Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TRAILBLAZER HEALTH ENTERPRISES, LLC: AUDIT OF MEDICARE CLAIMS BY PODIATRISTS AND OPTOMETRISTS FOR COMPREHENSIVE NURSING FACILITY ASSESSMENTS FOR CALENDAR YEARS 1995 THROUGH 1998

JUNE GIBBS BROWN
Inspector General

OCTOBER 2000
A-09-00-00071

OFFICE OF INSPECTOR GENERAL

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Department of Health and Human Services

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TRAILBLAZER HEALTH ENTERPRISES, LLC: AUDIT OF MEDICARE CLAIMS BY PODIATRISTS AND OPTOMETRISTS FOR COMPREHENSIVE NURSING FACILITY ASSESSMENTS FOR CALENDAR YEARS 1995 THROUGH 1998

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

JUNE GIBBS BROWN
Inspector General

OCTOBER 2000
A-09-00-00071

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

CIN: A-09-00-00071

OCT 30 2000

Ms. Marti Mahaffey
Executive Vice President
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, Executive Center III
Dallas, TX 75243

Dear Ms. Mahaffey:

The purpose of this letter report is to provide TrailBlazer Health Enterprises, LLC (TrailBlazer) with the results of our audit of Medicare claims by podiatrists and optometrists in Texas for comprehensive nursing facility (CNF) assessments during Calendar Years 1995 through 1998. Our objective was to determine the extent to which podiatrists and optometrists in Texas inappropriately billed Medicare for CNF assessments.

Our audit disclosed that podiatrists and optometrists submitted claims for CNF assessment services totaling $3,939,316 and $2,191,830, respectively. Of the total amount claimed by podiatrists, TrailBlazer allowed $3,034,911 and paid $2,166,213. Of the total amount claimed by optometrists, TrailBlazer allowed $1,846,961 and paid $1,316,246. TrailBlazer's payments for services billed by 49 podiatrists represented 78 percent of the paid $2,166,213, and its payments for services billed by 12 optometrists represented 94 percent of the paid $1,316,246. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

In our opinion, the inappropriate payments occurred because TrailBlazer had not informed podiatrists and optometrists that CNF assessments were outside the providers' scope of licenses and therefore should not be billed. In addition, TrailBlazer did not have computer edits in place to prevent payment to podiatrists and optometrists for CNF assessments.

We recommended that TrailBlazer: (1) issue a reminder to podiatrists and optometrists to bill Medicare only for services they are licensed to perform, and (2) implement computer edits to prevent payment to podiatrists and optometrists for CNF

assessments. We requested that TrailBlazer not seek recovery of the overpayments at this time as we are still evaluating the issue.

In a written reply to our draft report, TrailBlazer indicated agreement with our recommendations. The company notified podiatrists and optometrists in its June 1, 2000 Part B Newsletter that they are not to bill for CNF assessments, and stated that it implemented computer edits on July 1, 2000 to prevent payment to podiatrists and optometrists for CNF assessments. Although TrailBlazer has taken corrective action on our recommendations, it believes that prior payment of CNF claims should not be considered as overpayments. It was of the view that no national or carrier policy denying such payments existed at the time they paid these claims. TrailBlazer's comments are included in their entirety as appendices to this report, except we excluded the non relevant sections of its Part B Newsletter.

INTRODUCTION

BACKGROUND

The Medicare program, established by the Social Security amendments of 1965, consists of two parts:

- Part A which covers services rendered by hospitals, skilled nursing facilities (SNFs), home health agencies and hospice providers, and
- Part B which covers physician care, among other services.

Payments for medical benefits under Part B are administered by carriers, usually existing private insurance companies that contract with the Federal Government for this purpose. In addition to processing and paying claims, carriers also make coverage determinations and provide administrative guidance to providers.

Medicare Part A, 42 Code of Federal Regulations (CFR) 483.20 and 483.20(b) require SNFs to perform a comprehensive assessment of each resident's functional capacity within 14 days of admission and after significant changes in a resident's condition or at least every 12 months. These resident assessments cover the patient's entire well-being, such as physical functioning, sensory impairments, nutritional requirements, mental and psychosocial status, cognitive status, etc.

The responsibility for completion of the resident assessment lies with the SNF which must assure that appropriate health professionals participate. However, some of the information required to be collected can only be provided by a physician, and, thus, physicians play a crucial role in the assessment process. The 42 CFR 483.40(a) states, "...The facility must ensure that -- (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable." (emphasis added) Additionally, 42 CFR 483.40(b) states, "...The physician must -- (1) Review the resident's total program of care, including medications and treatments, at each visit..." (emphasis added)

Texas law also requires the attending physician to be responsible for the resident's total care plan. Section 242.151(b) of the Texas State Statutes, Health and Safety Code, states "The attending physician is responsible for a resident's assessment and comprehensive plan of care and shall review, revise, and sign orders relating to any medication or treatment in the plan of care."

The Health Care Financing Administration (HCFA) issued guidance to carriers in a Program Memorandum (Carriers) No. B-93-3, dated August 1, 1993 (the Memorandum), which states that there are three key components in selecting the level of evaluation and management (E&M) service when performing a CNF assessment: (1) a history, (2) a comprehensive examination, and (3) medical decision making that includes either the creation of a new ***comprehensive medical care plan*** or a review and affirmation of the current ***comprehensive medical care plan***. The Memorandum also describes how physicians participating in resident assessments of beneficiaries in nursing facilities are to bill for their services. Physicians should use the Physicians' Current Procedural Terminology[1] (CPT) codes for CNF assessments (99301-99303) to report E&M services involving resident assessments.

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[1] The Physicians' Current Procedural Terminology is published by the American Medical Association. It is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties.

The complexity of the E&M service performed determines the CPT code. The CPT manual defines the key components and gives examples[2] of the types of services performed for CNF assessments (CPT codes 99301-99303) as follows:

99301 Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components:

a detailed interval history;
a comprehensive examination; and
medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

Example: Annual nursing facility history and physical and a uniform minimum data set/resident assessment instrument (MDS/RAI) evaluation for a 2-year nursing facility resident who is an 84-year old female with multiple chronic health problems, including: stable controlled hypertension, chronic constipation, osteoarthritis, and moderated stable dementia.

99302 Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components:

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[2] The CPT code examples are from the 1998 version of the American Medical Association's Physicians' Current Procedural Terminology.

a detailed interval history;
a comprehensive examination; and
medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status.

The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

Example: Nursing facility assessment of an 88-year old male resident with a permanent change in status following a new cerebral vascular accident (CVA) that has triggered the need for a new MDS/RAI and medical plan of care.

99303 Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components:

a comprehensive history;
a comprehensive examination; and
medical decision making of moderate to high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

The creation of a medical plan of care is required. Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

> *Example*: Nursing facility assessment and creation of medical plan of care upon readmission to the nursing facility of an 82-year old male who was previously discharged. The patient has just been discharged from the hospital where he had been treated for an acute gastric ulcer bleed associated with transient delirium. The patient returns to the nursing facility debilitated, protein depleted, and with a stage III coccygeal decubitus.

For all CNF assessments, the required examination must be a comprehensive examination. The CPT manual defines a comprehensive examination as a general multi-system examination or a complete examination of a single organ system.

In addition to the comprehensive examination for CNF assessments, either a detailed interval history or a comprehensive history is required. According to the CPT manual, a detailed history includes, "...chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; and pertinent past, family, and/or social history directly related to the patient's problems." (emphasis added) The CPT manual states that a comprehensive history includes "...chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history." (emphasis added)

According to 42 CFR 483.20(d)(1), a comprehensive care plan must be developed for "...each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe...(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." (emphasis added)

For ***other physician visits*** of new or established patients, the Memorandum states, "Physicians should use the CPT codes for subsequent nursing facility care (99311-99313) when reporting services that do not involve resident assessments." (emphasis added)

With regard to CNF assessments claimed by podiatrists and optometrists, the Social Security Act covers the services of these providers to the extent the services performed comply with ***Medicare regulations*** and are within the scope of their ***State license***.

> *Podiatry*. The Social Security Act, Section 1861(r), states, "The term physician, when used in conjunction with the performance of any function or action, means, ... (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them...." (emphasis added)
>
> *Optometry*. The Social Security Act, Section 1861(r), states, "The term physician, when used in conjunction with the performance of any function or action, means, ... (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them...." (emphasis added)

According to Title 40, Part 1, Chapter 19, Subchapter B, Rule §19.101 of the Texas Administrative Code, an attending physician is defined as "A physician, currently licensed by the Texas State Board of Medical Examiners, who is designated by the resident or responsible party as having primary responsibility for the treatment and care of the resident." Podiatrists and optometrists are not licensed by the State Board of Medical Examiners. Instead, podiatrists are licensed by the Texas State Board of Podiatry Examiners and optometrists are licensed by the Texas Optometry Board. Therefore, in our opinion, podiatrists and optometrists are not licensed under Texas law to be the attending physicians of nursing facility patients.

In addition, limited scope providers (such as podiatrists and optometrists) are not licensed to perform the key medical service components required to bill Medicare for CPT codes 99301-99303, such as preparation of a comprehensive medical care plan that is outside the scope of their specialty. The Texas Occupations Code (the Code) restricted podiatrists to treatment and care planning of the foot. Section 202.001(4) of the Code limited the practice of podiatry to the treatment of "...any disease, disorder, physical injury, deformity, or ailment of the human foot by any system or method."

As for optometrists, the Code restricted these providers to treatment and care planning of the eye and adnexa. Section 351.002 (6) of the Code limited the practice of optometry to "...using objective or subjective means, with or without the use of topical ocular pharmaceutical agents, to: (A) determine or measure the powers of vision of the human eye as provided by Section 351.355; (B) examine or diagnose visual defects, abnormal conditions, or diseases of the human eye or adnexa; or (C) prescribe or fit

lenses or prisms to correct or remedy a defect or abnormal condition of vision as provided by Section 351.356." Also, Section 351.002 (7) of the Code limited the practice of therapeutic optometry to "...using objective or subjective means to: (A) determine or measure the powers of vision of the human eye as provided by Section 351.355; (B) examine or diagnose visual defects, abnormal conditions, or diseases of the human eye or adnexa; (C) prescribe or fit lenses or prisms to correct or remedy a defect or abnormal condition of vision as provided by Section 351.356; (D) administer or prescribe a drug or physical treatment in the manner authorized by this chapter; or (E) treat the eye or adnexa as authorized by this chapter without the use of surgery or laser surgery."

Since podiatrists and optometrists are not licensed by Texas law as "attending physicians" and they are limited scope providers, they cannot serve as the patient's attending physician in a nursing facility, and they cannot review a patient's total care program, which includes either creating or reviewing and affirming the medical care plan. Accordingly, podiatrists and optometrists should not be billing Medicare for CNF assessments, CPT codes 99301-99303.

OBJECTIVES, SCOPE AND METHODOLOGY

The objective of the audit was to determine the extent to which podiatrists and optometrists in Texas inappropriately billed Medicare for CNF assessments.

Our review was conducted in accordance with generally accepted government auditing standards. Accordingly, we performed such tests and other auditing procedures as necessary to meet the objectives of our review. We did not review the overall internal control structure of TrailBlazer or of the Medicare program. Our review of internal controls was limited to obtaining an understanding of TrailBlazer's payment procedures and system edits for processing Texas CNF assessment claims for podiatrists and optometrists. We obtained a general understanding of these procedures and system edits through discussions with TrailBlazer personnel and an analysis of claims data.

Our survey showed that two of the limited scope provider types, dentists and chiropractors, billed TrailBlazer for a very insignificant number of CNF assessments and, therefore, they were excluded from this review.

We obtained an understanding of the Medicare regulations regarding CNF assessments. We reviewed the Texas Administrative Code to determine the State's definition of an

attending physician, the Texas Health and Safety Code to determine the requirements of an attending physician in a Texas nursing facility, and the Texas Occupations Code to ascertain the scope of medical practice authorized for Texas podiatrists and optometrists.

Our audit included an analysis of TrailBlazer CNF assessment payments for services billed by Texas podiatrists and optometrists. The data for this payment analysis were obtained from HCFA's National Claims History database. We did not perform an analysis of the procedures used to accumulate the Claims History data nor did we validate the accuracy of the data.

The fieldwork was performed from December 1999 through July 2000 at TrailBlazer in Dallas, Texas, and the Office of Audit Services' San Diego Field Office in San Diego, California.

FINDINGS AND RECOMMENDATIONS

Texas podiatrists and optometrists inappropriately billed Medicare for CNF assessment services totaling $3,939,316 and $2,191,830, respectively. Of the total amount claimed by podiatrists, TrailBlazer allowed $3,034,911 and paid $2,166,213. Of the total amount claimed by optometrists, TrailBlazer allowed $1,846,961 and paid $1,316,246. TrailBlazer's payments for services billed by 49 podiatrists represented 78 percent of the paid $2,166,213, and its payments for services billed by 12 optometrists represented 94 percent of the paid $1,316,246. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

ANALYSIS OF MEDICARE DATA: PODIATRISTS

We determined that podiatrists submitted claims to TrailBlazer for CNF assessments totaling $3,939,316 during Calendar Years 1995 through 1998. Of the total claimed amounts, TrailBlazer allowed $3,034,911 and actually paid $2,166,213.

Further analysis of the payment data showed that CNF assessments performed by a relatively small number (49 of the 358 podiatrists billing for CNF assessments) accounted for 78 percent of the $2,166,213 in invalid payments. The invalid payments for the 49 podiatrists averaged $34,497 per provider. In contrast, CNF assessments

performed by the remaining 309 podiatrists represented payments of $475,865, or an average of $1,540 per provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 49 providers.

Total Amount Paid	Number of Providers	Percent of Providers
$10,000 to $19,999	21	43%
$20,000 to $49,999	20	41
$50,000 to $99,999	4	8
$100,000 to $199,999	3	6
$200,000 and Over	1	2
Totals	49	100%

ANALYSIS OF MEDICARE DATA: OPTOMETRISTS

We determined that optometrists submitted claims to TrailBlazer for CNF assessments totaling $2,191,830 during Calendar Years 1995 through 1998. Of the total claimed amounts, TrailBlazer allowed $1,846,961 and actually paid $1,316,246.

Further analysis of the payment data showed that CNF assessments performed by a few (12 of the 65 optometrists billing for CNF assessments) accounted for 94 percent of the $1,316,246 in invalid payments. The invalid payments for the 12 optometrists averaged $102,609 per provider. In contrast, CNF assessments performed by the remaining 53 optometrists represented payments of $84,934, or an average of $1,603 per provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 12 providers.

Total Amount Paid	Number of Providers	Percent of Providers
$10,000 to $19,999	2	17%
$20,000 to $49,999	2	16
$50,000 to $99,999	4	33
$100,000 to $199,999	2	17
$200,000 and over	2	17
Totals	12	100%

EDITS AND INSTRUCTIONS

We found that TrailBlazer had neither issued specific guidance to Texas podiatrists and optometrists nor implemented computer edits to prevent the payment of CNF assessments to Texas podiatrists and optometrists.

In our discussions with TrailBlazer representatives, they indicated that it would be feasible to implement edits and, in addition to Texas, the edits would apply to the Maryland service area. In January 1995, TrailBlazer started processing Medicare claims for Maryland (excluding Prince Georges and Montgomery counties). The predecessor carrier for this jurisdiction did not have computer edits in place to prevent payments for CNF assessments to podiatrists or optometrists. As a result of our inquiry on this issue, TrailBlazer issued guidance to providers in June 2000 and is developing edits for its Texas and Maryland claims processing systems.

In addition, TrailBlazer informed us that they started processing Medicare claims for Delaware, District of Columbia, the Maryland counties of Prince Georges and Montgomery, and the Virginia counties of Arlington and Fairfax and city of Alexandria in March 1998. The predecessor carrier for these jurisdictions had computer edits in place to prevent payments for CNF assessments to podiatrists and optometrists, which TrailBlazers has continued to enforce.

In our view, the issuance of a reminder to providers and the implementation of computer edits by TrailBlazer should virtually eliminate the inappropriate payments for CNF assessments to podiatrists and optometrists.

OTHER SERVICES

For the reasons previously cited, podiatrists and optometrists were not entitled to payment for CNF assessments of beneficiaries in nursing homes. What is not known, however, is whether the providers may have performed other, different services and incorrectly claimed CNF assessments. Such a determination could only be made by a detailed review of the providers' records.

RECOMMENDATIONS

We recommended that TrailBlazer:

1. Issue a reminder to podiatrists and optometrists not to bill for any service they are not licensed to perform, such as CNF assessments, and

2. Implement computer edits to prevent payment for CNF assessments claimed by podiatrists and optometrists.

As to recovery of the improper payments that have been made, we requested that TrailBlazer not seek recovery at this time. We are still evaluating the recovery issue and will advise TrailBlazer on this matter at a later time.

TRAILBLAZER'S COMMENTS

In a written response to our draft report, TrailBlazer indicated agreement with our recommendations by initiating the following actions:

1. Notified providers in its June 1, 2000 Part B Newsletter that it would no longer pay podiatrists and optometrists for CNF assessments claimed after June 30, 2000 (see Appendix B), and

2. Implemented computer edits on July 1, 2000, that would exclude podiatrists and optometrists from receiving payment for CNF assessment codes (99301-99303).

TrailBlazer commented that it requested and received the approval of HCFA before it took the recommended actions. On February 17, 2000, the company contacted the HCFA Dallas Regional Office (Region VI) requesting approval to no longer pay claims for CNF assessments submitted by podiatrists and optometrists. The Region VI Office forwarded TrailBlazer's request to its Central Office on February 18, 2000 requesting a determination. TrailBlazer received a response from HCFA's Central Office on March 29, 2000 stating that, after much discussion, it agreed with the Office of Inspector General's recommendations.

Further, TrailBlazer stated that no national policy addressing payment of CNF assessment claims submitted by podiatrists and optometrists existed at the time they

paid these claims. Also, its new policy of denying such claims began on July 1, 2000. Therefore, it believed it would be inappropriate to consider these payments as overpayments.

TrailBlazer's comments are included in their entirety as appendices to this report, except we excluded the non relevant sections of its Part B Newsletter.

OAS RESPONSE

For Medicare reimbursement, the services required to bill for CNF assessment codes (99301-99303) are outside podiatrists' and optometrists' scope of practices. As indicated on page 11 of our report, a detailed review of each provider's records is necessary to determine if other, different services were performed and incorrectly claimed as CNF assessments.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. To facilitate identification, please refer to common identification number (CIN) A-09-00-00071 in all correspondence relating to this report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services' reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

Sincerely,

Lawrence Frelot

Lawrence Frelot
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Dr. James R. Farris, M.D.
Regional Administrator
Health Care Financing Administration - Region VI
1301 Young Street
Dallas, TX 75202

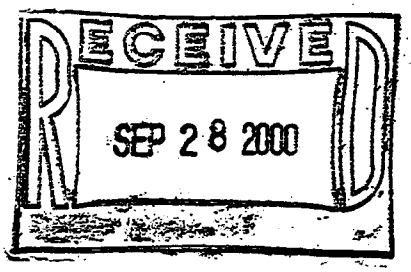
APPENDICES

HCFA
Health Care Financing Administration

MEDICARE
Part A Intermediary
Part B Carrier

September 27, 2000

Mr. Lawrence Frelot
Regional Inspector General for Audit Services
Region IX, Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102



In reply to: CIN: A-09-00-00071

Dear Mr. Frelot:

As requested, we have reviewed the findings and recommendations that were included in your draft report on your audit of Medicare claims by podiatrists and optometrists for comprehensive nursing facility assessments in Texas during 1995 through 1998. The following are our comments:

On February 10, 2000 TrailBlazer staff met with OIG to discuss our policy at that time of allowing podiatrists and optometrists to bill the nursing home assessment codes. We discussed the fact that there was no national policy addressing this issue. OIG indicated they had contacted the Texas State Boards but had not received confirmation that the Boards agreed this was not within the scope of practice for podiatrists and optometrists. We indicated we would contact the Dallas Regional Office concerning the removal of those specialties from payment for the nursing home assessment codes. If the regional office approved, then a newsletter article would be written, providers notified and editing would be put in place.

On February 17, 2000 an electronic message was sent to the Dallas Regional Office regarding this issue. In this message we indicated that we had not been able to confirm with the State Boards whether or not the assessment codes are within the scope of practice for podiatrists and optometrists. We also indicated to the Regional Office that we would like to publish a newsletter article stating that we will no longer reimburse codes 99301-99303 for podiatrists and optometrists because we believe those codes require assessments outside the scope of practice for these specialties. The policy would be implemented 30 days from the newsletter date.

The Regional Office sent our request to the HCFA Central Office on February 18, 2000 requesting a determination. A response was received on March 29, 2000 from the HCFA Central Office advising us that after much discussion, they agreed with the OIG.

Our next scheduled newsletter was published on June 1, 2000. An article was included to notify the optometrists and podiatrists that we would no longer cover these codes for their specialties for dates of service on or after July 1, 2000. For this reason, we feel that overpayments would be inappropriate. For your reference, I am enclosing a copy of Part B Newsletter No. 00-006, dated June 1, 2000.

An edit was implemented on July 1, 2000, to ensure that no future payments for the nursing home assessment codes would be made to podiatrists and optometrists.

Thank you for the opportunity to comment. If you have any questions, feel free to contact me at 469-372-7397.

Sincerely,

Judie Culver
Director, Medical Review/Policy
Enclosure (1)

cc: Dr. James R. Farris, M.D.,Regional Administrator, HCFA-Region VI
Mr. Donald Dille, Regional Inspector General for Audit Services, OIG/OAS-Region VI
Ms. Martha P. Mahaffey, Executive Vice President and COO

Podiatrists Billing for Nursing Facility Assessments

Effective for claims received on or after July 1, 2000, podiatrists may no longer bill for CPT codes 99301-99303 (comprehensive nursing facility assessments). These codes require an evaluation and management of a new or established patient. It is the opinion of the Health Care Financing Administration (HCFA) that only a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state may serve as a physician for the purpose of compliance with the regulation at 42 CFR 483.40 (b)(1) which requires the physician to review the resident's total program of care. The requirement for performing these particular services includes areas of assessment which are outside the scope of a podiatrist's practice. The patient's attending or admitting physician must perform a full assessment.

Podiatrists may bill codes 99311-99313 (subsequent nursing facility care), which by definition, include new or established patients. ☆

Hyperbaric Oxygen Therapy Revision Delayed

Change Request No. 1138
Program Memorandum AB-00-15

In Texas and Maryland:

Medicare received a transmittal from the Health Care Financing Administration (HCFA) concerning the HBO therapy policy that was recently published in Special Medicare Part B Newsletter No. 165 in Texas and No. 032 in Maryland, dated June 1, 1999. Medicare notified providers in Special Medicare Part B Newsletter Nos. 166 in Texas and 033 in Maryland, dated June 15, 1999, that implementation of this policy had been delayed until April 1, 2000. All providers were referred to Special Medicare Part B Newsletter Nos. 153, in Texas, dated October 3, 1997, and 020 in Maryland, dated October 3, 1997, for the current policy until further notice.

Implementation of the revised policy has again been delayed until further notification. Please refer to Special Medicare Part B Newsletter Nos. 153 in Texas, and No. 020 in Maryland, dated October 3, 1997, for the current policy on HBO. This policy will remain in effect until further notice.

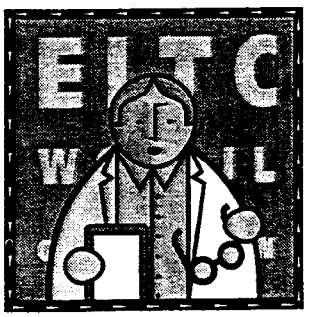
In District of Columbia/ Delaware:

Medicare received a transmittal from the Health Care Financing Administration (HCFA) concerning the HBO therapy policy that was recently published in Special Medicare Part B Newsletter No. 013, dated June 1, 1999. Medicare notified providers in Special Medicare Part B Newsletter No. 014, dated June 15, 1999, that implementation of this policy had been delayed until April 1, 2000. All providers were advised that the current policy would remain in effect until further notice.

Implementation of the revised policy has again been delayed until further notification. The current policy will remain in effect until further notice. ☆

Optometrists Billing for Nursing Facility Assessment

Effective for claims received on and after July 1, 2000, optometrists may no longer bill for CPT codes 99301-99303 (comprehensive nursing facility assessments). These codes require an evaluation and management of a new or established patient. It is the opinion of the Health Care Financing Administration (HCFA) that only a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state may serve as a physician for the purpose of compliance with the regulation at 42 CFR 483.40 (b)(1) which requires the physician to review the resident's total program of care. The requirement for performing these particular services include areas of assessment which are outside the scope of an optometrist's practice. The patient's attending or admitting physician must perform a full assessment.



Optometrists may bill codes 99311-99313 (subsequent nursing facility care), which by definition, include new or established patients. ☆