Coding, Billing, Compliance Issues

Valerie Palmer, RN, ACHRN, CWCN, CWS, CMBS, FACCWS

Coding, Billing, Compliance Issues for Hyperbaric Oxygen Therapy

Valerie Palmer, RN, ACHRN, CWCN, CWS, CMBS, FACCWS, UHMSADS
Director of Operations and Compliance
National Baromedical Services, Inc.

No Financial Conflict of Interest to Disclose

Medicare Payment Systems Affecting Reimbursement for Hyperbaric Oxygen Therapy

- Physician Fee Schedule
- Inpatient Prospective Payment System
- Outpatient Prospective Payment System
- Off-Campus Provider Based Alternative Payment Model
- Home Health Prospective Payment System
- SNF/Nursing Home Payment System
- Clinical Lab Fee Schedule

Physician Payment for Hyperbaric Oxygen Therapy

- CPT CODE 99183
- Paid as a single 'per treatment' amount
- Same for Medicare & Commercial payors

Inpatient Prospective Payment System (CMS Hospital Payment)

- Based upon DRG's (Diagnosis Related Groups)
- Payment incrementally increased by additional diagnoses
- Reimbursement all inclusive
- CPT codes do not determine reimbursement
- No separate payment for HBO

Inpatient Hospital Payment (Commercial Payors)

- Facility CPT code may be 99183 or G0277 (verify)
- May pay separately for HBO
- Obtain pre-authorization prior to starting
  ~ *emergency conditions*

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

- A fixed payment amount based on the primary diagnosis and correlating home health resource group
- Quarterly, consolidated billing list by CMS
- Can have outpatient HBO while having Home Health services

SNF/NURSING HOME PAYMENT SYSTEM

- Paid under a DRG System
- A few 'Carve Out' services
- Services not included in the list of 'carve out(s)' have to be paid for by the SNF unit
- HBO is not on the list of 'Carve Out(s)'
- Suggest contractual arrangement between facilities for patients in Part A stay
- Physician Supervision may be billed directly to CMS

HOSPITAL CHARGES FOR HBO UNDER OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

- Hospital CPT code G0277
- Billed in 30 minute increments
- Must be 16 minutes into 30 minute segment to charge

SECTION 603 OF BIPARTISAN BUDGET ACT OF 2015

- Signed into law November 2, 2015
- Changed rules for off-campus provider based department reimbursement
- Reimbursement based upon:
  - Location to the main hospital
  - Date services were first provided
- Modifiers PO and PN created to identify proper reimbursement rate for **off-campus** providers

PROVIDER BASED DEFINITIONS

- **Campus**
  - Bordering the main building
  - Located within 250 yards of the main building
- **Remote Location of a Hospital**
  - Facility or organization created or acquired by hospital that is main provider
  - Provides inpatient hospital services under the name, ownership, and financial and administrative control of main provider
  - Does not include a satellite facility

"PO" MODIFIER

- Used by **off-campus** provider based departments (> than 250 yards from main hospital)
- Services provided prior to November 2, 2015
- Modifier "PO" appended to every service provided and reported on hospital claim to represent "excepted" services
- Facility continues to be paid under OPPS
- **If department relocates, even within the same building, excepted status can be lost**
- **Facility payment decreased to 40% of OPPS rate for clinic visit charge (CPT code G0463) in 2020.**

"PN" MODIFIER

- Used by **off-campus** provider based departments (> than 250 yards from main hospital, or remote location of hospital)
- Services were **<u>NOT</u>** being provided prior to November 2, 2015
- Modifier "PN" appended to every service provided and reported on hospital claim to represent "non-excepted" services
- Facility paid under MPFS at 40% of OPPS amount for **<u>all</u>** services provided

CRITICAL AREAS FOR CORRECT REIMBURSEMENT (HOSPITAL AND PHYSICIAN)

- Coverage Determinations
- CPT Codes
- Modifiers
- ICD-10 Codes
- Documentation

TYPES OF CMS COVERAGE DETERMINATIONS

- National Coverage Determinations
- Local Coverage Determinations

  Medicare Administrative Contractor (MAC)

CMS NATIONAL COVERAGE DETERMINATIONS

- Supersede local coverage policies
- List service description, indications and non-covered conditions
- Began including diagnosis codes with implementation of ICD-10
- Provide limited medical necessity criteria
- Local MAC has the authority to add additional requirements

CMS LOCAL COVERAGE DETERMINATIONS

- Communicates what services/procedures are covered & criteria to determine medical necessity for each
- Coverage requirements/criteria can vary among MACs
- **Crucial to know your MAC**
- Found on each MACs web site, or the CMS web site (**www.cms.gov**)

CMS.gov

Medicare Medicaid/CHIP Marketplace & Private Insurance Priorities Training & Education

What are you looking for today?

Search

Inflation Reduction Act

Medicaid renewals

Innovation Center

No Surprise Billing

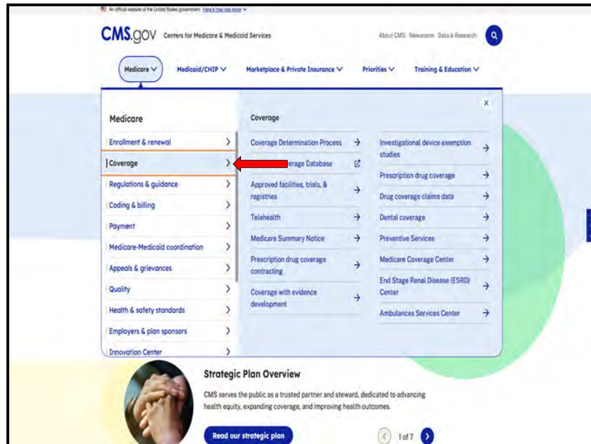
Nursing home resources

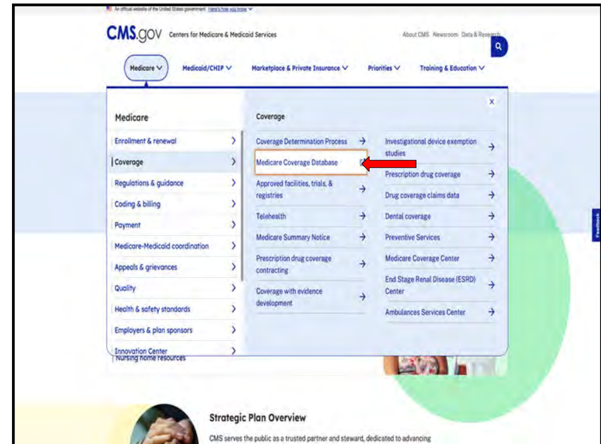
Inflation Reduction Act

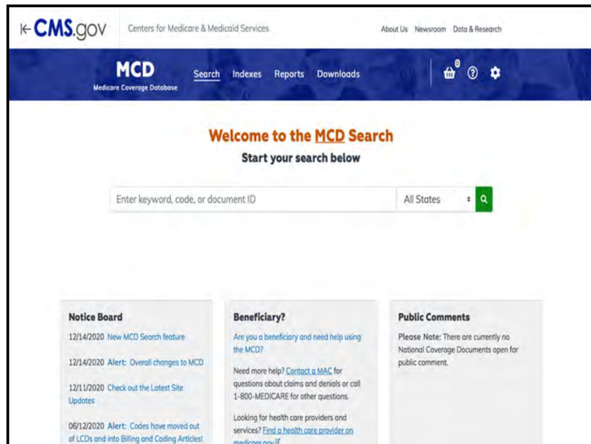
Learn what's changing

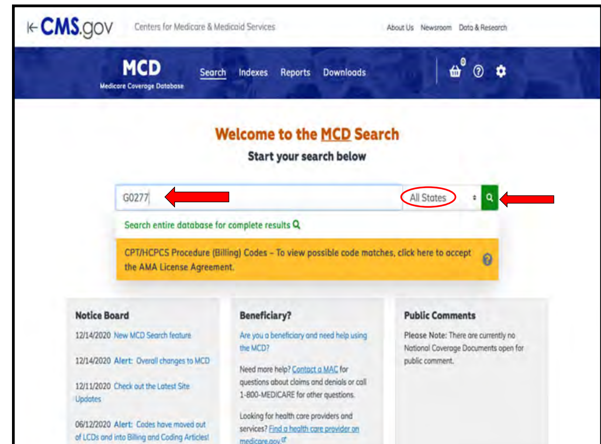
Strategic Plan Overview

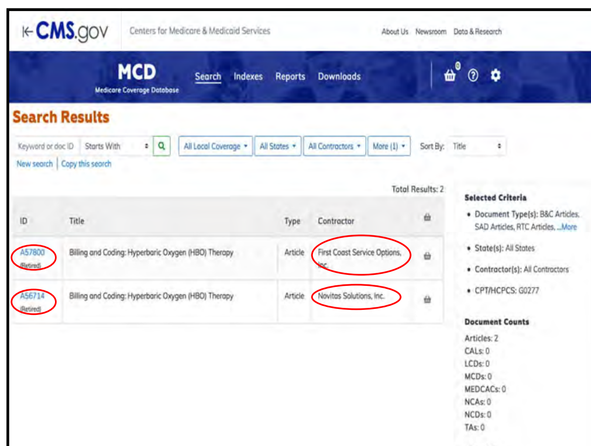
Read our strategic plan

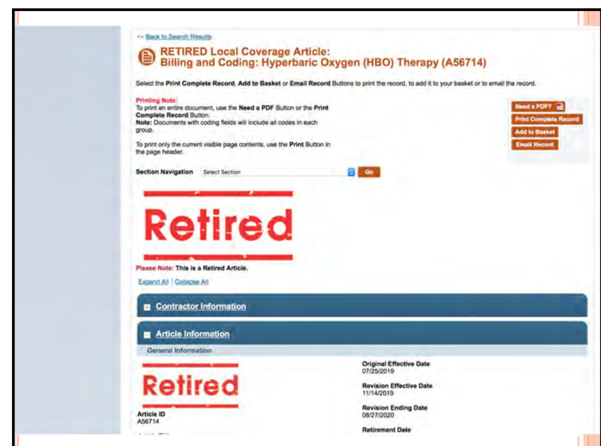

CMS.gov Centers for Medicare & Medicaid Services
Medicare
Medicaid/CHIP
Marketplace & Private Insurance
Priorities
Training & Education
Medicare
Enrollment & renewal
Coverage
Regulations & guidance
Coding & billing
Payment
Medicare-Medicaid coordination
Appeals & grievances
Quality
Health & safety standards
Employers & plan sponsors
Innovation Center
Coverage
Coverage Determination Process
Approved facilities, trials, & registries
Telehealth
Medicare Summary Notice
Prescription drug coverage contracting
Coverage with evidence development
Investigational device exemption studies
Prescription drug coverage
Drug coverage claims data
Dental coverage
Preventive Services
Medicare Coverage Center
End Stage Renal Disease (ESRD) Center
Ambulances Services Center
Strategic Plan Overview
CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.
Read our strategic plan
1 of 7


CMS.gov Centers for Medicare & Medicaid Services
Medicare
Medicaid/CHIP
Marketplace & Private Insurance
Priorities
Training & Education
Medicare
Enrollment & renewal
Coverage
Regulations & guidance
Coding & billing
Payment
Medicare-Medicaid coordination
Appeals & grievances
Quality
Health & safety standards
Employers & plan sponsors
Innovation Center
Coverage
Coverage Determination Process
Medicare Coverage Database
Approved facilities, trials, & registries
Telehealth
Medicare Summary Notice
Prescription drug coverage contracting
Coverage with evidence development
Investigational device exemption studies
Prescription drug coverage
Drug coverage claims data
Dental coverage
Preventive Services
Medicare Coverage Center
End Stage Renal Disease (ESRD) Center
Ambulances Services Center
Strategic Plan Overview
CMS serves the public as a trusted partner and steward, dedicated to advancing


CMS.gov Centers for Medicare & Medicaid Services
About Us Newsroom Data & Research
MCD
Medicare Coverage Database
Search Indexes Reports Downloads
Welcome to the MCD Search
Start your search below
Enter keyword, code, or document ID
All States
Notice Board
12/14/2020 New MCD Search feature
12/14/2020 Alert: Overall changes to MCD
12/11/2020 Check out the Latest Site Updates
06/12/2020 Alert: Codes have moved out of LCDs and into Billing and Coding Articles!
Beneficiary?
Are you a beneficiary and need help using the MCD?
Need more help? Contact a MAC for questions about claims and denials or call 1-800-MEDICARE for other questions.
Looking for health care providers and services? Find a health care provider on medicare.gov
Public Comments
Please Note: There are currently no National Coverage Documents open for public comment.


CMS.gov Centers for Medicare & Medicaid Services
About Us Newsroom Data & Research
MCD
Medicare Coverage Database
Search Indexes Reports Downloads
Welcome to the MCD Search
Start your search below
G0277
All States
Search entire database for complete results
CPT/HCPCS Procedure (Billing) Codes – To view possible code matches, click here to accept the AMA License Agreement.
Notice Board
Beneficiary?
Public Comments


CMS.gov Centers for Medicare & Medicaid Services
About Us Newsroom Data & Research
MCD
Medicare Coverage Database
Search Indexes Reports Downloads
Search Results
Keyword or doc ID
Starts With
All Local Coverage
All States
All Contractors
Sort By: Title
New search | Copy this search
Total Results: 2
ID
Title
Type
Contractor
A57800 (Retired)
Billing and Coding: Hyperbaric Oxygen (HBO) Therapy
Article
First Coast Service Options, Inc.
A56714 (Retired)
Billing and Coding: Hyperbaric Oxygen (HBO) Therapy
Article
Novitas Solutions, Inc.
Selected Criteria
Document Type(s): B&C Articles, SAD Articles, RTC Articles, ...More
State(s): All States
Contractor(s): All Contractors
CPT/HCPCS: G0277
Document Counts
Articles: 2
CALs: 0
LCDs: 0
MCDs: 0
MEDCACs: 0
NCAs: 0
NCDs: 0
TAs: 0


Back to Search Results
RETIRED Local Coverage Article:
Billing and Coding: Hyperbaric Oxygen (HBO) Therapy (A56714)
Printing Note:
Need a PDF?
Print Complete Record
Add to Basket
Email Record
Section Navigation
Retired
Please Note: This is a Retired Article.
Expand All | Collapse All
Contractor Information
Article Information
General Information
Retired
Article ID
A56714
Original Effective Date
07/25/2019
Revision Effective Date
11/14/2019
Revision Ending Date
08/27/2020
Retirement Date

Associated Documents

Related Local Coverage Document(s)

LCD(s)
L35021 - Hyperbaric Oxygen (HBO) Therapy

Related National Coverage Document(s)

NCD(s)
20.29 - Hyperbaric Oxygen Therapy

Statutory Requirements URL(s)
N/A

Rules and Regulations URL(s)
N/A

CMS Manual Explanations URL(s)
N/A

Other URL(s)
N/A

Public Version(s)
Updated on 08/27/2020 with effective dates 11/14/2019 - 08/27/2020
Updated on 11/08/2019 with effective dates 11/14/2019 - N/A
Updated on 07/19/2019 with effective dates 07/25/2019 - N/A

Keywords

N/A

Read the Article Disclaimer

Submit Feedback/Ask a Question

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

For purposes of coverage under Medicare, HYPERBARIC OXYGEN THERAPY (HBOT) is a modality in which the ***entire body is exposed to oxygen under increased atmospheric pressure***. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O_2) at greater than one atmosphere pressure. Either a mono-place chamber pressurized with pure O_2 or a larger multi-place chamber pressurized with compressed air where the patient receives pure O_2 by mask, head tent, or endotracheal tube may be used.

HYPERBARIC OXYGEN therapy serves four primary functions:

1. It increases the concentration of dissolved OXYGEN in the blood, which augments oxygenation to all parts of the body; and
2. It replaces inert gas in the bloodstream with OXYGEN, which is then metabolized by the body; and
3. It may stimulate the formation of a collagen matrix and angiogenesis; and
4. It acts as a bactericide for certain susceptible bacteria.

Developed as treatment for decompression illness, this modality is an established therapy for treating medical disorders such as carbon monoxide (CO) poisoning, gas gangrene, acute decompression illness and air embolism. Hyperbaric oxygen (HBO) therapy is also considered acceptable as adjunctive therapy in the treatment of sequella of acute vascular compromise and in the management of some disorders that are refractory to standard medical and surgical care or the result of radiation injury.

Covered Indications

Detailed information regarding the covered conditions for HBO therapy may be found in the National Coverage Determination (NCD) 20.29. Please refer to CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 1, Section 20.29 Hyperbaric Oxygen Therapy for full coverage information.

SPECIFIC CONDITIONS

The guidelines below are presented relative to specific treatment conditions and include criteria for diagnosis with expected frequency and duration of treatment.

1. Patients manifesting signs and symptoms of serious carbon monoxide poisoning (e.g., transient or prolonged unconsciousness, neurologic signs, cardiovascular dysfunction or severe acidosis) should be referred for HBO therapy regardless of carboxyhemoglobin (COHb) level, as COHb levels do not correlate with signs and symptoms. However, referral of patients with COHb greater than or equal to 25% is reasonable or when neuropsychological testing is abnormal. Treatment should begin at the time of diagnosis. Optimal dosing (pressure, duration, frequency) is not known but optimal benefit from HBOT occurs in those treated with the least delay after exposure. The majority of facilities offer single session HBOT to CO-poisoned patients; however, in selected patients repeated treatments may yield better outcome. Several protocols have been developed; however, most offer 2.8-3.0 atmosphere absolute (ATA) initial compression, then 2 ATA for 120-140 minutes, occasionally followed by additional 2 sessions for 90 minutes in six to twelve hour intervals, without further HBOT. Even with appropriate HBOT some patients will develop cognitive or other neurologic sequela which does not appear to be altered by continued HBOT. Children may be treated safely but may still have long-term problems. Pregnant women may be treated safely. Evidence of fetal distress is indication of need for HBOT despite normal carboxyhemoglobin levels and the absences of symptoms in the mother.
2. Decompression Illness (Sickness) is the result of inert gas bubbles in tissues or blood causing organ dysfunctions. It can be caused by a reduction in ambient pressure during ascent from a dive, rapid altitude excursion or a hyperbaric/hypobaric chamber. The resulting clinical manifestations include joint pain (bends), cutaneous eruptions or rashes, neurological dysfunction, cardiorespiratory symptoms and pulmonary edema, shock and death. Diagnosis of decompression injury is made on the basis of signs and symptoms after a dive or altitude exposure, manifest as paresthesia, hypesthesia, joint pain, skin rash and malaise while more serious signs may be motor weakness, ataxia, dyspnea, hypotension and shock leading to death. All symptoms manifest within 24 hours unless there is an additional insult. Treatment of choice for decompression illness is HBO therapy with mixed gases. The result is immediate reduction in the volume of bubbles. Recommended treatment is administration of 100% oxygen (1 ATA) at ground level or at elevated pressure (HBO) when feasible. The majority of symptoms will resolve with supportive measures; however, it is generally agreed that complete resolution is most likely to occur with HBO therapy. The treatment prescription is highly variable and case specific, however the great majority of cases respond to a single treatment. …

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The medical record documentation must support the medical necessity of the services as stated in the NCD and this policy.
4. Documentation that a trained emergency response team is available and that the setting provides the required availability of ICU services that could be needed to ensure the patient's safety if a complication occurred.
5. The documentation present in the clinical record must provide an accurate description and diagnosis of the medical condition supporting that the use of HBO is reasonable and medically necessary. The medical documentation must include but is not limited to the following:
   - An initial assessment, which includes a history and physical that clearly substantiates the condition for which HBO is recommended. This should also include any prior medical, surgical or HBO treatments.
   - Documentation of the procedure (logs) including ascent time, descent time and pressurization level. There should be a treatment plan identifying timeline and treatment goals.
   - Physicians' progress notes that describe the physical findings, type(s) of treatment(s) provided, number of treatments provided, the effect of treatment(s) received and the assessment of the level of progress made toward achieving the completion of established therapy goals.
   - Physician-to-physician communications or records of consultations, additional assessments, recommendations or procedural reports.
   - Laboratory reports (cultures or Gram stains) that confirm the diagnosis of necrotizing fasciitis are required and must be present as support for payment of HBO.
   - X-ray findings and bone cultures confirming the diagnosis of osteomyelitis are required and must be present as support for payment of HBO.
   - Documentation to support the presence of gas gangrene as proven with laboratory reports (Gram stain or cultures) and X-ray.
   - Documentation of date and anatomical site of prior radiation treatments.
   - Documentation supporting date of skin graft and compromised state of graft site.
   - For diabetic wounds of the lower extremity, the Wagner classification of the wound and the failure of an adequate course (at least 30 days) of standard wound therapy must be documented at the initiation of therapy:
     - Documentation must include criteria and exam consistency to establish the diagnosis of a Wagner's grade III wound.
     - Documentation of standard wound care in patients with diabetic wounds must include: assessment of a patient's vascular status and documentation of correction of any vascular problem sufficient to impair wound healing in the affected limb; documentation of optimization of nutritional status; documentation of optimization of glucose control; documentation of debridement by any means to remove devitalized tissue; documentation of maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; documentation of efforts for appropriate off-loading; and documentation of necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there is no documentation of measurable signs of healing for at least 30 consecutive days post optimization for healing. The medical record must include, at a minimum, a wound evaluation at least every 30 days during administration of HBO therapy.

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Use of HBOT exceeding the outlined frequencies in the covered indications will be considered Not Reasonable and Necessary. Reconsideration for extension of treatment duration will be available upon appeal.

Medicare will cover a total of 60 Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy sessions per 12 month period.

Medicare expects that treatment of most covered indications will require 5 or fewer services of Hyperbaric oxygen under pressure, full body chamber sessions per day per beneficiary. Coverage of greater than 5 of these services per day per beneficiary may require medical record review.

The diagnosis should be established by the referring or treating physician prior to the initiation of HBO therapy.

Continued HBO therapy without documented evidence of effectiveness does not meet the Medicare definition of medically necessary treatment. Thorough re-evaluation should be made at least every 30 days for documentation of response to therapy. Documentation to support effectiveness of the therapy must be made available upon request to the Contractor.

HBO therapy should not be a replacement for other standard successful therapeutic measures. Depending on the response of the individual patient and the severity of the original problem, treatment may range from less than 1 week to 1-2 months' duration, the average being 2 to 4 weeks. The use of Hyperbaric …

<< Back to Search Results

National Coverage Determination (NCD) for HYPERBARIC OXYGEN THERAPY (20.29)

Select the **Print Complete Record**, **Add to Basket** or **Email Record** Buttons to print the record, to add it to your basket or to email the record.

Print Complete Record
Add to Basket
Email Record

Expand All | Collapse All

Tracking Information

Publication Number
100-3

Manual Section Number
20.29

Manual Section Title
HYPERBARIC OXYGEN THERAPY

Version Number
4

Effective Date of this Version
4/3/2017

Implementation Date
12/18/2017

Description Information

Benefit Category
Incident to a physician's professional Service
Outpatient Hospital Services Incident to a Physician's Service
Physicians' Services

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Revision History

07/01/1997 - Clarified coverage limited to conditions listed under §35-10.A. Effective date 08/11/1997. (TN 102)

04/01/1999 - Clarified covered conditions and physician supervision requirement. Effective date 05/01/1999. (TN 112)

10/19/2000 - Manualized program memorandum AB-00-15 (dated 4/1/2000) and clarified that "preparation and preservation of compromised skin graft" in section 35-10A.9 is not for primary management of wounds. Effective date NA. (TN 129) (CR 1138)

12/27/2002 - Expanded coverage for treatment of diabetic wounds of the lower extremities in patients that meet three criteria. Effective date 04/01/2003. (TN 164) (CR 2388)

03/2006 - Technical corrections to the NCD Manual. Effective date 06/19/2006. (TN48) (CR4278)

01/2013 - CMS translated the information for this policy from ICD-9-CM/PCS to ICD-10-CM/PCS according to HIPAA standard medical data code set requirements and updated any necessary and related coding infrastructure. These updates do not expand, restrict, or alter existing coverage policy. Implementation date: 04/01/2013 Effective date: 10/1/2015. (TN 1165) (CR 8109)

05/2014 - CMS translated the information for this policy from ICD-9-CM/PCS to ICD-10-CM/PCS according to HIPAA standard medical data code set requirements and updated any necessary and related coding infrastructure. These updates do not expand, restrict, or alter existing coverage policy. Implementation date: 10/06/2014 Effective date: 10/1/2015. (TN 1388) (TN 1388) (CR 8691)

08/2015 - This change request (CR) is the 3rd maintenance update of ICD-10 conversions/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CR7818, CR8109, CR8197, CR8691, & CR9087. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding. These updates do not expand, restrict, or alter existing coverage policy. Implementation date: 01/04/2016 Effective date: 10/1/2015. (TN 1537) (CR 9252)

12/2015 - This change request (CR) is the 3rd maintenance update of ICD-10 conversions/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CR7818, CR8109, CR8197, CR8691, & CR9087. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding. Implementation date: 01/04/2016 Effective date: 10/1/2015. (TN 1580) (CR9252)

04/2016 - Transmittal 1630, dated February 26, 2016, is being rescinded and replaced by Transmittal 1658 to (1) remove duplicate spreadsheet NCD210.3, (2) add missing spreadsheet NCD20.33, (3) add B/MAC to requirement 3 at request of WPS/B, (4) rename the spreadsheet titles, and, (5) provide a link to the attached spreadsheets for more efficient ease of reference and accessibility. All other information remains the same. (TN 1658) (CR9540)

05/2016 - This change request (CR) is the 7th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, and CR9540. Some are the result of revisions required to other NCD-related CRs released separately. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. (TN 1665) (CR9631)

06/2016 - Transmittal 1665, dated May 13, 2016, is being rescinded and replaced by Transmittal 1672 to: (1) 9631.1: Remove FISS responsibility and 1st sentence; (2) 9631.2: Remove additional procedure codes, including 0075T, 0076T; (3) 9631.4: Revise descriptor of dx L59.8; (4) 9631.6: Add deletion of dx C49.10, C65.9, remove deletion of dx C54.9, remove deletion of invalid dx C47.90; (5) 9631.8: Remove deletion of invalid dx C51.29, replace with deletion of dx C50.029; (6) 9631.9: Add deletion of 0V504ZZ, 0V500ZZ, override capability, and contractor discretion verbiage. All other information remains the same. (TN 1672) (CR9631)

05/2017 - This change request (CR) constitutes a maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.
Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. (TN 1854) (CR10086)

11/2017 - This Change Request (CR) constitutes a maintenance update of International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. (TN 1975) (CR10318)

01/2018 - This Change Request (CR) constitutes a maintenance update of International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. (TN 2005) (CR10318)

Medicare Coverage - General Information

Compendia 1861 (t)(2) - Anti-cancer
Erythropoietin Stimulating Agents Policies
ICD-10
Lab NCDs - ICD-9
Lab NCDs - ICD-10

ICD-10

The International Classification of Disease (ICD)-10 code sets provide flexibility to accommodate future health care needs, facilitating timely electronic processing of claims by reducing requests for additional information to providers. ICD-10 also includes significant improvements over ICD-9 in coding primary care encounters, external causes of injury, mental disorders, and preventive health. The ICD-10 code sets' breadth and granularity reflect advances in medicine and medical technology, as well as capture added detail on socioeconomics, ambulatory care conditions, problems related to lifestyle, and the results of screening tests.

As a result, medical terminology and disease classifications are being updated to be consistent with current clinical practice per regulations at 45 CFR Part 162. All Centers for Medicare & Medicaid Services (CMS) ICD-10 system changes have been phased-in and are scheduled for completion by October 1, 2014, giving a full year for additional testing, fine-tuning, and preparation prior to full implementation of ICD-10 CM/PCS for all Health Insurance Portability and Accountability Act (HIPAA)-covered entities. ICD-10-CM/PCS will replace ICD-9-CM/PCS diagnosis and procedure codes in all health care settings for dates of service, or dates of discharge for inpatients, that occur on or after the implementation date of ICD-10.

The Coverage and Analysis Group at CMS is the Federal entity that oversees National Coverage Determination (NCD) and Local Coverage Determination (LCD) policies. NCDs and LCDs constitute Medicare coverage decisions made by CMS and applied both nationally and locally across all health insurance payers. In light of HIPAA as it relates to ICD-10, CMS is responsible for converting the ICD-9 codes to ICD-10 codes in NCDs and LCDs as the Agency finds appropriate. There are approximately 330 NCDs spanning a range of time and not all NCDs are appropriate for translation. CMS has determined which NCDs/LCDs should be translated and is in the process of completing the associated systems changes. CMS change request (CR) transmittals and Medicare Learning Network Articles (MLN Matters®) are the vehicles used to communicate information regarding NCD/LCD translations.

The table below contains the various CRs and associated documents that CMS/CAG has issued to date as part of its ICD-10 conversion activities related to NCDs. It will be updated periodically. For more in depth information related to the contents of the table, please contact: Pat Brocato-Simons, patricia.brocatosimons@cms.hhs.gov, 410-786-0261.

The information below is for translations of NCDs. If you have questions about translations of LCDs, please contact your Medicare Administrative Contractor. The contact information can be found here.

Links related to ICD-10 NCDs (as of 10-14-2020)

Transmittal	Issue Date	Subject	CR#	NCD#
R10454NCD R10454CP	2020-11-13	National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy	11783	110.24
R10586OTN	2021-	International Classification of Diseases, 10th …	12027	20.5, 20.33, 110.10, …
R2243OTN	2019-02-01	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)	11134	20.29, 110.18, 110.21, 110.23, 150.3, 160.18, 160.24

Home | About CMS | Newsroom | Archive | Help | Print

CMS.gov
Centers for Medicare & Medicaid Services

Search CMS | Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Back to 2019 Transmittals

R2243OTN

Transmittal #	R2243OTN
Issue Date	2019-02-01
Subject	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)
CR #	11134
Publication #	100-20
MM Article #	MM11134
MM Article Release Date	2019-02-06

Downloads

MM11134 (PDF)
R2243OTN.zip (ZIP)
R2243OTN (PDF)

R2243OTN

Favorites: iCloud Drive, Applications, Downloads, Recents, Desktop, Documents, AirDrop
Devices: Valerie's M..., Remote Disc
Shared: hpd89d67...
Tags

Primary Train...er 2019.pdf
Primary Train...er 2020.pdf
Primary Train...er 2019.pdf
Prisma Healt...1.2019.docx
Prisma Healt...14-2020.pdf
Prisma Woun...020MM.xlsx
Prisma Woun....3.2021.xlsx
Prisma Woun...ts 2021.xlsx
Prisma Woun...indings.docx
PRismalegal.xlsx
Progress_Notes.doc
Prohibited_P...nt_Items.docx
PTC 11.202....08.2020.pdf
Puraply Costs.pdf
QAPI 2021 E-FILE.pdf
QAPI-WHC 2020
QSO-20-13-Hospitals.pdf
Quarterly Ag...l-Sept-2.docx
Quarterly Ag...ul-Sept.docx
Quarterly Sta...nda WC.docx
R2243OTN

R2243_OTN1.xlsx
R2243_OTN2.xlsx
R2243_OTN3.xlsx
R2243_OTN4.xlsx
R2243_OTN5.xls
R2243_OTN6.xls
R2243_OTN7.xls

R2243_OTN2.xlsx
52 KB
Created 1/31/19, 8:30 AM
Modified 1/31/19, 8:30 AM
Last opened --
Add Tags...

ICD Diagnosis | ICD Procedures | Rule Description

ICD Diagnosis | ICD Procedures | Rule Description

SETTING REQUIREMENTS FOR PROVISION OF HBO

- Inpatient or Outpatient Hospital
- 2015 started covering in free standing & physician office settings
- Immediate availability of ACLS team when the chamber is in operation
- ICU level of care services available in a hospital setting

HYPERBARIC PHYSICIAN TRAINING REQUIREMENTS

- Complete introductory hyperbaric training course
- ACLS ***recommended*** in provider based settings where "code blue" team is available
- ACLS ***required*** in freestanding or off site settings

PHYSICIAN CREDENTIALING

- Must be **credentialed** in hyperbaric medicine by the hospital where the hyperbaric services are provided

RENEWAL OF PHYSICIAN PRIVILEGES FOR HBO

- UHMS recommends 24 hours every two years
- ACHM recommends 15 hours every two years
- Licensing & accrediting bodies refer to local medical staff by-laws & credentialing criteria
  - UHMS accreditation requires a minimum of 24 hours every two years

PHYSICIAN SUPERVISION DURING HBO

- Federal Register / Vol. 84, No. 218 / Tuesday, November 12, 2019
- Changed the level of supervision for all outpatient therapeutic services provided in hospitals
- Minimum required level of supervision reduced from direct to general supervision
- Hospitals are allowed to require stricter levels if they choose

PHYSICIAN SUPERVISION DURING HBO

- Important to note this final rule only applies to Part A Regulations
- CMS found direct supervision difficult to monitor
- Easier to use electronic billing edits (data mining) to monitor supervision

PHYSICIAN SUPERVISION DURING HBO

- If G0277 is billed, system edits require a correlating 99183 for supervision to also be billed
- Since 99183 is like an E&M code, it can't be billed unless an actual service is provided
  - "Physician attendance and supervision of HBO"
- CMS felt this requirement would keep patients safe by ensuring supervision still occurred & be easier to monitor
- Most MACs don't feel the final rule changed any previous requirements

PHYSICIAN SUPERVISION DURING HBO

- Supervising practitioner must be immediately available physically
- Immediately available, according to CMS, is defined as "without lapse of time"
- Must not be providing or performing another service that cannot be safely interrupted.

SUPERVISION BY NON-PHYSICIAN PRACTITIONERS

- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists

NON-PHYSICIAN PRACTITIONERS MAY DIRECTLY SUPERVISE SERVICES WHICH:

- May perform themselves under their State License & Scope of Practice
- If state requires collaborative practice agreement, it must be with a credentialed & trained HBO physician
- They have been granted privileges by hospital to supervise specific services where supervision taking place
- Must complete same training requirements as required of the physicians

NON-PHYSICIAN PRACTITIONERS MAY DIRECTLY SUPERVISE SERVICES WHICH:

- Effective January 1, 2020 CMS revised their regulations for physician supervision requirements for PAs
- PAs function according to state laws and state scope of practice rules in the state where services are furnished
- Absent state laws, practice agreements and medical staff by-laws would determine level of physician supervision

HBO SUPERVISION BY LIMITED LICENSE PHYSICIANS

- Verify limitations with specific contractors
- May allow supervision if an unlimited license physician is immediately available

CMS APPROVED HYPERBARIC INDICATIONS

- Acute carbon Monoxide Intoxication
- Decompression Illness
- Gas Embolism
- Gas Gangrene
- Acute Traumatic Peripheral Ischemia
- Crush Injuries & Suturing of Severed Limbs
- Cyanide Poisoning
- Actinomycosis
- Necrotizing Fasciitis
- Acute Peripheral Arterial Insufficiency
- Preparation & Preservation of Compromised Skin Grafts or Flaps
- Chronic Refractory Osteomyelitis
- Osteoradionecrosis
- Soft Tissue Radionecrosis
- Diabetic Wounds of the Lower Extremities

UHMS INDICATIONS FOR HBO

- Carbon Monoxide Poisoning
- Cyanide Poisoning
- Gas Gangrene
- Necrotizing Infections
- Crush Injuries, Compartment Syndrome, Other Acute Traumatic Peripheral Ischemias
- Decompression Sickness
- Air or Gas Embolism
- Delayed Radiation Injury
- Refractory Osteomyelitis
- Compromised Skin Grafts and Flaps
- ***Enhancement of healing in selected problem wounds***
- ***Thermal Burns***
- ***Exceptional Blood Loss Anemia***
- ***Intracranial Abscess***
- ***Idiopathic Sudden Sensorineural Hearing Loss***
- ***Acute Retinal Artery Occlusion***

MOST COMMON HBOT INDICATIONS

- Diabetic wounds of the lower extremity
- Chronic refractory osteomyelitis
- Soft tissue radionecrosis
- Osteoradionecrosis
- *Preparation and preservation of compromised skin grafts or flaps*
- *Acute peripheral arterial insufficiency*

REQUIREMENTS FOR ALL HBO INDICATIONS

- Initial evaluation, to include H&P
- Clear description of condition for which HBOT is recommended
- Documentation of any prior medical, surgical and/or HBO treatments that have been provided
- Wound evaluation by physician at least every 30 days
- Clinical Photographs, when possible, to support diagnosis

DIABETIC WOUNDS OF THE LOWER EXTREMITY

- Patient has documented Type I or Type II diabetes <u>and</u> a LE wound that is documented as being <u>due to diabetes</u>
- Wound is documented as a Wagner Grade 3 or higher
- Documentation must demonstrate:
  - Abscess
  - Joint sepsis
  - Bone involvement/osteomyelitis
  - Tendonitis
  - localized or extensive gangrene of the foot

WAGNER GRADING SCALE

- **Grade 1**- Superficial ulcer without penetration to deeper layers.
- **Grade 2**- Deeper ulcer extending through dermis. Tendon, ligaments, joint capsule or bone may be exposed.
- **Grade 3**- Deeper ulcer with abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths
- **Grade 4**- Localized gangrene of toes or forefoot, which may be wet or dry
- **Grade 5**- gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated

DIABETIC WOUNDS OF THE LOWER EXTREMITY CONTINUED

- Patient has failed 30 days of standard wound therapy & previous treatment is documented, including dates of treatment
- During every 30 day treatment period, while using HBO, there must be documented, measurable signs of healing

DIABETIC WOUNDS OF THE LOWER EXTREMITY CONTINUED

- Evaluate & optimize patient's:
  1. Vascular status
  2. Nutritional status
  3. Glucose control

DIABETIC WOUNDS OF THE LOWER EXTREMITY CONTINUED

- Additional Therapies to Document:
  1. Debridement of devitalized tissue
  1. Moist dressings to maintain healthy granulation tissue
  3. Efforts towards appropriate offloading
  3. Treatment to resolve any infection

CHRONIC REFRACTORY OSTEOMYELITIS

- Confirmed by plain X-ray, MRI, bone scan and/or bone culture
- Exposed bone is not sufficient
- Defined as an infection in the bone that persists or recurs, following appropriate, first line interventions
- Most contractors consider 6 weeks of failed care to be chronic (common orthopedic definition)

CROM FIRST LINE INTERVENTIONS

- Use of appropriate antibiotics
- Aspiration of the abscess
- Surgical debridement (or documentation why bone debridement is not appropriate)
- Immobilization of affected extremity and/or removal of any involved ORIF hardware

SOFT TISSUE RADIONECROSIS & OSTEORADIONECROSIS

- Documentation of date and anatomical site of prior radiation treatments
- Obtain records from radiation oncologist when possible
- Documentation of radiation dose & number of treatments
- Documentation of tissue necrosis and/or breakdown
- XRT must have ended at least 6 months prior to HBO *(common time frame for post radiation complications to be considered chronic & meet HBO medical necessity criteria)*

SOFT TISSUE RADIONECROSIS

- Must document primary diagnosis as **soft tissue radionecrosis** of (anatomical site)
  - L59.8 – Other specified disorders of the skin & SubQ related to radiation
  - *Verify code with payors other than Medicare (May use T66.XXXA, M79.9 or Z92.3)*
- Some payors want the presenting condition coded as well *(anatomical site of radiation injury, such as, radiation proctitis, open breast wound, etc.)*

OSTEORADIONECROSIS

- ORN coded as primary diagnosis:
  - M27.2 – Inflammatory conditions of the jaw
  - M27.8 – Other specified diseases of the jaw

OSTEORADIONECROSIS

- Verify codes with payors other than Medicare
- Prophylaxis for ORN prior to tooth extraction not covered by Medicare
- Some payors may want *Z92.3 - history of radiation* code included

PREPARATION AND PRESERVATION OF COMPROMISED SKIN GRAFT OR FLAP

- Documentation of date and type of surgical procedure
- Documentation of compromised state of skin graft or flap
  - *(dusky appearance, dehiscence of suture line, failure of adherence of STSG, loss of skin, necrosis, eschar)*

PREPARATION AND PRESERVATION OF COMPROMISED SKIN GRAFT OR FLAP

- Documentation of "non-healing amputation stump wound" does **not** meet medical necessity requirements
- Documentation of "compromised flap" at amputation site **does** meet medical necessity requirements **IF** a true flap was created during surgery (*AKA or BKA flap*)
- **Approximation of surgical incision skin edges does not meet medical necessity**

PREPARATION AND PRESERVATION OF COMPROMISED SKIN GRAFT OR FLAP

- May not be used for primary management of skin grafts or flaps that are not compromised/failing
- Intended for acute management (*within 24 hours of signs of compromise*)
- Only use HBO to prepare site for graft/flap if previous graft/flap failure in same anatomical location
- Excludes artificial skin grafts (Apligraf, Dermagraft, etc.)

ACUTE PERIPHERAL ARTERIAL INSUFFICIENCY

- CMS is very clear that this is for the management of **ACUTE** conditions
- Not for the management of chronically ischemic wounds (> 2 weeks)
- CMS defines as "sudden occlusion of a major artery in an extremity"
- Secondary to arterial embolism or thrombus
- HBO is ***adjunctive*** to surgical intervention (embolectomy, thrombectomy, etc.)
- Must have documented above measures to restore blood flow

PRIOR AUTHORIZATION PROGRAM

- Fee-for-service Compliance program
- Intended to detect unnecessary utilization & prevent improper payments to providers
- Was only implemented in Illinois, Michigan and New Jersey
- States chosen due to higher utilization rate & higher improper payment rate than other states

PRIOR AUTHORIZATION PROGRAM

- Applied to only 5 indications identified by CMS as non-emergent:
  - Chronic refractory osteomyelitis
  - Diabetic ulcers of the lower extremity
  - Osteoradionecrosis
  - Soft tissue radionecrosis
  - Actinomycosis
- Ended in February, 2018

TARGETED PROBE AND EDUCATE PROGRAM (TPE)

- Intended to increase accuracy of claims in very specific areas
- Providers who have unusual billing practices or high error rates
- Items/Services that have high error rates and are a financial risk to Medicare

TARGETED PROBE AND EDUCATE PROGRAM

- Provider notified by letter that they have been chosen for the TPE Program
- MAC requests 20-40 claims and correlating medical records for review
- If found to be compliant, no further reviews for at least a year
- Errors result in one on one education sessions

TARGETED PROBE AND EDUCATE PROGRAM

- 45 days given to implement changes/corrective action
- MAC requests 20-40 more claims and correlating medical records for review
- If found to be compliant, no further reviews for at least a year
- Errors result in additional one on one education sessions
- Continued errors after 3 educational sessions will result in referral to a higher authority within Medicare, possibly exclusion from Government funded programs

Prepayment Service Specific Probe Review Notice for Outpatient Hyperbaric Oxygen Therapy (HBO), HCPCS Code G0277 (Hyperbaric Oxygen Under Pressure, Full Body Chamber, Per 30 Minute Interval) in North Carolina, South Carolina, Virginia and West Virginia

Palmetto GBA A/B MAC will be performing pre-payment service-specific probe medical review on outpatient claims for Outpatient Hyperbaric Oxygen Therapy (HBO), HCPCS code G0277 (Hyperbaric Oxygen Under Pressure, Full Body Chamber, Per 30 Minute Interval) in North Carolina, South Carolina, Virginia and West Virginia.

This probe is based on internal data analysis and prioritization, which identified HCPCS code G0277 as a major risk. Probe edits will be set in North Carolina, South Carolina, Virginia and West Virginia and will select a sample of 100 claims from each state.

Providers who receive an Additional Documentation Request (ADR) must submit the requested medical record information within 45 days of the date listed on the

TRANSCUTANEOUS OXIMETRY

("NON-INVASIVE VASCULAR TESTING" OR "NON-INVASIVE PHYSIOLOGIC STUDIES")

- 93923 (Complete): 3+ Levels
- 93922 (Limited): 1-2 Levels
- 93922-52 (Limited, unilateral): 1-2 Levels
- Meant to be bilateral, select next lower charge if not
- Provocative functional maneuvers a bonus. Select the next higher charge if there is one (e.g. oxygen challenge)

Transcutaneous Oximetry

("Non-invasive Vascular Testing" or "Non-invasive Physiologic Studies")

- "Levels" does not mean electrodes
  - Levels: toes, midfoot, ankle, calf, thigh
- Must also do an ABI to bill for TCOM
- Hospital use modifier TC (technical component only)
- Physician use modifier 26 (interpretation only)

"X" Modifiers

- 4 modifiers created as a subset of modifier 59
  - **XE – separate encounter on the same date (i.e., multiple HBO Txs/same DOS)**
  - XS – Separate structure/organ on the same date
  - XP – Different practitioner on the same date
  - XU – Unusual non-overlapping service (does not overlap usual components of the main service)

"X" Modifiers

- Effective date January 1, 2015
- Modifier 59 has not stopped being recognized
- Coding compliance requires the use of most specific modifier
- Routine use of modifier 59 may trigger pre-payment audit

ICD-10 Codes & OPPS

- OPPS payment relies on accurate assignment of diagnosis codes
- Claims have procedure to diagnosis editing
- If the codes do not match, the claim will be denied for payment due to 'Lack of Medical Necessity'
- The wrong diagnosis code on an inpatient claim may result in a reduced reimbursement
- The wrong diagnosis code on an OPPS claim may result in no payment at all

Tips to Ensure Documentation Gets Coded Properly

- Make sure the diagnosis does not change between physicians
- Make sure the diagnostic test(s) results don't conflict with the documented diagnosis
- OPPS reimbursement **is not** increased by having multiple diagnoses listed
- Documenting conditions unrelated to the treatment provided may result in an ICD-10 code that causes the claim to be denied

Documentation Tips

- Wound grade is for diabetic ulcers and stage is for pressure ulcers. The words matter, don't mix them up!!
- Ensure your documentation makes sense (electronic records often don't print out well)
- Make clear, concise diagnostic statements
- Make sure electronic record encounter notes have consistent diagnosis in all sections
- Be consistent with your diagnosis, unless a reason for change is clearly documented

Critical Documentation Requirements for ICD-10

- Laterality
- Anatomical location
- Chronic vs acute
- Severity (for ulcer codes)
  - Limited to skin break down
  - Fat layer exposed
  - Necrosis of muscle
  - Necrosis of bone

Critical Documentation Requirements for ICD-10

- Injuries & bites:
  - Accidental, intentional, or assault
  - Specific type of bite
    - (*rattlesnake, Brown Recluse Spider, Jelly Fish, etc.*)

ICD-10 7th Character Selection

- Used primarily with injuries, external causes & wounds
- Services have A, D, or S as 7th character
  - A = Initial encounter
  - D = Subsequent encounter
  - S = Sequela
- Based on patient's perspective, not customary use of terms

A = Initial Encounter

- **Used for all encounters as long as patient is receiving active care**
- Continue to use as long as the patient is getting active treatment & progressing
- Use with complications of other conditions as it relates to treatment (i.e., infection from previous surgery)

D = Subsequent Encounter

- Routine care during healing or recovery phase (i.e., medication adjustment, aftercare)
- Patient is no longer progressing, but provider wishes to continue providing care to aid healing

S = Sequela

- New term in ICD-10 for "late effects"
- Conditions that arise as a direct result of another condition (i.e., chronic pain after an injury)
- Not the same as an acute complication
- Must use injury code that precipitated sequela as well
- "A" is used at the end of the current sequela being treated
- "S" is used at the end of the initial injury that led to the sequela

HOW CAN YOU MANAGE CMS PAYMENT SYSTEMS?

- Have someone that keeps up with program updates
- Assign billing & coding staff specific to the department
- Have clinical, coding & billing staff audit claims against the medical records on a regular basis
- Involve clinical staff in plan to resolve any identified issues
- Contact MAC for guidance

REVIEW NCD'S & LCD'S REGULARLY

- Keep up with changes to existing policies
- Be aware of new policies
- There is a comment period (draft policy) for any new or changing coverage determination and this is your chance to express any concerns you may have

PROVIDE EDUCATION

- Educate physicians and staff about coverage determinations that impact their clinical area
- Provide tools to allow appropriate staff quick and simple access to medical necessity criteria

THANK YOU!

QUESTIONS?