Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2001*
IMPLEMENTATION DATE: January 1, 2001

Section 4121, Extracorporeal Immunoadsorption (ECI) Using Protein A Columns, adds a new section providing coverage, billing and payment instructions for ECI using Protein A columns. For claims with dates of service on or after May 6, 1991 through December 31, 2000, the use of Protein A columns is covered by Medicare only for the treatment of patients with idiopathic thrombocytopenia purpura (ITP) failing other treatments as currently described in the Coverage Issues Manual §35-90. For claims with dates of service on or after January 1, 2001, Medicare covers the use of Protein A columns for the treatment of ITP failing other treatments and, under limited conditions, for the treatment of severe rheumatoid arthritis (RA).

Section 4121.2, Coding and Payment, adds a new section providing billing and payment instructions for ECI using Protein A columns.

Section 4121.1, Coverage Summary, adds a new section providing coverage instructions for ECI using Protein A columns.

Section 4121.3, Denial Messages, adds a new section providing a denial message for conditions not indicated in Section 4121.

This section of the Medicare Carriers Manual is based on a national coverage decision made under §1862(a)(1) of the Social Security Act (the Act). National coverage determinations (NCDs) are binding on all Medicare carriers, fiscal intermediaries, Peer Review Organizations, and other contractors. Under 42 CFR 422.256(b) an NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not disregard, set aside, or otherwise review a national coverage decision issued under §1862(a)(1) of the Act. (42 CFR 405.732, 405.860.)

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER IV
CLAIMS REVIEW AND ADJUDICATION PROCEDURES

Section

Line Review - Form HCFA-l490S

Line Review - Health Insurance Claim Form

Items and Services Having Special Review Considerations

CHAPTER IV
CLAIMS REVIEW AND ADJUDICATION PROCEDURES

the course of treatment to evaluate the status of the lesion and watch for complicating factors, and active treatment by one or a combination of the following modalities:

(1) surgical excision (avulsion) of the affected nail(s);
(2) mechanical debridement of the lesion;
(3) topical treatment; or
(4) systemic treatment.

With the appropriate advice from physicians who treat foot infections (e.g., dermatologists, podiatrists and surgeons), guidelines should be developed concerning accepted standards of medical practice with respect to appropriate utilization of the above types of services for different types of infectious conditions, taking into account such factors as the indications for various modalities of treatment, the required duration of different courses of therapy, and the required frequency of follow-up evaluation examinations. For example, when a physician prescribes a topical medication for an infection, patients are usually expected to perform most of the treatment by themselves at home (or if residing in nursing homes or skilled nursing facilities, etc., the staff of the facility is expected to perform most of the treatment), with perhaps occasional follow-up visits to (or by) the physician for evaluation of the status of the lesion. As part of the initial diagnostic and follow-up evaluation visits, the physician may cleanse the lesion and apply medication and these services would, of course, be covered where they are an accepted integral component of such visits; however, if the patient regularly comes to the physician to receive the care which he is expected to perform himself at home and there are no special medical circumstances relating to the infection warranting such special care, this would represent excessive utilization of physicians' services and should be excluded.

Carriers' utilization guidelines should enable them to identify where a course of therapy involves more frequent follow-up visits than are the accepted standards of physician care for that modality of therapy and to deny payment for such excessive visits unless there is documentation of special medical circumstances relating to the infection justifying the extra visits. For instance, in the case of claims for patients whose initial course of treatment includes a medically necessary visit to the physician for mechanical debridement of a mycotic lesion of the toenail, carriers must use a 60-day claims processing screen for identifying excessive follow-up services for the patient (i.e., the presumption would be that only one follow-up visit is covered every 60 days following the end of the initial treatment period unless medical documentation is submitted that supports more frequent visits). Similarly, utilization guidelines should identify when visits extend beyond the period of follow-up evaluation which is the accepted standard for a particular course of treatment for an infection and to deny payment for visits beyond the period unless development reveals complications in the infectious condition necessitating more prolonged treatment.

4121 EXTRACORPOREAL IMMUNOADSORPTION (ECI) USING PROTEIN A COLUMNS

4121.1 Coverage Summary. -- Extracorporeal immunoadsorption using Protein A columns has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases. The technique involves pumping the patient's anticoagulated venous blood through a cell separator from which 1-3 liters of plasma are collected and perfused over adsorbent columns, after which the plasma rejoins the separated, unprocessed cells and is retransfused to the patient. Medicare covers this procedure for the conditions noted below.

A. For Claims with Dates of Service on or After May 6, 1991 Through December 31, 2000

Medicare covers the use of Protein A columns only for the treatment of patients with idiopathic thrombocytopenia purpura (ITP) failing other treatments.

B. For Claims with Dates of Service on or After January 1, 2001

Medicare continues to cover the use of Protein A columns for the treatment ITP failing other treatments. In addition, Medicare covers its use for the treatment of rheumatoid arthritis (RA) for patients having both of the following conditions:

1. Severe RA. Patient disease is active, having > 5 swollen joints, > 20 tender joints, and morning stiffness > 60 minutes.

2. Failed an adequate course of a minimum of 3 Disease Modifying Anti-Rheumatic Drugs (DMARDs). Failure does not include intolerance.

Other uses of these columns are currently considered to be investigational and/or experimental and, therefore, not reasonable and necessary under the Medicare law. (See §1862(a)(1)(A) of the Act; also refer to §35-90 of the Coverage Issues Manual.)

4121.2 Coding and Payment.-The following codes and payment methodology apply to claims for ECI using protein A columns. Deny claims lacking the appropriate procedure-diagnosis code combinations for the dates of service indicated.

A. For Claims with Dates of Service on or After January 1, 2000

Code		
CPT/Description (Short Descriptor)	ICD-9-CM/Description	Payment Methodology
36521/Therapeutic apheresis; plasma and/or cell exchange with extracorporeal affinity column adsorption and plasma reinfusion	287.3/Primary thrombocytopenia;	Refer to the Medicare Physician Fee Schedule Database.

B. For Claims with Dates of Service on or After January 1, 2001

Code		
CPT/Description (Short Descriptor)	ICD-9-CM/Description	Payment Methodology
36521/Therapeutic apheresis; plasma and/or cell exchange with extracorporeal affinity column adsorption and plasma reinfusion	287.3/Primary thrombocytopenia; 714.0/Rheumatoid arthritis 714.1/Felty's Syndrome 714.2/Other rheumatoid arthritis with visceral or systemic involvement 714.30, 714.31, 714.32, 714.33/Types of juvenile rheumatoid arthritis	Refer to the Medicare Physician Fee Schedule Database.

C. For Claims with Dates of Service From May 6, 1991, Through December 31, 1999

Use HCPCS code Q0068 (Extracorporeal plasmaphersis immunoadsorption with staphylococcal protein A columns) and ICD-9-CM 287.3.

4121.3 Denial Messages.--When you deny the claim, use the following messages:

A. MSN/EOMB

21.22/16.58 "Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances."

B. Remittance Advice --

American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message B22, "This claim/service is denied/reduced based on the diagnosis."

4125. EYE REFRACTIONS (ITEM 7C).

The carrier must exclude that part of the total charge made by the physician for services involving eye care that relate to the procedures performed to determine the refractive state of the eyes. It will be necessary for the carrier to undertake appropriate development, wherever necessary, to ascertain whether refractive procedures were performed and to establish the reasonable charge for these procedures.

Example: A beneficiary complaining of failing vision and watering of the eyes was examined by an ophthalmologist. In the course of the diagnostic ophthalmological eye examination the physician performed procedures to determine the refractive state of the eyes. The physician's bill showed a single inclusive charge for the entire diagnostic examination. Apart from the refractive procedures, all of the other services furnished by the ophthalmologist to the beneficiary are covered. Since the physician did not show separate charge for the refractive procedures, the carrier must determine what portion of the physician's total charge represents the charge for the procedure performed to determine the refractive state of the eyes.

In other situations, the physician may indicate the charge for procedures to determine the refractive state of the eye by an itemization of the specific charge, or by a statement of a percentage or proportion of the total charge. These values, if stated, should be evaluated by the carrier under the guidelines stated in §5217.

4130. PORTABLE X-RAY SERVICES (ITEM 7C).

A. Supplier Bills.-- Whether a supplier of portable X-ray services completes an SSA-l490 or furnishes an itemized bill, both the supplier and the physician who ordered the services must be shown. In addition, all bills for portable X-ray services involving the sheet must show the reason an X-ray was required. If any of the information is not submitted with the claim, the carrier should obtain it before making payment. Where it is found that the service is not within the scope of the portable X-ray benefit (see §2070.4) or was not ordered by a physician, no payment may be made.

Carriers should assure, before making payment, that services are not routine screening procedures or tests in connection with routine physical examinations.

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B. Physician Bills.-- Where a physician bills for X-ray services performed in a beneficiary's home, it may be assumed, in the absence of evidence to the contrary, that the services were performed by the physician himself or by others under his direct personal supervision, and payment may be made. If there is any question as to the circumstances under which the services were performed, the carrier should develop the claim in accordance with existing procedures for developing claims involving the issue of "incident to physician's service." (See §2050.) The services may be covered:

1. under the provisions of §2050, if incident to the physician's services, or

2. under the portable X-ray provision, if under the general supervision of the physician and if health and safety conditions are met. (See §2070.4 concerning coverage and reimbursement of portable X-ray services.)

4131. CLAIMS FOR TRANSPORTATION IN CONNECTION WITH FURNISHING DIAGNOSTIC TESTS

Under the physician fee schedule, pay travel expenses in the practice expense (PE) component of the RVUs for a service. Prior to January 1, 1996, in the absence of specific instructions, it was within your discretion to determine when additional payment for the transportation of diagnostic equipment should be made. For dates of service on and after January 1, 1996, allow separate payment for transportation expense only in connection with furnishing portable x-ray and standard EKG services payable under the physician fee schedule in accordance with the national policy as set forth in §§2070 and 15026.

Install edits to allow payment for codes R0070 and R0075 only to portable x-ray suppliers in connection with furnishing services described in §2070.4.C. Install an edit to allow payment for code R0076 to portable x-ray suppliers in connection with furnishing standard EKG procedures (CPT codes 93000 and 93005 if the interpretation is billed with the tracing). Install an edit to allow payment for code R0076 to independent physiological laboratories in connection with furnishing standard EKG procedures (CPT code 93000 and 93005).

Allow additional payment for unusual travel expense (CPT code 99082) on a "by report" basis only. Deny billings for codes R0070 or R0075 by providers other than approved portable x-ray suppliers using the EOMB messages 16.16 and 16.82 ("You should not be billed separately for this service. You do not have to pay this amount."). Use remittance advice 16.14 ("We do not pay for this service separately since payment is included in our allowance for other services provided on the same day.") when denying these claims.

Deny billings for code R0076 by providers other than approved portable x-ray suppliers and independent physiological laboratories using EOMB messages 16.16 and 16.79. Use remittance advice 16.14 when denying these claims.

Review billings for code 99082 according to §15026. Use EOMB messages 16.16 and 16.79 and remittance advice 16.14 when denying these claims.

4135. RADIOLOGY AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS (ITEM 7C)

See §8316.1 for the pricing rules for professional component charges for patient services billed by hospital based radiologists.

A physician in the "field of radiology or pathology" includes not only a specialist in one of those fields, i.e., a radiologist or a pathologist, but also a physician who normally performs the radiology or pathology services for patients of a particular hospital, even though the physician does not restrict his practice to radiology or pathology.

When a radiologist or pathologist bills directly, reimburse at the 100-percent rate only after determining that the services were performed for a beneficiary while an inpatient of a qualified hospital. When a physician who is not known to specialize in radiology or pathology bills the beneficiary for services furnished while a hospital inpatient, pay on the 100 percent basis only if the service was performed by a physician who has responsibility for the hospital's radiology or pathology department and the beneficiary was an inpatient of a qualified hospital.

Anatomic pathology services furnished to hospital inpatients are subject to the following reimbursement rules:

- Where the service is performed in the hospital laboratory, the intermediary reimburses the technical component, you reimburse the professional component.

- Where the service is performed in a laboratory outside of the hospital in which the beneficiary is an inpatient, reimburse both the technical and professional components.

4137. ANESTHESIOLOGY SERVICES (ITEM 7C)

Where the anesthesiology service was performed by the physician, the service is reimbursable under Part B. The fact that the service was rendered personally and the time involved must be shown on the claim's form. However, for concurrent anesthesiology services furnished by hospital-employed anesthetists to be reimbursable by you, the requirements in §83l0.l must be met. Through your educational releases and other established means, ensure that anesthesiologists understand the requirements for medical direction of qualified anesthetists. For concurrent anesthesiology services furnished by hospital-employed anesthetists, the anesthesiologist must certify on the claim form the number of anesthetists (certified registered nurse anesthetist, anesthesia assistant, or other qualified individual) directed concurrently. The claim must include:

- The elapsed time from the preparation of the patient for induction to the moment when the physician and the anesthetist are no longer in personal attendance.

- The employment status of the anesthetist, i.e., whether employed by the hospital or by the physician.

- The number of concurrent services.

Additionally, all claim forms must include the following certification, as applicable:

- I certify that I performed this service personally. or,

- I certify that I directed ____#__ anesthetists concurrently and I have on file each procedure performed and the name of each anesthetist directed for services on this claim.

Physicians submitting EMC claims must sign a one time certification letter stating that they have on file each procedure performed and the name of each anesthetist directed. If neither of the above certifications is on an unassigned claim, request documentation from the physician. Documentation for each claim must include the number of anesthetists directed, the name of each and each procedure performed.