Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

Title
Billing and Coding Guidelines for Category III Codes

Original Effective Date

Revision Effective Date

AMA CPT/ ADA CDT Copyright Statement

CMS National Coverage
Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout this policy. NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f) (1) (A) (i) of the Social Security Act.

Title XVIII of the Social Security Act (SSA): Section 1862(a) (1) (A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862(a)(1)(D) refers to limitations on items or devices that are investigational or experimental.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 14, 10 Coverage of Medical Devices

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 23, 30 Services paid under the Medicare Physicians Fee Schedule

CMS Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, 5.1 Reasonable and necessary provisions in LCDs 7.1 Evidence supporting LCDs.

Text:
This document is provided to be used in combination with the local coverage determination (LCD) for CPT Category III Codes. The LCD can be accessed through our contractor web site at www.WPSMedicare.com. It can also be viewed on the Medicare Coverage Database at www.cms.gov/medicare-coverage-database

Effective Date:

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines
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 ClaimsProcessing Manual,* Chapter 30, for complete instructions.

For claims submitted to the carrier or Part B MAC:
1. All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.
2. Submission of claims for any of the codes not published in another LCD or coverage document would be for the purpose of receiving a denial from WPS Medicare, as these are not medically necessary services. Only Category III codes published in this LCD or another LCD or coverage document extending coverage will be considered for payment.

For claims submitted to the fiscal intermediary or Part A MAC:
Hospital Inpatient Claims:
1. 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.*
2. *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.*
3. For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:
1. *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.
2. 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 Examinationand Investigation of Individuals and Populations (V70-V82).*
3. *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.*
4. For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Limitation of liability and refund requirements apply when denials are anticipated, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Sources of Information
National Government Services published articles: A48249, A51453, A44880 and A46075
WPS Medicare Medical Staff

Date Published

Revision History Explanation

Notes:
Italicized lettering (font) indicates CMS wording

* An asterisk indicates most recent publishing or revision

NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f) (1) (A) (i) of the Social Security Act.