

Coding, Billing, Compliance Issues

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CODING, BILLING, COMPLIANCE ISSUES FOR HYPERBARIC OXYGEN THERAPY

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**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 **NOT** 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 **all** services provided

CRITICAL AREAS FOR CORRECT REIMBURSEMENT (HOSPITAL AND PHYSICIAN)

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

TYPES OF CMS COVERAGE DETERMINATIONS

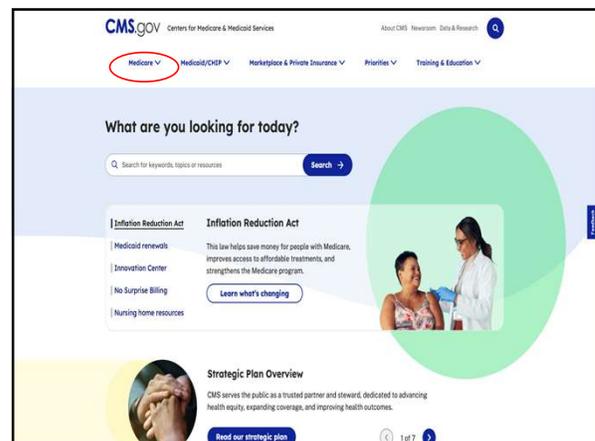
- National Coverage Determinations
- Local Coverage Determinations
Medicare Administrative Contractor (MAC)

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)



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- Coverage**
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- Coding & billing
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- Medicare-Medicaid coordination
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CPT/HCPCS Procedure (Billing) Codes - To view possible code matches, click here to accept the AMA License Agreement.

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Search Results

Keyword or doc ID: Starts With: All Local Coverage All States All Contractors More (1) Sort By: Title

Total Results: 2

ID	Title	Type	Contractor
A5780 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): BIC 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

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RETIRED Local Coverage Article: Billing and Coding: Hyperbaric Oxygen (HBO) Therapy (A56714)

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Section Navigation

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Please Note: This is a Retired Article.

Contractor Information

Article Information

General Information

Original Effective Date: 07/25/2019
 Revision Effective Date: 11/14/2019
 Revision Ending Date: 06/27/2025
 Article ID: A56714
 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)
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Updated on 11/06/2019 with effective dates 11/14/2019 - N/A
Updated on 07/19/2019 with effective dates 07/25/2019 - N/A

Keywords
N/A

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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 (HBO)** 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 (O₂) at greater than one atmosphere pressure. Either a mono-place chamber pressurized with pure O₂ or a larger multi-place chamber pressurized with compressed air where the patient receives pure O₂ by mask, head tent, or endotracheal tube may be used.

HYPERBARIC OXYGEN therapy serves four primary functions:

- It increases the concentration of dissolved OXYGEN in the blood, which augments oxygenation to all parts of the body; and
- It replaces inert gas in the bloodstream with OXYGEN, which is then metabolized by the body; and
- It may stimulate the formation of a collagen matrix and angiogenesis; and
- 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 sequelae 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, 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:

- 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 20% is reasonable, or when neurophysiological testing is abnormal. Treatment should begin at the time of diagnosis. Optimal dosing (pressure, duration, frequency) is not known but optimal benefit from HBO occurs in those treated with the least delay after exposure. The majority of facilities offer single session HBO to CO-poisoned patients; however, in selected patients repeated treatments may yield better outcome. Several protocols have been developed. However, most offer 2-3.0 atmospheres absolute (ATA) initial compression, then 2 ATA for 120-140 minutes, occasionally followed by additional 2 sessions for 90 minutes at six to twelve hour intervals, without further HBO. Even with appropriate HBO some patients will develop cognitive or other neurologic sequelae which does not appear to be altered by continued HBO. 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 HBO despite normal carboxyhemoglobin levels and the absence of symptoms in the mother.
- Decompression illness (Sickness) is the result of inert gas bubbles in tissues or blood causing organ dysfunction. It can be caused by a reduction in ambient pressure during ascent from a dive, rapid altitude ascension or a hyperbaric/hypobaric chamber. The resulting clinical manifestations include joint pain (bends), colic/nausea/vomiting or rashes, neurological dysfunction, cardiovascular 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 parosmia, hyperreflexia, joint pain, skin rashes, severe headache, severe weakness, dizziness, 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 resolution in the volume of bubbles. Recommended treatment is administration of 100% oxygen (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

Documentation Requirements

- All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
- Every page of the record must 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.
- The medical record documentation must support the medical necessity of the services as stated in the NCD and this policy.
- 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 occurs.
 - 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 (log) including ascent time, descent time and pressurization level. There should be a treatment plan identifying time and treatment goals.
 - Physician 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 to establish the diagnosis of a Wagner 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 permit 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 dressing; 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 Rule 95-1 (V), utilization of these services should be compliant with locally acceptable standards of practice.

Use of HBO exceeding the outlined frequencies in the covered indications will be considered Not Reasonable and Necessary. Reconsideration for extension of treatment duration will be considered 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 1 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. Through- or non-remission 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 month's duration, the average being 2 to 4 weeks. The use of hyperbaric

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

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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 12/8/2017

Description Information

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

Phone 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 935-1.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 "prevention and preservation of compromised skin graft" in section 30-15A is not a primary management of wounds. Effective date NA. (TN 175) (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 153) (CR 238)

03/20/06 - Technical corrections to the NCD Manual. Effective date 06/19/2006. (TN18) (CR478)

01/01/13 - CMS translated the information for this policy from ICD-9-CM-PCS to ICD-10-CM-PCS according to HIPAA standard medical data code sets 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: 01/01/2013) (CR 810)

06/20/14 - CMS translated the information for this policy from ICD-9-CM-PCS to ICD-10-CM-PCS according to HIPAA standard medical data code sets requirements and updated any necessary and related coding infrastructure. These updates do not expand, restrict, or alter existing coverage policy. Implementation date: 01/01/2014 (Effective date: 01/01/2014) (CR 810)

06/20/15 - This change request (CR) is the 3rd maintenance update of ICD-10 conversion/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs: 10, CR819, CR 187, CR869, CR 189, CR891, CR 190, CR892, CR 191, CR893, CR 192, CR894, CR 193, CR895, CR 194, CR896, CR 195, CR897, CR 196, CR898, CR 197, CR899, CR 198, CR900, CR 199, CR901, CR 200, CR902, CR 201, CR903, CR 202, CR904, CR 203, CR905, CR 204, CR906, CR 205, CR907, CR 206, CR908, CR 207, CR909, CR 208, CR910, CR 209, CR911, CR 210, CR912, CR 211, CR913, CR 212, CR914, CR 213, CR915, CR 214, CR916, CR 215, CR917, CR 216, CR918, CR 217, CR919, CR 218, CR920, CR 219, CR921, CR 220, CR922, CR 221, CR923, CR 222, CR924, CR 223, CR925, CR 224, CR926, CR 225, CR927, CR 226, CR928, CR 227, CR929, CR 228, CR930, CR 229, CR931, CR 230, CR932, CR 231, CR933, CR 232, CR934, CR 233, CR935, CR 234, CR936, CR 235, CR937, CR 236, CR938, CR 237, CR939, CR 238, CR940, CR 239, CR941, CR 240, CR942, CR 241, CR943, CR 242, CR944, CR 243, CR945, CR 244, CR946, CR 245, CR947, CR 246, CR948, CR 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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	○ Necrotizing Fasciitis
○ Decompression Illness	○ Acute Peripheral Arterial Insufficiency
○ Gas Embolism	○ Preparation & Preservation of Compromised Skin Grafts or Flaps
○ Gas Gangrene	○ Chronic Refractory Osteomyelitis
○ Acute Traumatic Peripheral Ischemia	○ Osteoradionecrosis
○ Crush Injuries & Suturing of Severed Limbs	○ Soft Tissue Radionecrosis
○ Cyanide Poisoning	○ Diabetic Wounds of the Lower Extremities
○ Actinomycosis	

UHMS INDICATIONS FOR HBO

○ Carbon Monoxide Poisoning	○ Refractory Osteomyelitis
○ Cyanide Poisoning	○ Compromised Skin Grafts and Flaps
○ Gas Gangrene	○ Enhancement of healing in selected problem wounds
○ Necrotizing Infections	○ Thermal Burns
○ Crush Injuries, Compartment Syndrome, Other Acute Traumatic Peripheral Ischemias	○ Exceptional Blood Loss Anemia
○ Decompression Sickness	○ Intracranial Abscess
○ Air or Gas Embolism	○ Idiopathic Sudden Sensorineural Hearing Loss
○ Delayed Radiation Injury	○ 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 and a LE wound that is documented as being due to diabetes
- 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
 2. Moist dressings to maintain healthy granulation tissue
 3. Efforts towards appropriate offloading
 4. 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 500 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 Tx/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 & OPPTS

- OPPTS 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 OPPTS 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
- OPPTS 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?