

Article for Biologic Products for Wound Treatment and Surgical Interventions - Supplemental Instructions Article (A48793)

Contractor Information

Contractor Name

NHIC, Corp.

Contractor Number

14401

Contractor Type

MAC - Part A

Article Information

Article ID Number

A48793

Article Type

Article

Key Article

Yes

Article Title

Biologic Products for Wound Treatment and Surgical Interventions - Supplemental Instructions Article

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Primary Geographic Jurisdiction

Rhode Island

Original Article Effective Date

05/15/2009

Article Revision Effective Date

06/01/2009

Article Text**Coding Guidelines:*****General Guidelines for claims submitted to Carriers and Intermediaries or Part A or Part B MAC:***

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and UPIN or NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Advance Beneficiary Notification of Noncoverage(ABN) Modifier Guidelines (for outpatient services):

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. **Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, revised 09/05/2008, for complete instructions.**

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The -GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary **or Part A MAC**, occurrence code 32 and the date of the ABN is required.

The -GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

The total size of the sheet(s) reported should reflect the total body surface involved, and NOT the area per wound or the number of sites/wounds.

Coding guidelines for CPT codes 15340, 15341, 15360, 15361, 15365 and 15366 (used for procedures involving the integumentary system, specifically skin replacement and skin substitutes):

- The reported codes must correlate with the correct anatomical site and the site modifier (RT or LT) must be reported if the anatomical site is an extremity.
- Except in Part A settings, these CPT codes must be for the same date of service and submitted on the same claim as the graft or they will be denied.
- Payable places of service will be identified in appropriate articles.

Coding guidelines for CPT codes 15170, 15171, 15175 and 15176 (used for procedures involving the integumentary system, specifically skin replacement and skin substitutes):

- The reported codes must correlate with the correct anatomical site and the site modifier (RT or LT) must be reported if the anatomical site is an extremity.
- Payable places of service will be identified in appropriate articles.
- When the product is used for procedures other than the integumentary system, use the code that most appropriately describes the procedure involved. For example, in the case of a ventral hernia repair, CPT code 49568 should be used.

For claims submitted to the carrier or Part B MAC:

- Claims for this service should be submitted on Form CMS 1500 or its electronic equivalent.
- Payable places of service will be defined in the product specific coverage article attached to the LCD.

For claims submitted to the fiscal intermediary or Part A MAC:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-08, *Medicare Program Integrity Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Applicable bill types will be provided in the product specific coverage article attached to the LCD.

Applicable revenue codes will be provided in the product specific coverage article attached to the LCD.

Bill Type Guidelines

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B) states that *no type of technical services, such as...a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers...Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.*

Per CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B), *only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); ...telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.*

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment...: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100[B].)

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

11x	Hospital-inpatient (including Part A)
12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPSS 13X must be used for ASC claims submitted for OPSS payment -- eff. 7/00)
73x	Clinic-independent provider based FQHC (eff 10/91)
83x	Special facility or ASC surgery-ambulatory surgical center (Discontinued for Hospitals Subject to Outpatient PPS; hospitals must use 13X for ASC claims submitted for OPSS payment -- eff. 7/00)
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)
99x	Reserved-reserved for national assignment

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary **or Part A MAC**. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier **or Part B MAC**.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

Revenue codes 096X, 097X and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called Option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing professional services at the CAH may elect to bill their carrier **or Part B MAC** or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill the FI **or Part A MAC** using revenue codes 096X, 097X or 098X.

036X	Operating room services-general classification
045X	Emergency room-general classification
049X	Ambulatory surgical care-general classification
051X	Clinic-general classification
0636	Drugs requiring specific identification-detailed coding (eff 3/92)
076X	Treatment or observation room-general classification

No Coding Information has been entered in this section of the article.

Other Information

Other Comments

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Part A MAC - 14101 Maine and 14201 Massachusetts Contractor Numbers were added.

Revision History Explanation

R2

06/01/2009

Contractor number 14401-RI (effective for services on or after 6/1/2009) was added to the article.

Contractor number 14301-NH and Contractor number 14501-VT (effective for services on or after 6/5/2009)

R1

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Part A MAC - 14101 Maine and 14201 Massachusetts Contractor Numbers were added.

All Versions

Updated on 05/22/2009 with effective dates 06/01/2009 - N/A