Coders' Desk Reference *for* HCPCS

2016

Contents

Appeals, Grievances, and Sanctions

Medicare Appeals

Providers and suppliers of DMEPOS have the right to request an adjustment or review of a claim felt to be inaccurately or unfairly adjudicated by the Medicare or DME Medicare administrative contractor (DME MAC) entity. In most cases, it behooves the provider or supplier to have specific internal protocol established for these claim re-evaluation options. There are important steps to follow when pursuing a re-evaluation of a claim determination.

If a supplier requests a review or other type of appeal on a nonassigned claim, the request must be made in writing and a patient authorization must accompany the request. Without the appropriate patient authorization, the request will be denied. Acceptable review requests must also include the following pieces of information:

- Beneficiary name
- Beneficiary date of birth
- Medicare health insurance claim (HIC) number
- Name and address of provider/supplier of item/ervice
- Date of initial determination
- Date of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form)
- Item and/or service, if any, at issue in the appeal

If the Medicare contractor or DME MAC entity return an initial claim for DMEPOS services or items to the supplier or provider, calling it unprocessable, then there are no immediate appeal rights. The claim must be refiled as a new claim.

CMS has determined that appeal rights should be granted only to the initial claim determination. Some providers and suppliers had been submitting another claim to extend the appeal time frame. Additional claims that duplicate the originally denied claim will be rejected as duplicates. DME MAC remittance remarks and beneficiary notices will be changed to state that the claim was a duplicate of a previously processed claim and that there are no appeal rights for a duplicate claim.

DMEPOS Claims Adjustments

When a claim is processed incorrectly due to an error made by the DME MAC, the provider or supplier can request an adjustment to the claim. In most cases this can be done over the telephone with a DME MAC representative. Examples of DME MAC errors necessitating claims adjustments include the following:

- Incorrect date of death
- Incorrect number of DMEPOS units or services
- Incorrect date of service

DMEPOS Claims Reviews

If a patient, provider, or supplier is dissatisfied with a claim determination for DMEPOS, the dissatisfied party has the right to request an appeal of the claim adjudication. A request for a claims appeal is now more commonly called a request for a review. DMEPOS claims denied due to medical necessity may only be appealed through the review process; claim adjustments cannot be made to these claims.

Parties who hold the right to request a review of a claim include the following:

- The patient
- The patient's choice of a representative
- A provider or supplier who has accepted assignment
- A supplier responsible for indemnification
- Medicaid state agency or the party authorized to act on behalf of the Medicaid state agency

Medicare has a five-level appeals process and each level must be completed before an appeal can proceed to the next level. The five levels are (1) redetermination, (2) reconsideration, (3) administrative law judge, (4) Departmental Appeals Board (DAB) review Appeals Council, and (5) federal court review. The first two levels of appeal are the quickest and least costly for both the contractor and the provider. The majority of claims are resolved at one of these two levels.

Level One—Redeterminations

An initial review can be requested up to 120 days following the initial date of the claim determination, as indicated on the EOMB or electronic remittance

A per-dialysis treatment base rate for adult patients is adjusted to reflect differences in wage levels among the areas in which ESRD facilities are located, by patient-level adjustments for case-mix, an outlier adjustment (if applicable), facility-level adjustments, a training add-on (if applicable), adjustments specific to pediatric patients (dialysis patients that are under the age of 18), and a budget neutrality adjustment during the transition period.

Effective January 1, 2011, all drugs reported on the renal dialysis facility claim are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and no separate payment is to be made to ESRD facilities.

The Medicare Improvements for Patients and Providers Act (MIPPA) eliminated method II home dialysis claims effective with dates of service January 1, 2011, and later. All home dialysis claims must be billed by a renal dialysis facility and paid under the ESRD PPS. ESRD patients are no longer required to file CMS-382 form with the Medicare contractor. Report modifier AY to indicate that an item, drug, or biological is unrelated to the ESRD treatment and payment may be made separately.

Financial Management Guidelines

This section of the *Coders' Desk Reference for HCPCS* reviews important areas of DMEPOS dispensing that every provider's practice and supplier's office should be intimately familiar with. Applying these formulas, tips, and guidelines will help to monitor profit and loss, and ultimately help the DMEPOS provider and supplier remain profitable.

DMEPOS dispensers should have knowledge of or develop the following:

- Financial formulas related to medical care used to regularly monitor the charges and reimbursements for DMEPOS items and services furnished
- Business formulas to monitor overhead and associated expenses
- Tips on how to perform a cost study and a reimbursement analysis
- Guidelines for doing a managed-care viability analysis to determine a managed-care plan's contribution or detriment to the business's bottom line; this should be done for both regular capitation or fee-for-service scenarios and for managed-care contracts that include DMEPOS as a carve-out service
- A checklist of simple office controls for tighter financial management

Financial Formulas

Financial management for DMEPOS providers and suppliers has become quite complicated over the past several years. A great deal of financial management concern has been placed on the numerous managed-care plans with which the DMEPOS provider and supplier must participate.

The DMEPOS provider and supplier must regularly monitor the financial trends of each health insurance plan they contract with by conducting a basic financial analysis of collections and accounts receivable (A/R). The fundamental structure of collections and A/R analysis begins with three key financial elements:

- Charges
- Adjustments
- Payments

Every provider and supplier's office should generate monthly financial information in these areas, either by a computerized billing system or by manual bookkeeping reports. These key elements, when used in the basic formulas provided in this section, will provide a snapshot of the provider and supplier's financial strength or weakness in terms of collections and A/R status.

Conducting Cost and Reimbursement Analyses

Becoming or remaining profitable when furnishing patients with DMEPOS items involves monitoring all aspects of the financial investment made to furnish those items. Patient charges, mandatory health insurance adjustments, and other types of adjustments and insurance and patient payments (reimbursements) must be meticulously followed and studied. Becoming or remaining profitable also involves tracking all associated costs for dispensing DMEPOS items. These costs are easy to track, and include a range of considerations from the actual purchase price of the DMEPOS item to the costs of any supplies used in furnishing the item. The payer must track reimbursement for the DMEPOS items because the profit margin for a single item of DMEPOS can vary greatly between one payer and another.

A cost and reimbursement analysis should be performed at least every six months, and no less than once every year.

DMEPOS Cost Study

The costs of furnishing DMEPOS items must be closely monitored, as many times escalating costs can out-rise reimbursement for those items, thereby nullifying any potential profits. If all of the costs are not tracked alongside the reimbursements, a deceptively healthy financial picture surrounding

Medicare Noncovered Codes

The following is a list of Medicare noncovered HCPCS Level II codes (as indicated in the HCPCS code set master file):

A0021
A0080
A0090
A0100
A0110
A0120
A0130
A0140
A0160
A0170
A0180
A0190
A0200
A0210
A0225
A0380
A0382
A0384
A0390
A0392
A0394
A0396
A0398
A0420
A0422
A0424
A0888
A0998
A4210
A4232
A4250
A4252
A4261
A4264
A4266
A4267
A4268
A4269
A4466
A4490
A4495
A4500
A4510
A4520
A4554
A4555
A4566
A4570
A4575
A4580
A4590
A4611
A4612
A4613
A4627
A4670
A6000
A6413
A6530
A6533
A6534
A6535
A6536
A6537
A6538
A6539
A6540
A6541
A6544
A6549
A9152
A9153
A9180
A9270
A9272
A9273
A9274
A9275
A9276
A9277
A9278
A9279
A9280
A9281
A9282
A9283
A9300
B4100
E0172
E0203
E0231
E0232
E0240
E0241
E0242
E0243
E0244
E0245
E0270
E0273
E0274
E0315
E0446
E0457
E0459
E0481
E0571
E0625
E0637
E0638
E0641
E0642
E0936
E0970
E1085
E1086
E1089
E1090
E1130
E1140
E1250
E1260
E1285
E1290
E1300
E8000
E8001
E8002
G0122
G0219
G0235
G0252
G0255
G0282
G0295
G0428
G9013
G9014
G9016
G9050
G9051
G9052
G9053
G9054
G9055
G9056
G9057
G9058
G9059
G9060
G9061
G9062
G9147
H0001
H0002
H0003
H0004
H0005
H0006
H0007
H0008
H0009
H0010
H0011
H0012
H0013
H0014
H0015
H0016
H0017
H0018
H0019
H0020
H0021
H0022
H0023
H0024
H0025
H0026
H0027
H0028
H0029
H0030
H0031
H0032
H0033
H0034
H0035
H0036
H0037
H0038
H0039
H0040
H0041
H0042
H0043
H0044
H0045
H0046
H0047
H0048
H0049
H0050
H1000
H1001
H1002
H1003
H1004
H1005
H1010
H1011
H2000
H2001
H2010
H2011
H2012
H2013
H2014
H2015
H2016
H2017
H2018
H2019
H2020
H2021
H2022
H2023
H2024
H2025
H2026
H2027
H2028
H2029
H2030
H2031
H2032
H2033
H2034
H2035
H2036
H2037
J1055
J1680
J2271
J3487
J3488
J3520
J3535
J3570
J7184
J7300
J7301
J7302
J7303
J7304
J7306
J7307
J8499
J8515
J9001
J9002
J9010
K0740
L2861
L3215
L3216
L3217
L3219
L3221
L3222
L3891
L7600
L8680
L8685
L8686
L8687
L8688
L8692
M0075
M0076
M0100

continuous positive airway pressure device. Pressurized device used to maintain the patient's airway for spontaneous or mechanically aided breathing. Often used for patients with mild to moderate sleep apnea.

contractor. Entity who enters into a contractual agreement with CMS to service a component of the Medicare program administration, for example, fiscal intermediaries, carriers, program safeguard coordinators.

conversion. In health care contracting, shifting a member under a group contract to an individual contract in accordance with contract terms and occurring with a change in employer benefits or when the covered person leaves the group.

conversion factor. ***1)*** Dollar value for each relative value unit. When this dollar amount is multiplied by the total relative value units, it yields the reimbursement rate for the service. ***2)*** National multiplier that converts the geographically adjusted relative value units into Medicare fee schedule dollar amounts that applies to all services paid under the MPFS.

coordinated care. In health care contracting, system of health care delivery that influences utilization, quality of care, and cost of services. Managed care integrates financing and management with an employed or contracted organized provider network that delivers services to an enrolled population.

copayment. Cost-sharing arrangement in which a covered person pays a specified portion of allowed charges. In relation to Medicare, the copayment designates the specific dollar amount that the patient must pay and coinsurance designates the percentage of allowed charges.

Correct Coding Initiative. Official list of codes from the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Policy Manual for Medicare Services that identifies services considered an integral part of a comprehensive code or mutually exclusive of it.

corridor deductible. Fixed out-of-pocket amount the member must pay before benefits are available.

COT. Certified ophthalmic technician.

COTA. Certified occupational therapy assistant.

counseling. Discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education.

Coverage Issues Manual. Revised and renamed the National Coverage Determination Manual in the CMS manual system, it contained national coverage decisions and specific medical items, services, treatment procedures, or technologies paid for under the Medicare program. This manual has been converted to the Medicare National Coverage Determinations Manual (NCD manual), Pub. 100-03.

covered charges. Charges for medical care and supplies that are medically necessary and met coverage and program guidelines.

covered person. Any person entitled to benefits under the policy, whether a member or dependent.

CPR. Cardiopulmonary resuscitation. Substitutionary action made for both the heart and lungs in sudden death cases by artificial respiration and external cardiac compression.

CPT. Current Procedural Terminology. Definitive procedural coding system developed by the American Medical Association that lists descriptive terms and identifying codes to provide a uniform language that describes medical, surgical, and diagnostic services for nationwide communication among physicians, patients, and third parties, used in outpatient reporting of services.

CPT codes. Codes maintained and copyrighted by the AMA and selected for use under HIPAA for noninstitutional and nondental professional transactions.

CPT modifier. Two-character code used to indicate that a service was altered in some way from the stated CPT or HCPCS Level II description, but not enough to change the basic definition of the service.

credentialing. ***1)*** Reviewing the medical degrees, licensure, malpractice, and any disciplinary record of medical providers for panel and quality assurance purposes and to grant hospital privileges. ***2)*** Coding certification.

CRNA. Certified registered nurse anesthetist. Nurse trained and specializing in the administration of anesthesia. Anesthesia services rendered by a CRNA must be reported with HCPCS Level II modifier QX, QY, or QZ.

crosswalk. Cross-referencing of CPT codes with ICD-9-CM, anesthesia, dental, or HCPCS Level II codes.

CRT. Certified respiratory therapist.

CSO. Clinical service organization. Health care organization developed by academic medical centers to integrate medical school, faculty practice plan, and hospital.

CST. Certified surgical technologist.

CTLSO. Cervical-thoracic-lumbar-sacral orthosis.

C2618

C2618 Probe/needle, cryoablation

Lay Description
Cryoablation probes are hollow needles (cryoprobes) through which cooled, thermally conductive fluids are circulated. Cryoprobes are inserted into or placed adjacent to diseased tissue. Ablation occurs in tissue that has been frozen by at least three mechanisms: 1) formation of ice crystals within cells thereby disrupting membranes; 2) coagulation of blood thereby interrupting blood flow; 3) induction of apoptosis, the so-called programmed cell death cascade.

C2619-C2620

C2619 Pacemaker, dual chamber, nonrate-responsive (implantable)

C2620 Pacemaker, single chamber, nonrate-responsive (implantable)

Lay Description
A pacemaker is an electronic device that regulates contraction rhythms of the heart through electrical impulses. A pacemaker has two components: a pulse generator and lead(s). The pulse generator is connected to leads positioned inside the heart or on its surface. These leads are used to deliver electrical impulses, sense the cardiac rhythm, and pace the heart, as needed. The various leads are connected to a pulse generator, which is implanted in a pouch beneath the skin of the chest or abdomen. Dual chamber pacemakers can sense and pace in both heart chambers, atrium and ventricle. Single chamber pacemakers sense and pace in only one heart chamber, usually the ventricle. Rate responsive pacemakers sense both physiologic and nonphysiologic signals and adjust their output to meet patient needs. Nonrate-responsive pacemakers deliver a consistent fixed rate.

C2621

C2621 Pacemaker, other than single or dual chamber (implantable)

Lay Description
A pacemaker is an electronic system that monitors the electrical impulses of the heart and delivers an electrical charge when necessary to set normal heart rhythms. This code represents an implantable pacemaker that is neither a single nor dual chamber model.

C2622

C2622 Prosthesis, penile, noninflatable

Lay Description
A non-inflatable penile prosthesis consists of a pair of malleable cylinders that are surgically inserted into the penis. This prosthesis maintains the penis in a semi-rigid state. The penis must be manually positioned, up for intercourse or down for everyday activities.

C2625

C2625 Stent, noncoronary, temporary, with delivery system

Lay Description
A noncoronary, temporary stent, with a delivery system is a small hollow tube made of a biocompatible substance, such as phosphorylcholine, silicone, or metal, that is inserted into a natural body passage or conduit. The stent maintains the body passage or conduit allowing less restricted flow. A temporary stent is designed to be removed and is placed for a period of less than one year. This code represents a stent packaged with a delivery system, generally including components such as a stent mounted or unmounted on a balloon angioplasty catheter, introducer, and sheath.

C2626

C2626 Infusion pump, nonprogrammable, temporary (implantable)

Lay Description
A nonprogrammable, temporary infusion pump is a short term pain management system which is a component of a permanent implantable system used for the management of chronic pain.

C2627

C2627 Catheter, suprapubic/cystoscopic

Lay Description
A suprapubic catheter is a flexible hollow tube that is inserted through the abdomen into the urinary bladder to drain urine. It is a popular method of long-term bladder drainage in voiding dysfunction. A cystoscopic catheter is a flexible hollow tube that is used in a cystoscopy.

C2628

C2628 Catheter, occlusion

Lay Description
An occlusion catheter is a flexible hollow tube with a balloon at the tip. The device is placed into an organ or blood vessel and the balloon is inflated. This blocks or occludes the vessel stopping blood flow.

C2629

C2629 Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser

Lay Description
An intracardiac, electrophysiological introducer or sheath is a small hollow tube made of nonabsorbable material that is used in the heart. The sheath or introducer, which separates into two pieces, is guided to the target area. A laser is placed through the introducer and the sheath is removed.