course of management for their disease. It is not yet clear how effective this procedure will be in everyday use. Therefore, Medicare will be paying for PET scans on an interim basis in accord with the terms of this policy. During the period of this interim coverage, Medicare will continue to seek and review information on the clinical effectiveness of this procedure. Medicare will also encourage researchers to continue to refine and expand the knowledge base necessary to assure that such scans are fully and properly utilized.

HCFA intends to closely monitor not only the provision of services furnished under this coverage, but also the development of additional information developed by non-HCFA studies. HCFA believes that a full understanding of the clinical effectiveness of PET for the staging of cancer, including NSCLC, will be found after additional clinical research. HCFA will be collecting and analyzing claims data on this service but will expect and encourage others to continue their study on the use of PET with FDG for the staging of lung cancer, including randomized clinical trials.



HCFA will continue to review the medical literature, as well as studies, assessments, and other information developed by the medical and scientific community to assure that its coverage of these scans is appropriate.

Coverage of PET scans for staging non-small cell lung carcinoma-PET scans using the glucose analog 2-(fluorine-18)-fluoro-2-deoxy-D-glucose (FDG) are covered, subject to the conditions and limitations described below, only when used for the initial staging of suspected metastatic NSCLC in thoracic (mediastinal) lymph nodes in patients who have a confirmed primary lung tumor, but whose extent of disease has not yet been established. The primary purpose of such staging should be to determine the progress and extent of the disease, as well as the probable rate of its progression, in order to plan future management for the patient. (Note: this instruction covers only the initial staging of NSCLC. Multiple stagings using PET is considered monitoring of the progress of the disease, rather than staging, and is not covered at this time).

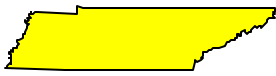
The procedure consists of the glucose analog FDG being injected into the patient intravenously, with image acquisition usually beginning 30-60 minutes later, and continuing for a period of 10-20 minutes. The FDG is metabolized by both normal and cancerous tissue in proportion to the rate of glycolysis. Since tumor cells have shown an increased utilization of glucose, those regions observed to have an increased FDG uptake relative to background indicate areas of cancerous tissue.

The coverage of PET scans using FDG for the purpose of staging NSCLC is limited to situations in which the patient has been tested and evaluated in accordance with the provisions outlined below. These provisions were developed using models for clinical practice in collaboration with the PET industry, as well as professional opinion from several sources familiar with the proper use of PET scans. These provisions are designed to limit coverage of this service to those situations in which it is effective in determining the course of future patient treatment. This criterion, the medical effectiveness of a service in determining the course of treatment, is generally applied by Medicare to diagnostic modalities that substitute for, or are intended to replace, other diagnostic modalities for the same medical purpose. As with any other Medicare claim, claims for PET scan facilities must maintain sufficient documentation on-site to answer inquiries from contractors as to the performance of PET scans for which they make claims for payment.

Requirements for Payment of Claims for Staging Metastatic NSCLC Lung Cancer with PET using FDG:

1. Evidence of primary tumor - Since this service is covered only in those cases in which a primary cancerous lung tumor has been confirmed, claims for PET should include a statement or other evidence of the detection of such primary lung tumor. This should include, but is not restricted to, a surgical pathology report which documents the presence of an NSCLC.
2. Whole body PET scan results and results of concurrent computed tomography (CT) and follow-up lymph node biopsy - In order to ensure that the PET scan is properly coordinated with other diagnostic modalities, claims must include both (1) the results of concurrent thoracic CT, which is necessary for anatomic information, and (2) the results of any lymph node biopsy performed to finalize whether the patient will be a surgical candidate. The ordering physician is responsible for providing this whether the patient will be a surgical candidate. The ordering physician is responsible for providing this biopsy result to the PET facility.

NOTE: A lymph node biopsy will not be covered in the case of a negative CT and negative PET, where the patient is considered a surgical candidate, given the presumed absence of metastatic NSCLC unless medical review supports a determination of medical necessity of biopsy. A lymph node biopsy will be covered in all other cases, i.e., positive CT + positive PET; negative CT + positive PET; positive CT + negative PET. Physicians should discuss with their patients the implications of these points, both with respect to the patient's responsibility for payment for such a biopsy if desired (in the case of a negative CT + negative PET), as well as the confidence the physician has in the results of such PET scans, prior to ordering such scans for this purpose. This physician-patient decision should occur with a clear discussion and understanding of the sensitivity and specificity trade-offs between CT and PET scans. In cases where a lymph node biopsy is performed, it is the responsibility of the physician ordering the lymph node biopsy to provide sufficient documentation of the medical necessity limited to, a description of the features of the PET scan that call into question whether it is an accurate representation of the patient's condition, the existence of other factors in the patient's condition that call into question the accuracy of the PET scan, and such other information as the contractor processing the claim deems necessary to determine whether the claim for the lymph node biopsy should be covered and paid.



ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

162.3 to 162.5	(Malignant neoplasm of lung) (Solitary nodule)
410.00 to 410.02	Acute myocardial infarction of anterolateral wall
410.00 to 410.12	Acute myocardial infarction of other anterior wall
410.20 to 410.22	Acute myocardial infarction of inferolateral wall
410.30 to 410.32	Acute myocardial infarction of inferoposterior wall
410.40 to 410.42	Acute myocardial infarction of other inferior wall
410.50 to 410.52	Acute myocardial infarction of other lateral wall
410.60 to 410.62	True posterior wall infarction
410.70 to 410.72	Subendocardial infarction
410.80 to 410.82	Acute myocardial infarction of other specified sites
410.90 to 410.92	Acute myocardial infarction of unspecified sites
411.0	Postmyocardial infarction syndrome
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute and subacute form of ischemic heart disease
412	Old myocardial infarction
413.0 to 413.9	Angina pectoris
414.00 to 414.03	Coronary atherosclerosis
414.10	Aneurysm of heart (wall)
414.11	Aneurysm of coronary vessels
414.19	Other aneurysm of heart
414.8	Other specified forms of chronic ischemic heart disease
414.9	Unspecified chronic ischemic heart disease
793.1	Nonspecific abnormal findings on radiological and other examination of body structure and lung field (for Coin lesions)

REASONS FOR DENIAL:

1. All other uses of PET scans except as defined in this policy are not covered by Medicare and are still considered investigational and not reimbursable.
2. All codes which are not listed as covered for these procedures described in this policy in the ICD-9 Codes That Support Medical Necessity list in the Indications section will not be covered by Medicare Part B.

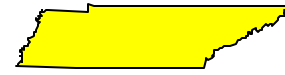
SOURCES OF INFORMATION:

- MCM, section 50-36
- Scientific American, CTM:III 3-6, CTM:X: 17-18, Cardiology 1:7
- Program Memorandum (MCMG-DCM), Transmittal #AB-97-22, Change Request #362 and #A-98-9, change request #465, 3/98

CODING GUIDELINES:

1. Consult current correct coding guidelines for applicable specific code combinations or reductions in payment due to specific codes billed.
2. Providers should use CPT codes G0030 through G0125-G0126 to indicate the conditions under which a PET scan was done. These codes represent the global service, so providers performing just the technical component of the test should use modifier-TC and providers performing just the professional component should use modifier -26.
3. Claims for PET scans must include the following information. Failure to submit this information may result in denial of a claim. The PET center must, for any PET scan for which payment is claimed, complete all required information on the claim form (including proper codes and modifiers), and indicate the results of the PET scan, as well as information as to whether the PET scan was done after an inconclusive noninvasive cardiac test (for codes G0020-G0047). The information submitted with respect to the previous cardiac test must specify the type of test done prior to the PET scan and whether it was inconclusive unsatisfactory.

Claims for staging metastatic non-small-cell lung cancer need to include evidence of the detection of primary NSCL



tumors. A surgical pathology report which documents the presence of an NSCLC must be kept on file by the provider. In order to ensure that the PET scan is properly coordinated with other diagnostic modalities, claims must include both the results of a concurrent thoracic CT (which is necessary for anatomic information), and the results of any lymph node biopsy.

For claims characterizing SPNs include evidence of the initial detection of a primary lung tumor. The evidence should contain an indication of the results of a CT or another detection method, documenting an indeterminate or possibly malignant lesion, not exceeding four centimeters. This indication should be included with the claim, along with results of the PET scan, using appropriate modifiers. PET scan claims must always include the results of a concurrent thoracic CT (which is necessary for anatomic information), in addition to the detection method used.

In addition to the standard modifiers indicating whether the claim is for the professional component only or the technical component, a two-digit modifier will be used to indicate the results of the PET scan and the previous test, the presence or absence of myocardial ischemia or a malignant pulmonary nodule. (The modifier will not be required for the technical component, - billing or billings to the intermediary.) The first alpha character will be used to indicate the result of the PET scan while the second alpha character will indicate the results of the prior test. The test result modifiers, which may be used in any combination, and their descriptions are listed below:

<u>Modifier</u>	<u>Description</u>
N	Negative
E	Equivocal
P	Positive, but not suggestive of, extensive ischemia or not suggestive of malignant single pulmonary nodule.
S	Positive and suggestive of extensive ischemia (>20% of the left ventricle) or malignant single pulmonary nodule.

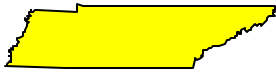
As an example, G0034SE-26 means that the original SPECT study was equivocal, the PET scan was positive and that only the professional component is being billed by the involved physician. Another example for pulmonary pathology is G0125SE-26, which means that the CT study was equivocal and the PET scan was positive for a malignant single pulmonary nodule and only the professional component is being billed.

4. The submitted claim must also include an ICD-9-CM code. Completion of all items requested on claim forms is expected. As with any other Medicare claims, the PET scan facility must complete all required information on the claims form, including any codes or modifiers required by HCFA.
5. Maintenance of patient record data onsite - As with any claim, but particularly in view of the limitations on this coverage, Medicare may decide to conduct post-payment reviews to determine that the use of PET scan is consistent with these instructions.

These medical records will be used in any post-payment reviews and must include the information necessary to substantiate the need for the PET scan. These records must include standard information (e.g., age, sex, and height) along with sufficient patient histories to allow determination that the steps required in this instruction were followed. Such information must include, but is not limited to, the date, place and results of previous diagnostic tests (e.g., cytopathology and surgical pathology report, CT, pertinent X-rays, etc.), as well as the results and reports of the PET scan(s) performed at the center. If available, such records should include the prognosis derived from the PET scan, together with information regarding the physician or institution to which the patient proceeded following the scan for treatment or evaluation. The ordering physician is responsible for forwarding appropriate clinical data to the PET scan facility.

DOCUMENTATION REQUIREMENTS:

1. PET center must keep patient record information on file for each Medicare patient for whom a PET scan claim is made. The record must include standard information (e.g., age, sex, height) along with any annotations regarding body size or type which indicated a need for a PET scan to determine that the patient's condition (i.e., the nature of the patient's body size or type) mandated the use of a PET scan in order to continue treatment.
2. Hospital or outpatient records or procedure reports should clearly document the reason for the PET scan and its frequency and what was done.



3. Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.
4. No special requirements are necessary with electronic claims submission. If it is suspected that the claim(s) will be denied, submit appropriate documentation (e.g., a cover letter or an appropriate copy of pertinent office record explaining the necessity for the scan).

OTHER COMMENTS:

1. Since PET scanning is not done in an office or free standing radiology unit at this time, payment by Part B for Rubidium 82 is not reimbursable. Technical component (TC) costs (e.g., hospital costs) associated with these procedures when furnished to hospital outpatients will be payable by intermediaries on a reasonable cost basis.
2. Copyright Current CPT Manual (Physicians' Current Procedural Terminology), American Medical Association.

CAC NOTES:

START DATE OF COMMENT PERIOD:

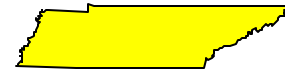
October 28, 1998

START DATE OF NOTICE PERIOD:

March 15, 1999

EFFECTIVE DATE:

May 1, 1999



Medicare Part B -TN Local Medical Review Policy

SUBJECT:

Spinal Cord Stimulators

POLICY NUMBER:

9903

DESCRIPTION:

Spinal cord stimulation block conduction pathway and stimulate endorphins. The neurostimulator, electrodes used for this purpose are implanted percutaneously in the epidural space through a special needle. Some patients may need an open procedure requiring laminectomy to place the electrodes.

After placement of the electrodes, the patient is provided with an external neurostimulator, initially on a trial basis, the trial period may be external up to four weeks. If during the trial period it is determined that the modality is not effective or it is not acceptable to the patient, the electrodes may be removed.

If the trial has been successful, a spinal neurostimulator and pulse generator that activates through a radio frequency device is inserted subcutaneously and connected to the electrodes already in place.

HCPCS SECTION BENEFIT CATEGORY:

Surgery - Nervous System

HCPCS CODES ©

63650	Percutaneous implantation of neurostimulator electrodes; epidural
63655	Laminectomy for implantation of neurostimulator electrodes; epidural
63685	Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling.

HCFA'S NATIONAL POLICY:

- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.
- Title XVIII of the Social Security Act, section 1862 (a) (7). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.
- Medicare Coverage Issues Appendix 35-20; 35-27; 5-8; Intermediary Manual 3110.4 CIA 65-8.

INDICATIONS AND LIMITATIONS OF COVERAGE:

Indication:

1. To treat chronic pain caused by lumbosacral arachnoiditis that has not responded to medical management including physical therapy. (Presence of arachnoiditis is usually documented by, presence of high levels of proteins in the CSF and/or by myelography or MRI).
2. To treat intractable pain caused by nerve root injuries, post surgical or post traumatic including that of Post aminectomy syndrome (failed back syndrome).
3. To treat Intractable pain caused by complex regional pain syndrome I & II.
(Term causalgia Reflex sympathetic dystrophy changed to complex regional pain syndrome I & II)



4. To Treat intractable pain caused by Phantom limb syndrome that has not responded to medical management.
5. To treat Intractable pain caused by end stage peripheral vascular disease under the following circumstances:
 - When the patient cannot undergo vascularization.
 - When vascularization has failed to relieve painful symptoms and the pain has not responded to medical management.
6. To treat intractable pain caused by Post Herpetic Neuralgia.
7. To treat intractable pain caused by Plexopathy.
8. To treat Intractable pain caused by Intercostal Neuralgia that did not respond to medical management and nerve blocks.
9. To treat intractable pain caused by Cauda Equina Injury.
10. To treat intractable pain caused by incomplete spinal cord injury.

Limitation:

1. The implantation of the spinal cord stimulator is used only as a choice of last resort, after other treatment modalities including medical management and where applicable less invasive surgical procedures like appropriate blocks have been tried and did not prove to be satisfactory, or these have been judged to be unsuitable or contraindicated for the given patient.
2. Besides this the patients must undergo careful screening and evaluation by a multi disciplinary team prior to implantation. Such screening must include physical as well as psychological evaluation.
3. The relief of pain must have been demonstrated with a temporarily implanted electrode, prior to permanent implantation. All of the above conditions must be met before the Medicare coverage can be extended.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

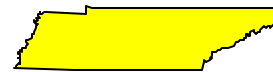
053.19	Post Herpetic Neuralgia
353.8	Intercostal Neuralgia
722.82	Postlaminectomy syndrome Thoracic Region
722.83	Postlaminectomy syndrome Lumbar Region
952.4	Cauda Equina Injury
322.2	Chronic arachnoiditis
337.21	Reflex sympathetic dystrophy of the upper limb
337.22	Reflex sympathetic dystrophy of the lower limb
337.29	Reflex sympathetic dystrophy of the specified site
353.6	Phantom limb (syndrome)
440.22	Atherosclerosis of extremities with rest

REASONS FOR DENIAL:

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied pro-actively as well as retroactively as “not reasonable and necessary” under Section 1862 (a) (1) of the law.

NONCOVERED ICD-9 CODES:

All ICD-9-CM codes not listed as covered in this policy. Individual consideration can be given when the claim is submitted with a special report detailing the reason for performing the procedure for any other condition.



SOURCES OF INFORMATION:

- Satterthwaite, Dollison. Handbook of Pain Management, 2nd Edition, 1994, Williams and Wilkins.
- Yale University School of Medicine, Department of Pain Management.
- Connecticut Society of Anesthesiology.
- Local Medical Policy from Nationwide Insurance Company.
- Medicare Operations Spine Five: 193-200, 1980.
- Journal of Neurosurgery 43: 448-451, 1975.
- Joint section of pain, the American Association of Neurological Surgeons and Congress of Neurological Surgeons.
- American Pain Society.

CODING GUIDELINES:

Use the appropriate CPT code in box 24D of the HCFA 1500 form and link it to the applicable ICD-9-CM code in box 24E of the form. If the service has been provided for a diagnosis that is not listed in the covered ICD-9-CM codes section the provider must thoroughly document the medical necessity and rationale for providing the service for the unlisted diagnosis in the patient's medical records. EMC claims should use the following statement on the comment line:

"Medical necessity documented in the patient's medical record."

Paper claims must submit documentation for the service and attach it to the HCFA-1500 claim form.

DOCUMENTATION REQUIREMENTS:

Documentation must reflect the medical necessity of providing the service. Medical necessity of implanting dorsal column stimulators, as outlined in the Indications and Limitations section, must clearly be documented in the patient's records.

OTHER COMMENTS:

Note: CPT codes listed in this policy may not be used to treat the patient with acupuncture techniques or variations of those techniques.

©Copyright , 1995; 1996 CPT Physicians' Current Procedural Terminology, American Medical Association.

CAC NOTES:

This policy does not represent the sole opinion of the Carrier Medical Director. It was developed in consultation with the medical community via the Carrier Advisory Committee.

START DATE OF COMMENT PERIOD:

October 28, 1998

START DATE OF NOTICE PERIOD:

March 15, 1999

EFFECTIVE DATE:

May 1, 1999

From the Medical Directors

Idaho - Richard Light, M.D. (Interim)
North Carolina - Eddie Humpert, M.D.
Tennessee - Richard Light, M.D.

The following is reprinted from the August/September 1997 Medicare Bulletin.

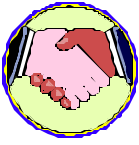
Professional Interpretation Versus Review

The Regional Office of the Health Care Financing Administration supports the following regarding what constitutes a professional interpretation of a test under the Medicare Program.

When a provider bills for the professional interpretation of a test, they should have on file a complete written report of their findings. The report should be similar to that which would be prepared by a specialist in the field when a patient is referred. A brief notation such as "agree" or the provider's initials appended to a computerized result will be considered as merely a review of the findings and included in the E & M services billed on that date.

For example: A notation in the medical records saying "fx-tibia" or "EKG-normal" would not suffice as a separately payable "interpretation and report" of the procedure and will be considered a review of the findings payable through the E&M service. An "interpretation and report" should address the findings, relevant clinical issues, and comparison of previous findings.

In addition, when CPT or HCPCS codes are billed that are described as including both the technical and professional component, a written interpretation by a physician is required to qualify for Medicare reimbursement. When documentation is requested by Medicare, both the technical component and the professional component must be justified. [Based on Letter from Regional Office dated May 13, 1997]



Provider Enrollment

If you have any questions concerning provider enrollment or changes to your provider information, please feel free to contact Provider Enrollment at 615.782.4509 or by writing them at Provider Enrollment, P.O. Box 25226, Nashville, TN 37202.

New Applications

- All 5/97 versions of the HCFA 855 applications that were in process prior to September 30, 1998, will continue to be processed through completion. This includes applications that have been received prior to September 30, 1998, then returned to the applicant and subsequently resubmitted to CIGNA Medicare after September 30, 1998.
- Beginning October 1, 1998, the HCFA 855 (1/98) is the only application that will be accepted; therefore, any 5/97 application received for the first time after September 30, 1998, will be returned with blank 1/98 applications and a note explaining that the 5/97 applications are obsolete.

Top Reasons Applications are Returned

Please check the following sections of your application before sending it to CIGNA Medicare. If you have any questions, please call 615.782.4509 before sending in your application.

- The individual application is correct. However, the group did not submit an 855 application for the satellite location in which the individual is applying.
- The original group signature is missing in section 7 of the new 855R.
- The IRS CP-575 is missing. We can no longer accept a W-9 to verify the legal business name. We must have something from the IRS to show proof of tax ID information.
- A physical location is not listed in section 3 of the 855R. P.O. Box addresses are not accepted.
- An 855 was not submitted with the 855R application. All providers or entities that do not currently have a provider number with CIGNA Medicare must submit an 855 application.

Physician Leaving One Practice to Join Another

When an individual physician who already has a provider number leaves a group to join another group, the group must apply for a new provider number for that physician. If the physician bills using his previous provider number, the payment will be sent to the previous group.

You should also terminate a provider number at a previous location so that if a claim is filed under the old number, the claim would be denied and would then be easily reprocessed. When such changes occur, it is important to contact the EDI Department for your state so they can update their files. In North Carolina, call 336.605.6460; in Idaho and Tennessee, call 615.782.4505.

Misdirected HCFA-1500 Claim Forms

Please do not send HCFA-1500 claim forms to the Provider Enrollment P.O. Box. This only delays the claims going to the appropriate department. All HCFA-1500 claim forms should be sent to:

ID Providers: CIGNA Medicare
P.O. Box 22599
Nashville, TN 37202

NC Providers: CIGNA Medicare
P.O. Box 671
Nashville, TN 37202

TN Providers: CIGNA Medicare
P.O. Box 1465
Nashville, TN 37202

FOCUSED Medical Review

“Incident to” Billing to Medicare

As a result of recent reviews conducted by Medical Review, CIGNA Medicare has determined that providers continue to bill Medicare for services of their employees that do not meet the “incident to” criteria. A specific example of the above includes:

- physician assistants (PA) and nurse practitioners (NP) providing solo inpatient services and using a physician’s provider number when billing for these services (there is no inpatient “incident to”).

Please review the following information carefully to validate that you are correctly billing Medicare.

The Health Care Financing Administration defines three levels of supervision:

1. **General** - The supervising physician is only available by phone. (This level is never sufficient for meeting “incident to” criteria.)
2. **Direct** - The supervising physician is in the office suite and available for immediate assistance if necessary. (This level is required when billing for “incident to” services in an office setting.)
3. **Personal** - The supervising physician is in the same room. (This level is required when billing for “incident to” services outside the office setting.)

The following is taken from the Medicare Carrier’s Manual, Section 2050.1:

“Incident to” a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s professional services in the course of diagnosis or treatment of an injury or illness. Coverage of services and supplies “incident to” the professional services of a physician in private practice is limited to situations in which there is direct physician supervision when the service is provided in the office setting and personal supervision in other settings. This applies to services of auxiliary personnel employed by the physician and working under his/her supervision.

Such service or supply could be considered to be “incident to” when furnished during a course of treatment where the physician performs an initial

service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. (The CIGNA carrier has determined that the billing physician/practitioner needs to personally perform at least one out of every three services for the “incident to” criteria to be met.) The direct or personal supervision requirement must be met with respect to every nonphysician service.

Office setting - The physician is not required to be present in the same room with his or her assistant. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the assistant is performing services. (Please refer to page 3 of the May/June 1998 *Medicare Bulletin* for additional information of meeting Medicare’s “incident to” requirements in office settings.)

Stand-alone clinics that are owned and operated by a hospital are considered by Medicare to be included under the umbrella of the hospital outpatient department. Services of auxiliary personnel provided “incident to” a physicians’ services are covered in the hospital cost report submitted to the Medicare Intermediary. As a result, the “incident to” criteria for “office settings” does not apply. Services in these stand-alone clinics that are billed to the Medicare Carrier should be **performed personally** by the physician or other billing provider.

Outside the office setting - The services of auxiliary personnel are covered “incident to” a physician’s service only if there is personal supervision by the physician.

Home - If a nurse accompanied the physician on house calls and administered an injection, the nurse’s services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered.

Hospital (and other PPS settings) - There is **no** Medicare coverage of the services of physician-employed auxiliary personnel as services “incident to” physicians’ services under Section 1861(s)(2)(A) of the Social Security Act. Services billed to Medicare need to be **performed personally** by the physician or other billing provider. A Medicare Intermediary could make payment for services provided by the auxiliary personnel under the hospital outpatient or inpatient benefit, but these services are not billable to your Part B Carrier, CIGNA Medicare.

Non-hospital institution criteria (skilled nursing facility, nursing or convalescent home) - The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute personal supervision. There needs to be over-the-shoulder supervision to bill the services as "incident to." As a result, providers are rarely actually fulfilling the national requirements to receive Medicare reimbursement for "incident to" services in these institutions. (Please refer to page 7 of the May/June 1998 Medicare Bulletin for information on PA and NP billing inappropriately under a physician number as "incident to" in institutions.)

Additional information on national guidelines for billing "incident to" in institutions is found in *Coverage Issues* 45-15. When a physician establishes an office within a nursing home or other institution, coverage of services and supplies furnished in the office are determined in accordance with the "incident to a physician's professional service" provision as in any physician's office. A physician's office within an institution must be confined to a separately identified part of the facility which is used solely as the physician's office and cannot be construed to extend throughout the entire institution.

In an (non-hospital) institution, services performed outside the "office" area would be subject to the coverage rules applicable to services furnished outside the office setting. Services performed by the employee of the physician outside the "office" area must be **personally supervised** by the physician; his presence in the facility as a whole would not suffice to meet this requirement. Establishment of an office within an institution would not modify rules otherwise applicable for determining coverage of the physician's personal professional services within the institution.

The same criteria apply to non-physician providers billing for "incident to" services. Although the term "physician" is used in the verbiage of "incident to" information, other health care practitioners recognized by Medicare, such as non-physician practitioners (enrolled NPs, PAs, clinical nurse specialists, and certified nurse midwives) and clinical psychologists, are allowed by national policy to bill for services that are incidental to their professional services. Licensed Clinical Social Workers are not allowed to bill for employees working in any "incident to" setting.

In an office setting, services that are incidental to the professional services of the billing provider should be included in the documentation of the office visit in the patient's record. If the only service provided is an incidental service such as a blood pressure check, the

note should include the reason for the follow-up, for example "on medication" or "abnormal on last visit" etc.) However, in other settings where **personal supervision** is required, documentation should reflect that a service is being billed "incident to" **under the personal supervision of the physician or practitioner.**

Billing Medicare for services performed by auxiliary personnel that do not meet the "incident to" criteria is considered abuse.

Registered Nurses (RN)/Health Professional as Surgical Assistants in a Hospital Setting

It has come to our attention that physicians are using RNs or other persons with training as a surgical assistant in surgeries performed in hospitals. These individuals are not non-physician practitioners that are recognized under the Social Security Act. The surgical assistants are employees of the physician and are not covered under the Medicare law.

We have had inquiries on whether the service can be billed as "incident to" with personal supervision, or as a non-covered service which would lead to a denial. If it is a non-covered service the surgical assistants want to have the beneficiary sign an advanced beneficiary notice, then bill the beneficiary directly.

Neither scenario is appropriate. Incident to services cannot be billed for inpatient services. The services of nursing personnel are bundled into the hospital's costs. Likewise, it is not a non-covered service; it is a Part A covered service. An advanced beneficiary notice would be inappropriate. The beneficiary should not make additional payment for the surgical assistant's services. The surgical assistant services by RN in a hospital setting should not be billed to Medicare Part B. If claims are filed for these services, they will be denied as a bundled service.

A hospital is at risk if they knowingly allow non-hospital employees to perform services with the knowledge that the non-hospital employee, or the physician on her/his behalf, is billing the beneficiary. [TN EM99-032]

An Important Update from HCFA:



In a recent meeting for all Medicare contractors across the United States, Nancy-Ann Min DeParle, the administrator for the Health Care Financing Administration, asked us to convey this important message to you:

“Y2K is HCFA’s top priority. HCFA has been actively preparing for Y2K and will be ready. HCFA will do everything it must to ensure that its mission critical systems and those of its contractors will function in the Year 2000. Hospitals and physicians will continue to be paid and critical information will continue to be available. HCFA has also launched a provider outreach effort to assist medical providers in making their diagnostic equipment and office systems Y2K compliant. Being ready for the Year 2000 will not be easy, but HCFA and its partners are meeting the Y2K challenge.”

For more information about HCFA and Y2K, please visit their Web site: <http://www.hcfa.gov>.

CIGNA Medicare Y2K Update

Year 2000 Disclosure: This is a Year 2000 readiness disclosure as defined under the Year 2000 Information and Readiness Disclosure Act and is Issued by or with the approval of Connecticut General Life Insurance Company, CIGNA Health Corporation or their subsidiaries, with respect to their Year 2000 processing or products offered by them.

- CIGNA Medicare is very serious about winning the challenge posed by the Year 2000. In fact, making sure our customers continue to receive uninterrupted health care services through 2000 and beyond is our highest business priority.
- We recognized very early the significant challenge posed by Year 2000 and launched an initiative to assess the problem and develop a plan for fixing it. Recognizing the significant size of this effort, we reprioritized all of our systems development projects to make sure that sufficient resources would be directed at solving the Year 2000 problem. Activities to deal with Year 2000 technical issues are now nearing completion
- throughout CIGNA HealthCare, of which CIGNA Medicare is a division.
- Our goal with our Year 2000 work was to make sure that our critical systems applications and computer hardware were Year 2000 ready by December 31, 1998. We are pleased to report we have substantially met this goal, and can focus in 1999 on integrated testing and external readiness issues.
- A crucial milestone for CIGNA Medicare was the submission of our Y2K self-certification statement to the Health Care Financing Administration (HCFA) on January 11, 1999. This statement signifies that CIGNA Medicare has successfully completed millennium readiness testing for our renovated Medicare internal mission critical systems and associated software in accordance with our Medicare Agreement/Contract.

Strategy, Plan, and Organization

- CIGNA adopted a Year 2000 strategy establishing corporate and divisional accountability and strong corporate oversight. In addition, CIGNA Medicare developed our own, more detailed implementation plans for completing Year 2000 work.
- We completed detailed assessments to determine our application, hardware and software requirements to achieve Year 2000 readiness. We then developed a model to determine our monetary and staffing requirements to complete this vital effort.
- Teams incorporating members from all facets of the enterprise addressed the readiness of the corporation’s technology infrastructure, and the many hardware and software products that support our automated processes.
- All systems were required to conduct unit, system, and acceptance testing, including key dates and in environments with clocks set to 2000 and later. This testing occurred as part of the individual system remediation projects. Senior Management examined test plans and results, and certified the Year 2000-readiness of systems they “own.”
- In addition to this system-level testing, CIGNA HealthCare is conducting several cycles of end-to-end testing of all systems in a fully integrated Year 2000 environment in the first three quarters in 1999. CIGNA Medicare plans to resubmit to HCFA the Y2K readiness of its systems at least once in 1999.

Progress

- The major systems that directly affect the operation of our business have been made Year 2000-ready and are currently processing live business in production environments in a Year 2000-ready fashion.
- CIGNA Medicare has made necessary changes to comply with HCFA's Year 2000 mandate requiring an eight-digit date format (MMDDCCYY). By HCFA mandate, effective April 5, 1999, all claims must be submitted with the required 8-digit Y2K-compliant format. HCFA's Y2K specifications can be found on the Web: for electronic claims <http://www.hcfa.gov/medicare/edi/edi3.htm>; for paper claims <http://www.hcfa.gov/medicare/edi/edi5.htm>.
- CIGNA HealthCare has identified and is addressing technology readiness needs through major hardware and software upgrades and replacements on its desktops. This effort includes remediation and conversion of end user-written applications such as spreadsheets, databases, document templates, electronic forms, etc. This project is currently running ahead of plan, and is scheduled to be completed in the third quarter of 1999. CIGNA Medicare completed replacement of its desktop computers in December 1998.

Business Risks

- CIGNA's Chief Executive Officer (CEO) and Senior Management continue to ensure that the business implications of Year 2000, both external and internal, are addressed. Our operational and financial plans require both Year 2000 business and systems issues be addressed.
- Our internal and external auditors are actively involved in monitoring our progress. Formalized project monitoring, best practices, and operating principles are being applied. With the exception of our outside auditors, CIGNA HealthCare has not retained the services of any third parties to review or certify its Year 2000 program.
- Contingency and business resumption plans are being developed to reduce the likelihood that Year 2000 events outside of our control will adversely affect customer service. These plans are being developed to help us to be prepared if, despite our best efforts, we are affected by Year 2000 issues. Contingency plan leaders in each operations unit oversee the process, which includes prioritizing risks and developing response strategies, staffing and mobilizing "rapid response teams," identifying interim processing and service sourcing

alternatives, and defining preventive and corrective actions. Some of the areas being assessed include increased call center volumes, increased manual claim submissions, and other factors critical to the continuation of healthcare access and delivery.

- Our Corporate Facilities operation has assessed and prepared appropriate remediation plans for Year 2000 exposures in our building comfort, logistical, and security systems. This work is substantially complete.

External Entities

- CIGNA Medicare has relationships with various third-party entities in the ordinary course of business. We have identified third-party entities critical to our operations. We are assessing and attempting to take steps to mitigate risks due to the failure of these entities to be Year 2000 ready. These steps include among other things, reviewing where possible, their formal Year 2000 plans and obtaining Year 2000 readiness affirmations. We are in the process of a comprehensive analysis of the operational problems that would be reasonably likely to result from the failure by certain third-parties to complete efforts necessary to achieve Year 2000 compliance on a timely basis. We expect to complete this analysis in early 1999.
- We have identified the key service suppliers with whom we are taking steps to ensure uninterrupted service to clients. For the most critical we are conducting on-site Year 2000 assessments.
- We are working to make sure we know when and how organizations with whom we exchange data electronically will be making their systems and data Year 2000-ready.

Working Together

- The project managers of the individual remediation projects determine the necessity of external interface testing, based on the project needs and the nature of the interfaces. If the project manager(s) for the CIGNA Medicare system(s) with which you have electronic interfaces(s) determine that modifications are required on your part, and/or there is the need to conduct joint testing with you, they will contact your staff with whom they normally work to communicate and coordinate modification needs, test specifications, and schedules. Should you wish to initiate such testing, please call your regular CIGNA Medicare contact for the interface(s) you wish to test.

- As you know, many of our business processes rely on data you provide, especially claim data. Inaccurate electronic submissions could cause errors in several areas. Please make sure that the systems you use to generate the claim information you submit to us are Year 2000-ready. If you subcontract for these services, please check with your vendors to be sure they are also Year 2000-ready.

1999 Activities

In 1999 our major efforts focus on completion of the following:

- Contingency and business resumption planning for key processes.
- Critical vendor assessments and site visits, including alternative sourcing strategies.
- Integrated, end-to-end testing of backbone systems.

In conclusion . . .

We hope you find this information helpful in addressing your questions, and that it leaves you with a sense of confidence about CIGNA HealthCare's and CIGNA Medicare's readiness for the Year 2000. We expect the millennium change will not materially affect CIGNA HealthCare's ability to meet customer commitments, provide expected customer service, and meet financial targets. Please visit our web site at <http://www.cignamedicare.com> for additional information about CIGNA Medicare and the Year 2000.

Rebundling Edits

There are **three types of rebundling edits** implemented by carriers at the Health Care Financing Administration's (HCFA's) direction.

The first rebundling edits were introduced in 1991 as a part of Physician Payment Reform (PPR). These were individual edits developed by HCFA in consultation with various medical societies for implementation by all Medicare carriers. Information regarding these edits was generally published in Medicare policy notices via Medicare carrier general release bulletins over the years.

The second stage of rebundling edits, known as the Correct Coding Initiative (CCI), was implemented in January 1996. CCI basically replaced the old

rebundling edits, though some of the old edits remained as a part of the new CCI edits. The CCI edits resulted from a contract HCFA had with Administar Federal to develop a series of coding pair edits to check for billing appropriateness. Information regarding these edits is available from the National Technical Information Service (NTIS).

The most recent set of edits, implemented in October 1998, are **HBOC (commercial)** coding pair edits. These new edits are similar in type to the CCI edits, but are not connected to them and have been implemented along with the CCI edits. The HBOC edits were purchased by HCFA from a private company and are proprietary in nature. Therefore, Medicare carriers are unable to release a listing of the edits or provide detailed information about these commercial edits in a general release to the public.

More specific information about the HBOC edits:

Effective October 1, 1998, Medicare carriers implemented approximately 200 commercial edit coding pairs that HCFA acquired from HBOC, a commercial vendor that markets editing software known as *Claim Check*. These HBOC edits are similar to those edits that were developed for HCFA under the Correct Coding Initiative (CCI).

The HBOC commercial edits have been reviewed by HCFA to ensure consistency with HCFA policy. Again, all are procedure-to-procedure edits similar to those in the CCI, but as stated before, *they are separate from the CCI edits and should not be confused or identified with them*. **No list of the HBOC edits is publicly available.** There are two sub-types of HBOC edits: (1) those that identify mutually exclusive procedures, and (2) those that identify a comprehensive procedure reported along with a component part.

If a provider or beneficiary disagrees with a carrier decision that was made based on one of the HBOC edits (or any rebundling or CCI edit), the decision may be appealed by writing to the Appeals Department to request a review of the claim decision in question. The request for the review must be made within six months of the date of the initial determination. Reviewers **will** provide policy and rationale information to the appellant on specific HBOC coding pairs that are questioned but remain unallowed.

Anatomic modifiers such as -RT (right) or -LT (left), and modifier -59 (distinct procedural service) may still be used to bypass the HBOC edits, *when appropriate and documented in the patient's medical records*. HCFA continues to assess both the CCI and HBOC edits as well as other edit options available in an effort

to utilize only those edits that are appropriate and effective. As a result of this continuing assessment, some of the CCI and HBOC edits have been deleted, and other edit criteria are being identified for implementation. When claims have been denied inappropriately as a result of subsequently deleted edits, Carriers are required to identify and adjust those claims accordingly. [CO EM98-142]

Mutually Exclusive Denials

The clinical edits and the accompanying rationale, if any, ("Material") contained herein are proprietary data and trade secrets of HBO & Company and its Subsidiaries ("HBOC") and are intended solely for the educational purpose of this provider bulletin only. The material may not be used, distributed, duplicated, or otherwise disseminated without the express written consent of HBOC.

Definition

Mutually exclusive edits relate to procedures that:

- cannot reasonably be done in the same session;
- represent two methods of performing the same service;
- represent medically impossible or/improbable code combinations; and
- CPT describes as inappropriate coding of procedure combinations.

Payment

Medicare allows the procedure with the lowest RVU for payment.

Examples

Open And Laparoscopic Approach Reported To Treat The Same Medical Condition:

<u>Code</u>	<u>Description</u>
47605	Cholecystectomy; with cholangiography
56341	Laparoscopy, surgical; cholecystectomy with cholangiography

Procedure 47605 represents an open cholecystectomy that is performed through an incision in the upper abdomen. Cholangiography is performed to examine the common duct for calculi and/or abnormalities. Procedure 56341 represents a cholecystectomy performed through a laparoscope. A cholangiography

to examine the common duct for calculi and/or abnormalities is included.

These procedures represent different methods of accomplishing a cholecystectomy with cholangiography. Thus, to report both a laparoscopic and an open surgical approach to accomplish the same clinical outcome represents duplicity of efforts and overlapping of services.

Therefore, Medicare denies procedure 47605 as mutually exclusive to procedure 56341 when submitted with the same date of service.

Initial And Subsequent Services Provided On The Same Date Of Service:

<u>Code</u>	<u>Description</u>
70450	Computerized axial tomography (CAT), head or brain; without contrast material
76380	Computerized tomography, limited or localized follow-up study

Procedure 70450 describes a CAT scan of the head or brain. If suspicious areas are identified from this scanning, with a contrast enhanced study, or if clinical findings direct attention to a specific region, thinner sections or special scanning techniques such as coronal reconstruction may be performed to provide additional diagnostic information.

Procedure 76380 is used to report a limited, localized follow-up computerized tomographic study that is performed as a comparison study to check progress after treatment, or to document changes that may occur over time.

Both procedures represent CAT scans performed at different times and for different indications. Procedure 70450 represents an initial CAT scan indicated to diagnose a medical condition pertaining to the head or brain. Procedure 76380 represents a subsequent CAT scan that provides follow-up information relating to the original diagnosis. These procedures describe initial and subsequent services that are not typically performed on the same day of service.

Therefore, Medicare denies procedure 76380 as mutually exclusive to procedure 70450 when submitted with the same date of service.

CPT Definition

<u>Code</u>	<u>Description</u>
88300	Level I - Surgical pathology, gross examination only
88309	Level VI - Surgical pathology, gross and microscopic examination

Procedure 88300 is used to report gross examination of a surgically obtained specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination.

Procedure 88309 is used to report a surgical pathology procedure performed on a specimens listed as Level VI, requiring both gross and microscopic examination as well as complex dissection in order to accurately identify the specimen.

Both procedures include gross examination of a given specimen. Procedure 88300 states that the specimen is analyzed by means of gross examination only, implying that no further modalities need to be utilized to identify the specimen. Procedure 88309 includes gross and microscopic examination of the appropriate specimen that may be necessary to establish a definitive diagnosis. Thus, to report both procedures to accomplish the same clinical outcome on the same day of service represents a duplication of efforts and overlapping of services.

Therefore, Medicare denies procedure 88309 as mutually exclusive to procedure 88300 when submitted with the same date of service.

Component Edit Denials

Definition

Component edits relate to procedures that are:

- Included as part of a more extensive procedure
- Specified as “separate procedures” by CPT
- Defined in CPT guidelines
- Misuse of column 2 code with column 1 code

Payment

Medicare allows the procedure with the higher RVU for payment.

Examples

More Extensive Procedure:

<u>Code</u>	<u>Description</u>
35474	Transluminal balloon angioplasty, percutaneous; femoral-popliteal
35493	Transluminal peripheral atherectomy, percutaneous; femoral-popliteal

Procedure 35474 is used to report percutaneous transluminal balloon angioplasty of the femoral-popliteal artery or vein. A catheter is placed percutaneously and advanced to the area of stenosis under fluoroscopic guidance. A guide wire is passed through the catheter

and manipulated through the narrowing of the artery or vein. A balloon tip catheter replaces the introducer and is inflated to dilate the vessel.

Procedure 35493 is used to report percutaneous transluminal atherectomy of the femoral-popliteal artery or vein. A catheter is placed percutaneously and advanced to the area of stenosis under fluoroscopic guidance. A guide wire is passed through the catheter and manipulated through the narrowing of the artery or vein. A catheter with an atherectomy device replaces the introducer and removes the stenotic tissue from the vessel.

Surgical treatment to reestablish patency of occluded arteries or veins may be accomplished by percutaneous transluminal atherectomy and/or balloon angioplasty depending on the nature of the occlusion. During the performance of an atherectomy, it may be necessary to dilate other stenotic areas. This is accomplished by replacing the atherectomy device with a balloon tip catheter. Thus, balloon angioplasty, if necessary, is considered clinically integral to the successful outcome of the primary atherectomy procedure.

Therefore, Medicare denies procedure 35474 as a component of procedure 35493 when performed during the same operative session.

Separate Procedure

<u>Code</u>	<u>Description</u>
49505	Repair initial inguinal hernia, age 5 years or over; reducible
55520	Excision of lesion of spermatic cord (separate procedure)

Procedure 49505 is used to report the surgical repair of a reducible inguinal hernia in a child older than 5 years. This surgical repair is accomplished through an inguinal incision. Once the hernia sac is identified, it is either excised or reduced through the area of weakness. During a direct hernia repair, the “floor” of the inguinal canal is either repaired or replaced with a mesh patch.

Procedure 55520 is used to report the excision of a lesion of the spermatic cord. This can be accomplished by a transverse incision in the scrotum in older children. However, in adults an inguinal approach is usually used.

While performing an inguinal hernia repair, the surgeon makes an incision in the groin and dissects tissue to expose the hernia sac, internal oblique muscle and the spermatic cord that runs beside it. At the time of the hernia repair, any lesions identified on the spermatic cord can also be excised. Thus, excision of a spermatic cord lesion is considered a component of the comprehensive hernia repair procedure.

Therefore, Medicare denies procedure 55520 as a component of procedure 49505 when performed during the same operative session.

CPT Definition

<u>Code</u>	<u>Description</u>
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40490	Biopsy of lip
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88304	Level III - surgical pathology, gross and microscopic examination
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Procedure 40490 is used to report biopsy of a lesion on the lip. An incision is made in the lip and a portion of the lesion as well as some normal tissue is removed. This procedure is commonly performed to diagnose malignancies of the lip.

Procedure 88304 is used to report surgical pathology of a defined specimen as listed as a Level III specimen. This includes gross and microscopic examination and diagnosis of presumptively abnormal tissue removed from a patient.

CPT provides specific guidelines for the use of surgical pathology procedure codes. Pathologic examination of tissue as described in procedure 88304 does not correspond with the lip biopsy specimen obtained during procedure 40490. Thus the reporting of these two procedures with the same date of service is inappropriate.

Therefore, Medicare denies procedure 88304 when submitted with procedure 40490 with the same date of service.

Misuse Of Column 2 Code With Column 1 Code:

<u>Code</u>	<u>Description</u>
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20605	Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (e.g., temporomandibular, acromioclavicle, wrist, elbow or ankle, olecranon bursa)
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76001	Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)
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Procedure 20605 describes arthrocentesis that involves aspiration of fluid or injection of medication into an intermediate joint, bursa or ganglion cyst in joint locations such as the temporomandibular, wrist, elbow or ankle. The physician inserts a needle of the appropriate size and length into the affected joint and

aspirates fluid with a syringe. If a medication is to be injected, this is easily performed through the same needle by switching syringes. This procedure is indicated for diagnostic or therapeutic purposes.

Procedure 76001 is used to report the use of fluoroscopy by a physician who assists a non-radiologic physician in the performance of a procedure. The fluoroscopic assistance requires more than one hour of the radiologist's time.

Typically, a general or orthopedic surgeon performs an arthrocentesis of an intermediate joint, bursa or ganglion cyst. This procedure usually does not require fluoroscopy. Additionally, procedure 76001 describes fluoroscopy performed by a radiologist who is providing assistance to a surgeon or other non-radiologic physician who is performing a diagnostic or therapeutic procedure. Since the radiologist is generally not performing both procedures, reporting of both procedures by the same provider is inappropriate.

Therefore, Medicare denies procedure 76001 when submitted with procedure 20605 with the same date of service.

Applicability Of Modifiers:

The rationale for each code combination is based on the interpretation of the individual codes as described by its nomenclature. However, according to the CPT manual, in those instances, where the reporting physician can indicate that a service or procedure that has been performed "has been altered by some specific circumstance, but not changed in its definition or code", an applicable modifier should be attached to the relevant code. Such modifiers are those that add specificity to the services provided (e.g., anatomic differences, such as left/right or different site of procedure) or explain the circumstances under which one of the services was provided (e.g., at a later encounter on the same day.)

HCFA believes that modifiers are inherent part of the HCPCS. Therefore, each code combination in the commercial edits has been evaluated and a determination made as to whether or not the furnishing of the two procedures could appropriately be performed and explained by the use of a modifier. Code combinations that are correctly coded are not subject to automatic denials.

Thus, practitioners are encouraged to use an appropriate modifier whenever documentation in the medical record would support the use of that modifier.

[TN/NC EM99-037]

The OIG Advises Physicians Against Improper Certifications

In a recent OIG Special Fraud Alert, Inspector General June Gibbs Brown addressed the OIG's focus on the inappropriate ordering of home health care and durable medical equipment and supplies for Medicare beneficiaries. Inspector General Brown explains, *"while physician fraud in this area is infrequent, physician laxity in reviewing and completing certifications of medical necessity is a problem that can contribute to fraudulent and abusive practices by unscrupulous suppliers and home health providers."*

The Alert cautions providers (1) not to prescribe services and items as a courtesy to a patient, service provider, or medical equipment supplier, without first certifying medical necessity, (2) not to knowingly or recklessly sign false or misleading medical certifications, and (3) not to accept kickbacks in return for their signature. The OIG has cited numerous instances in which physicians have ordered durable medical equipment without validating the medical necessity for the item or knowing the beneficiary. Individuals found to be participating in these activities may be held to the legislative penalties in these cases even if they did not receive financial or other benefits from providers or suppliers.

To link to the full texts of the OIG Special Fraud Alerts, and/or learn more about Medicare fraud and abuse, visit the "Fraud and Abuse" section of the CIGNA HealthCare Medicare Administration web site at: <http://www.cignamedicare.com>.

Medical Record Cloning

Documentation Reminder

Cloning of documentation has been found on reviews of several providers. Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary.

Cloning often occurs on claims for procedures that have very limited, select, or specific set of criteria for Medicare coverage. Cloned documentation is most often found in the form of pre-printed, template type notes. It would not be expected that every patient had

the same exact problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.

All documentation in the medical record should be patient specific. Cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Paper Remittance Advice Notices

The Health Care Financing Administration (HCFA), which administers the Medicare program, made a number of changes in the payment notices sent to physicians, practitioners and suppliers in 1996. This was a part of HCFA's continuing effort to eliminate any variations in the administration of Medicare across the States and to furnish a uniform level of information to all providers of health care about the decisions made on their claims. Remittance notices are also known as Medicare Summary Vouchers.

Reason Codes and Medicare-Specific Remarks Codes and Messages

Reason codes, and the text messages that define those codes, are used to explain why a claim may not have been paid in full. For instance, there are reason codes to indicate that a particular service is never covered by Medicare, that a benefit maximum has been reached, to identify non-payable charges which exceed the fee schedule, or a psychiatric reduction. Under the standard format, only reason codes approved by the American National Standards Institute (ANSI) X12.835 Insurance Subcommittee and Medicare-specific supplemental messages approved by HCFA may be used.

ANSI is a non-governmental private association, of which HCFA is a member, that sets national standards for not only health care transactions but also for banking, transportation, electrical appliances, and a very wide range of items and services that affect all Americans. The ANSI X12.835 reason code messages are expected to become the standard for use by all health payers in the United States.

The X12.835 reason codes were designed to replace the large number of different coding systems used by health payers in this country, and to relieve the burden on medical providers to interpret each of the different coding systems.

As the standard X12.835 reason messages were developed as generic messages to be used by all national health payers, few are specific to Medicare. With the concurrence of ANSI X12.835, HCFA supplemented the generic reason codes and messages with appeals and developmental codes and messages specific to Medicare. Although reason codes and HCFA message codes appear in the body of the remittance notice, the text of each code that is used will be printed at the end of the notice to facilitate interpretation.

In the pursuit of simplification, ANSI X12.835 issued two provisos to keep in mind when you interpret their messages. Any references to procedures or services in the reason codes apply equally to products, drugs or equipment, and references to prescriptions also include certificates of medical necessity. Beyond that, the messages should be self-explanatory.

As standard codes and messages are not customized to report the identity of any third party payer or alternate carrier to whom your claims may have been transferred for processing, whenever the ANSI X12.835 message, *"The claim has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor."* or the HCFA remark message, *"The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them."* is used, Medicare will also identify that other payer or carrier, DME carrier or Railroad office to whom the data was sent.

Group Codes

An ANSI X12.835 group code will always be shown with a reason code to indicate when you may, or may not, bill a beneficiary for the non-paid balance of the services or equipment you furnished. This corresponds to payment information being sent to beneficiaries in their Medicare Summary Notices (MSNs).

All denials or reductions from your billed amount with a group code of **PR** (patient responsibility) are the financial responsibility of the beneficiary or his/her supplemental insurer (if it covers that service). Due to their frequency of use, separate columns have been set aside for reporting of deductible and coinsurance, both of which are also patient responsibility. PR amounts, including the deductible and coinsurance, are totaled in the Patient Responsibility field at the end of each claim. If you already collected an amount from a beneficiary

for this claim in excess of the Patient Responsibility total prior to receipt of the remittance notice you are required by law to refund the excess to the beneficiary.

You may not hold a beneficiary financially responsible for any adjustments identified with group code **CO** (contractual obligation). CO is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial liability, such as participation agreement violation amounts, limiting charge violations, late filing penalties, or amounts for services not considered to be reasonable and necessary.

Group code **OA** (other adjustment) will be used when neither PR nor CO applies, such as with the reason code message that indicates the bill is being paid in full. A final group code, **CR** (correction or reversal to a prior decision), will be used whenever there is a change to the decision on a previously adjudicated claim, perhaps as result of a subsequent reopening. CR explains the reason for a change and would always be used in tandem with PR, CO, or OA to show revised information.

Transition to the Standard Format

Carriers began to send informational remittance notices to nonparticipating physicians concurrent with this change in the remittance notices. As they will be reminded in their claim messages, the preprinted appeal rights do not apply to nonparticipating physicians unless the claim involved a denial under section 1862 (a) (1) of the Social Security Act for services not considered reasonable and necessary for the beneficiary's care.

To help those providers who balance their billed amounts against the Medicare payments and adjustments, paid and adjusted amounts are totaled at the end of the assigned claims listings. Information on any unassigned claims will be listed separately after the assigned claims to avoid any inadvertent use of unassigned claims information, for which Medicare payment is not issued to a provider, to balance accounts.

Offsets to payments, perhaps for a prior Medicare overpayment, will be shown as an adjustment from your payment at the summary level rather than as an adjustment against an individual claim in that remittance notice. As individual claims in the remittance notice would not have contributed toward the overpayment being collected, such withholding should be shown at the provider summary level. The Financial Control Numbers (FCNs), that will enable you to associate the offset with those claims and payments that led to the

withholding or to identify the reason for the offset will still be shown.

Abbreviations

To make the most efficient use of space, a number of abbreviations are used in the remittance advice. You may be familiar with most of them already, but the following key is provided to dispel any confusion.

ACNT	Patient account number assigned by the provider
ADJS	Adjustments
ALLOWED	Allowed amount (prior to deductions or offsets)
ASG	Whether assignment accepted (Y or N)
BILLED	Billed amount
COINS	Coinsurance due
DEDUCT	Deductible due
FCN	Financial control number of prior claims that contributed to the overpayment or that explains the reason for the offset
HIC	Medicare health insurance claim number
ICN	Internal control number (also known as DCN)
INT	Interest
MOA	Medicare outpatient adjudication remark code
MODS	HCPCS modifiers
MSP	Amount paid by an insurer primary to Medicare
NOS	Number of services
OTHER	Other claim level adjustments that apply
PD TO BENE	Amount paid to beneficiary for this claim
POS	Place of service
PREV PD	Previous payment on this claim
PROC	HCPCS/procedure code (if different, the billed HCPCS will be printed under the paid HCPCS)
PROV PD	Paid to provider
PT RESP	Patient responsibility
RC AMT	Adjustment reason code other than deductible and coinsurance. If more than one, additional adjustment codes and amounts will appear on the next line.
REM	Remarks codes
SERV DATE	Date of service

New Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR 405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate (5 percent) for calendar year 1999. The Secretary of the Treasury notified the Department of Health and Human Services that the PCR has been revised to 13.75 percent. The new PCR was published in the Federal Register (Vol. 64, No. 20, dated 02/01/1999). Therefore, effective February 1, 1999, the new interest rate for Medicare overpayments and underpayments is 13.75 percent. [CO EM99-039]

MPFSDB 1st Quarter Updates

Changes included in this update are as follows:

<u>CPT Code</u>	<u>Revision</u>
Q0164 - Q0180	Changed the procedure status from an 'E' (Excluded from physician fee schedule by regulation) to an 'X' (Statutory exclusion).
31623, 31624, 31643	The multiple surgery indicator was changed from a '2' (Standard payment adjustment rules for multiple procedures apply) to a '3' (Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family). The endoscopic base code should be 31622.
38724	Changed the bilateral indicator from an '0' (150% payment adjustment for bilateral procedure does not apply) to a '1' (150% payment adjustment for bilateral procedures applies).
88291	Changed the procedure status indicator from an 'A' (Active code) to an 'X' (Statutory exclusion).
77600 - 77620	Changed the global period from '090' to 'XXX.'

[CO EM99-041]

Laboratory Codes - 1999 Gap-fill Pricing

The following gap-fill fee schedule amounts have been set for 1999. These are for the states of Idaho, North Carolina, and Tennessee.

87536	\$120.33
88142	17.15
88143	17.15
88144	17.15
88145	17.15
88147	7.15
88148	7.15
88271	20.00
88272	25.00
88273	35.00
88274	45.00
88275	75.00
G0123	17.15
G0143	17.15
G0144	17.15
G0145	17.15
G0147	7.15
G0148	7.15

Administration Codes for Injectable Drugs

The description for CPT codes 90782 through 90788 (used for the administration of injectable drugs) includes the following statement:

“Specify the material injected”

If you are billing codes 90782 through 90788 without a drug code (J0120 through J3480, J3520 through J9600, or a temporary HCPCS Q code), the name of the drug must be in Item 19 for paper claims and in the notepad for electronic media claims. Even if the patient brings the medication in to be administered, the name of the drug has to be included on the claim when you bill for administering the drug.

If the drug being administered is not one of the above J codes or a temporary Q code, use J3490 for non-chemotherapy drugs and J9999 for chemotherapeutic drugs. When billing either J3490 or J9999, the name of the drug and the actual dosage given must be included in Item 19 for paper claims and in the notepad for electronically filed claims.

Oral Anti-Emetics Used As Complete Replacement Therapy for Intravenous Anti- Emetic Therapy

When billing for Oral Anti-Emetics for nausea due to Chemotherapy Infusion, Q0163 – Q0181, be sure to include ICD-9 codes for the Cancer related diagnosis and the ICD-9 code 7870 for Nausea. Effective June 1, 1999, claim submitted without the cancer-related diagnosis and the nausea diagnosis will be denied

Effective for dates of service on or after January 1, 1998, oral anti-emetic drugs will be covered when used as full therapeutic replacement for intravenous dosage forms as part of a cancer chemotherapeutic regimen when the drug is administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

The allowable period of covered therapy includes day one, the date of service of the chemotherapy drug (beginning of the time of treatment), plus a period not to exceed two additional calendar days, or a maximum period up to 48 hours. The oral anti-emetic drug should be prescribed only on a per-chemotherapy-treatment basis. For example, only enough of the oral anti-emetic for one 24- or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment at a time. These drugs may be supplied by the physician in the office or through a supplier (e.g., a pharmacy).

In order for the oral anti-emetic drugs to be covered by Medicare, the physician must indicate on the prescription that the beneficiary is receiving the oral anti-emetic drug as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. This will indicate to the supplier of the drug that the claim should be submitted using one of the Q codes in §4460.1. When the oral anti-emetic drug is provided in the physician's office and billed to the local Carrier, the physician's use of the appropriate Q code on the claim serves as his/her affirmation of the correct use of this benefit. Common Working File edits these claims to assure that the beneficiary is receiving the oral anti-emetic as part of a cancer chemotherapeutic regiment by requiring a diagnosis of cancer.

Claims Processing Instructions

Please see **Claims Processing Jurisdictions** below:

<u>Combination</u>	<u>Under OBRA '93</u>	<u>Under BBA '97</u>
Oral chemotherapy drug with oral anti-emetic drug	DMERC processes both chemotherapy drug (J code) [1] and the anti-emetic drug (K0415 code) [2].	DMERC maintains responsibility for J w/ K0415 drug code combinations [1] & [2]. Local carrier processes J chemotherapy drug and Q oral anti-emetic drug [3] when provided in the physician's office (administrative decision). DMERC processes J oral chemotherapy drug and/or Q code oral anti-emetic drug when supplied by a pharmacy.
Oral chemotherapy drug with rectal anti-emetic drug	DMERC processes both the chemotherapy drug (J code) [1] and the anti-emetic drug (K0416 code) [2].	No change. DMERC maintains responsibility [1] & [2] (administrative decision).
Oral chemotherapy drug with intravenous anti-emetic drug	DMERC processes the oral chemotherapy drug (J code) [1] and the local carrier processes the intravenous anti-emetic drug (J code) [4].	No change. DMERC maintains responsibility for the J oral chemotherapy drug [1] and the local carrier processes the intravenous anti-emetic J code drug [4] (administrative decision).
Intravenous chemotherapy drug with oral anti-emetic drug	Local carrier processes intravenous chemotherapy drug (J code) [4] and self-administered oral anti-emetic drug is non-covered.	Local carrier processes the intravenous J code chemotherapy drug [4]. The anti-emetic Q code drug [3] is processed by the local carrier when provided in the physician's office or by the DMERC if provided by a supplier.
Intravenous chemotherapy drug with intravenous anti-emetic drug	Local carrier processes both intravenous chemotherapy drug (J code) [4] and intravenous anti-emetic drug (J code) [4].	No change. Local carrier processes both intravenous chemotherapy J code Drug [4] and intravenous anti-emetic J code drug [4].

[CO EM99-035]

Providers Ineligible for Medicare Reimbursement

Section 1128 of the Social Security Act provides the Secretary of the Department of Health and Human Services (DHHS) the authority to exclude various health care providers, individuals, and businesses from receiving Medicare payment for services that would otherwise be payable. This sanction practice represents the full range of administrative remedies and actions available to deal with questionable, improper, or abusive practices of providers under the Medicare program.

When an exclusion is imposed, no payment is made after the date of the exclusion to anyone for any item or service (other than emergency items or services not provided in a hospital emergency room) furnished, ordered, or prescribed by an excluded party. This is based on Sections 1128 and 1156 of the Social Security Act.

Therefore, Medicare must deny any service submitted, ordered, or prescribed by a sanctioned provider. **It is the sanctioned providers' responsibility to inform Medicare patients of the providers' exclusion prior to rendering a service.** If a group hires a sanctioned person, they may also be sanctioned.

If claims are submitted by a sanctioned provider for items or services furnished under the Medicare program after the date of the sanction, the provider is liable for criminal prosecution as well as additional civil penalties.

Reinstatement is not automatic at the end of the sanction period. A provider may apply for reinstatement at the expiration of the sanction period or any time thereafter. Requests for reinstatement should be sent to the Office of the Inspector General.

A Cumulative Sanction report is available on U.S. Department of Health and Human Services Office of Inspector General's website. The address is:

www.dhhs.gov/progorg/oig

CIGNA HealthCare Medicare Administration will not issue payments for services performed, ordered, or referred by these providers after the indicated dates of exclusion.

[SSA, Sections 1128 and 1156]

Beneficiary Right to Itemized Statement for Medicare Items and Services

Requirements of the Law

Effective January 1, 1999, section 4311(b) of the Balanced Budget Act of 1997 gives beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any Medicare item or service. The law requires that providers/suppliers furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of \$100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the Medicare contractor to review specific issues (i.e., services not provided, billing irregularities, and appropriate measures to recover any amount inappropriately paid).

Medicare contractors currently issue beneficiaries an Explanation of Medicare Benefits (EOMB) or a Medicare Summary (MSN). Information that may be listed include the following: date(s) of services, a description of services provided, number of services provided, benefit days used, noncovered charges, deductible and coinsurance, beneficiary liability, amount charged, claim number, name of provider/supplier submitting the claim, claim total paid by Medicare and referring physician (if applicable). Other information that may be included are deductibles, appeal rights or notices, and explanatory notes and general information regarding the specific claim. On April 1, 1999, at most Medicare contractors, these notices will begin to include the following statement: "You have a right to request an itemized statement which details each Medicare item or service which you have received from your physician, hospital or any other health supplier or health professional. Please contact them directly if you would like an itemized statement." The remaining Medicare contractors will print this message beginning July 1, 1999.

Guidance Concerning the Format and Substance of the Itemized Statement

Included below are suggestions regarding the types of information that might be helpful for the beneficiary to receive on an itemized statement. We hope this information will enable the beneficiary to reconcile the itemized statement with the Medicare notice. These are recommendations only. Since most providers/suppliers have established an itemized billing system for internal accounting procedures and billing of other payers, the furnishing of an itemized statement should not pose a significant additional burden. However, some providers/suppliers may not regularly create or furnish hardcopy itemized statements and may wish to reexamine their internal billing and tracking process to ensure that it has the capability to comply with this new requirement. Providers/suppliers should not charge beneficiaries for the itemized statement.

Itemized Statement Recommendations:

- Name of beneficiary,
- Date(s) of services,
- Description of item or service furnished,
- Number of services furnished,
- Provider/supplier charges,
- An internal reference or tracking number

If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are:

- Amounts paid by Medicare,
- Beneficiary responsibility for co-insurance,
- Medicare claim number

The statement should also include a name and a telephone number for the beneficiary to call if there are further questions.

Reconciliation of the Itemized Statement with the MSN/ EOMB

After receiving an itemized statement, beneficiaries may attempt to reconcile it with the MSN or EOMB. In situations where there are questions, especially involving some services and payment methods, providers/suppliers are requested to assist beneficiaries in understanding any differences between the two documents.

In addition, although Medicare contractor customer service representatives may not have a copy of the itemized statement, they will also answer any beneficiary inquiries regarding the EOMB/MSN and attempt to reconcile it with the itemized statement. Where appropriate, customer service representatives will attempt to resolve any questions by generally explaining applicable Medicare reimbursement rules, (prospective payment systems, revenue codes, bundling, interim rates, HCPCS/CPT codes, etc.).

Beneficiary Right to Request Review of the Itemized Statement

Beneficiaries may submit a written request to their Medicare contractor for a review of a claim based on information they provide from their itemized statement. The request should identify the specific items or services that the beneficiary believes were not provided as claimed, or any other billing irregularity (including duplicate billing). A review will be conducted into the matter by the Medicare contractor and providers/suppliers may be requested to assist in the review of the itemized statement/Medicare claim. Contractors will review and take appropriate actions to resolve the complaint. [CO EM99-050]

Enforcement of Child Support Provisions of the Debt Collection Act of 1996

The Debt Collection Act of 1996 and Executive order 13019 allow delinquent child support payments to be offset from Federal payments. The Health Care Financing Administration (HCFA) is working with the Administration for Children and Families to identify individuals delinquent in their child support obligations who receive Federal payments and to consider withholding Federal payments, if appropriate. HCFA also plans to coordinate its efforts with the States, which have authority under recent welfare reform legislation to revoke licenses of health professionals who are delinquent in child support payments.

[CO EM99-001]

CIGNA Medicare Web Site Available

CIGNA HealthCare Medicare Administration can now be found on the World Wide Web at www.cignamedicare.com. The site is designed to provide CIGNA Medicare customers with the most up-to-date information and services in the most efficient manner.

The new Web site is going to be a tremendous benefit to the health care providers. You will have information you use every day, like the *Medicare Bulletins*, Fee Schedules, and the Provider Manual, at your fingertips without sacrificing space and time. Plus, the site's search capabilities will allow you to search by subject, another big time saver.

The *Medicare Bulletins* from January 1997 through July/August 1998 are currently available. Customers can also find out what CIGNA Medicare is doing about Year 2000 and learn what they should be considering to prepare for the next Millennium.

We want to hear your comments. Take a look and tell us what you think using the e-mail.

Medicare Bulletin Subscription Offered

Due to ever increasing budget constraints, we regret that we are no longer able to provide additional copies of the *Medicare Bulletin* to our provider community. We will provide one copy of the *Medicare Bulletin* to each group practice or individually practicing physician. *Medicare Bulletins* are mailed to the same location as remittance checks. Therefore, if your checks are mailed to a billing service, so are your issues of the *Medicare Bulletin*.

We realize the inconvenience this may pose to many of the larger practices and hospitals. Therefore, we are offering additional copies of the *Medicare Bulletin* for an annual subscription rate of \$50.00 per each additional subscription.

1997 and 1998 (through July/August '98) issues of the *Medicare Bulletin* are available (free) on our Web site at: www.cignamedicare.com and on the Informational Bulletin Board System (IBBS). (IBBS instructions follow.) As always, you are free to make as many photo copies that you would like. If you would like to purchase an annual subscription of the *Medicare Bulletin*, complete the form on page 21 and return with your check or money order (\$50.00 for each subscription you wish to receive).

To receive a back issue of the *Medicare Bulletin*, complete the form on page 21 and send \$10 per copy to the following address. ***Issues published prior to 1992 are not available. We are not able to take subscription and back copy orders by fax or phone.***

CIGNA HealthCare Medicare Administration
Attn: Medicare Bulletin Subscription
PO Box 22029
Nashville, TN 37202

Where do I look for my Medicare Bulletins?

- Your "bill to" address (where you receive checks)
- Medicare Web site (www.cignamedicare.com)
- IBBS
- Subscription

IBBS Instructions

The Informational Bulletin Board System (IBBS) is now available for providers. You can reach the IBBS through your computer's modem by dialing 336.605.6488. The bulletin board is for informational purposes only and not for uploading electronic claims. The following are examples of information that can be found on the IBBS:

- n *Medicare Bulletins*
- n Certified and Select Certified Vendor Directories
- n Medicare Updates
- n Workshop announcements & handouts
- n Specifications (ANSI and NSF)
- n Vendor Newsletters
- n OCNA List
- n Applications for Electronic Media Claims (EMC), Electronic Remittance Notice (ERN), Electronic Funds Transfer (EFT), and Electronic Receipt List (ERL)
- n ANSI Reason Codes

Following are the hardware and software requirements for the IBBS. **Please consult with your computer vendor to see if your hardware and software meet these specifications.**

Communication Software

You can access the Informational Bulletin Board by using either the Wildcat Navigator software (available in the Information and Instruction area of the IBBS) or by using another telecommunications package which supports the following:

1. Industry protocol standards - Xmodem, Xmodem-CRC, Xmodem-1K, Ymodem (all) and Zmodem (all). **Zmodem is recommended.**
2. Configurable to the following:

Parity:	None
Data Bits:	8
Stop Bits:	1
Emulation:	VT100 or ANSI BBS

The IBBS is maintained in Greensboro, North Carolina. In the event you have a problem getting information from the electronic bulletin board, you may call 336.605.6460 between 8:00 a.m. and 5:00 p.m. EST.

EFT Enrollment Form

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

PROVIDER/PHYSICIAN
NAME _____

PROVIDER/PHYSICIAN
ID NUMBER _____

CITY _____

STATE _____

I hereby authorize Connecticut General Life Insurance Company, hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY
NAME _____

BRANCH _____

CITY _____

STATE _____ ZIP _____

ROUTING NUMBER _____

ACCOUNT NUMBER _____

Please Check One: Enrollment
 Change
 Cancellation

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination or change in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination (at least 10 days notice).

NAME _____
(Please Print)

TITLE _____

SIGNED _____

DATE _____

Please include a voided check with this agreement. Return this agreement to:

CIGNA HealthCare Medicare Administration
Attn: EFT Enrollment
P.O. Box 25226
Nashville, TN 37202

Overpayment Refunds

Personal provider checks sent to us for any reason should be sent to the following address:

Idaho Providers CIGNA Federal Insurance Benefits - ID
P.O. Box 10957
Newark, NJ 07193-0957

North Carolina Providers CIGNA Federal Insurance Benefits - NC
P.O. Box 10820
Newark, NJ 07193-0820

Tennessee Providers CIGNA Federal Insurance Benefits - TN
P.O. Box 10924
Newark, NJ 07193-0924

Checks should never be sent to our Nashville operations, as this will create delays in the process. In situations where you have received a letter of notification regarding a Medicare overpayment, these delays can result in payment offset.

If you are responding to a particular person or department, include that information on the envelope or correspondence. CIGNA Medicare checks that need to be returned to us should be sent to the following address:

Idaho Providers CIGNA HealthCare Medicare Administration
P.O. Box 22599
Nashville, TN 37202

North Carolina Providers CIGNA HealthCare Medicare Administration
P.O. Box 671
Nashville, TN 37202

Tennessee Providers CIGNA HealthCare Medicare Administration
P.O. Box 1465
Nashville, TN 37202

Medicare Bulletin

. . . a service of



CIGNA HealthCare Medicare Administration
Two Vantage Way
Nashville, TN 37228
615.244.5680

The Medicare Bulletin, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines.

Our newsletter will often contain a reference at the end of an article [MCM 2050.5, etc.]. This reference indicates where the Carrier instructions are found. Basically, this is a ready reference for our employees when providers ask for additional information.

Medicare Bulletins are mailed to the same location as Medicare checks. If a provider is billing under a group number, the group will receive one Bulletin. The provider in the group will not receive one for his/her individual provider identification number (PIN).

Medicare Bulletin EDI Reader Service Sheet

Provider Name: _____

Provider Number: _____

Contact Name: _____

Title: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

If you would like more information on Electronic Data Interchange (EDI), please check the appropriate box(es) below:

- | | |
|---|--|
| <input type="checkbox"/> Electronic Media Claims (EMC)
<i>electronic claim filing allows Medicare to pay you faster.</i> | <input type="checkbox"/> Beneficiary Eligibility
<i>permits you to determine the eligibility of a Medicare beneficiary electronically.</i> |
| <input type="checkbox"/> Electronic Remittance Notices (ERNs)
<i>provide you with payment/denial information electronically (most packages post patient accounts).</i> | <input type="checkbox"/> On-line Claim Status Inquiry
<i>enables you to check on the status of a claim by using a computer and a modem.</i> |
| <input type="checkbox"/> Electronic Funds Transfer (EFT)
<i>gives you the ability to have claim payments "directly deposited" to an account of your choice.</i> | <input type="checkbox"/> Billing Service Directory
<i>furnishes you with contact information for outsourcing your electronic claim submission through a billing service.</i> |
| <input type="checkbox"/> Vendor Directory
<i>supplies you with a list of Medicare-certified vendors for obtaining the necessary hardware and/or software to file claims electronically.</i> | |

Other Questions or Comments:

Please fax your completed *Medicare Bulletin* EDI Reader Service Sheet to one of the following fax numbers. If you do not have access to a fax machine, you may mail your completed Reader Service Sheet.

ID/TN Providers:
CIGNA Medicare
Attn: EDI Department
Two Vantage Way
Nashville, Tennessee 37228
Fax: 615.782.4653

NC Providers:
CIGNA Medicare
Attn: EDI Department
7736 McCloud Rd., Suite 240
Greensboro, NC 27409
Fax: 336.605.6495

Revised Medicare Part B Provider Manual

CIGNA Medicare is working on updating the Medicare Part B
Provider Manual/Reference List that was last printed in June 1996.

Final changes are being made and your new Provider Manual should
be in the mail soon.

**BULK RATE
U.S. POSTAGE
PAID**



**CIGNA HealthCare
Medicare Administration**

Two Vantage Way
Nashville, TN 37228