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Agenda

• Review National Coverage Determination (NCD) for Hyperbaric Oxygen Therapy

• Billing Units for Time-Based Code

• Resources
# Helpful Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
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<tr>
<td>HICN</td>
<td>Health Insurance Claim Number</td>
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<tr>
<td>HBOT</td>
<td>Hyperbaric Oxygen Therapy</td>
</tr>
<tr>
<td>IOM</td>
<td>Internet Only Manual</td>
</tr>
<tr>
<td>FISS</td>
<td>Fiscal Intermediary Shared System</td>
</tr>
<tr>
<td>NCD</td>
<td>National Coverage Determination</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>UOS</td>
<td>Unit of Service</td>
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</tbody>
</table>
Objective

• Provide an overview of NCD qualifications

• Highlight the appropriate billing of units and complying with physician orders

• Locate CMS and Noridian references
Hyperbaric Oxygen Therapy (HBO)
National Policy
National Coverage Determination (NCD) 20.29

• Medicare coverage program definition
• “Hyperbaric oxygen therapy (HBO) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure”
• Limited to services administered in a chamber
Covered Indications

- Acute carbon monoxide intoxication
- Decompression illness
- Gas embolism
- Gas gangrene
- Progressive necrotizing infections
- Acute peripheral arterial insufficiency
- Cyanide poisoning
Covered With Adjunctive Treatment

- Acute traumatic peripheral ischemia
- Crush injuries and suturing of severed limbs
- Chronic refractory osteomyelitis
- Osteoradionecrosis
- Soft tissue radionecrosis
- Actinomycosis
Graft Versus Surgical Wound

• Preparation and preservation of compromised skin grafts
  – Not for primary management of wounds
• Graft is skin transplanted to new site on the body
• Flap is a piece of tissue partly severed
• Surgical wound is a cut or incision in the skin
Diabetic Wound Coverage

• Three criteria must be met
  – Patient has type I or type II diabetes and a lower extremity wound that is a result of diabetes
  – Patient has a wound classified as Wagner grade III or higher
  – Patient has failed an adequate course of standard wound therapy
    • No measurable sign of healing for 30 days
Standard Diabetic Wound Care

- Assessment and or correction of vascular status
- Nutritional status has been optimized
- Glucose control
- Debridement of devitalized tissue
- Maintenance of clean bed of granulation tissue
- Appropriate off-loading
- Resolution of any infection
Noncovered Indications

• Refer to NCD 20.29 for complete list of non-covered indications
  – Cutaneous, decubitus and stasis ulcers
  – Chronic peripheral vascular insufficiency
  – Multiple sclerosis

• Topical application of oxygen
Documentation Requirements
Documentation to Support HBO Services

• Description of Wound
  – Measurement of wound prior to initiation of therapy
  – Evidence of failed conventional wound therapy
  – Evidence of vascular assessment/optimization
  – Explicit measurements of each wound being treated during therapy

• Documentation supporting removal of devitalized tissue

• Blood glucose
Documentation to Support HBO Services

- Physician order
- HBO treatment notes including dive times
- Documentation supporting diagnosis for HBO
  - Osteomyelitis
  - Radiation cystitis
  - Soft tissue radionecrosis
Medical Review Analysis

- Common denials were
  - Documentation did not support adjunctive conventional treatment
  - Documentation did not support wound measurements
  - Documentation was not received timely or at all
Medical Review Analysis

• Prolonged therapy unsupported
• Documentation must support there is an improvement with HBO services and reasonable to continue treatment
• Re-assessment of wound every 30 days including wound measurements
Medical Record Submission

Probe and Provider on Review (POR)
Complex Medical Review

• Completed by a licensed medical professional either prepayment or post-payment review
• Claim review of verification for reasonable and necessary and/or coding of a claim
• Post-payment may result in no change or a revised determination
HBO Pre-payment Review

• Providers are notified by letter of prepayment review
• Additional Documentation Request (ADR) is generated
  – Respond within 45 days to avoid payment delay
  – Non-response generates a denial reason code of 56900 (non-receipt of medical records)
Medical Records Requested

1. Legible physician/clinician signatures and credentials for services provided. Signature logs and attestation statements should be submitted when physician and/or clinician signatures are illegible.

2. Physician order

3. Initial evaluation

4. Physician clinic/progress notes
Medical Records Requested

5. Treatment plan
6. HBO dive logs/treatment records
7. Wound treatment records
8. Diabetic lower extremity wounds-Wagner grade classification, diagnostic testing to support Wagner grade and documentation of prior failed treatment
9. E&M documentation if billed on same date of service under medical review
Medical Records Requested

10. Itemization of services
11. Notice of non-coverage, if applicable
12. Records of patient’s condition before, during and after this billing period to support medical necessity & the reason the service was provided.
13. If an electronic health record is utilized, include your facility’s process of how the electronic signature is created. Include an example of how the electronic signature displays once signed by the physician.
Provider Options of Medically Denied HBO Claim

• Request for reopen on claim denied for non-response (56900)
  – Send complete medical records
  – 120 days to file

• Request for appeal on claim or line items denied after medical review
  – Review claim when dissatisfied with original/initial determination
  – Submit redetermination to Noridian
  – 120 days to file
Redetermination Requests

• Redetermination requests formats
  – Noridian’s Interactive Redetermination/Reopening Form
    • Note the heading type Medicare Part A for institutional claims only
  – Provider Letterhead/Stationary
  – CMS Form CMS-20027
    • Link provided on our website under “Forms”
  – esMD
  – Noridian Medicare Portal (NMP)
Coding Guidelines

ICD-10 coding effective 10/1/2015
Implementation date 1/4/2016
HBO Coding

• Billable type of bills
  – 0111, 0131, 0851
• Revenue code 0413 Respiratory Services
• CAHs electing Method I, report HBO under appropriate revenue code with HCPCS code
• CPT/HCPCS codes
  – 99183 physician or other qualified health care professional attendance and supervisions of HBO per session
  – G0277 HBO under pressure, full body chamber, per 30 minute interval
HBO Coding

• ICD-10-CM diagnosis codes may be downloaded from the zip file located in MLN Matters MM9252

• Refer to covered diagnoses in the NCD 20.29
Hospital Outpatient HBO Therapy Service

• Report service using HCPCS code G0277
  – Per 30 minute interval, HBO under pressure, full body chamber, equals one unit
  – Time spent by the patient under 100% oxygen

• Elements to consider when calculating time
  – Time for descent
  – Time for air breaks
  – Time for ascent
Hospital Outpatient HBO Therapy Service

- Physicians order for 90-minutes would not exceed 4 billed units
  - Patient receives 90-minutes in chamber
  - Additional time may be added to provide descent, air breaks and ascent
  - Session duration = 4 units; which covers 106 - 135 total minutes
# Medically Unlikely Edit (MUE)

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Outpatient Hospital Services - MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0277</td>
<td>5</td>
<td>3 Date of Service: Clinical</td>
<td>Clinical:Data</td>
</tr>
</tbody>
</table>
MUE$_2$

• Units of services (UOS) are calculated based on the same
  – Date of service
  – Health Insurance Claim Number (HICN)
  – Provider (NPI or rendering provider)

• Contractors review current and prior finalized claims
Advanced Beneficiary Notice of Non-coverage (ABN)

• Issued before rendering otherwise covered Part B services that are physician ordered and health care provider believes that Medicare may not pay because service(s)
  – Medical necessity
  – Frequency limitations

• On claim add GA modifier and Occurrence code 32 with date of service
CMS Resources

• Medicare National Coverage Determinations Manual Chapter 1, Part 1, Section 20.29

• Medicare Claims Processing Manual Chapter 12, Section 30.6
CMS Resources

• Change Request (CR) 9205

• Facility Outpatient Services MUE Table
  – https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
Noridian Resources

• JEA - Additional Documentation Request (ADR) Submissions

• JFA - Additional Documentation Request (ADR) Submissions
Noridian Resources

- JEA - Draft LCDs
  - https://med.noridianmedicare.com/web/jea/policies/lcd/draft
- JFA - Draft LCDs
  - https://med.noridianmedicare.com/web/jfa/policies/lcd/draft
Questions?

Thank you!