

VOLUME 1**ISSUE 4**

Indiana and Kentucky CARRIER ADVISORY COMMITTEE (CAC) COMMUNIQUÉ

NEXT CAC MEETING

Indiana: February 13, 2006 5:00 PM Kentucky: February 23, 2006 12:00 PM

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FACTOID

Did You Know???

The Region B DMERC has published guidelines to assist physicians in evaluating patients for mobility products. The Part B Medical Review Unit has a link to these documents on the AdminaStar Federal Website. For further information please click on the following URL

<http://www.adminastarfederal.com/Providers/Carrier/MedicalReview/PowerMobilityDevices.html>

POLICY UPDATES

Radiation Oncology--External Beam Treatment Only (R4)

Source of Revision: Annual HCPCS coding update.

The descriptions for CPT/HCPCS codes 77295, 77412, 77413, 77414, and 77416 were changed in group 1.

In the narrative section of the "Indications and Limitations of Coverage and/or Medical Necessity" the section for "Services Bundled Into Treatment Codes" was updated to reflect the 2006 HCPCS coding deletions and additions. This section is a direct quote from the CMS Manual System (Pub. 100-04; Chapter 13, Section 70) which has not been updated. The updates will not be non-italicized and are as follows:

CPT/HCPCS codes 16010, 16015 were deleted and replaced with 16020, 16025, and 16030.

The description of 99050 was changed.

CPT/HCPCS codes 99052 and 99054 were deleted and replaced with new CPT/HCPCS codes 99051 and 99053 for which the descriptions were updated.

G0345, G0346, G0347, G0348, G0349, and G0350 were deleted and replaced with 90760, 90761, 90765, 90766, 90767, and 90768.

In the "Other Comments" section, "by the contractor" was added to the following statement: "A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of all pertinent medical information."

The coding guidelines in the Supplemental Instructions Article (SIA): Radiation Oncology - External Beam Treatment Only (R4) were revised to implement these coding updates.

Sacral Nerve Stimulation (R3)

Source of Revision: Annual HCPCS coding update.

CPT/HCPCS codes E0752 and E0756 were deleted from group 1 and replaced with L8680, L8681, L8684, and L8686.

The description for CPT/HCPCS code 95971 was changed in group 1.

In the "Other Comments" section, "by the contractor" was added to the following statement: "A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of all pertinent medical information."

The coding guidelines in the Supplemental Instructions Article (SIA): Sacral Nerve Stimulation was revised to implement these coding updates.

Bariatric Surgery (R3)

Source of Revision: Annual CPT/HCPCS coding update.

The description for code 43848 (Revision of gastric restrictive procedure for morbid obesity [separate procedure]) was revised and now excludes adjustable gastric band procedures.

New CPT codes 43770, 43771, 43772, 43773, 43774 were added to the policy and will be utilized in place of CPT code 43659 (Unlisted laparoscopy procedure, stomach) to report laparoscopic surgical gastric restriction using adjustable gastric band technique placement, revision, removal and/or replacement of adjustable gastric band and subcutaneous port components.

New CPT codes 43886, 43887, 43888 were added to the policy and will be utilized in place of CPT code 43999 (Unlisted procedure, stomach) to report open gastric restrictive procedures involving the revision, removal, and/or replacement of the subcutaneous port component.

The description for CPT/HCPCS code 43848 was changed in group 1.

In the "Other Comments" section, "by the contractor" was added to the following statement: "A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of all pertinent medical information."

The coding guidelines in the Supplemental Instructions Article (SIA): Bariatric Surgery were also revised to implement this coding update.

Erythropoietin Analogues for Non-End Stage Renal Disease (Non-ESRD) Anemia (R3)

Source of Revision: Annual CPT/HCPCS Coding Update

CPT/HCPCS codes J0880 and Q0137 were deleted and replaced with J0881.

CPT/HCPCS code Q0136 was deleted and replaced with J0885.

In the “Other Comments” section, “by the contractor” was added to the following statement: “A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of all pertinent medical information.”

The coding guidelines in the Supplemental Instructions Article (SIA): Erythropoietin Analogues for Non-End Stage Renal Disease (Non-ESRD) Anemia were also revised to implement this coding update.

Intravenous Immune Globulin (IVIG) (R10)

Source of Revision: Annual HCPCS coding update.

CPT/HCPCS codes Q9941 and Q9942 were deleted and replaced by J1566.

CPT/HCPCS codes Q9943 and Q9944 were deleted and replaced by J1567.

The following statement was removed from the paragraph prior to the list of CPT/HCPCS codes: "Although the effective date of this revision is April 15, 2005, HCPCS codes Q9941-Q9944 became effective on April 1, 2005."

In the “Other Comments” section, “by the contractor” was added to the following statement: “A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of all pertinent medical information

The coding guidelines in the Supplemental Instructions Article (SIA): Intravenous Immune Globulin (IVIG) were also revised to implement this coding update.

Magnetic Resonance Imaging (R13)

Source of Revision: Annual CPT/HCPCS coding update.

CPT/HCPCS code A4643 was deleted from the list of codes in group 1. References to A4643 were deleted throughout the policy.

The following statement was removed from the paragraph preceding the list of CPT/HCPCS codes:

Please note: A second MRI of the brain or spine (70553, 72156, 72157, 72158), utilizing a standard amount of contrast material, may be allowed following the first procedure performed without contrast material. A third MRI would not be separately reimbursed since the narrative in the CPT manual for the above-cited codes is and further sequences. However, if the third MRI utilized a higher dose of contrast material for an enhanced study, the contrast material would be separately payable using HCPCS code A4643. (Please see Coding Guidelines for additional information.)

CPT/HCPCS code 76375 was deleted from the CPT/HCPCS codes in Group 1 and replaced with CPT/HCPCS codes 76376 and 76377.

CPT/HCPCS code 76375 was deleted from statements found in the paragraphs preceding the ICD-9 Codes that Support Medical Necessity coding groups and was replaced with 76376 and 76377 as follows:

Head, Neck, Face, Orbit, Jaw: (MRI CPT/HCPCS codes: 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 76376, 76377)

MRI Chest and Thorax: (MRI CPT codes: 71250, 71260, 71270, 76376, 76377)

MRI Abdomen and Pelvis: (MRI CPT codes: 72192, 72193, 72194, 74150, 74160, 74170, 76376, 76377)

MRI Cervical Spine: (MRI CPT codes: 72125, 72126, 72127, 76376, 76377)

MRI Thoracic Spine: (MRI CPT codes: 72128, 72129, 72130, 76376, 76377)

MRI Lumbar Spine: (MRI CPT codes: 72131, 72132, 72133, 76376, 76377)

MRI Upper Extremity: (MRI CPT codes: 73200, 73201, 73202, 76376, 76377)

MRI Lower Extremity: (MRI CPT codes: 73700, 73701, 73702, 76376, 76377)

The following statement was added to the ICD-9 Codes that Support Medical Necessity " paragraphs preceding all coding groups where CPT/HCPCS code 76375 was replaced with codes 76376 and 76367:

Report CPT/HCPCS codes 73636 or 76367 in conjunction with CPT/HCPCS

code(s) for base imaging procedures(s).

The following statement was removed from the Indications and Limitations of Coverage and/or Medical Necessity section of the policy:

The medical record should document the medical necessity for reconstruction when billing CPT code 76375 (Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed axial tomography, magnetic resonance imaging, or other tomographic modality).

The following statement was added to the Indications and Limitations of Coverage and/or Medical Necessity section of the policy:

The medical record should document the medical necessity for 3D rendering when billing CPT code 76376 and 76377.

The following statement was revised in the Other Comments section and reads as follows:

A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor on review of all pertinent medical information.

The coding guidelines in the Supplemental Instructions Article (SIA): Magnetic Resonance Imaging were revised to implement these coding updates.

Botulinum Toxins (R3)

Source of Revision: Annual HCPCS coding update.

The description for CPT/HCPCS code 64613 was changed in group 1.

CPT/HCPCS codes 95860, 95861, 95867, 95868, 95869, 95870 were deleted and replaced with new add-on codes 95873 - Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) and 95874 - Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedures).

In the "Other Comments" section, "by the contractor" was added to the following statement: "A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of

all pertinent medical information."

The coding guidelines in the Supplemental Instructions Article (SIA): Botulinum Toxins were revised to implement these coding updates.

Psychiatry and Psychology Services (R6)

Source of Revision: Annual HCPCS coding update.

The description for CPT/HCPCS code 90870 was changed in group 1.

CPT/HCPCS code 90871 (Multiple seizures) was deleted and all references to this code were removed from the narrative. This code was a non-covered service on the Medicare Physician Fee Schedule Database (MFSDB).

CPT/HCPCS code 96100 was deleted from group 1 and replaced with 96101, 96102, and 96103.

CPT/HCPCS code 96115 was deleted from group 1 and replaced with 96116.

CPT/HCPCS code 96117 was deleted from group 1 and replaced with 96118, 96119, and 96120.

The "Indications and Limitations of Coverage and/or Medical Necessity" narrative was updated in Section VI: Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing) to incorporate the 2006 CPT/HCPCS coding updates (deletion of codes 96100, 96115 and 96117 and the addition of codes 96101, 96103, 96116, 96118, 96119, 96120).

In the "Other Comments" section, "by the contractor" was added to the following statement: "A claim that does not fulfill the coverage requirements described above may be given individual consideration by the contractor based on review of all pertinent medical information."

The coding guidelines in the Supplemental Instructions Article (SIA): Psychiatry and Psychology Services (R6) were revised to implement these coding updates.

Supplemental Instructions Article (SIA): Epidural Injections: Transforaminal

Revision 1 Effective Date: 01/01/2006

Source of Revision: Medicare Physician Fee Schedule Update

The coding guidelines for CPT/HCPCS codes 64479, 64480, 64483, 64484 were updated as follows:

The CPT codes 64479 and 64483 have a bilateral surgery indicator of “1.” Thus, they are considered “unilateral” procedures and the 150% payment adjustment for bilateral procedures applies. When injecting a nerve root bilaterally, file with modifier –50. When injecting a nerve root unilaterally, file the appropriate anatomic modifier –LT or –RT.

Only one (1) unit of service should be submitted for a transforaminal epidural injection for a unilateral or bilateral injection at the same level.

Indicate the nerve root(s) injected, e.g., C3, L5, etc., in the electronic notepad or in Item 19 of the CMS-1500 form.

The CPT codes 64480 and 64484 are “add-on” procedures which should be listed separately in addition to the code for the primary procedure. Use 64480 in conjunction with 64479, and 64484 in conjunction with 64483. These “add-on” codes have a bilateral surgery indicator of “0” and the 150% adjustment for bilateral procedures and modifier 50 do not apply to these codes. Therefore, modifier-50 should not be appended for bilateral procedures at the same level

Only one (1) unit of service should be submitted for a transforaminal epidural injection for a unilateral or bilateral injection at the same level.

Indicate the nerve root(s) injected, e.g., C3, L5, etc., in the electronic notepad or in Item 19 of the CMS-1500 form.

No changes were made to the local coverage determination (LCD) for Epidural Injections: Transforaminal (Contractors Determination Number NEUR-C-0811) which is associated with this policy.

IN THE KNOW

CMS is pleased to announce a redesigned CMS web page dedicated to providing all the latest NPI news for health care providers! Visit <http://www.cms.hhs.gov/NationalProvdentStand/> on the web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml> on the web.