Question For: Medicare

Question: Does NGS allow for initial simulation with IMRT treatment planning? Is there specific CMS guidance and standards of medical practice to follow for IMRT?

Additional Details: Unable to locate LCD for IMRT services. Typical course of radiation requires 1-3 simulations to prepare the patient for treatment planning and ensure accurate treatment; following treatment planning to direct the treatment beams and during treatment to account for changes in port size, boost dose or tumor volume.

Code(s): 77280-77295

Setting(s):

Provider(s):

Submitted by: Tami Jones, Healthcare Consultant
SVA
608-826-2147
jonest@sva.com

Response: National Government Services does not have a specific LCD for Intensity Modulated Radiation Therapy codes 77385-77386. If there was an NCD, we would follow NCD guidelines first and if there are no NCDs also look to Radiation Oncology standards of practice and CPT guidance as well. The therapeutic radiology simulation-aided fields setting codes mentioned below 77280-77295, are considered mostly facility codes. However, if the physician is involved, could be reported with a 26modifier. Codes for IMRT (77385-77386) are not bundled with codes 77280-77295 according to the NCCI procedure to procedure edit tables. So they would not be precluded from being billed at the same time.
Question For: Medicare

Question: Please clarify coverage of code J9217 for diagnoses 174.0-174.9. Per Medical Policy Article A49923 Indications, this should be covered as an off-label indication. Additionally, these diagnoses are included in the covered list. However, in the Coding Information Table, which shows the HCPCS codes, associated conditions and their covered doses, this is not listed. Is there a dosage/frequency limitation for J9217 for the treatment of breast cancer? If so, can this be clarified in the policy?

Additional Details:

Code(s): J9217

Setting(s): Palliative treatment of advanced breast cancer in pre-menopausal or perimenopausal women

Provider(s): N/A

Submitted by: Monica Vadenheuvel, Billing & Reimbursement Analyst
Dean Health Systems, Inc.
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Response: The “Indications” section of the article specifies whether carcinoma of the breast is an FDA approved or an off-labeled indication. The provider should refer to the following information in the January 1, 2015 “Revision History Explanation” section: The following statement has been added to the “Limitations” section: Doses that exceed those listed in the “Indications” section above or found in the FDA approved label may be denied as not medically necessary unless there is documentation to justify the medical necessity in the individual case.

The “Coding Information” section and the table listing the drug, administration and coding have been removed.
**Question:** Do the global surgical package guidelines outlined in IOM 100-04, Chapter 12, Section 40 apply to Assistant Surgeon services?

**Response:**

IOM 100-4 Section 40 - Surgeons and Global Surgery reads as follows:

A national definition of a global surgical package has been established to ensure that payment is made consistently for the same services across all carrier jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. The national global surgery policy became effective for surgeries performed on and after January 1, 1992.

The instructions that follow describe the components of a global surgical package and payment rules for minor surgeries, endoscopies and global surgical packages that are split between two or more physicians. In addition, billing, mandatory edits, claims review, adjudication, and postpayment instructions are included.

In addition to the global policy, uniform payment policies and claims processing requirements have been established for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeries.

Since this section also includes a number of subsections. In general, the global surgery policy applies to anyone acting as a surgeon, co-surgeon, team surgeon, assistant surgeon, etc.
Question For: Medicare

Question: J7307 is listed on the Medicare Physician's Fee Schedule Relative Value file as a Status I, which means "Not valid for Medicare purposes. Medicare uses another code for [Type text] reporting of, and payment for, these services." What other code would Medicare like us to use to report the Etonogestrel contraceptive implant system?

Additional Details:

Code(s): J7307

Setting(s):

Provider(s):

Submitted by: Monica Vandenheuvel, Billing & Reimbursement Analyst
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Response: The narrative for HCPCS Code J7307 is: Etonogestrel (contraceptive) implant system, including implant and supplies. This code is indicated in the 2015 HCPCS book as noncovered by Medicare. The contraceptive supplies and implantable systems found on the 2015 HCPCS Jurisdiction list include codes A4261, A4264 and A4266-A4269. However, all of these codes are noncovered by Medicare. Medicare does not pay for contraceptive coverage.
Question For: Medicare

Question: Several ICD-9 based LCD's have been updated since April 2, 2014, when they were originally converted to ICD-10 LCD's. When will the corresponding ICD-10 LCD's be updated consistent with updates made to ICD-9 LCD's in the previous 15-17 months? For example. LCD L26003 had language added to the Indications section of the policy, effective 01/01/15, that reads "Applied to wounds that have demonstrated a failed or insufficient response to no fewer than four weeks of conservative wound care measures. For initial applications of skin substitutes/replacements, a failed response to conservative measures is defined as an ulcer that has increased in size or depth or for which there has been less than 30% closure from baseline." This same language is still absent from the corresponding ICD-10 policy, LCD L33391. Can we expect these updates to be made prior to the Oct 1, 2015 implementation date of these new policies?

Additional Details:

Code(s): General
Setting(s): ICD-10 LCD's
Provider(s): Monica Vandenheuvel, Billing & Reimbursement Analyst
Dean Health Systems, Inc
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Response: We are in the process of revising the ICD-10-CM code versions of the LCDs and articles to reflect the changes made to the ICD-9-CM code versions which will be completed prior to 10/01/2015. The change cited in the question above has been incorporated into LCD ID number L33391 but it has not been approved for public view yet.
Question For: Medicare

Question: Regarding Future ICD-10 policy LCD L33614 for Debridement Services, what is the reason that such services will not be covered when billed with 7th character "D" diagnosis codes, representing subsequent encounters?

Additional Details:

Code(s): Debridement Services

Setting(s): N/A

Provider(s):

Submitted by: Monica Vandenheuvel, Billing & Reimbursement Analyst
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Response: The 7th character ICD-10-CM codes “D” for subsequent encounter and “S” for sequela will be added to the Debridement Services LCD.
Question For: Medicare

Question: For NGS Medicare – for transitional care management services (TCM), the MLN states that other reasonable and necessary Medicare services may be reported during the 30-day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS Codes G0181 and G0182. Does this mean that additional face-to-face visits within the 30 day period that are addressing the same diagnoses/issues addressed in the inpatient stay can be separately reported with the appropriate E&M code?

Additional Details:

Code(s): 99495 99496

Setting(s):

Provider(s): any

Submitted by: Beth Schmitz, Coding Supervisor
Aurora Health Care
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Response: Additional E&M services on subsequent dates, after the initial face-to-face, which is part of the TCM, can be reported as long as they are reasonable and medically necessary according to Medicare guidelines.
Question: How would you code the following scenario? Patient in operating room, general anesthesia administered. 4cm deep cervical cyst which extended into the submandibular triangle was excised. Incision carried out down to the platysma muscle, mass dissected and was adherent to strap muscles which extended along the medial aspect of the left submandibular gland. Would you code this with an unlisted code, 21556 or 11424?

Additional Details: If unlisted CPT code, what do you require for coverage/payment?

Code(s): Unlisted musculoskeletal procedure 20999

Setting(s):

Provider(s):

Submitted by: Tami Jones, Healthcare Consultant
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Response: **Medicare Administrative Contractors are not allowed to code claims for providers. It is the providers responsibility to code their services since they are performing the service/procedure.**

*When using unlisted procedure codes, additional documentation (i.e., operative note) may be requested via an ADR if the information does not accompany the initial claim and is needed for processing.*
**Question For:** Third Party Payer | Medicaid | Medicare

**Question:** When patients are seen in our Urgent Care/Convenient Care clinic we are submitting the claim as POS 11 (Clinic). Payers have been asking us to change the POS to 20 (Urgent Care facility) to indicate that the patient was in an urgent care setting. Apparently some plan designs have different copay for urgent care settings. We don’t feel that POS 20 is correct because this POS code applies to a location distinct from a hospital emergency department, an office, or a clinic. Our Urgent Care/Convenient Care is clinic based. Box 32 shows convenient care. How do the payers want us to handle this situation?

**Additional Details:**

**Code(s):** POS 11 vs POS 20

**Setting(s):** Clinic

**Provider(s):** All Providers

**Submitted by:** , Coding/Reimbursement Specialist
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**Response:** Place of service 20 is designated as “Urgent Care Facility” with the following definition: Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Place of service 11 is designated as “Office” with the following definition: Location, other than a hospital, skilled nursing facility (SNF), military treatment center, community health center, State or local public health clinic, or immediate care facility (IRF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Whether the definition of your facility is an Urgent Care or Office, the correct place of service should be used and box 32 of the CMS 1500 form include the facility or office complete address and zip code.
Question For: Third Party Payer | Medicaid | Medicare

Question: We are thinking this is going to be a retail service because in the past carriers were not reimbursing for video visits.

Additional Details:

Code(s): Video Visits

Setting(s): Provider completes a video visit with a patient. Does coverage change if it is for Psych?

Provider(s): All - not sure if we are going to utilize in Urgent Care, Surgery, etc.

Submitted by: Dean Cravillion, Director of Business Office
Prevea Health
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Response: We would need to know the procedure code you would be billing for a “video visit”. You can check the Medicare Physician Fee Schedule Database look up on CMS website to see if the code is valid for Medicare purposes and if there is a fee established for that procedure.
Question For: Third Party Payer | Medicaid | Medicare

Question: In regards to HCPCS code G0455 - Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen, we have providers using commercial fecal specimens or another provider is performing the donor assessment. In the case where the provider is only performing the instillation of the fecal transplant and not performing the donor assessment and/or the preparation of the specimen, should G0455 be reported with the modifier 52 or would it be appropriate to report CPT 45378 - Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)?

Additional Details:

Code(s): G0455

Setting(s):

Provider(s): Gastro, general surgery, FP, IM

Submitted by: Beth Schmitz, Coding Supervisor
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Response: Medicare Administrative Contractors are not allowed to code claims for providers. It is the providers’ responsibility to code their services since they are performing the service/procedure.

The narrative for modifier 52 (Reduced Services) follows: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.