2025 Medicare Update Part 1

Gabriel Halperin, DPM, DABPS, FACFAS

Member, Noridian Medicare physician advisory committee

CPMA Medicare & insurance committees

Disclosures

Gabriel Halperin, DPM, FACFAS, DABFAS has no relevant financial interests to disclose.

Disclosure will be made when a product is discussed for an unapproved use.

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Commercial support was not received for this activity.

Learning Objectives

- Identify new programs that CMS is planning
- Analyze the Medicare Carrier's expectations regarding our documentation
- Demonstrate to use the language of the LCD to protect our documentation
- Understand the different audits and appeals
- Introduce potential new services that can enhance, ethically, our office income
- Identify the sources available to us to code correctly for services rendered to our patients

California Wildfire Information

Active LCDs | Appeals | Claims

Fee Schedules | Noridian Medicare Portal (NMP) | Register for an Education Event

SYSTEM NOTICES

- All Systems Normal

Customer Service

NMP

IVR

ALERTS

See All

There are currently no open alerts.

LATEST UPDATES

See All

Articles	Source	Posted
Travel Allowance Fees for Specimen Collection - 2025 Updates	CR13947	02/14/2025
HCPCS Codes Used for SNF CB Enforcement: April 2025 Quarterly Update	CR13945	02/14/2025
Ambulatory Surgical Center Payment Update - January 2025	CR13934	02/14/2025
MLN Connects - February 14		02/14/2025

Noridian Medicare Portal

Access Login | Registration Guide | User Manual

Provider Contact Center

Availability | Holiday Closures | Training Closures | IVR Guide

Browse by Topic

- Advance Beneficiary Notice of Noncoverage (ABN)
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- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
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- Preventive Services

California Wildfires

Medicare Response to Wildfires in California - Public Health Emergency (PHE)

A public health emergency (PHE) was announced on January 10, 2025, providing flexibility to support beneficiaries in the State of California, effective date retroactive to January 7, 2025, due to California Wildfires.

During the California PHE, Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the state of California for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the disaster.

Sections listed in the presidential declaration, and authorized waivers and modifications under §1135 of the Social Security Act are currently in effect and will be valid for 90 days from the effective date of the PHE, unless otherwise notified.

- Hospitals, Psychiatric Hospitals, including Cancer Centers and Long-Term Care Hospitals (LTCHs)
- Skilled Nursing Facilities (SNF)
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- End Stage Renal Dialysis (ESRD)
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Review the 2025 Southern California Wildfire Waivers webpage for details.

Mandatory Use of CR Modifier and DR Condition Code

In accordance with IOM Pub.100-04, Chapter 38 Section 38.10, "CR" modifier (CMS-1500) and the "DR" condition code (UB-04) are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either §1135 or §1812(f) of the Social Security Act.

Provider Enrollment Relief

Noridian will offer provider enrollment relief to providers impacted by the wildfires in Southern California (Los Angeles County). This applies to applications received on or after January 7, 2025, and will remain in effect for a period of 90 days.

- All off-cycle revalidation due dates for Skilled Nursing Facilities (SNFs) were previously extended and should not be impacted by this new declaration.
- Allowing retrospective billing privileges of up to 90 days prior to the receipt date of the application or the effective date of the

- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Review the 2025 Southern California Wildfire Waivers webpage for details.

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- All off-cycle revalidation due dates for Skilled Nursing Facilities (SNFs) were previously extended and should not be impacted by this new declaration.
- Allowing retrospective billing privileges of up to 90 days prior to the receipt date of the application or the effective date of the declaration, whichever is later.
- Temporary changes for providers or suppliers must be submitted via the appropriate CMS-855 application.

Providers and suppliers must resume compliance with normal Medicare fee-for-service rules and regulations as soon as they are able to do so and, in any event, the waivers or modifications a provider and supplier was operating under are no longer available after the termination of the emergency period.

California Wildfire Resources

The Centers for Medicare & Medicaid Services (CMS) has announced additional resources and flexibilities to support beneficiaries during the California wildfires:

- Waivers and Flexibilities: CMS has issued waivers to ensure continued access to care, including the use of the "CR" modifier and "DR" condition code on claims.
- Apply for an 1135 Waiver
- CMS Announces Resources and Flexibilities to Assist with the Public Health Emergency in the State of California
- California Wildfire Fact Sheet [PDF]
- California PHE FAQ [PDF]

For more information, visit the CMS Newsroom.

Last Updated Jan 29 , 2025

MIPS

- Potential Automatic Waiver for the PHE
- Will be announced on the website QPP.Gov
- zip code or entire county
- We should have an announcement in March
- If not, we have the MIPS lecture later tomorrow

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Contact information

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  - Social and dinner reservations ☺
- Office # 323.264.7796
- Cell# 213.300.1116
- Fax # 800.876.9750

Agenda

- Introduction
- Medicare Policy Updates
  - Fee schedule
  - Wildfires PHE
  - Coding Changes
  - CME – Dr Lurvey talking notes to providers
  - Update on Regenerative Medicine, Amniotic Membranes & Medicare / CMS
  - New Noridian Audit Division SMRC
  - UPIC Increase
  - E/M Coding & Documentation
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  - E/M Telehealth Changes

Agenda

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- Denials & Reviews
- Medicare Advantage and Pvt Insurance
- CAC Meetings
- Denials, Appeals & Audit Suggestions
- Noridian SMRC Audit Plans
- TPE – Targeted Probe & Education
- Covered Routine Foot Care Overview

Sources

- APMA Webinars
- APMA CAC/PIAC Meeting, November 2024
- Carrier Advisory Committee
  - Tony Poggio- Northern California
  - Gabriel Halperin- Southern California
- Noridian Carrier Meetings, 2024
- CPMA Alerts
- APMA Health Affairs Committee
- Noridian Bulletins
- PM News
- Private Conversations

Sources

- DME
  - Paul Kesselman

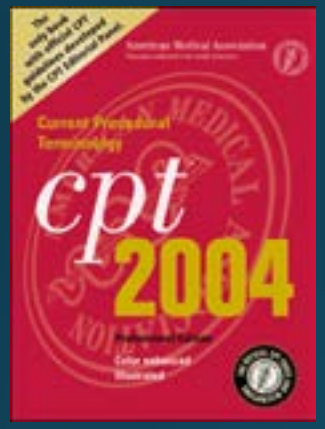
- MIPS
- Coding
- E/M
  - Jeffrey Lehrman

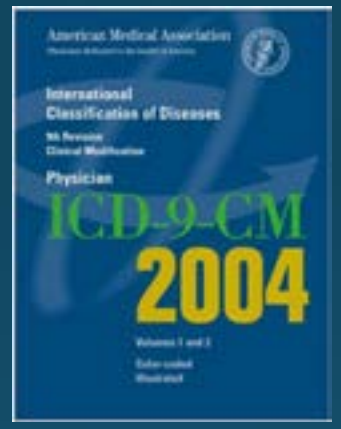
"Manuals" To Keep in the Office

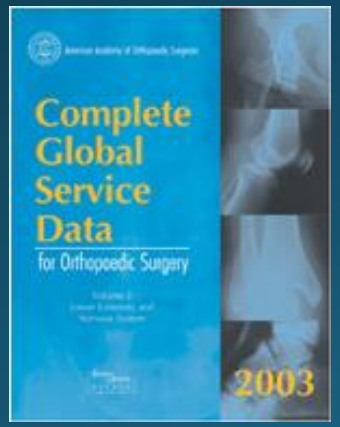
- Medicare Compliance Handbook
- HIPPA Handbook
- Employee Handbook
- OSHA Handbook
- Need to mention what coding manuals or services you use;
  - physical or electronic

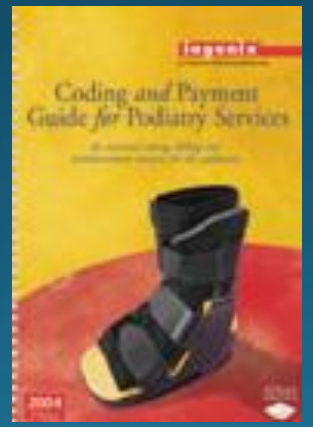
- All available on APMA members section

Tools of the Trade









APMA Coding Resource Center

- **The coding manuals no longer needed physically in the office, except for the Compliance Manual and OSHA Manual**
- Online, real-time complete coding resource
- www.APMACodingRC.org.
- Online access to CPT, ICD-10 and HCPCS codes
- Online current CCI Edits with instructions
- Automatic updates
- All LCDs and LCA by state

And for those interested in information on the

www.apmacodingrc.org

apma | Coding Resource Center

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APMA Coding Resource Center
301-581-9200 coding.hpp@apma.org
11400 Rockville Pike, Suite 220 Rockville, MD 20852

How to Get Information

- Noridianmedicare.com
  - Jurisdiction E (JE); Part B
- APMA website
- CPMA website
  - www.CALpma.org
- APMA & CPMA Emails
- APMA CRC

CPMA ALERT: Congress Fails to Stop Medicare Cut/Grants for Young Physician Observers to APMA HOD25/APMA Considers Class Action Lawsuits/CPMA Dues are Tax Deductible

CPMA CALIFORNIA PODIATRIC MEDICAL ASSOCIATION

Doctors dedicated to keeping Californians on their feet!

CPMA Alert
December 23, 2024

Season's Greetings from CPMA

Wishing You and Your Loved Ones

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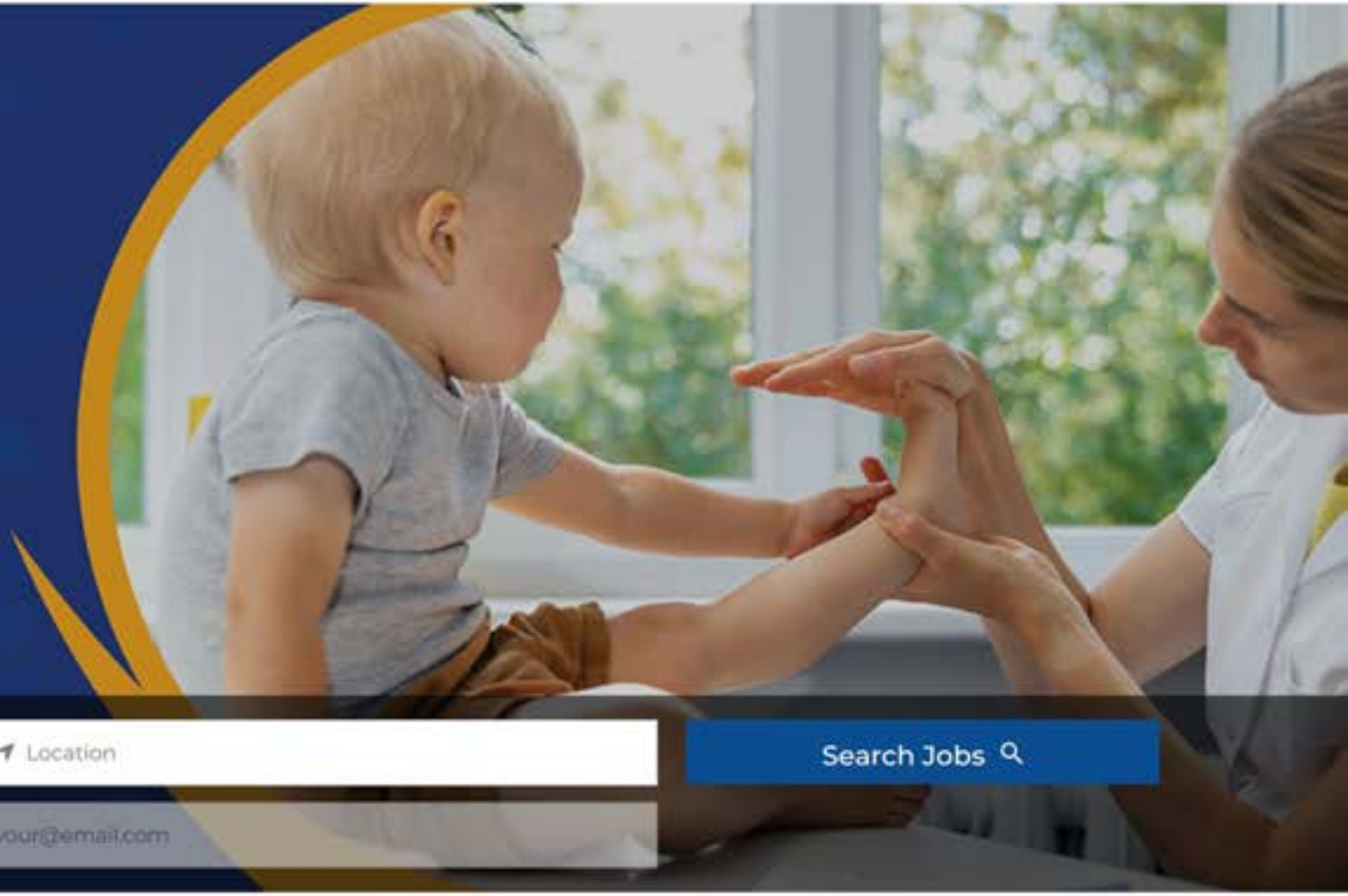
Connecting Opportunities for YOU!



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Featured Podiatry Jobs

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February 20, 2024

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Upcoming Events

- **February 26:** How Podiatry Business Leaders Can Improve Their Bottom Line
- **March 5:** MIPS PY 2024: Improvement Activities Performance Category
- **March 6:** Sponsored Webinar by NextGen Healthcare
- **March 15–18:** 2024 APMA House of Delegates
- **March 18–20:** 2024 APMA Legislative Conference
- **March 21:** Avoid These Pitfalls for Forefoot Surgical Coding
- **April 27–28:** APMA 2024 Coding and Clinical Education Seminar

In the Spotlight ...

apma | MIPS CORNER

APMA Makes Recommendations for MIPS 2025 PY Podiatry Specialty Measure Set

Last Friday, APMA submitted comments to CMS, in response to its solicitation for recommendations related to the MIPS 2025 Performance Year Podiatry Measure Specialty Set. More specifically, APMA recommended removing Measure #219: Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairment from the Podiatry Specialty Measure Set for 2025. | **READ MORE >**

apma | Weekly Focus

February 13, 2024

*APMA gratefully acknowledges the support of **Ortho Dermatologics** as Weekly Focus sponsor.*

Upcoming Events

- **Recording Now Available:** MIPS PY 2024: Promoting Interoperability Performance Category
- **March 15–18:** 2024 APMA House of Delegates
- **March 18–20:** 2024 APMA Legislative Conference
- **March 21:** Avoid These Pitfalls for Forefoot Surgical Coding
- **April 27–28:** APMA 2024 Coding and Clinical Education Seminar

In the Spotlight ...

apma | MIPS CORNER

MIPS PY 2024: Promoting Interoperability Performance Category Webinar Recording

A recording is now available for APMA Health Policy and Practice's third webinar in its 2024 MIPS Performance Year Webinar Series, "Promoting Interoperability Performance Category." Jeffrey Lehrman, DPM, APMA health policy consultant, and Rachel Groman, MPH, vice president, Hart Health Strategies, presented.

HEALTHCARE LEGISLATION

Bill Introduced to Reverse 2.83% Physician Medicare Cuts

A bipartisan coalition of 10 House lawmakers introduced legislation on Jan. 31 aimed at reversing a 2.83% Medicare physician payment reduction and implementing a 2% increase to help stabilize physician practices and protect patient access to care. If enacted, the Medicare Patient Access and Practice Stabilization Act would retroactively nullify the 2.83% cut that took effect on Jan. 1, with changes set to take effect on April 1. A similar proposal garnered bipartisan, bicameral backing in December, but Congress ultimately failed to act on it before the end of the session.

The American Medical Association has strongly endorsed the measure, pledging to collaborate with lawmakers to incorporate it into forthcoming legislation to extend federal government funding beyond the March 14 deadline.

MIPS - Exceptions

2024 Cyber Attack & 2025 Wildfires

- If you want to take an exception:
- Automatic vs requested
  - 2024 Cyber Attack was requested
  - 2025 California Wildfire PHE is Automatic
- Do not send any MIPS data to Medicare. This will invalidate the Exception and obligate you to fulfill the regular MIPS
- Taking the Exception will not let you obtain any bonus from MIPS

NORIDIAN Medicare
HEALTHCARE SOLUTIONS

Jurisdiction E - Medicare Part B
California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands

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JE Part B > Fees and News > Latest Updates > Article Detail

Fees and News

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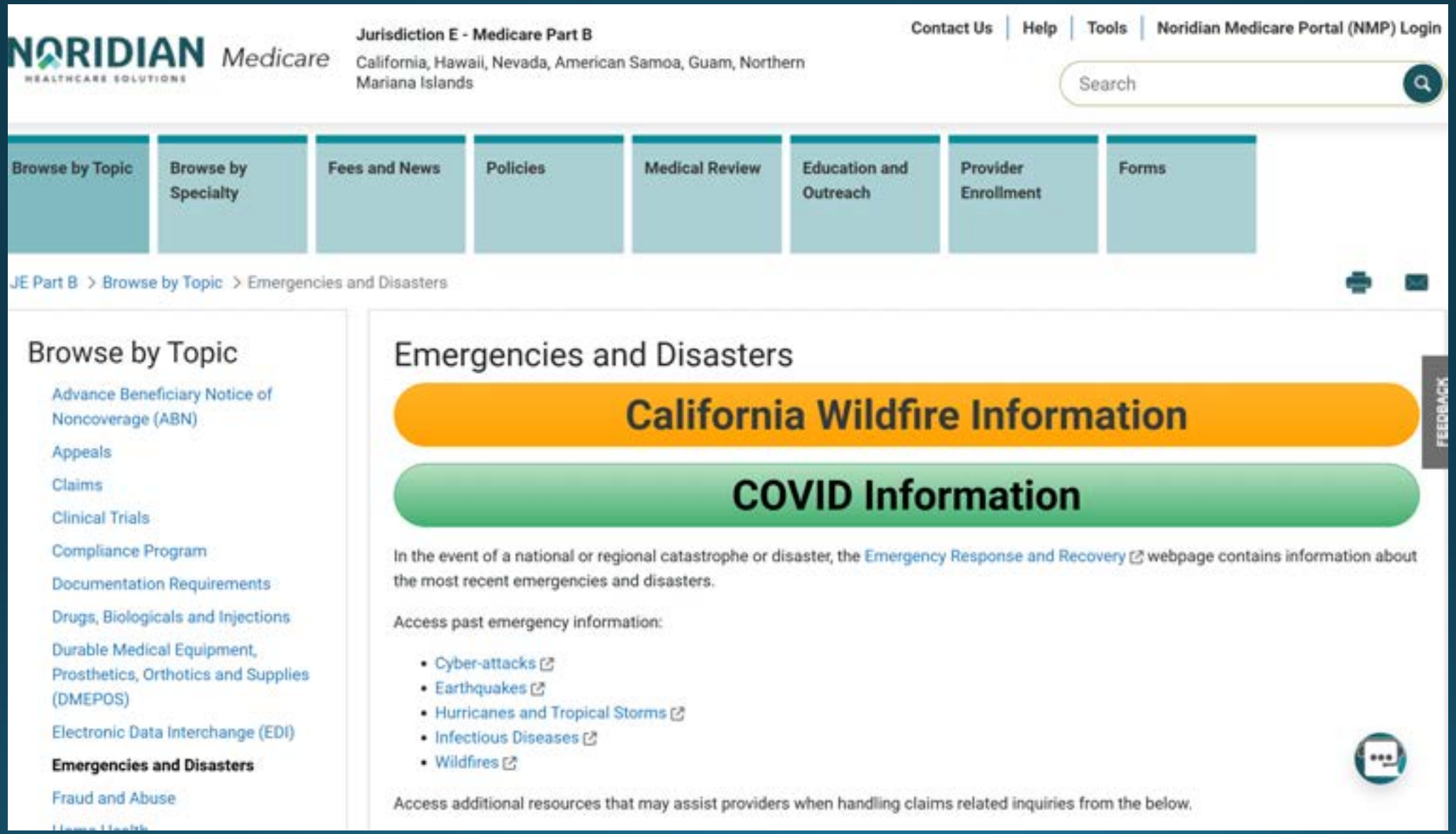
- Frequently Asked Questions (FAQs)
- Latest Updates

California Wildfires

A Public Health Emergency (PHE) was announced on January 10, 2025, providing flexibility to support beneficiaries in the State of California, effective retroactive to January 07, 2025, due to California Wildfires.

Review the Emergency and Disasters webpage for details.

Last Updated Jan 16 , 2025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California Wildfire Information
COVID Information
In the event of a national or regional catastrophe or disaster, the Emergency Response and Recovery webpage contains information about the most recent emergencies and disasters.
Access past emergency information:
Cyber-attacks
Earthquakes
Hurricanes and Tropical Storms
Infectious Diseases
Wildfires
Access additional resources that may assist providers when handling claims related inquiries from the below.
FEEDBACK

SNF POS Recoupment

- OIG report and audit
  - Calendar years, 2019 and 2020
  - POS 31 and 32
    - 31 - skilled nursing facility – lesser reimbursement (facility based fees)
    - 32 – long-term care, domicile – greater reimbursement (home-based fees)
  - Over $150 million dollars in overpayments
  - National problem
- OIG instructed CMS to initiate recoupment procedures

SNF POS Recoupment

- Additionally, OIG has instructed CMS to request providers to self audit the last six years, minus calendar years 2019 and 2020.
  - Providers to arrange for reimbursement the difference between payments received for services erroneously at the higher rate using POS 32
- PICA is concerned that self - audits that result in voluntary payback will not provide the providers the possibility of appeals
- The self audit will be particularly cumbersome and in many cases impossible due to the records not being available. Medicare is not making all the records available to providers regarding whether the patient was in a skilled bed or a non-skilled bed at any time in the past

SNF POS Recoupment - Causes

- This is discussed in the CPMA alert dated 1/30/2024
- There were many factors in the erroneous use of POS 31/32
- Poor record-keeping by the SNF facility
- The facility staff giving the wrong information to the provider
- The face sheet being out of date
- The SNF Business Office not answering phone calls or email
- The Medicare Carrier's online portal giving erroneous information or slow information
- Many providers did not know the difference between the POS codes and use them indiscriminately

SNF POS Recoupment - Causes

- The Medicare carrier was never instructed by CMS to program the computers to identify the error in the POS
- There was no cross referencing by CMS, who had records of the patients on skilled beds on a daily basis and did not make use of this information regarding the place of service for service by providers

SNF POS Confusion – Solution

- Offices to create protocol to speak to SNF business offices to verify POS on the daily basis
- Obtain access to the SNF's EMR, to see the patient status on a daily basis
- Evaluate the possibility of a class action lawsuit. In reality and in practice, there is no difference between a patient in a skilled bed versus a patient in a non-skilled bed. The work is the same to the provider and there should be no difference in terms of POS.

- Most recently, legal opinion: no action by the providers until we receive a letter from the Medicare Carrier for any payback/ recoupment

SNF POS Recoupment - PICA

- PICA recommends to call PICA's offices as soon as they are contacted by their Medicare carrier or OIG

Skin Substitutes

Conjecture based on Conversations with People Who Know

- The LCD & LCA due to take effect in February were postponed until April by the old administration, prior to the handoff
- There have been talks with President Trump's team, on the very highest level in Washington and Mar a Lago.
- The manufacturers are leading this and formed several consortiums
- Podiatrists who have used biologics will be represented on the consortiums
- We have been told that once the President's appointments are in place, the LCD /LCA should be removed. (RFK Jr, Dr Oz, rest of teams)
- Negotiations have been already underway to ensure continued use of Skin Substitutes/ TCPs and to a wider range of patients that would benefit.

Conjecture based on Conversations with People Who Know

- Hopes of the 3 consortiums are to:
- Creation of an NCD
- Reduce the cost of product
- Allow a wider use of the Skin Substitute / TCPs
- Remove the exclusions of the products
- Put a hold on newer products, temporarily
- Discussions on the application limits
- More input by real on-the-ground doctors who use the products

Conjecture based on Conversations with People Who Know

- **How to stay safe:**
- Try to stay within a reasonable threshold ASP price with the Skin Subs/TCPs
  - $500-$600 per layer
  - Dual Layer biologic – below 1200-1400
  - Triple Layer biologic – 1800-2000
  - 4 Layer Biologic – 2400-2600
- Application to muscle does not seem to be brought up on Audit
- Do not change the graft to a more expensive one without medical necessity

Conjecture based on Conversations with People Who Know

- **How to stay safe:**
- Create discussions on medical necessity if using more than 8-10. why you need more
- Remember there is no LCD by Noridian, if they remove the present one scheduled for April.
- But Auditors may use it for guidance on Audits, so read the LCD and LCA, so you can make medical necessity discussions whether you comply or don't comply with the removed LCD
  - The consortiums will deal with this problem, with the provider sections
- Remember the LCDs deal only with DFU and VLU

Conversation with Dr Graves: Novatas CMD

- Dr graves "wrote" the LCD for Skin Substitutes and DFU and VLU for Novitas
- She spoke with Dr Thomas Rambacher and myself at the APMA CAC meeting, privately.
- She reiterated that the LCD was specifically for the DFU and VLU.
- The LCD shall not be used to set any standard for any other type of wound.
- If it is used as a guide for an audit for any other type of wound, it would be an error and should be appealed.

Noridian Website

NORIDIAN Medicare

Medicare
Providing high quality administrative services to Medicare since 1966

Jurisdiction E

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- NPE East - National Provider Enrollment Contractor
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SMRC

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About Noridian

Contact Us

Start Your Medicare Provider Enrollment Here

Are You a Person with Medicare?

Contact Medicare with your Hospital Insurance (Medicare Part A), Medical Insurance (Medicare Part B), and Durable Medical Equipment (DME) questions.

Call
1-800-Medicare (1-800-633-4227)
or TTY/TDD - 1-877-486-2048

Electronic Medicare Summary Notice
- Learn More About eMSN

Mail
Medicare Beneficiary Contact Center
P.O. Box 39
Lawrence, KS 66044

Website
Medicare.gov

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Jurisdiction E

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Noridian Medicare Portal: 30-Minute Registration	02/11/25
Noridian Medicare Portal: 30-Minute Registration	02/25/25

Login | How to Register | User Manual

Noridian Medicare Portal (NMP)

The Noridian Medicare Portal (NMP) is a free and secure, internet-based portal that allows users access to beneficiary and claim information. The portal is available for all Part A, Part B and Durable Medical Equipment (DME) users in the Noridian MAC Jurisdictions of JA, JD, JE and JF. The Centers for Medicare & Medicaid Services (CMS) governs the security regulations and other policies of NMP.

More information on logging into, registering for, or using the NMP can be found by using the buttons above.

The chart below shows the hours, by jurisdiction, the Contact Centers are available for questions related to NMP. The Contact Centers are available Monday - Friday.

	Jurisdiction A DME	Jurisdiction D DME	Jurisdiction E	Jurisdiction F
Contact Us	866-419-9458	877-320-0390	855-609-9960	877-908-8431
Functionality Inquiries	Customer Service 8 a.m. - 5 p.m. ET	Customer Service 8 a.m. - 6 p.m. CT	Customer Service 6 a.m. - 5 p.m. PT	Customer Service 8 a.m. - 6 p.m. CT
Passwords/Account Support	User Security 9 a.m. - 5:30 p.m. ET	User Security 8 a.m. - 4:30 p.m. CT	User Security 6 a.m. - 2:30 p.m. PT	User Security 8 a.m. - 4:30 p.m. CT

Last Updated Dec 10 , 2023

Related Articles

The below are topic specific articles which have been published to "Latest Updates" and sent out in Noridian emails within the past two years. Exclusions to this include time sensitive related announcements such as: Noridian and CMS educational events, Ask-the-Contractor Teleconferences and claims processing downtime.

Policies

Local Coverage Determination (LCD)
- Active LCDs
- Proposed LCDs
- Retired LCDs
- Open Public Meeting

Billing and Coding Articles

Clinician's Corner
- Clinician's Checklists

Medical Director Articles

Molecular Diagnostic Services

National Coverage Determination (NCD)

Noridian Medical Directors

Self Administered Drugs (SADs)

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Noridian Medicare Portal (NMP)
Overpayment and Recoupment
Preventive Services

Registration 02/11/25

Registration 02/25/25

User Manual

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Last Updated Dec 10 , 2023

Policies

- Local Coverage Determination (LCD)
- Billing and Coding Articles
- Clinician's Corner
- **Medical Director Articles**
- Molecular Diagnostic Services
- National Coverage Determination (NCD)
- Noridian Medical Directors
- Self Administered Drugs (SADs)

Medical Director Articles

The term "article" is used to describe any bulletin article, web site article, educational handout or any other non-LCD document intended for public release that contains coverage/coding statements or medical review related billing or claims considerations.

Articles address local coverage, coding or medical review related billing and claims considerations, and may include any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy.

The article listing will continue to expand as additions are made.

Last Updated Jan 30 , 2024

Articles	Source	Posted
Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) - Published for Review and Comments		Feb 10, 2025
Open Public Meeting Announcement - Allergy Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT) - March 6, 2025		Feb 10, 2025
Billing and Coding: MolDX: Minimal Residual Disease Testing for Solid Tumor Cancers (A58454) - R9 - Effective November 18, 2024		Feb 10, 2025
MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (L39001) - R3 - Effective January 30, 2025		Feb 06, 2025
Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (A57948) - R4 - Effective December 1, 2024		Jan 30, 2025
Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720)- R23 - Effective January 1, 2025		Jan 23, 2025
Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (A58718)- R5 - Effective September 11, 2024		Jan 23, 2025
Update Regarding Part B Editing for NCD 110.21 - Erythropoiesis Stimulating Agents (ESAs) in Cancer and		Jan 22, 2025

POLICIES

- Cliniciens Corner
  Documentation Checklists
- Local Coverage Determination (LCD)
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  National Coverage Determination (NCD)
  Noridian Medical Directors
  Pricing Data Analysis and Coding (PDAC)

Same or Similar Denials for Orthoses and the Appeals Process

Joint DME MAC Article
Posted August 27, 2020

Items that are identical or similar to items previously paid for by Medicare may be provided when the item is lost, stolen, irreparably damaged, or there has been a change in the beneficiary's medical/physiological condition. The delivery of an orthosis that is the same or similar to an item, previously provided and paid by Medicare, and is within the Reasonable Useful Lifetime (RUL), may be denied on the basis of the RUL. Orthotic devices have a minimum 5-year reasonable useful lifetime (RUL) per the Medicare *Benefit Policy Manual* (Internet-Only Manual 100-02), Chapter 15, Section 110.2, with the exception of certain knee orthoses which have HCPCS code specific RUL instructions of 1, 2, or 3 years depending upon the HCPCS code. These specific RULs are listed in the Knee Orthoses Policy Article (A52465).

An orthosis that is denied as same or similar may be submitted for a redetermination. The DME MACs will review documentation to determine if the previous item was lost, stolen, irreparably damaged by a specific incident, or if there was a change in the beneficiary's medical/physiological condition.

Change In Medical Condition

If a claim for an orthosis is denied as same or similar, the supplier may submit a redetermination. If the replacement orthosis is provided due to a change in medical condition, the supplier should submit the following at a minimum (with the redetermination form):

1. Standard written order (SWO);
2. Proof of delivery; and
3. Medical record documentation to substantiate a change of medical/physiological condition.

The medical records should demonstrate the beneficiary's change in medical/physiological condition necessitating the need for the new orthosis. A focused history and examination of the impacted body part is critical to establishing medical necessity. The medical record should include (but is not limited to):

- the beneficiary's diagnosis
- prognosis
- duration of condition
- functional limitations
- clinical course
- past experience with related items
- reasons why previous orthotic devices are not functional nor appropriate for the current condition.

Policies

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Educational Resources

Policy Related Forms

Policies (LCDs and NCDs)

Local Coverage Determination (LCD) - View/Access Active | Proposed | Retired LCDs; Contractor Advisory Committee (CAC) Meeting locations, dates, times, membership and contact information; LCD Reconsideration Process; New LCD Request Process; and Open Public Meeting dates, times, agenda and attendee options

Billing and Coding Articles - View coverage articles on topics found outside NCDs and LCDs

MolDX - View coverage and reimbursement information for molecular diagnostic tests

National Coverage Determination (NCD) - View NCD related Noridian coverage requirement articles

Self Administered Drugs (SADs) - View information on how providers are able to determine which drugs are usually self-administered by the patient and see the SAD exclusion list

Last Updated May 31 , 2024

CPT, ADA, and AHA End User License Agreement for Providers

Note: Should you have landed here as a result of a search engine (or other) link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the files unless you read, agree to, and abide by the provisions of the copyright statement. Read the copyright statement now and you will be linked back to here.

Browse by Topic

Browse by Topic

Advance Beneficiary Notice of Noncoverage (ABN) - View an ABN overview, medical necessity, triggering events, tips, key points and resources.

Appeals - If dissatisfied with an initial claim determination, you have the right to request an appeal. There are many appeal levels and each level must be processed before proceeding to the next.

Claims - Access the CMS-1500 instructions and tutorial and view other claim submission related information.

Clinical Trials - View information on the different clinical research studies, Medicare coverage for those types, as well as billing guidance and scenarios and solutions.

Compliance Program - View overview of Medicare compliance program requirements.

Documentation Requirements - View checklists to help providers submit appropriate documentation to Medicare.

Drugs, Biologicals and Injections - View guidance on drugs, biologicals and injections.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) - Access the Noridian DME Homepages, Latest Updates, contact information, Local Coverage Determinations (LCDs) and articles and Jurisdiction Lists.

Electronic Data Interchange (EDI) - Connect with EDI regarding electronic claim submissions.

Emergencies and Disasters - In the event of a national or regional catastrophe or disaster, view resources.

Fraud & Abuse - View information regarding fraud, abuse, and the related process to report potential concerns.

Home Health - View certification, recertification, and Care Plan Oversight (CPO) coverage for home health and hospice services.

Hospice - Hospice care is a benefit under the hospital insurance program.

Incentive Programs - View variety of CMS programs with financial incentives for providers.

Incident To - View criteria, terminology, direct supervision, direct personal supervision, employment and billing information.

Medicare Secondary Payer (MSP) - View general MSP related information, information on Benefits Coordination & Recovery Center (BCRC), billing electronically, payment examples and access the payment calculator.

Modifiers - Modifiers can be two digit numbers, two character modifiers, or alpha-numeric indicators.

Non-Covered Services - View the differences between not medically necessary services/items and those statutorily excluded.

Noridian Medicare Portal (NMP) - Access General, Registration, End User, and Administrator function related guides and details.

Browse by Topic

Wound Care

Access the below wound care related information from this page.

Hyperbaric Oxygen (HBO) Therapy - Modality in which patient's entire body is exposed to oxygen under increased atmospheric pressure. View details

Skin Substitute Codes - The invoice price for payment of skin substitute codes in Q41XX-Q42XX range that do not have pricing on CMS quarterly ASP file is required. View submission details

Last Updated May 04 , 2022

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Last Updated May 04 , 2022

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- Remittance Advice (RA)
- Telehealth
- Wound Care

Skin Substitute Codes

If the CMS quarterly ASP file does not contain pricing for a skin substitute code that is within the Q41XX-Q42XX range, the claim must include the total invoice price (amount physician paid, per invoice, for patient's specific item).

We may reimburse for the total invoice price plus shipping but no additional fees (tax, handling fees, delivery fees, administrative fees).

Total invoice price is the net amount a provider pays for an item/service, taking into account ALL discounts, rebates, refunds, or other adjustments. *

ASP File Contains Code

- Enter number of units in Item 24G of CMS-1500 claim form or Loop 2400/SV104 for EMC

ASP File Does Not Contain Code

- Enter procedure code and total invoice price in Item 19 of CMS-1500 claim form or Loop 2400/SV101-7 for EMC
    - 'Invoice' or 'Inv' followed by the price in a currency format using a decimal
        - Examples:
            - Invoice $130 - claim priced at $1.30
            - Invoice $130.00 - claim priced at $130.00
            - Invoice 13000 - claim priced at $130.00
            - Invoice $13000 - claim priced at $130.00
            - Invoice $1,300 - claim priced at $1,300.00

A provider may bill wastage using the JW modifier. However, it is Noridian's expectation where there are multiple sizes of a specific product available, the size that best fits the wound with the least amount of wastage will be utilized by the provider. JW modifier is for single use only packaging and remnants billed as wastage may not be utilized on other patients.

If a provider intends to bill for wastage and total invoice price, please bill invoice price of the portion administered separately from invoice price of the portion discarded along with the JW modifier.

Example: Q41XX Invoice $XXX, Q41XX-**JW** Invoice $XXX

Any use of skin substitute codes must be accompanied **on the same claim** by a CPT/application procedure code consistent with use of the product. For example, CPT 15271-15278.

Products billed with Q4100 (skin substitute, not otherwise specified) must be at a minimum accompanied by the actual name of the product, number of units used, and total invoice price. In addition, Q4100 must be accompanied **on the same claim** by a CPT procedure/application code consistent with use of the product.

If the claim does not include the required information, the item will deny as unprocessable.

Providers must maintain an invoice copy within the patient's file, and it must be made available to Noridian upon request

Note: CMS ASP pricing does not equate to coverage, as provision of any item or service must also meet all Medicare statutory requirements.

References

(include but not limited to)

- Publication #15-1, The Provider Reimbursement Manual, Chapter 8, Section 804
- Medicare Fraud & Abuse: Prevent, Detect, Report (ICN MLN4649244)
- 42 U.S.C. § 1320a-7b(b)(3)
- 42 CFR § 1001.952
- SSA Section 1128J(d)

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Wound Care

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- Wound Care

Educational Resources

- Clinician's Checklist
- Education on Demand Tutorials

Hyperbaric Oxygen (HBO) Therapy

Hyperbaric Oxygen (HBO) therapy is a modality covered under Medicare in which the entire body is exposed to oxygen under increased atmospheric pressure. Program reimbursement for HBO is limited to services administered in a chamber.

On this page, view the following related information:

Coverage

The CMS HBO National Coverage Determination (NCD) 20.29 lists the indications and limitations of coverage.

HBO therapy is a valuable adjunctive treatment used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened. HBO is indicated within the first 4-6 hours of the acute event, and only after documented restoration of the blood circulation. For reperfusion injuries, crush injuries or pending compartment syndrome, therapy beyond 2-3 days has not shown beneficial salvage or further limit to loss of tissue or limb.

Documentation must support no measurable sign of healing for 30 days prior to starting HBO including wound measurements prior to the initiation of HBO and wound measurements after HBO. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

Noncovered Conditions

No program payment may be made for any conditions other than those listed in NCD 20.29 under A. Covered Conditions.

Documentation Requirements

Diabetic wound(s)

- Wagner grade classification (must be Wagner grade III or higher) with diagnostic testing to support Wagner grade
- Patient has type 1 or type 2 diabetes and has lower extremity wound due to diabetes
  - NCD does not cover surgical or injuries complicated by diabetes
- Documentation supporting prior failed treatment using standard wound care
- Documentation supporting there were no measurable signs of healing for at least 30 consecutive days of treatment when using standard wound therapy
- Evaluation of wound at least every 30 days during administration of HBO therapy that supports evidence of measurable signs of healing

Standard Diabetic Wound Care Therapy Prior to Starting HBO

- Assessment of patient's vascular status and correction of problems, if applicable
- Support of optimization of nutritional status
- Support of optimization of glucose control
- Support of debridement of the devitalized tissue
- Support of wound care management that includes maintenance of a clean, moist bed of granulated tissue with appropriate moist dressing
- Support of appropriate off-loading
- Support of treatment to resolve infection

The documentation submitted to a review entity should support the diagnosis used with HBO therapy. Clearly support wound measurements/assessments by providing documentation before and during HBO therapy.

BROWSE BY TOPIC

- Advance Beneficiary Notice of Noncoverage (ABN)
- Appeals
- Claims
- Clinical Trials
- Compliance Program
- Documentation Requirements
- Drugs, Biologicals and Injections
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Electronic Data Interchange (EDI)
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Documentation Requirements

Billing and Coding

Facility Services - UB-04 or electronic equivalent

Type of Bill (TOB)	• 0111, 0131, 0851
Revenue Code Applicable	• 0413 respiratory services

HCPCS	• G0277 HBO under pressure, full body chamber, per 30-minute interval
	  ◦ Medically Unlikely Edits (MUE) apply – five units per date of service based on clinical benchmarks
	• Add time for all processes included in treatment: descent, air breaks and ascent
	  ◦ 46-75 minutes = 2 units
	  ◦ 76-105 minutes = 3 units
	  ◦ 106-135 minutes = 4 units

Physician Services - CMS-1500 Claim Form

CPT	• 99183 - Physician or other qualified health care professional attendance and supervision per session ◦ MUE apply • Physician attendance and supervision of HBO therapy (CPT 99183) includes evaluation and management (E&M) services related to HBO therapy

Tips and Additional Information

- Calculate total number of 30-minute intervals billable under HCPCS G0277
  1. Time spent by patient under 100% oxygen
  2. Time for descent
  3. Time for air breaks and
  4. Time for ascent
- Additional units may be billed for sessions requiring at least 16 minutes of next 30-minute interval
- Providers can appeal a denial if date of service exceeds five units. Documentation submitted must support units of service in excess were reasonable and necessary
- Radionecrosis: Avoid denials. Send documentation to support diagnosis or to support that radiation therapy was at least six months prior to wound development
- E&M services integral to HBO therapy include, but are not limited to, updating history and physical, examining patient, reviewing laboratory results and vital signs with special attention to pulmonary function, blood pressure, and blood sugar levels, clearing patient for procedure, monitoring and/or assisting with patient positioning, evaluating and treating patient for barotrauma and other complications, prescribing appropriate medications, etc.
- Physician may report E&M services performed on same date of service of HBO with modifier 25, if a physician performs unrelated, significant, and separately identifiable services
- Medicare coverage of topical oxygen for treatment of chronic wounds will be determined by local Medicare Administrative Contractors (MACs)
- NCD lists non-covered items and services, such as cutaneous, decubitus, and stasis ulcers. Locate NCD for full list

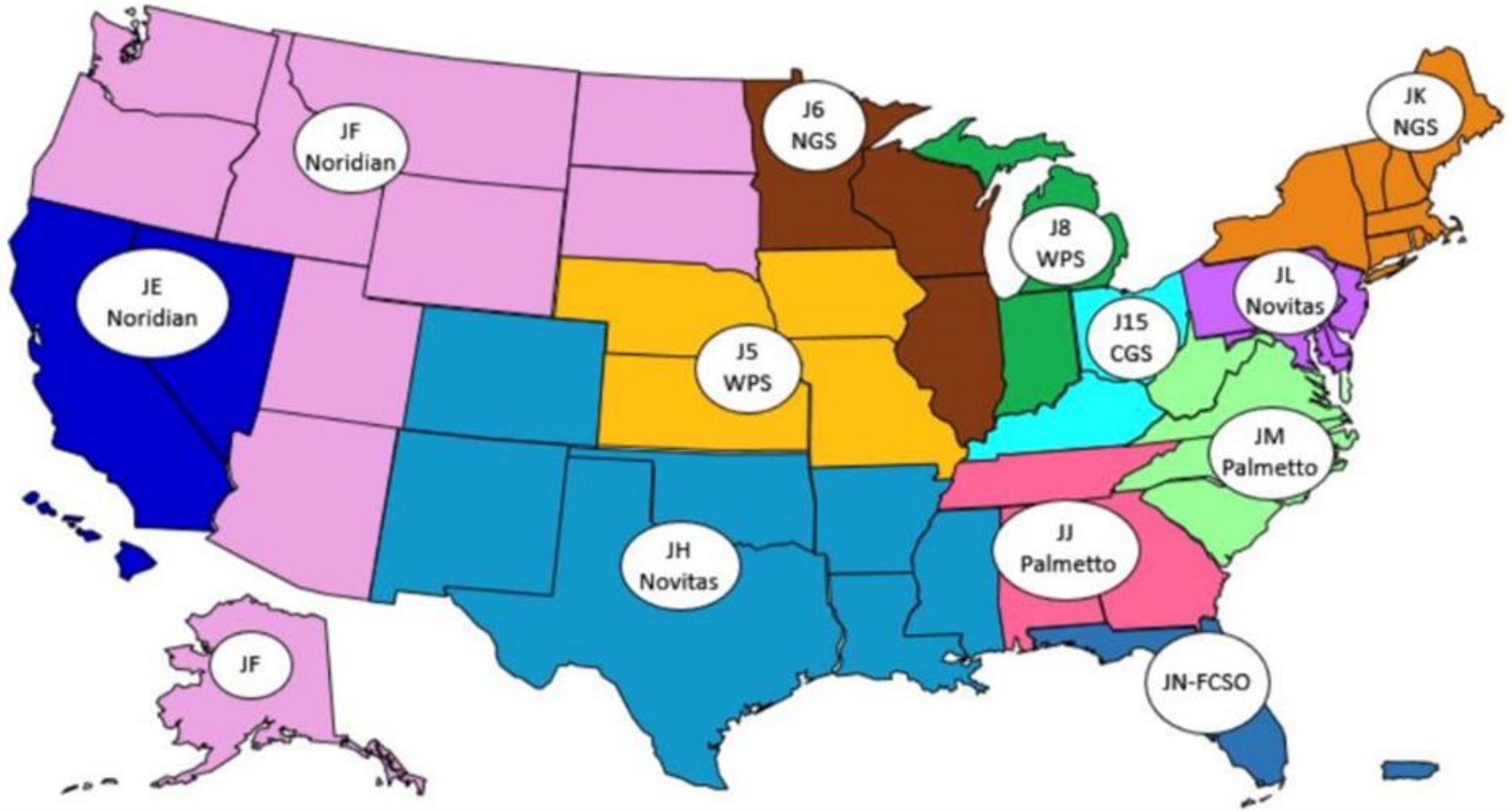
Resources

- CMS Internet Only Manual (IOM), Publication 100-03, Medicare National Coverage Determinations Manual (NCD), Chapter 1, Part 1, Section 20.29

New DME Update and Coding Information

- APMA & Private Conferences
- Covered in Dr Paul Kasselman's talks

A/B MAC Jurisdictions
as of October 2017



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- Cardiology
- Chiropractic
- Dental
- Diabetic, Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)
- End Stage Renal Disease (ESRD)
- Evaluation and Management (E/M)
- Fee-for-Time Compensation Arrangements and Reciprocal Billing
- Independent Diagnostic Testing Facility (IDTF)
- Laboratory
- Mental Health
- Nephrology
- Nonphysician Practitioner (NPP)
- Oncology / Hematology
- Optometry / Ophthalmology
- **Podiatry**
- Radiology
- Sleep Medicine
- Surgery

Podiatry

If provided by a physician (M.D.) or a Medicare-certified podiatrist (doctor of podiatric medicine, or DPM), medically necessary care for treatment of injury, disease, or other medical conditions affecting the foot, ankle, or lower leg is covered by Medicare Part B. Routine foot care that's not medically necessary is not covered.

Access the below podiatry related information from this page.

- Conditions that May Justify Foot Care Coverage
- Exclusions from Foot Care Coverage
- Foot Care for Patients with Chronic Disease
- Lower Extremity Wound Care
- Therapeutic Shoes for Persons with Diabetes: Decision-Making and Ordering

Resources

- CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 290

Last Updated Aug 13 , 2021

Related Articles

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Vulnerability

Educational Resources

- Podiatry Services Documentation Requirements
- MUE Lookup Tool

FEEDBACK

Podiatry

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Last Updated Aug 13 , 2021

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- Laboratory
- Mental Health
- Nephrology
- Nonphysician Practitioner (NPP)
- Oncology / Hematology
- Optometry / Ophthalmology
- Outpatient Therapy

Lower Extremity Wound Care

Electrostimulation and Electromagnetic Therapy for Wounds

CMS will allow for coverage for the use of electrical stimulation and electromagnetic therapy for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers when certain conditions are met

For more detailed information, see the CMS Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds National Coverage Determination (NCD).

Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)

For claims submitted on/after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy **only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy** and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, see the CMS Hyperbaric Oxygen Therapy NCD.

Last Updated Nov 03 , 2022

Therapeutic Shoes for Persons with Diabetes: Decision-Making and Ordering

Roles of various practitioners involved in the decision-making and provision process for diabetic shoes.

- **Certifying Physician:** The practitioner actively treating and managing the patient's systemic diabetic condition. This practitioner must be an M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) as outlined in the Social Security Act §1861(s) (12).
- **Prescribing Practitioner:** The Certifying Physician, a different MD or DO, physician's assistant (PA), nurse practitioner NP), clinical nurse specialist (CNS), or podiatrist (DPM). One of these practitioners may conduct the foot exam and write the detailed written orders required for Medicare's coverage of Therapeutic Shoes for Persons with Diabetes if the Certifying Physician does not complete the foot exam.
- **Supplier:** The person or entity that provides the shoes and/or inserts to the Medicare beneficiary and bills the Medicare program. A supplier may be a podiatrist, pedorthist, orthotist, prosthetist or other qualified individual. The Prescribing Practitioner may be the supplier.

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all the below criteria are met.

1. The beneficiary has diabetes mellitus (Reference diagnosis code section in the DME Policy Article (A52501)); and
2. The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:
   - Previous amputation of the other foot, or part of either foot, or
   - History of previous foot ulceration of either foot, or
   - History of pre-ulcerative calluses of either foot, or
   - Peripheral neuropathy with evidence of callus formation of either foot, or
   - Foot deformity of either foot, or
   - Poor circulation in either foot; and
3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes. The Certifying Physician must:
   - Have an in-person visit with the beneficiary during which diabetes management is addressed within six months prior to delivery of the shoes/inserts; and
   - Sign the certification statement on or after the date of the in-person visit and within three months prior to delivery of the shoes/inserts.
4. Prior to selecting the specific items that will be provided; the supplier must conduct and document an in-person evaluation of the beneficiary.
5. At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an objective assessment of the fit of the shoe and inserts and document the results.

The Certifying Physician must either:

BROWSE BY SPECIALTY

- Ambulance
- Ambulatory Surgical Center (ASC)
- Anesthesia and Pain Management
- Cardiology
- Chiropractic
- Dental
- Diabetic, Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)
- End Stage Renal Disease (ESRD)
- Evaluation and Management (E/M)
- Fee-for-Time Compensation Arrangements and Reciprocal Billing
- Independent Diagnostic Testing Facility (IDTF)
- Laboratory
- Mental Health
- Nephrology
- Nonphysician Practitioner (NPP)
- Oncology / Hematology
- Optometry / Ophthalmology
- Outpatient Therapy
- Podiatry
- Radiation Oncology
- Radiology
- Sleep Medicine
- Surgery

Therapeutic Shoes for Persons with Diabetes: Decision-Making and Ordering

Roles of various practitioners involved in the decision-making and provision process for diabetic shoes.

- **Certifying Physician:** The practitioner actively treating and managing the patient's systemic diabetic condition. This practitioner must be an M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) as outlined in the Social Security Act §1861(s) (12).
- **Prescribing Practitioner:** The Certifying Physician, a different MD or DO, physician's assistant (PA), nurse practitioner NP), clinical nurse specialist (CNS), or podiatrist (DPM). One of these practitioners may conduct the foot exam and write the detailed written orders required for Medicare's coverage of Therapeutic Shoes for Persons with Diabetes if the Certifying Physician does not complete the foot exam.
- **Supplier:** The person or entity that provides the shoes and/or inserts to the Medicare beneficiary and bills the Medicare program. A supplier may be a podiatrist, pedorthist, orthotist, prosthetist or other qualified individual. The Prescribing Practitioner may be the supplier.

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all the below criteria are met.

1. The beneficiary has diabetes mellitus (Reference diagnosis code section in the DME Policy Article (A52501)); and
2. The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:
   - Previous amputation of the other foot, or part of either foot, or
   - History of previous foot ulceration of either foot, or
   - History of pre-ulcerative calluses of either foot, or
   - Peripheral neuropathy with evidence of callus formation of either foot, or
   - Foot deformity of either foot, or
   - Poor circulation in either foot; and
3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes. The Certifying Physician must:
   - Have an in-person visit with the beneficiary during which diabetes management is addressed within six months prior to delivery of the shoes/inserts; and
   - Sign the certification statement on or after the date of the in-person visit and within three months prior to delivery of the shoes/inserts.
4. Prior to selecting the specific items that will be provided; the supplier must conduct and document an in-person evaluation of the beneficiary.
5. At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an objective assessment of the fit of the shoe and inserts and document the results.

The Certifying Physician must either:

Important in Audits

In your documentation:

- Use the language of the:
  - LCD
  - Local Carrier Articles
  - Medical Director Articles
  - the sample given in CPT book
  - Noridian Webinar Handouts

Various LCDs & LCAs

Local Coverage Determination
Local Coverage Article

Article - Billing and Coding: Routine Foot Care (A57954)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam

Article - Billing and Coding: Wound Care & Debridement – Provided by a Therapist, Physician, NPP or as Incident-to Services (A53296)

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Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern

Article - Billing and Coding: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A57079)

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Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii

Article - Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (A57161)

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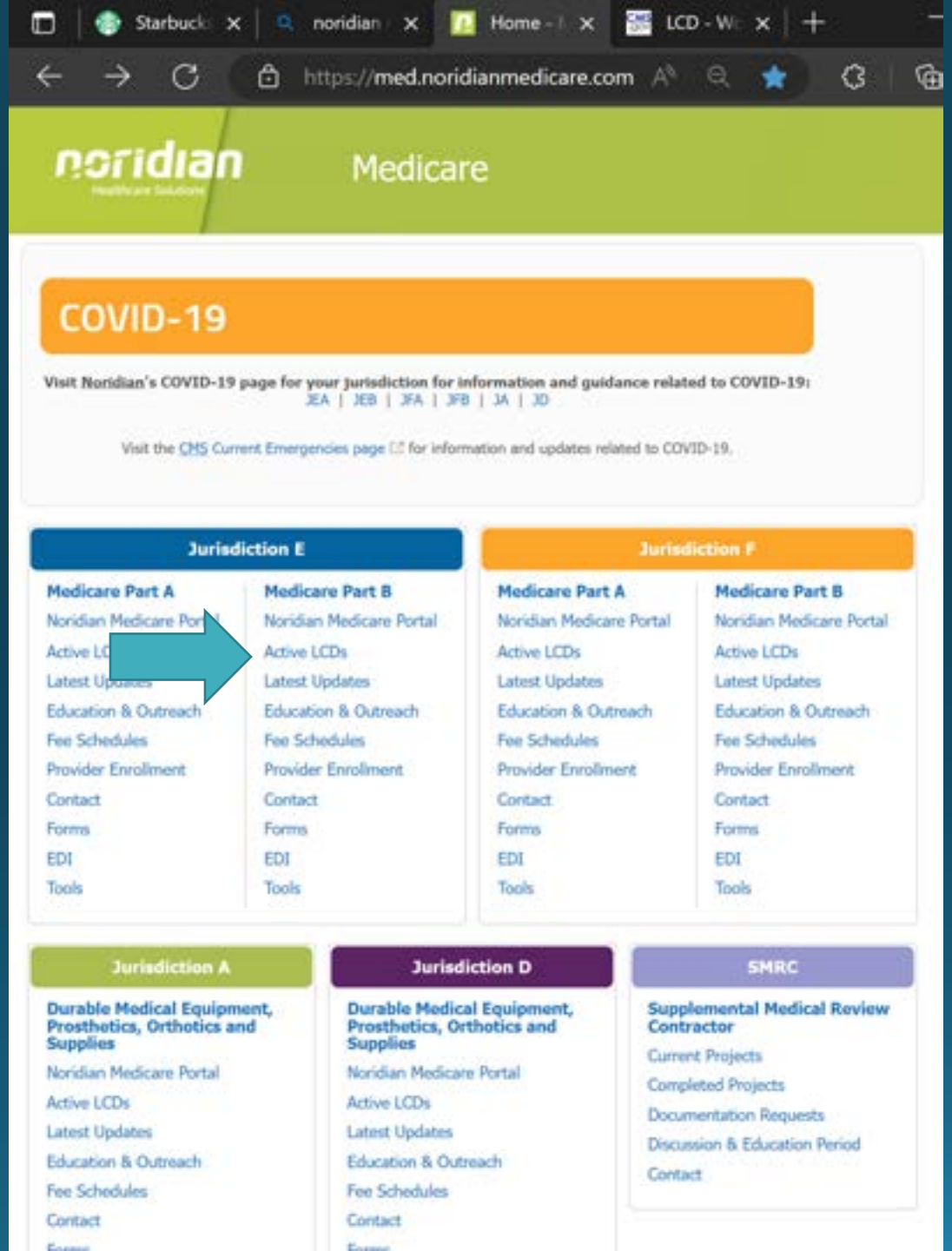
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions,	A and B MAC	01182 - MAC B	J - E	California - Southern

How Do you Find The LCD or LCA?


https://med.noridianmedicare.com
noridian
Medicare
COVID-19
Visit Noridian's COVID-19 page for your jurisdiction for information and guidance related to COVID-19:
JEA | JEB | JFA | JFB | JA | JD
Visit the CMS Current Emergencies page for information and updates related to COVID-19.
Jurisdiction E
Medicare Part A
Noridian Medicare Portal
Active LCDs
Latest Updates
Education & Outreach
Fee Schedules
Provider Enrollment
Contact
Forms
EDI
Tools
Medicare Part B
Noridian Medicare Portal
Active LCDs
Latest Updates
Education & Outreach
Fee Schedules
Provider Enrollment
Contact
Forms
EDI
Tools
Jurisdiction F
Medicare Part A
Noridian Medicare Portal
Active LCDs
Latest Updates
Education & Outreach
Fee Schedules
Provider Enrollment
Contact
Forms
EDI
Tools
Medicare Part B
Noridian Medicare Portal
Active LCDs
Latest Updates
Education & Outreach
Fee Schedules
Provider Enrollment
Contact
Forms
EDI
Tools
Jurisdiction A
Durable Medical Equipment, Prosthetics, Orthotics and Supplies
Noridian Medicare Portal
Active LCDs
Latest Updates
Education & Outreach
Fee Schedules
Contact
Jurisdiction D
Durable Medical Equipment, Prosthetics, Orthotics and Supplies
Noridian Medicare Portal
Active LCDs
Latest Updates
Education & Outreach
Fee Schedules
Contact
SMRC
Supplemental Medical Review Contractor
Current Projects
Completed Projects
Documentation Requests
Discussion & Education Period
Contact

https://med.noridianmedicare.com/web/jeb/policies/lcd/active

noridian

Jurisdiction E - Medicare Part B
California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands

Contact Us | Help | Tools | Noridian Medicare Portal (NMP) Login

Search

Browse by Topic | Browse by Specialty | Fees and News | Policies | Medical Review | Education and Outreach | Provider Enrollment | Forms

JE Part B / Policies / Local Coverage Determination (LCD) / Active LCDs

Share

POLICIES

- Local Coverage Determination (LCD)
  - **Active LCDs**
  - Proposed LCDs
  - Future LCDs
  - Retired LCDs
- Clinician's Corner
- Medicare Coverage Articles
- MolDX
- National Coverage Determination (NCD)
- Noridian Medical Directors
- Self Administered Drugs (SADs)

Educational Resources

Policy Related Forms

Medicare Coverage Database (MCD)

The official LCD version is in CMS Medicare Coverage Database

- California Northern - Contractor ID 01112
- California Southern - Contractor ID 01182
- Hawaii and Territories - Contractor ID 01212

Active LCDs

All LCDS are the same for each state within a Jurisdiction and are accessible from the table below.

Access LCD or Article: Select the LCD or Article number in the table below to view the policy or article on the Medicare Coverage Database (MCD).

Print the LCD or Article: Select the LCD or Article number in the table below to view the policy or article on the Medicare Coverage Database (MCD).

1. Click on the blue download arrow on the right side of page when LCD or Article appears.
2. Click the print when PDF opens.

View the ICD-9 to ICD-10 LCD number crosswalk.

Once you access the LCD, the "Coding Guidelines" can be found under the heading, "LCD Attachments" near the end of the document. Note: All CPT/HCPCS codes listed are mentioned in the LCD, but are not necessarily subject to diagnosis codes or coverage criteria.

Search for an LCD

LCD Title	LCD Number	Billing and Coding Companion Article	CPT / HCPCS Codes Referenced
Allergy Testing	L34313	A57181	86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95076, 95079
Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-	L39396	A59175	38240

Active LCDs

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LCD Title	LCD Number	Billing and Coding Companion Article	CPT / HCPCS Codes Referenced
Wound and Ulcer Care	L38902	A58565	11000, 11001, 11004, 11005, 11006, 11008, 11010, 11011, 11012, 11042, 11043, 11044, 11045, 11046, 11047, 11055, 11056, 11057, 29445, 29580, 29581, 97597, 97598, 97602, 97605, 97606, 97607, 97608, 97610

Local Coverage Determination (LCD)

Wound and Ulcer Care

L38902

Expand All | Collapse All

Contractor Information

LCD Information

Document Information

LCD ID
L38902

LCD Title
Wound and Ulcer Care

Proposed LCD in Comment Period
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Contents

Local Coverage Determination (LCD)

Wound and Ulcer Care

L38902

Expand All | Collapse All

Contractor Information

LCD Information

Document Information

LCD ID
L38902

LCD Title
Wound and Ulcer Care

Proposed LCD in Comment Period
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

LCD - Wound and Ulcer Care (L38902)

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Contractor Information

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Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana

LCD - Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (L34218)

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Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam

LCD - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L34233)

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Contractor Information

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Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands

BROWSE BY SPECIALTY

Podiatry

If provided by a physician (M.D.) or a Medicare-certified podiatrist (doctor of podiatric medicine, or DPM), medically necessary care for treatment of injury, disease, or other medical conditions affecting the foot, ankle, or lower leg is covered by Medicare Part B. Routine foot care that's not medically necessary is not covered.

Access the below podiatry related information from this page.

Resources

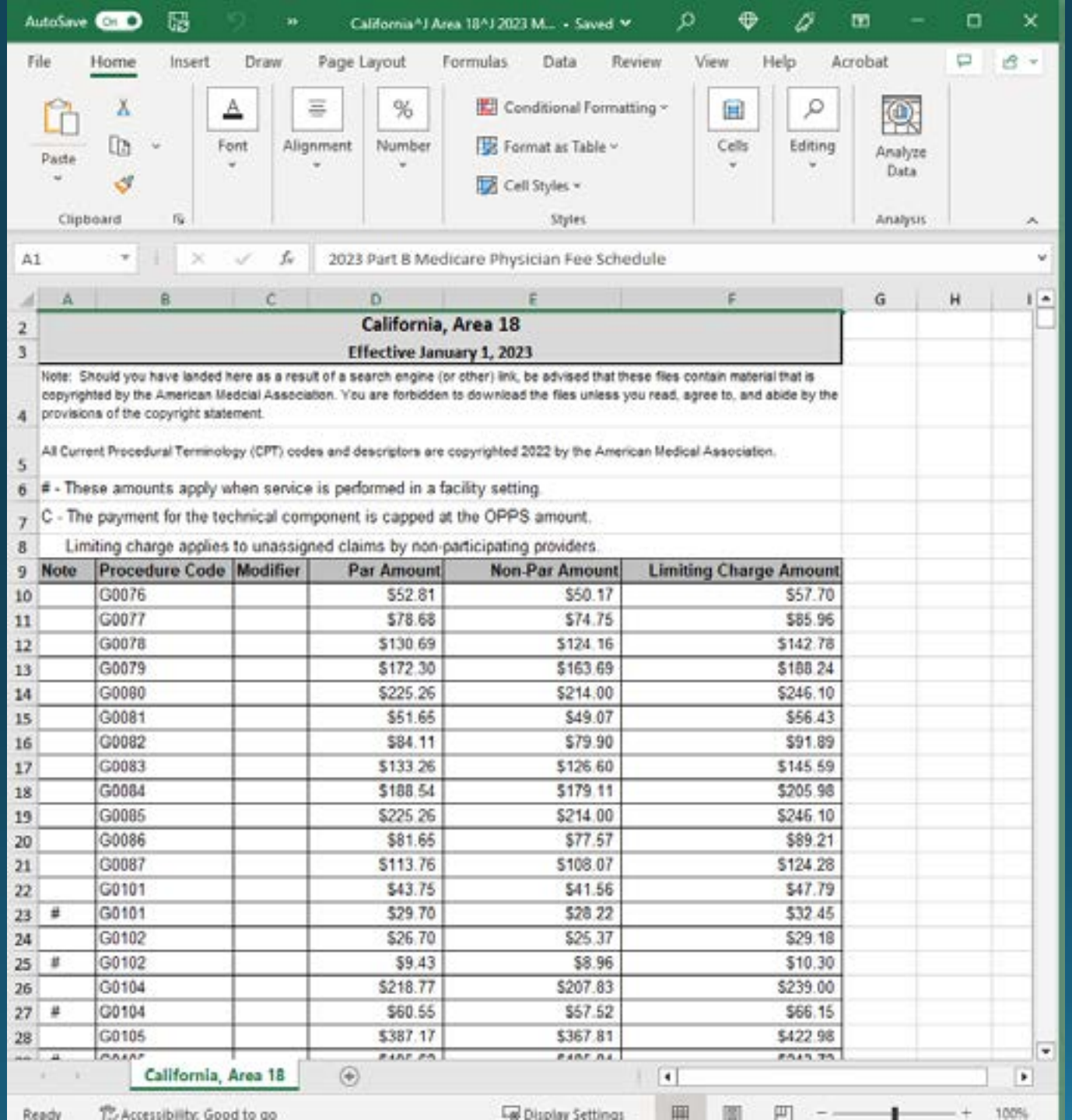
- CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 290

Last Updated Aug 13 , 2021

Vulnerability

Educational Resources

- Podiatry Services Documentation Requirements
- MUE Lookup Tool



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A1 | 2023 Part B Medicare Physician Fee Schedule

California, Area 18

Effective January 1, 2023

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- These amounts apply when service is performed in a facility setting

C - The payment for the technical component is capped at the OPPS amount.

Limiting charge applies to unassigned claims by non-participating providers.

Note	Procedure Code	Modifier	Par Amount	Non-Par Amount	Limiting Charge Amount
	G0076		$52.81	$50.17	$57.70
	G0077		$78.68	$74.75	$85.96
	G0078		$130.69	$124.16	$142.78
	G0079		$172.30	$163.69	$188.24
	G0080		$225.26	$214.00	$246.10
	G0081		$51.65	$49.07	$56.43
	G0082		$84.11	$79.90	$91.89
	G0083		$133.26	$126.60	$145.59
	G0084		$188.54	$179.11	$205.98
	G0085		$225.26	$214.00	$246.10
	G0086		$81.65	$77.57	$89.21
	G0087		$113.76	$108.07	$124.28
	G0101		$43.75	$41.56	$47.79
#	G0101		$29.70	$28.22	$32.45
	G0102		$26.70	$25.37	$29.18
#	G0102		$9.43	$8.96	$10.30
	G0104		$218.77	$207.83	$239.00
#	G0104		$60.55	$57.52	$66.15
	G0105		$387.17	$367.81	$422.98

California, Area 18

Ready | Accessibility: Good to go | Display Settings | 100%

Materials I Included

California Wound Healing Medical Group (323)264-7796 **Wound Assessment©** Page 1 Of ___

Patient: ☐ New Patient PMD: Date:

Facility: Room/Bed: D.O.B.: ☐ Established Patient Length of visit: minutes Provider:

Wound Type:
☐ Pressure ☐ Neuropathic
☐ Diabetic ☐ Trauma/Surgical
☐ Venous ☐ Mixed
☐ Arterial ☐ Other:

Factors Effecting Healing: ☐ Obesity ☐ Failure to Thrive ☐ Limited Mobility ☐ Hypoalbuminemia
☐ Diabetes ☐ CVA ☐ Respiratory Failure ☐ Hospice Status ☐ Weakness
☐ Neuropathy ☐ HTN ☐ PAD ☐ Medications
☐ Contracture ☐ CKD ☐ Patient non-compliant behavior
☐ CHF ☐ Other:

Discussion/Relevant Interim History: Last Exam Date:

☐ No report of Nausea, Vomiting, Fever, or Chills ☐ Medication List reviewed in patient chart, no action needed **Is this wound healable:** ☐ Yes ☐ No

Labs & Studies

Protein: Albumin: Pre-albumin:
HgbA1C: Sed Rate: CRP:
Last Blood Draw: _____ Last RD Evaluation: _____
Has there been a significant change in labs since last visit:
☐ Yes ☐ No
Other studies: (include results and comments)

Healing Factors

	Y	N		Y	N
Controllable?					
Pressure Reduction	☐	☐	Infection Control	☐	☐
Hydration Status	☐	☐	Vascular Disease	☐	☐
Nutritional Status	☐		followed with RD		
Metabolic Status	☐		followed with PMD		

Rationale:

Infection Control

☐ Wound Prophylaxis
Are there signs of possible infection ☐ Yes ☐ No
Studies: ☐ Culture & Sensitivity ☐ PCR
Intervention: ☐ Topical _____
Systemic antibiotics: ☐ PO ☐ IV

Peripheral Edema: ☐ Localized ☐ Generalized ☐ None
☐ Left ☐ Right ☐ Bilateral and Symmetrical
☐ Pitting ☐ Non-pitting ☐ Mild ☐ Moderate ☐ Severe
Stasis Changes?

Adequate Extremity Arterial Perfusion? ☐ YES ☐ NO
Evidence: ☐ Diminished Pedal Pulses
Capillary Refill Time: Right ___ sec Left ___ sec
Color: ☐ pink/normal ☐ erythematous ☐ pallor ☐ cyanotic
Distal Temp: ☐ warm ☐ cool ☐ cold ☐ ice-cold ☐ R/L and sym
Vascular Testing Performed: ☐ ABI ☐ Arterial Doppler
☐ $TcPO_2$ (digital O_2 perfusion) ☐ Toe-Brachial Index ☐ Angiogram
☐ Venous Doppler ☐ Venous Duplex ☐ Venography

Is vascular intervention planned? ☐ YES ☐ NO
Vascular specialist's opinion: ☐ patient healable
☐ candidate for surgical intervention and healable
☐ not a candidate for surgery, but healable
☐ not a candidate for revascularization surgery/not healable
Comments See note of _____

Nutritional Status

Current factors of concern:
☐ Decreasing BMI ☐ Increasing Risk of Pressure Injury
☐ Delay in Healing ☐ Increasing Loss of Weight
Interventions currently employed:
☐ Protein Supplement ☐ Protein Additive 3 6 8 gm/day
☐ MVI/Mineral supplement Add't Vitamins: A C D_3
Add't Mineral: Cu^{++} Fe^{++} Zn^{++}

Wound #: **Location:**
Pre- / Post- L / W / D /
Assessed Stage of Wound: 1 2 3 4
US DTI Non-Pressure
Wound Type (this wound):
Debridement: ☐ Selective ☐ Surgical ☐ Serial/Surgical

Prognosis

Healable: Goals
☐ Eventual Closure ☐ Convert to Self-care or Home Health (if patient's general health, medical issues, continuing adequate mental status, and home environment allow this change)
Non-healable: Goal – Palliation
Minimize the risk of the following:
☐ Additional Loss of Activity ☐ Psycho-social issues for the patient and their family
☐ Negative Progression of Wound ☐ Additional Devitalized Tissue ☐ Frequency of Hospitalization
☐ Hospital Length of Stay ☐ Infection ☐ Amputation ☐ Sepsis ☐ Death

Tissue Involvement/Uncovered: **Undermining:**
☐ Superficial ☐ Fascia ☐ Fat ☐ Muscle/Tendon
☐ Periosteum ☐ Bone ☐ Other: _____
Superior 9 3 Inferior
Drainage:
☐ None ☐ Scant ☐ Light ☐ Moderate ☐ Heavy ☐ Copious
Type: ☐ Serous ☐ Serosanguinous ☐ Seropurulent ☐ Purulent
Odor: ☐ None ☐ Increasing ☐ Decreasing
☐ Malodor ☐ Sweet ☐ Fecal ☐ Other _____
Wound Bed:
Pink % Yellow/White % Eschar % Slough %
Necrotic % Other: _____% Boney prominence ☐ Yes ☐ No
Sinus /Tunneling ☐ Yes ☐ No
Wound Margins & Periwound: (circle)
Intact Smooth Regular Macerated Hypergranular Epiboly Erythema Atrophic
Slough Thickened Irregular Friable Keratotic Indurated Ecchymosis Necrotic
Treatment: Topical & Dressing

Debridement Report: **Probe to Bone** ☐ Yes ☐ No
Debridement Level: I II III IV $AgNO_3$ Cautery
Instrument: 10/15 Blade Curette Scissors Nippers Forceps/Tweezers
Tissue Removed: Skin Fascia Fat Capsule Slough/Eschar/Necrosis
Hypergranulation Muscle/Tendon Bone
Hemostasis: EBL _____ cc ☐ None ☐ Minimal
☐ Pressure ☐ Gelfoam ☐ Thrombin
Pain: pre- /10 during Tx- /10 post- /10
Anesthesia: Pre-medicated Topical Injection None

Continue Debridement? ☐ Yes ☐ No ☐ Wound Closed
Rationale for Continued Debridement of this wound
Healable:
☐ Maintain the wound in the active/acute phase of healing
☐ Clinically, the wound is improving with continuing care, including regular surgical debridements.
☐ The wound is not amenable to self-care or homecare.
Non-healable:
☐ Continuing care with palliative goals (see above)
☐ Remove necrotic, non-vital and infected tissue from the wound

Hydration Consider Additional Hydration ☐ PO ☐ IV

Today's Treatment Plan

☐ Serial/Surgical Debridement performed today by the provider, with removal of biofilm, non-viable tissue, ☐ infected tissue ☐ excessive granulation
☐ Surgical debridement will continue as needed, performed by the provider, while non-selective active wound care continues by staff between visits
☐ Selective debridement will continue as needed, performed by the provider, while non-selective active wound care continues by staff between visits
☐ Pressure reduction and offloading continue: _____
☐ Healing factors addressed: ☐ Recommend Comprehensive RD Evaluation
☐ No New Orders

Continues →

Provider Signature: Supervising Physician: ☐ Kimberly Conley, MD ☐ James E Burrows, MD ☐ Herbert Marshak, MD

MEDICARE UPDATE FOR 2025

From APMA CAC/PIAC Meeting

Nov 15 , 2014

Washington, DC

Referencing: Noridian Medical Director, Cindy Moon, APMA,

PFS Topics

- Overall Payment Impacts
- Telehealth and Telemedicine E/M Services
- Global Surgical Services
- Skin Substitutes

2025 MEDICARE PHYSICIAN FEE SCHEDULE (PFS) FINAL RULE

Overall Payment Impacts

- **Final 2025 Conversion Factor**: 32.3465 (-2.83% compared to 2024)
  - *0.0% statutory annual update*
  - *0.02% budget neutrality adjustment*
  - *Elimination of Congressional assistance that was available for most of 2024 (2.93%)*

- **Overall CMS-estimated PFS impact on podiatrists for 2025:** 0%, *not including the elimination of the 2.93% Congressional assistance for 2024*

- *I found a less than 1% reduction of the fees off of the PFS when compared to the PFS 2024*

- *Congress has failed to rectify the reductions nor fix the formula by using the CPI for the determination odthe Conversion Factor for PFS*

HEALTHCARE LEGISLATION

Bill Introduced to Reverse 2.83% Physician Medicare Cuts

A bipartisan coalition of 10 House lawmakers introduced legislation on Jan. 31 aimed at reversing a 2.83% Medicare physician payment reduction and implementing a 2% increase to help stabilize physician practices and protect patient access to care. If enacted, the Medicare Patient Access and Practice Stabilization Act would retroactively nullify the 2.83% cut that took effect on Jan. 1, with changes set to take effect on April 1. A similar proposal garnered bipartisan, bicameral backing in December, but Congress ultimately failed to act on it before the end of the session.

The American Medical Association has strongly endorsed the measure, pledging to collaborate with lawmakers to incorporate it into forthcoming legislation to extend federal government funding beyond the March 14 deadline.

JAN 23, 2023

- Dear Senator/Representative,
- On behalf of the undersigned physician and non-physician organizations, representing more than one million clinicians and the patients they serve, welcome to the 118th Congress. Our combined memberships represent a *significant* portion of the clinicians in this nation, and we remain committed to ensuring America's seniors have access to high-quality care. Reforming the Medicare payment system is a crucial step in maintaining the clinician workforce that is necessary to serve America's seniors. We urge this Congress to hold Congressional hearings and work with all stakeholders to explore long-term payment solutions.
- While Congress has taken action to address some of these fiscal challenges by mitigating some of the recent Medicare Physician Fee Schedule (MPFS) cuts, payment continues to decline. According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, Medicare payments to clinicians have declined by 22% from 2001–2021.

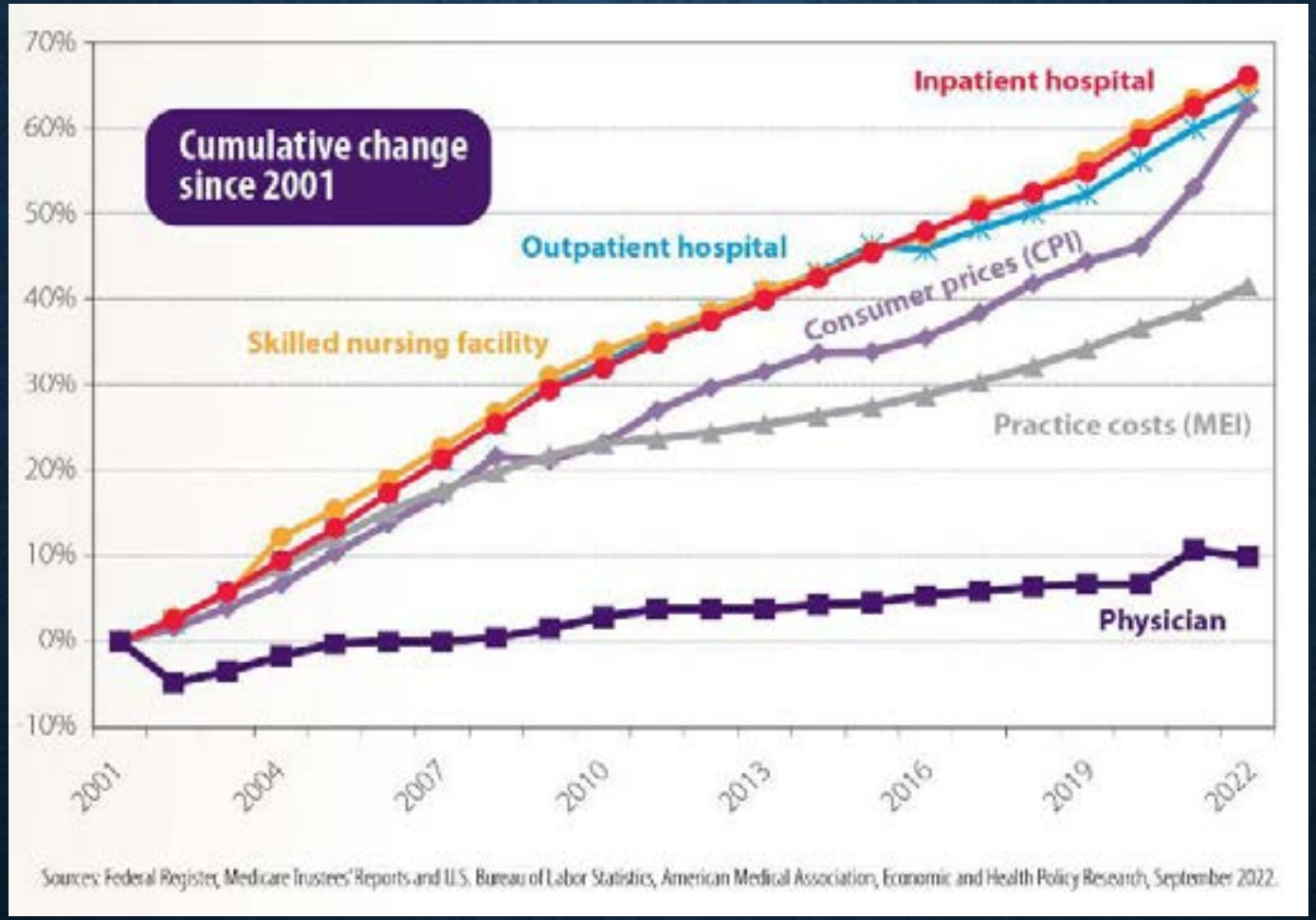
JAN 23, 2023

- Additionally, the MPFS lacks an annual inflationary update, even though clinicians — many of whom are small business owners — contend with a wide range of shifting economic factors, such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology when determining their ability to provide care to Medicare patients. The absence of an annual inflationary update, combined with statutory budget neutrality requirements, further compounds the difficulties our members face in managing resources to continue caring for patients in their communities.
- These year-over-year cuts, combined with a paucity of available alternative payment/value-based care models, clearly demonstrate that the Medicare payment system is broken. These systemic issues will continue to generate significant instability for health care professionals moving forward, threatening patient's timely access to essential health care services to seniors

JAN 23, 2023

- We again ask Congress to work with us on long-term, substantive payment reforms and urge Congressional hearings as soon as possible to begin exploring potential payment solutions to ensure America's seniors continue to receive access to the high-quality care they deserve.

- Signed by 110 medical associations and societies


Cumulative change since 2001
Inpatient hospital
Outpatient hospital
Skilled nursing facility
Consumer prices (CPI)
Practice costs (MEI)
Physician
70%
60%
50%
40%
30%
20%
10%
0%
-10%
2001
2004
2007
2010
2013
2016
2019
2022
Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022.

Medicare Telehealth Services

- Congress extended several COVID-19 PHE telehealth flexibilities through 2024, including:
  - Waiver of geographic restrictions
  - Waiver of originating site requirements
  - Expansion of the types of providers eligible to furnish services via telehealth (FQHCs, RHCs, PTs, OTs, SLPs, and Audiologists, plus MFTs and MHCs for 2024)
- Absent Congressional action , these flexibilities expired in 2025.

Additional Flexibilities CMS is Extending Through 2025

- Removal of telehealth frequency limitations for:
  - Subsequent inpatient visits
  - Subsequent nursing facility visits
  - Critical care consultation services
- Direct supervision via use of two-way audio/video communications technology
- Use of virtual presence for teaching physician supervision – only when the service is being furnished virtually (resident and patient in different locations)
- Waiver of requirement to report home address if they are providing telehealth services from their homes

Additional Updates to Telehealth Policy for 2025 and Beyond

- Permanently allowing audio-only telehealth when the following conditions are met:
  - Beneficiary is in their home
  - Physician is technically capable of using an interactive telecommunications system that includes:
    - Two-way, real-time interactive communication
    - Audio and video capability
  - Beneficiary is not capable of, or does not consent to, the use of video technology
- Services must be reported with the following modifier to verify that the above conditions have been met:
  - *93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system*
- Note: Absent Congressional action, only a few services may be furnished to beneficiaries in their homes (i.e., for diagnosis, evaluation, or treatment of a mental health or substance use disorder, and for certain monthly ESRD-related clinical assessments).

Additional Updates to Telehealth Policy for 2025 and Beyond

- Direct supervision via two-way/audio-video communications technology on a permanent basis for a subset of services:
  - Services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'
  - Services described by CPT code 99211 (*Office or outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care practitioner*)

TELEMEDICINE E/M VISITS

Codes	Code Descriptors	Final Rule Status
98000-98007	*Synchronous audio-video visit for the evaluation and management of a new or established patient*	• No separate payment. • Assigned status indicator "I" – *Not valid for Medicare purposes* • Providers should instead bill office and outpatient E/M codes.
98008-98015	*Synchronous audio-only visit for the evaluation and management of a new or established patient*	
98016	*Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion*	• Separate payment will be provided for 98016 in lieu of previous HCPCS code G2012. • Not considered a "telehealth" service.
99441-99443	*Telephone E/M services*	• Deleted by CPT Editorial Panel. • Not recognized for separate Medicare payment in 2025.

Global Surgical Services

- CMS reiterated its ongoing concerns with valuation of global surgical packages
- CMS stated, however, that MACRA (2015) precludes the Agency from revisiting the proposal to convert all 10- and 90-day globals to 0- day globals
- CMS focused on billing and coding to address some of its concerns:
  - Transfer of Care Modifier Expansion
  - Addition of Non-Surgeon Post-op Visit Code G0559

Global Surgical Services (cont.)

TRANSFER-OF-CARE MODIFIER EXPANSION

- Modifier ~ 54 (Surgical Care Only): Append to relevant global package code to indicate that the proceduralist performed only the surgical procedure portion of the global package
- Currently, for use when there is a "formal documented transfer of care agreement, that is, 'in the form of a letter or an annotation in the discharge summary, hospital record, or Ambulatory Surgical Center (ASC) record'"
- For 2025 onward, for 90-day globals only:
  - Modifier -54 should be applied to "instances when a practitioner only intends to perform the procedure and does not intend to provide the post-operative care," even when there is no formal, documented transfer of care

Global Surgical Services (cont.)

NON-SURGEON POST-OP VISIT CODE G0559

- CMS finalized a new E/M add-on code, G0559, "*that would account for resources involved in post-operative care for a global surgical package provided by a practitioner who did not furnish the surgical procedure and does not have the benefit of a formal transfer of care*"
- **Add-on code can be billed only once during the 90-day global period.**
- Can be billed by another practitioner in the same specialty as the practitioner who performed the procedure, but not in the same practice.
- CMS "would expect the documentation in the medical record to indicate the relevant surgical procedure, to the extent the billing practitioner can readily identify it, in order to aid our understanding of the post-operative care being furnished when there is no transfer of care modifier appended on the claim"

NON-SURGEON POST-OP VISIT CODE G0559

G0559 *(Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:* wRVU: 0.16

Global Surgical Services (cont.)

Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.

Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).

Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.

Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established)).

Skin Substitutes Update – PFS:

Official CMS Stance

- No new national proposals or final policies for 2025 under rulemaking
- CMS will “continue examining ways to treat skin substitute products as incident-to supplies under the [Physician Fee Schedule] ratesetting methodology.”
- ----------
- Must take into account a new Administration in the White House and in CMS
- Negotiations ongoing with the new Administration in Mar a Lago
- The stakeholders are the manufacturers, distributors, several authors. Three groups that have the ears of Administration Leadership.
- Expectation of the new LCD to be removed
- Negotiation for a new NCD
- Estimation of 1-2 years; possibly sooner
- Control of prices but wider use of CTPs

Skin Substitutes Update - LCDs

- Final LCDs on skin substitutes for DFU and VLU were issued by all Carriers, including Noridian.

- Some key takeaways:
  - Only 20 named products permitted for DFUs and only 5 products permitted for VLU; more than 200 codes considered non-covered
  - Up to 8 applications allowed, up from 4 in the draft LCD
    - KX modifier required after 4 application
    - Explanation for the medical necessity for the additional 4 applications.
    - Absolute stopping after 8 applications
  - An episode of care is considered up to 16 weeks, up from 12 in the draft LCD

- Final LCDs were to be effective starting February 12, 2025.

- The effective date was postponed by CMS, to April 13th , to allow the new administration time to review the LCD & LCA

- The webinar scheduled in Feb was postponed until September to allow new instructions to the carriers

Medicare Advantage

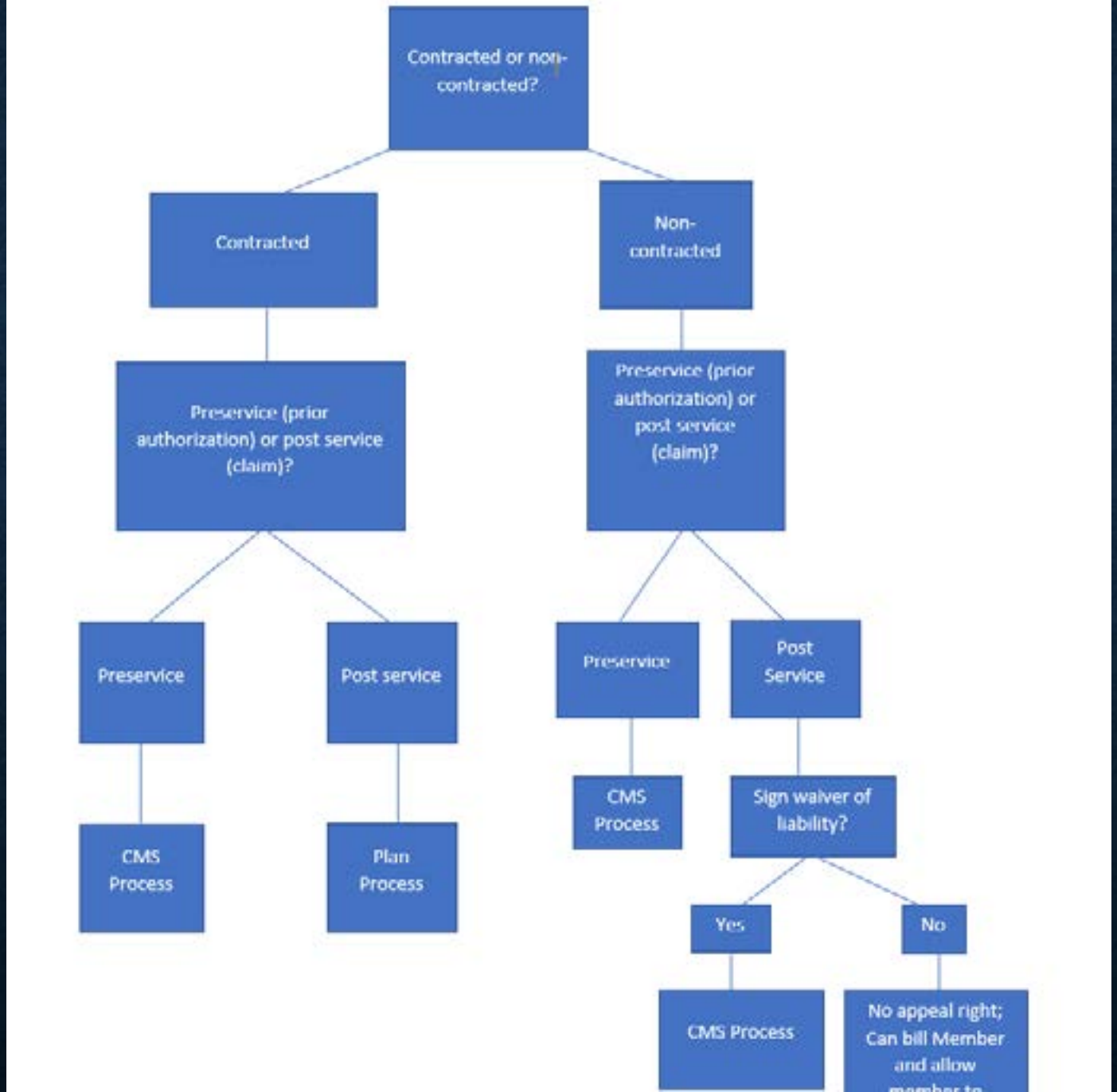
Determinations and Appeals

Part C Services

Regulatory Process[1]	Plan Process
Initial Decisions Claims payment determination – clean claims submitted by enrollees or non-contract providers must be paid in 30 days. All other claims submitted by non-contract providers must paid in 60 days. [42 CFR 422.520(a)] Pre-service organization determinations – Standard decisions must generally be made in 14 days.[2] [42 CFR 422.568] Expedited preservice organization determinations – Decisions must be made within 72 hours. An MAO must expedite a determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum. [42 CFR 422.572] Appeals[3] (1) Reconsideration – a reconsideration must be requested within 60 days of an adverse organization determination unless good cause is shown. [42 CFR 422.582(b) and (c)] Standard Reconsideration Decisions -- The plan must make a standard pre-service	Initial Decisions Claims payment determination – claim must be paid within the prompt payment timeframe set forth in agreement between the plan and provider. [42 CFR 422.520(b)] (Note that state prompt payment laws are preempted.) Appeals No process is prescribed by regulation. The plan process is determined by the relevant plan or by the parties through contract negotiations. Note that in reviewing Medicare Advantage plan policies, some of the largest plans (United, Humana and Anthem) offer two levels of internal appeals and no external appeals.

[1] Note that different (shorter) timeframes apply with regard to Part B drugs, but the process is the same. This chart does not address Part D drugs.

MA Appeals


Contracted or non-contracted?
Contracted
Non-contracted
Preservice (prior authorization) or post service (claim)?
Preservice (prior authorization) or post service (claim)?
Preservice
Post service
Preservice
Post Service
CMS Process
Plan Process
CMS Process
Sign waiver of liability?
Yes
No
CMS Process
No appeal right; Can bill Member and allow

E/M DOCUMENTATION (MY OPINION)

- The E/M documentation changes have placed an emphasis on time as well as MDM.
- Allowed all specialties to approach the higher E/M codes
- Podiatric Medicine has the same opportunity as any other specialty to use the higher codes, without the burden of more difficult paperwork. This was one of the reasons CMS initiated the changes
- We as an association need to create models to assist our members to successfully document to the higher levels.
- This will help to alleviate the budget cuts, and allow our members to use the G2211 code for complexity.
- The complexity should be specific to the specialty, as does the level of the E/M coding

E/M Services: G221

- G2211: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

- All specialties may use the code
- **Background/history:**
  - Previously finalized for implementation in 2021 (with other O/O E/M changes)
  - Subject to a Congressional payment moratorium until 2024
  - Billable/reportable, but assigned a bundled-payment status indicator with no associated payment

E/M Services: G2211 (cont)

- 2024 final policy: "Active" status indicator
  - Work RVUs = 0.33
  - Total RVUs (facility and non-facility): 0.49
- Billing considerations:
  - Add-on code for O/O E/M visits
  - Can be billed with new and established patients
  - Cannot be billed when the O/O E/M is reported with payment modifier -25
  - Reliant on having an appropriate ongoing relationship between the patient and practitioner, not when the care is of a "discrete, routine, or time-limited nature"
  - Not restricted for use based on specialty
- **Notably, CMS expects that the code will be billed with O/O E/M codes 54% of the time once it's fully adopted**
- Estimated to add $16.00 to the E/M code used on the visit

RPM and RTM Services Clarifications following PHE

- RPM services may only be furnished to established patients
  - Same restriction does not apply to RTM for 2024, but CMS seems likely to revisit through future rulemaking
- 16-day data collection requirements apply for RPM and RTM *data collection codes* but not for *treatment management codes*
- RPM and RTM services:
  - Cannot be billed concurrently with each other
  - Should only be reported once during a 30-day period
  - Can only be billed by one practitioner per beneficiary per month
  - Can be billed with CCM, TCM, BHI, PCM, and Chronic Pain Management services if all requirements to report each service are met and time/effort is not counted more than once
  - May be billed during a global period if certain conditions are met

Appropriate Use Criteria (AUC) Program

- AUC Program:
  - Established in 2014 via the Protecting Access to Medicare Act (PAMA)
  - Required consultation of appropriate use criteria for physicians ordering certain advanced diagnostic imaging, reporting of such consultation, and real-time claims reporting, among other activities
  - Implemented in phases over time, but never enforced
  - Resulted in numerous operational challenges for CMS
- Final Policy: To pause the AUC program and to rescind existing AUC regulations
- APMA had opposed the AUC program requirements due to concerns about provider burden, operational challenges, and patient access considerations
- CMS will "continue efforts to identify a workable implementation approach"

ADDITIONAL RPM & RTM DETAILS

Remote Physiologic Monitoring
Remote Therapeutic Monitoring

RPM CODE DESCRIPTORS

CPT	Code Descriptor
99453	*Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment*
99454	*Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*
99457	*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*
99458	*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)*

RTM CODE DESCRIPTORS

CPT	Code Descriptor
98975	*Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment*
98976	*Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days*
98977	*Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days*
98978	*Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days*
98980	*Remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes*
98981	*Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure*

NEW CPT CODES

APMA CRC

CODING LECTURE 2025

First, a quick summary

CPT codes 2025 includes 270 new codes, 112 revised codes, and 49 deleted codes.
There are no code changes for anesthesia, respiratory, or auditory services.
The most significant changes are to telemedicine evaluation and management (E/M) services, skin substitutes, laboratory and pathology services, and Category III codes or technology codes.

HOME / DOMICILE E/M CODING

A Review of 2024

HOME OR DOMICILE E/M SERVICES, NEW PATIENT

- 99341, straightforward medical decision making (MDM) or at least 15 minutes total time,
- 99342, low level MDM or at least 30 minutes total time,
- 99344 (code 99343 has been deleted), moderate level MDM or at least 60 minutes total time,
- 99345, high level MDM or at least 75 minutes total time.

HOME OR DOMICILE SERVICES, ESTABLISHED PATIENT

- 99347, straightforward MDM or at least 20 minutes total time,
- 99348, low level MDM or at least 30 minutes total time,
- 99349, moderate level MDM or at least 40 minutes total time,
- 99350, high level MDM or at least 60 minutes total time.

HOME OR DOMICILE SERVICES, ESTABLISHED PATIENT

- Select these codes based on either your level of medical decision making or total time on the date of the encounter, similar to selecting codes for office visits. The E/M codes specific to domiciliary, rest home (e.g., boarding home), or custodial care (99324-99238, 99334-99337, 99339, and 99340) have been deleted, and the above codes should also be used in those settings.

HOME OR DOMICILE SERVICES

- Select these codes based on either your level of medical decision making or total time on the date of the encounter, similar to selecting codes for office visits.
- The E/M codes specific to domiciliary, rest home (e.g., boarding home), or custodial care (99324-99238, 99334-99337, 99339, and 99340) have been deleted, and the previous codes should also be used in those settings.

NURSING FACILITY, INTERMEDIATE CARE INTELLECTUAL DISABILITY, PSYCH RESIDENTIAL

- Services provided in facilities where significant medical or psychiatric care is available (e.g., nursing facility, intermediate care facility for persons with intellectual disabilities, or psychiatric residential treatment facility) are reported with codes 99304-99310.

G0318 PROLONGED TIME

- For Medicare
- The CPT for the non-Medicare : 99417

- For 99345: New >140 min
- For 99350: Established >110 min

- Includes any work 3 days prior to the visit and 7 days after the visit

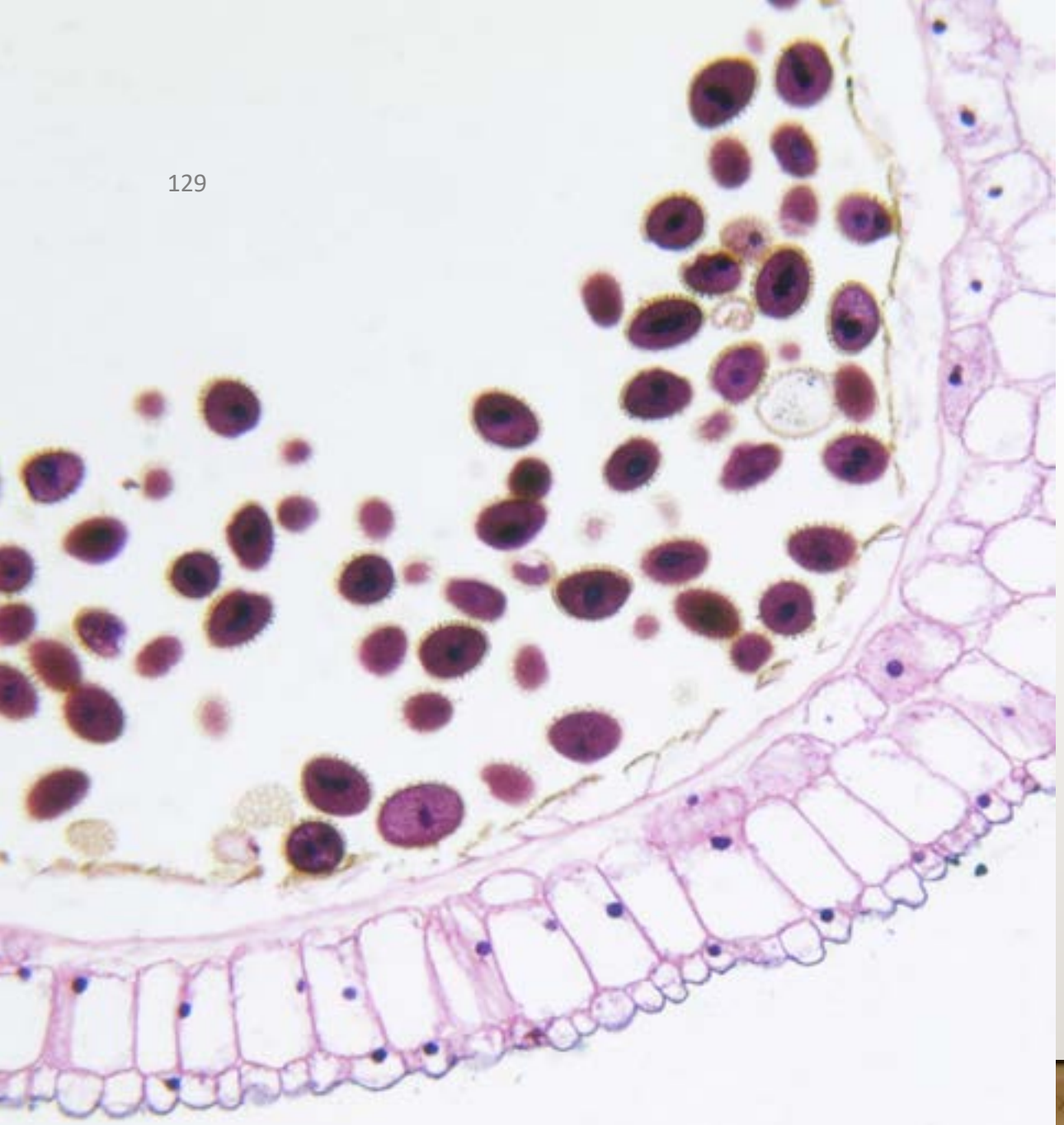
G0318 / 99417 ADD-ON CODES

- When total time on the date of the encounter exceeds the threshold for code 99345 or 99350 by at least 15 minutes, you can add code 99417 to report prolonged services.
- The exception to this is for patients with Medicare. For those patients, report prolonged home or residence services to Medicare with code G0318 in addition to 99345 (**requires total time ≥140 minutes**) or 99350 (**requires total time ≥110 minutes**). Code G0318 is not limited to time on the date of the encounter, but includes any work within three days prior to the service or within seven days after.

SELECTING CPT CODES: HAS NOT CHANGED

- Select the CPT code of the procedure or service that **accurately identifies** the procedure or service performed. Do not select a CPT code that merely **approximates** the procedure or service provided.

- **Furthermore, all the language within a code descriptor should be assessed when selecting the appropriate procedure or service. This includes information directly in the description that may be enclosed in parentheses.**



Example: Parenthesis

- CPT® 11042 - Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

'UNSPECIFIED' VS. 'OTHER'

- When reading from the CPT / ICD-10 books or quotations, be aware of the difference between the words: **unspecified** and **other.**
- Unspecified: When the medical records do not identify portion of the description of the CPT / ICD-10 code.
  - Laterality: neither left nor right
  - Condition: infected nor non-infected
  - **Means the medical record was incomplete : It is on us**
- Other: When the descriptors in the CPT / ICD-10 do not cover the physical findings
  - **It is not our fault**

EXAMPLE: "UNSPECIFIED VS. OTHER"

S93.40 - Sprain of **unspecified** ligament of ankle

S93.41 - Sprain of calcaneofibular ligament

S93.42 - Sprain of deltoid ligament

S93.43 - Sprain of tibiofibular ligament

S93.49 - Sprain of **other** ligament of ankle

NEW CPT CODES FOR 2025

TELEMEDICINE : EVALUATION & MANAGEMENT

- In the E/M section, descriptors for telephone services codes (99441-99443) were deleted and a new family of codes was created for telemedicine services that includes synchronous audio-video E/M for new patients (98000-98003) and established patients (98004-98007) and synchronous audio-only E/M for new patients (98008-98011) and established patients (90012-90015). A new code, 90016, was introduced for virtual check-in visits
- Section guidelines added for the new family of telemedicine services explain proper use of these CPT® codes, which are based on either medical decision making or total time. A new table added to the subsection further clarifies coding for telemedicine and non-face-to-face digital services.

TELEMEDICINE

- Beginning Jan. 1, CPT codes 99441–99443 are no longer available. Modifiers 93 and 95, indicating the service was provided via audio-only or audio-visual technologies, are no longer required (except for Medicare claims). The new code descriptors identify how the service was performed to streamline the coding process, eliminating the need for modifiers.
- Telemedicine * removed from CPT 99202 - 99205 and 99211 - 99215
- Telemedicine = Synchronous, real-time, interactive encounter
  - **Uses either combined audio-video or audio-only**

TELEMEDICINE

- Telemedicine services are not used to report **routine** telecommunications related to a previous encounter (eg, to communicate laboratory results).
  - E/M
- Patient or office can initiate the call
- Cannot be same day as an in-person E/M,
- Otherwise no restrictions

TELEMEDICINE

- It is expected that the provider has capability for synchronous Audio-Video E/M. The patient can elect to use Audio-only
- If using time for the coding, the time documented should be > or equal to the minimum listed for the E/M
  - 98002 – 45 minutes minimum

Breakdown of New CPT Codes 2025 for Audio-Visual Visits

New Patient Visits	Code	Established Patient Visits	Code
Straightforward MDM (15 minutes)	98000	Straightforward MDM (15 minutes)	98004
Low MDM (30 minutes)	98001	Low MDM (30 minutes)	98005
Moderate MDM (45 minutes)	98002	Moderate MDM (45 minutes)	98006
High MDM (60 minutes)	98003	High MDM (60 minutes)	98007
Prolonged Services (75+ minutes)	+99417	Prolonged Services (75+ minutes)	+99417

NEW AUDIO-VIDEO CODES

- **Audio-video codes:** Eight new synchronous **audio-video visit** codes have been introduced. These include codes like **98000**, which cover an audio-video visit for evaluating and managing a new patient.
- This code requires a medically appropriate history and/or examination with straightforward medical decision-making and a **minimum of 15 minutes** when using **total time** for code selection.
- At the higher end, code **98003** applies to visits involving high medical decision-making, requiring a minimum of 60 minutes for selection based on total encounter time.

NEW AUDIO-ONLY CODES

- **Deleted: 99441 – 99443**
- **Telephone E/M**

- **Replaced by a new set of Audio-Only E/M Codes**

NEW AUDIO-ONLY CODES

- **Audio-only codes:** Eight new synchronous **audio-only visit codes** have been introduced. For example, **98008** – this code applies to audio-only visits for the evaluation and management of an **established patient**, requiring a medically appropriate history and/or examination, straightforward medical decision-making, and over 10 minutes of medical discussion.
- Code selection is based on total time; a minimum of 15 minutes must be met or exceeded. Similarly, code **98015** covers visits with high medical decision-making, over **10 minutes of medical discussion**, and at least **40 minutes when using total time** for code selection.
- Audio-only for new patients – use codes **98008-98011**. Audio-only for **follow-up visits use codes 98012-98015**.

AUDIO-ONLY E/M

- **A word of caution – many insurance payers are NOT covering audio-only. Please check state guidelines before booking a patient consult for audio-only.**
- **Other crucial E/M guidelines for 2025** – when selecting a code based on total time on the date of the encounter, each of the new codes has a **specific minimum time requirement**. For instance,
- **98012** is straightforward MDM requiring 10-19 minutes;
- **98013** requires low MDM or 20-29 minutes;
- **98014** requires moderate MDM or 30-39 minutes;
- **98015** requires high MDMor 40-54 minutes.

VIRTUAL CHECK-IN CPT

- **The virtual check-in CPT code is 98016.**
- It is used for a brief virtual check-in with an **established** patient.
- It's used when a patient or caregiver **requests** a 5–10-minute medical discussion to determine if a more intensive E/M service is required.
- Not originating from a related E/M service provided within **prior 7 days** nor leading to a service within the **next 24 hours** or soonest available appointment.

AMERICAN RELIEF ACT, 2025 : HR 10545

- **Note – On Dec. 21, 2024, President Biden signed into law H.R. 10545, the American Relief Act, 2025.**
- **The following telehealth flexibilities have been extended until March 31, 2025:**
  - Eliminating geographic restrictions and broadening the range of originating sites for telehealth services.
  - Expanding the types of practitioners authorized to provide telehealth services.
  - Continuing telehealth services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
  - Postponing the in-person visit requirements for Medicare mental health services delivered via telehealth and telecommunications technology.
  - Permitting the provision of audio-only telehealth services.
  - Allowing telehealth to fulfill face-to-face encounter requirements before recertification.

INTEGUMENTARY SYSTEM CPT CODES 2025

SCSA – SKIN SUSPENSION AUTOGRAFT

- **There are eight new skin cell suspension autograft (SCSA) codes.**
- **Harvesting**: Skin suspension autograph codes and skin harvesting codes by size – 15011,15012
- **Preparation**: Skin suspension autograph codes and skin cell suspension preparation codes -15013, 15014
- **Application**: Skin suspension autograph codes and skin cell suspension spray-on application codes based on anatomical sites & size – 15015 through 15018.

- Placement of a separate additional autograft (split-thickness/full-thickness) prior to application of SCSA is separately reportable with 15040-15261, as appropriate
- Repair of the donor site requiring skin graft or local flaps is considered a separate procedure

INTEGUMENTARY SYSTEM 2025 CPT CODES

- New code 15778 is used for implanting absorbable mesh or other prostheses to treat delayed closure wound.
- New add-on codes 15853 and 15854 for removing sutures or staples without anesthesia. Add-on code with an E/M
  - 15853 – Sutures **or** Staples
  - 15854 – Sutures **&** Staples
  - By another surgeon or a 0-day global procedure
- CPT code 15850 is deleted. Removal of sutures by same surgeon.

MUSCULOSKELETAL SYSTEM 2025 CPT CODES

- Introducing the new 2025 CPT code 25448: Arthroplasty of intercarpal or carpometacarpal joints, including suspension, tendon transfer or transplant, and interposition (when applicable).

CARDIOVASCULAR SYSTEM 2025 CPT CODES

- No significant changes, but there are some changes in cardiovascular surgery.
- 33814 – new code for advanced techniques in septal defect obliteration.
- 93656 – new code for advanced techniques in arrhythmia treatment.
- New codes 38224 – 38228 for chemic antigen receptor T cell.
- 33471- code for pulmonary valvotomy has been deleted, and CPT 33737 for atrial open atrial septectomy or septostomy has been deleted.

DIGESTIVE SYSTEM 2025 CPT CODES

- There are no significant changes in gastro but changes in surgery codes.
- New descriptors 49186-49190 for inter abdominal tumor and cyst using open surgical approaches based on the length of tumor or cyst removed or destroyed.
    - **49186**: For tumors or cysts with a sum of the maximum length of 5 cm or less.
    - **49187**: For tumors or cysts with a sum of the maximum length of 5.1 to 10 cm.
    - **49188**: For tumors or cysts with a sum of the maximum length of 10.1 to 20 cm.
    - **49190**: For tumors or cysts with a sum of the maximum length of greater than 30 cm.

URINARY SYSTEM 2025 CPT CODES

- Bladder incision codes have been deleted, and some codes have been revised.
- New codes for Trans Ureteral ablations for males are – **51721 for i**nsertion of a transurethral ablation transducer to deliver thermal ultrasound for prostate tissue ablation; **55881 for t**ransurethral ablation of prostate tissue using thermal ultrasound, including MRI guidance and monitoring; **55882** for transurethral ablation of prostate tissue using thermal ultrasound, including MRI guidance and monitoring, plus insertion of a transurethral ultrasound transducer
- **52317 and 52318**: Used to describe litholapaxy, which is the crushing and removal of calculus in the urinary bladder.
- **53865**: Used for cystourethroscopy with the insertion of a temporary device for ischemic remodeling of the bladder, neck, and prostate.
- **53866**: Used for catheterization with the removal of a temporary device for ischemic remodeling. of the bladder, neck, and prostate.
- **52214**: Used for cystourethroscopy with fulguration (but does not include a biopsy).
- **52224**: Used for cystourethroscopy with fulguration or treatment of minor lesions.
- **58597** – Female Urethral system, excision of the ovary has been deleted, and in the parenthetical section, you are advised to use general surgery codes.

ENDOCRINE SYSTEM 2025 CPT CODES

- Two new codes for percutaneous ablation of thyroid nodules with radio-frequency ablation techniques:
- **60660 –** Used to report the ablation of one or more thyroid nodules in a single lobe or the isthmus, including imaging guidance.
- **60661 –** Used as an add-on code to report the ablation of additional nodules in an additional lobe.

NERVOUS SYSTEM 2025 CPT CODES

- **64466 – 64474 – New Pain block codes**.
- **64486**: Transversus abdominis plane (TAP) block, unilateral, by injection
- **64487**: Transversus abdominis plane (TAP) block, unilateral, by continuous infusion
- **64488**: Transversus abdominis plane (TAP) block, bilateral, by injection
- **64489**: Transversus abdominis plane (TAP) block, bilateral, by continuous infusion
- **64901**: Neurorrhaphy with nerve graft – repair of nerve with graft
- **64835**: Neurorrhaphy procedures

LOWER EXTREMITY FASCIAL PLANE BLOCK

- Fascial plane block = regional anesthesia
- Administration of local anesthetic for post-operative pain control and analgesia.
- Needle inserted in the space ["plane"] between two discrete fascial layers
- Anesthetic spreads to nerves traveling within this plane and to adjacent tissues.

LOWER EXTREMITY FASCIAL PLANE BLOCK

- CPT® 64473 - Lower extremity fascial plane block, unilateral; **by injection(s)**, including imaging guidance, when performed

- CPT® 64474 - Lower extremity fascial plane block, unilateral; **by continuous infusion(s)**, including imaging guidance, when performed

Surgery – Eye & Ocular 2025 CPT codes

- **66683** – Implantation of an iris prosthesis, including suture fixation and repair or removal of the iris. This code replaces Category III codes 0616T, 0617T, and 0618T.
- **92137** – OCT angiography (OCTA). This code cannot be billed at the same patient encounter as codes 92133 or 92134.
- **0936T** – Photo biomodulation therapy. This is a Category III code, which helps the CPT Editorial Panel collect data on emerging technologies.

Radiology 2025 CPT codes

- 76014 – 76019 – MRI safety assessments by trained clinical staff are time-based codes, and they are modifier 51 exempt.
- 76014-76016 These codes are performed days or weeks before MRI unless performed under emergency
- 76014-76015 These are time-based codes that may be performed before the MRI DOS.
- 76016 This is a risk-benefit analysis performance.

Path and Laboratory 2025 CPT codes

- **Pathology consultation** – CPT codes 88329–88334 are for specimen examination during surgery.
- **Surgical pathology** – CPT codes 88302–88309 are for surgical pathology gross and microscopic examination.

Medicine Section 2025 CPT codes

New codes for vaccines that prevent life-threatening diseases, including 90593 for the chikungunya virus vaccine, 90684 for pneumococcal conjugate vaccine, 90624 for meningococcal pentavalent vaccine, 90695 for the influenza virus vaccine (H5N8)

96380 is used to report the administration of a seasonal dose of a monoclonal antibody for respiratory syncytial virus (RSV) by intramuscular injection.

Category III codes

0870T-0875T – new emerging technology

Numerous new Category III codes have been introduced to address emerging technologies. For instance:

0870T–0875T pertain to subcutaneous peritoneal ascites pump procedures,

0877T–0881T apply to augmentative analysis of chest CT imaging data, and

0913T–0914T cover percutaneous transcatheter therapeutic drug delivery using an intracoronary drug-delivery balloon

G2211 – VISIT COMPLEXITY ADD-ON HCPCS CODE

- Healthcare Common Procedure Coding System (HCPCS) code G2211
- Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's **single, serious condition** or a **complex condition**.
- Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established, at any level

G2211 – VISIT COMPLEXITY ADD-ON HCPCS CODE

- To be used with E/M Codes 99202-99205, 99211-99215
- O/O (office/outpatient) E/M base codes
- G2211 captures the inherent complexity of the O/O E/M visit that is derived from the longitudinal nature of the practitioner and patient relationship.
- You are the continuing focal point for all needed services
- For ongoing care for a single serious condition or complex condition
- Can be used with another provider in the same group

G2211 – VISIT COMPLEXITY ADD-ON HCPCS CODE

- Can be used with another provider in the same group, a patient-care team within the office or other out-patient facility
- It is not limited to any provider specialty
- It may not be billed if the base E/M Code has a -25 modifier on the same day of service, for the same patient, by the same provider

- Medicare anticipates that it will be used up to 50% of the time when using O/O E/M codes
- Now it is seldom used due to confusion on its usage

G2211: WHAT MUST BE DOCUMENTED?

- No specific diagnosis is required for HCPCS code G2211 to be billed. For the billing practitioner, it would be appropriate to report a health condition that is a single, serious condition and/or a complex condition for which the billing practitioner is engaging the patient in a continuous and active collaborative plan of care related to an identified health condition—the management of which requires the direction of a practitioner with specialized clinical knowledge, skill, and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals.
- Several examples to clarify the use of HCPCS code G2211 in the context of specialty care. For example, HCPCS code G2211 could be billed by an infectious disease physician who is part of ongoing care for a patient with HIV (a single, serious condition and/or complex condition), or a practitioner who is part- of ongoing care for a patient with sickle cell disease.

G2211 – WHAT IS LONGITUDINAL CARE?

- The add-on code HCPCS code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship. **No specific definition is provided for "longitudinal" for HCPCS code G2211 to be billed**. **G2211 can be billed to recognize the services that enable practitioners to build longitudinal relationships with their patient** and address the majority of patient's health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

WHEN G2211 IS NOT APPROPRIATE

- When the relationship with the patient is discrete, routine or time-limited nature;
  - Such as a removal of a lesion, referral to another specialist; simple virus, counseling for sessional allergies, treatment of a fracture.
  - Where comorbidities either not present or not addressed, or when the provider has not taken responsibility for ongoing medical care for that patient with consistency and continuity over time; or does not plan to do so.

NEW CODE

CPT® 0869T - Injection(s), bone-substitute material for bone and/or soft tissue hardware fixation augmentation, including intraoperative imaging guidance, when performed

NEW CODE

CPT® 0946T - Orthopedic implant movement analysis using paired computed tomography (CT) examination of the target structure, including data acquisition, data preparation and transmission, interpretation and report (including CT scan of the joint or extremity performed with paired views)

NEW ICD-10 CODING 2025

NEW CODES

- **New Code:**
- D61.03 Fanconi anemia
- D61.09 Other constitutional aplastic anemia
  - **Delete inclusion term “Fanconi's anemia”**

NEW INSTRUCTIONS

- E08- Diabetes mellitus due to underlying condition

New: Use Additional injectable non-insulin antidiabetic drugs (Z79.85)

- E09- Drug or chemical induced diabetes mellitus

New: Use Additional injectable non-insulin antidiabetic drugs (Z79.85)

- E11- Type 2 diabetes mellitus

New: Use Additional injectable non-insulin antidiabetic drugs (Z79.85)

- E13- Other specified diabetes mellitus

New: Use Additional injectable non-insulin antidiabetic drugs (Z79.85)

NEW E10- 4TH CHARACTER (A)

- **New Codes:**
- E10.A- Type 1 diabetes mellitus, presymptomatic
  - E10.A0 Type 1 diabetes mellitus, presymptomatic, unspecified
  - E10.A1 Type 1 diabetes mellitus, presymptomatic, Stage 1
  - E10.A2 Type 1 diabetes mellitus, presymptomatic, Stage 2

NEW CODES

- Prior to 10-1-24, E66.8 was a complete code (Other obesity)
- Starting 10-1-25 E66.8- requires additional characters:
- New Codes:
- E66.81 Obesity class
- E66.811 Obesity, class 1
- E66.812 Obesity, class 2
- E66.813 Obesity, class 3
- E66.89 Other obesity not elsewhere classsified

ANOREXIA NERVOSA

- Prior to 10-1-24, F50.01 was a complete code (Anorexia nervosa, restricting type)
- Starting 10-1-24 F50.01- requires additional characters:
- **New Codes:**
- F50.010 Anorexia nervosa, restricting type, mild
- F50.011 Anorexia nervosa, restricting type, moderate
- F50.012 Anorexia nervosa, restricting type, severe
- F50.013 Anorexia nervosa, restricting type, extreme
- F50.014 Anorexia nervosa, restricting type, in remission
- F50.019 Anorexia nervosa, restricting type, unspecified

- Prior to 10-1-24, F50.02 was a complete code (Anorexia nervosa, binge eating/purging type)
- Starting 10-1-24 F50.02- requires additional characters:
- New Codes:
- F50.020 Anorexia nervosa, binge eating/purging type, mild
- F50.021 Anorexia nervosa, binge eating/purging type, moderate
- F50.022 Anorexia nervosa, binge eating/purging type, severe
- F50.023 Anorexia nervosa, binge eating/purging type, extreme
- F50.024 Anorexia nervosa, binge eating/purging type, in remission
- F50.029 Anorexia nervosa, binge eating/purging type, unspecified
- _____

- Prior to 10-1-24, F50.2 was a complete code (Bulimia nervosa)
- Starting 10-1-24 F50.2- requires additional characters:
- New Codes:
- F50.20 Bulimia nervosa, unspecified
- F50.21 Bulimia nervosa, mild
- F50.22 Bulimia nervosa, moderate
- F50.23 Bulimia nervosa, severe
- F50.24 Bulimia nervosa, extreme
- F50.25 Bulimia nervosa, in remission
- _____

BINGE EATING DISORDER

- Prior to 10-1-24, F50.81 was a complete code (F50.81 Binge eating disorder)
- Starting 10-1-24 F50.81- requires additional characters:
- New Codes:
- F50.810 Binge eating disorder, mild
- F50.811 Binge eating disorder, moderate
- F50.812 Binge eating disorder, severe
- F50.813 Binge eating disorder, extreme
- F50.814 Binge eating disorder, in remission
- F50.819 Binge eating disorder, unspecified

NEW CODES

- New Codes
- F50.83 Pica in adults
- F50.84 Rumination disorder in adults

PRURITUS

- Prior to 10-1-24, L29.8 was a complete code (Other pruritus)
- Starting 10-1-24, L29.8- requires additional characters:
- **New Codes**
- L29.81 Cholestatic pruritus
- L29.89 Other pruritus

LICHEN PLANOPILARIS

- Prior to 10-1-24, L66.1 was a complete code (Lichen planopilaris)
- Starting 10-1-24, L66.1- requires additional characters:
- **New Codes**
- L66.10 Lichen planopilaris, unspecified
- L66.11 Classic lichen planopilaris
- L66.12 Frontal fibrosing alopecia
- L66.19 Other lichen planopilaris

CICATRICIAL ALOPECIA

- Prior to 10-1-24, L66.8 was a complete code (Other cicatricial alopecia)
- Starting 10-1-24, L66.8- requires additional characters:
- **New Codes**
- L66.81 Central centrifugal cicatricial alopecia
- L66.89 Other cicatricial alopecia

DELETED CODE

- Delete "Calcaneal apophysitis" as inclusion term under

  M92.8 Other specified juvenile osteochondrosis

SYNOVITIS AND TENDONITIS

- Prior to 10-1-24, M65.9 was a complete code (Synovitis and tenosynovitis, unspecified)
- Starting 10-1-24, M65.9- requires additional characters:
- **New Codes**
- M65.96- Unspecified synovitis and tenosynovitis, lower leg
- M65.961 Unspecified synovitis and tenosynovitis, right lower leg
- M65.962 Unspecified synovitis and tenosynovitis, left lower leg
- M65.969 Unspecified synovitis and tenosynovitis, unspecified lower leg

SYNOVITIS AND TENDONITIS

- M65.97- Unspecified synovitis and tenosynovitis, ankle and foot
- M65.971 Unspecified synovitis and tenosynovitis, right ankle and foot
- M65.972 Unspecified synovitis and tenosynovitis, left ankle and foot
- M65.979 Unspecified synovitis and tenosynovitis, unspecified ankle and foot
- M65.98 Unspecified synovitis and tenosynovitis, other site
- M65.99 Unspecified synovitis and tenosynovitis, multiple sites

DISRUPTION OF WOUND

- Prior to 10-1-24, T81.32 (+7th character) was a complete code (Disruption of internal operation (surgical) wound, not elsewhere classified)
- Starting 10-1-24, T81.32 requires 6th character:
- **New Code**
- T81.328- Disruption or dehiscence of closure of other specified internal operation(surgical) wound

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Autologous Skin Cell Suspension for Full-Thickness Skin Defect Reconstruction: Current Evidence and Health Economic Expectations

Steven A Kahn [1], Jeffrey E Carter [2], Shelby Wilde [3], Aleisha Chamberlain [3], Thomas P Walsh [3,✉], Jeremiah A Sparks [3]

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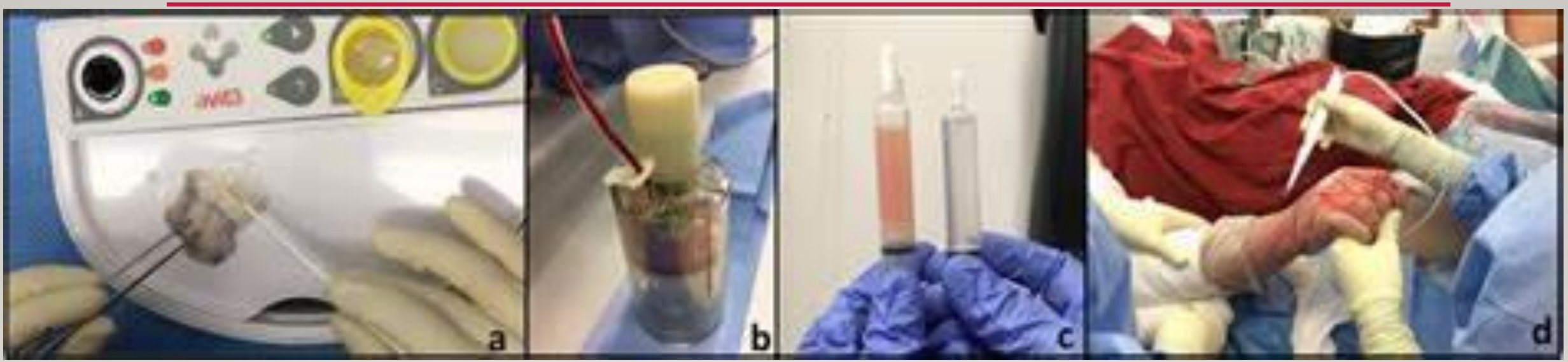
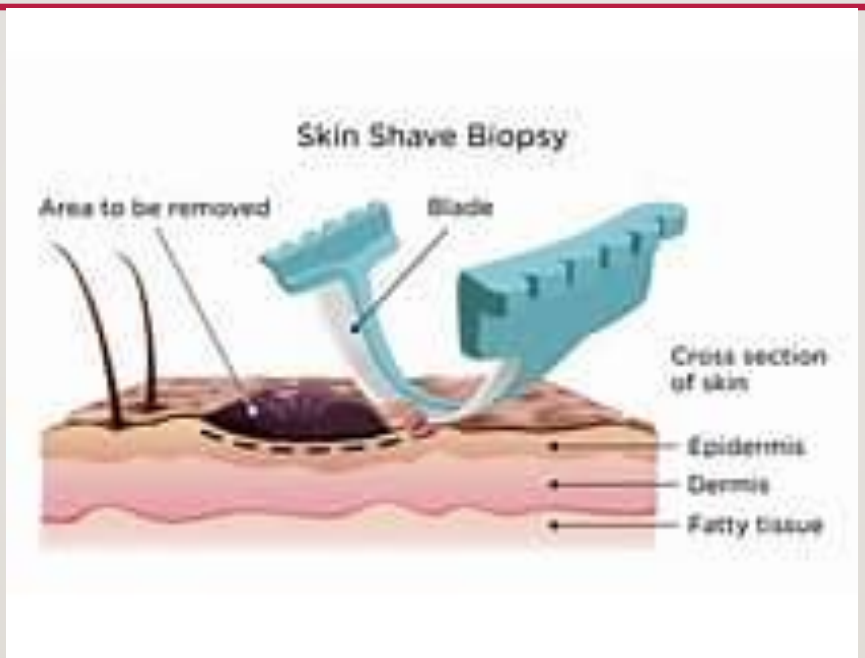
PMCID: PMC10879381 PMID: 38253788

Abstract

Despite differing etiologies, acute thermal burn injuries and full-thickness (FT) skin defects are associated with similar therapeutic challenges. When not amenable to primary or secondary closure, the conventional standard of care (SoC) treatment for these wound types is split-thickness skin grafting (STSG). This invasive procedure requires adequate availability of donor skin and is associated with donor site morbidity, high healthcare resource use (HCRU), and costs related to prolonged hospitalization. As such, treatment options that can facilitate effective healing and donor skin sparing have been highly anticipated. The RECELL® Autologous Cell Harvesting Device facilitates preparation of an autologous skin cell suspension (ASCS) for the treatment of acute thermal burns and FT skin defects. In initial clinical trials, the approach showed superior donor skin-sparing benefits and comparable wound healing to SoC STSG among patients with acute thermal burn injuries. These findings led to approval of RECELL for this indication by the US Food and Drug Administration (FDA) in 2018. Subsequent clinical evaluation in non-thermal FT skin wounds showed that RECELL, when used in combination with widely meshed STSG, provides donor skin-sparing advantages and comparable healing outcomes compared with SoC STSG. As a result, the device received FDA


a
b
c
d

SHAVING EXCISIONAL BIOPSY


Skin Shave Biopsy
Area to be removed
Blade
Cross section of skin
Epidermis
Dermis
Fatty tissue


Persomma
Persomma


Personna

SHAVING OF DERMAL LESION

- CPT code 11300 is used for the shaving of a single epidermal or dermal lesion that measures 0.5 cm or less in diameter, located on the trunk, arms, or legs1. CPT code 11301 is used when a provider performs the shaving procedure on a single epidermal or dermal lesion with a diameter ranging from 0.6 to 1.0 cm on the trunk, arms, or legs2. These codes are used for the removal of an epidermal or dermal lesion using a sharp tool

Shaving

CPT 1130X - Shaving of epidermal or dermal lesion, single lesion…

SHAVING

CPT 1130X - Shaving of epidermal or dermal lesion, single lesion…

2024 CPT Professional:

Shaving is sharp **removal**

SHAVING

CPT 1130X - Shaving of epidermal or dermal lesion, single lesion…

2024 CPT Professional:

Shaving is sharp **removal**
Shaving is removal of epidermal or dermal lesion
Shaving includes local anesthesia

11755 : BIOPSY OF NAIL

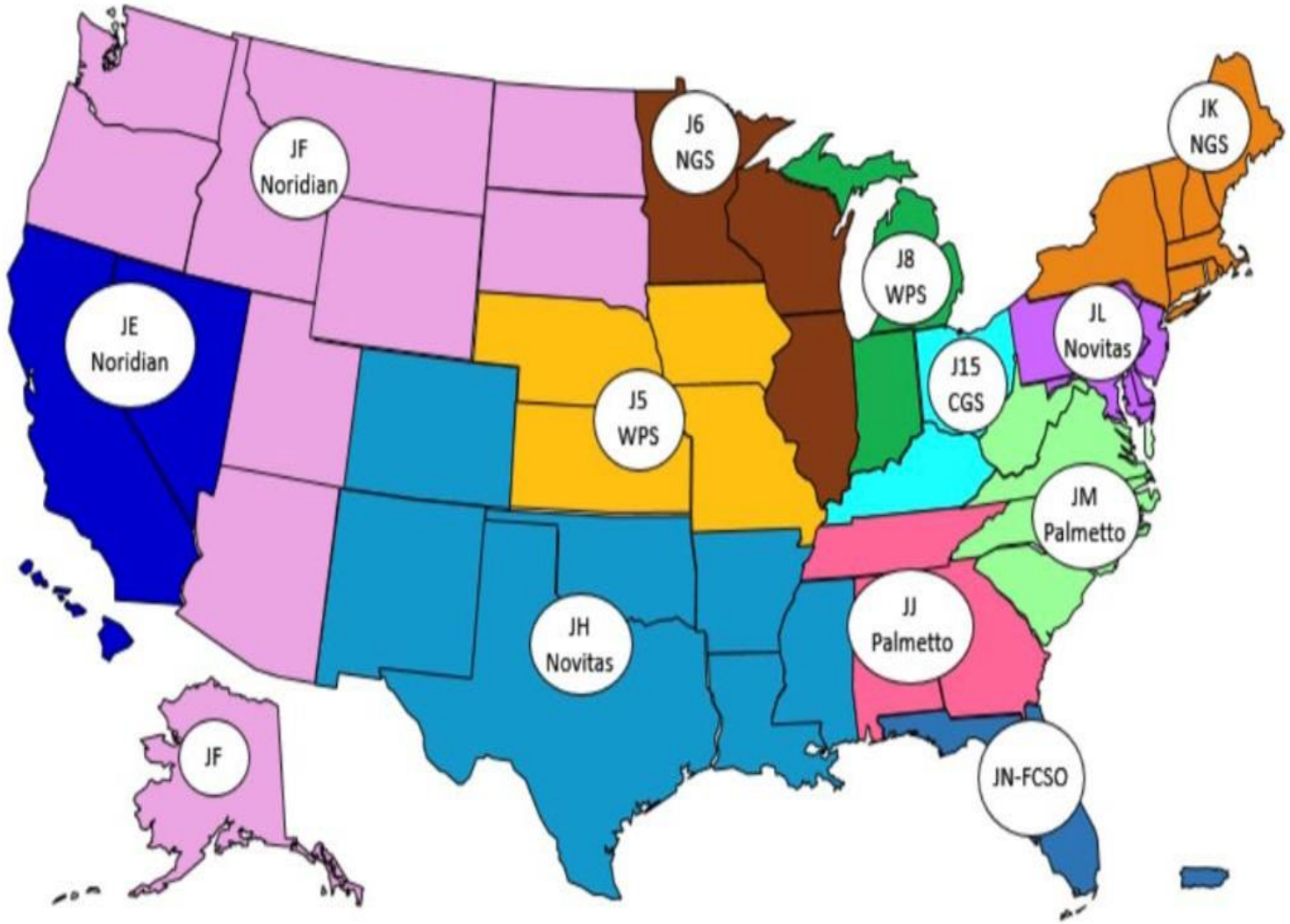
- This procedural code is used when the physician biopsies the nail plate, bed, hyponychium, proximal nail folds, or lateral nail folds.
- Cut through nail into underlaying nail bed and any tissue associated, to the underlaying periosteum.
- Used for histological biopsy. Not for identification of mycosis.
- Fragments of nail is not considered a biopsy.

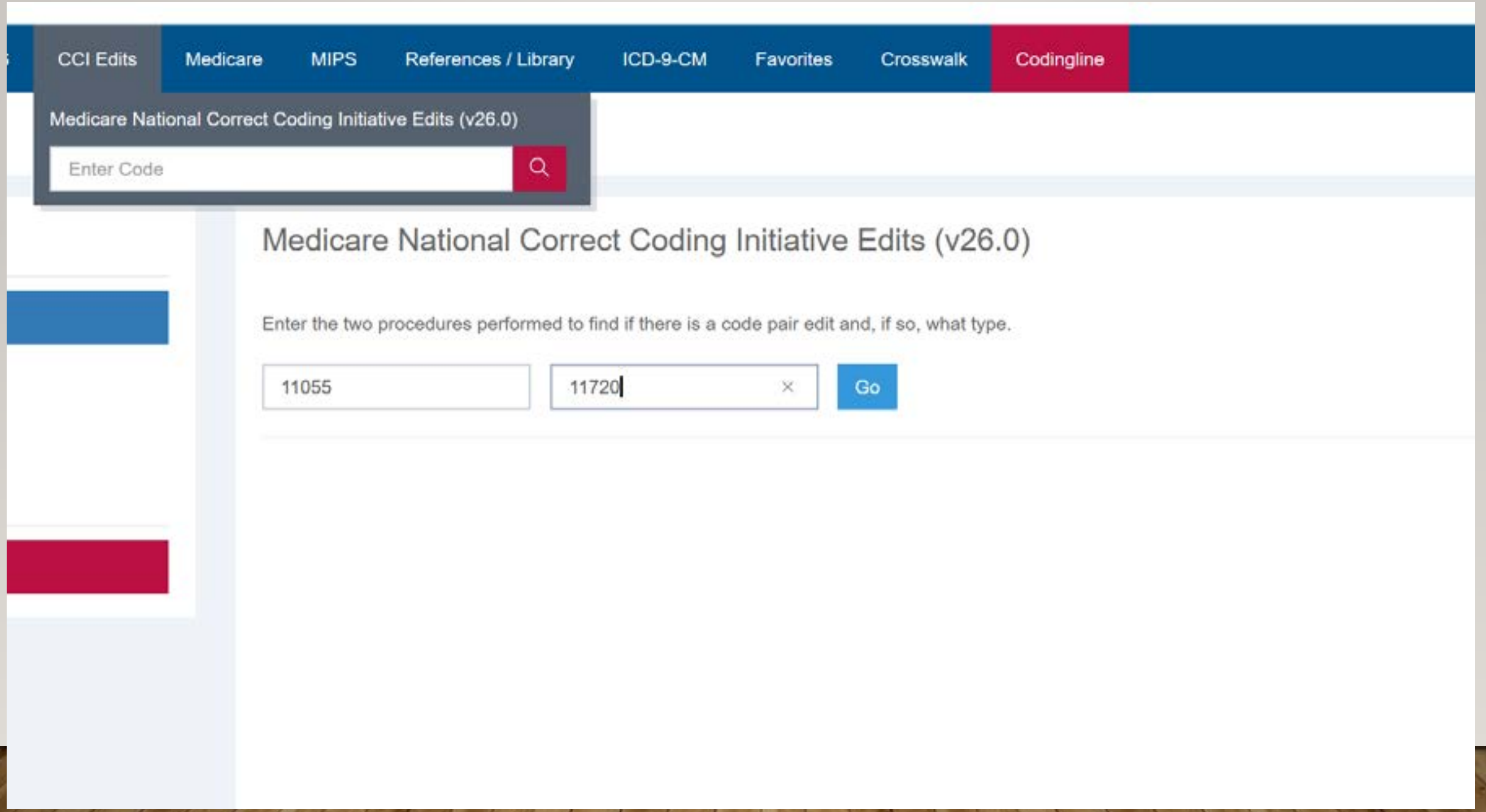
SURGERY OF NAILS

- 11073 – Avulsion of nail, partial or complete
- 11750 – Excision of nail and nail matrix for permanent removal, partial or complete

- Novitas, West Coast and WPS:
  - 11730 – may repeat in 32 weeks
  - 11750 – may not repeat unless documented medical explanation that the lesion grew back, or the other portion of the nail not excised. Will probably need to appeal the denial

A/B MAC Jurisdictions




CCI Edits
Medicare
MIPS
References / Library
ICD-9-CM
Favorites
Crosswalk
Codingline
Medicare National Correct Coding Initiative Edits (v26.0)
Enter Code
Medicare National Correct Coding Initiative Edits (v26.0)
Enter the two procedures performed to find if there is a code pair edit and, if so, what type.
11055
11720
Go

Medicare National Correct Coding Initiative Edits (v26.0)

Enter the two procedures performed to find if there is a code pair edit and, if so, what type.

11055 | 11720 | Go

Code 11055 : (Return to code)

Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion

Code 11720 : (Return to code)

Debridement of nail(s) by any method(s); one to five

The lists below shows the coding pairs associated with codes 11055 and 11720.

Code 1	Code 2	Indicator	Description
11055	11720	1	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11055	11720	1	Debridement of nail(s) by any method(s); one to five

Medicare National Correct Coding Initiative Edits (v26.0)

Enter the two procedures performed to find if there is a code pair edit and, if so, what type.

11720 G0127 Go

Code 11720 : (Return to code)

Debridement of nail(s) by any method(s); one to five

Code G0127 : (Return to code)

Trimming of dystrophic nails, any number

The lists below shows the coding pairs associated with codes 11720 and G0127.

Code 1	Code 2	Indicator	Description
11720	G0127	1	Debridement of nail(s) by any method(s); one to five
11720	G0127	1	Trimming of dystrophic nails, any number
11720	G0127	1	Trimming of dystrophic nails, any number [NOTE: 60 day edit]

Medicare National Correct Coding Initiative Edits (v26.0)

Enter the two procedures performed to find if there is a code pair edit and, if so, what type.

28296 | 28285 | Go

Code 28296 : (Return to code)

Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method

Code 28285 : (Return to code)

Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)

The lists below shows the coding pairs associated with codes 28296 and 28285.

Code 1	Code 2	Indicator	Description
28296	28285	1	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)
28296	28285	1	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method

CCI Edits on APMA-CRC

- The "0" indicator means that no modifiers are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid.
- The "1" indicator means that the modifiers associated with the CCI are allowed with this code pair when appropriate.
- The "9" indicator is used only on those code pairs that have been deleted when the deletion date was retroactive to the effective date. For all practical purposes, providers can ignore the "9" indicator.

Prior to submitting a claim with two procedure codes, one should review:

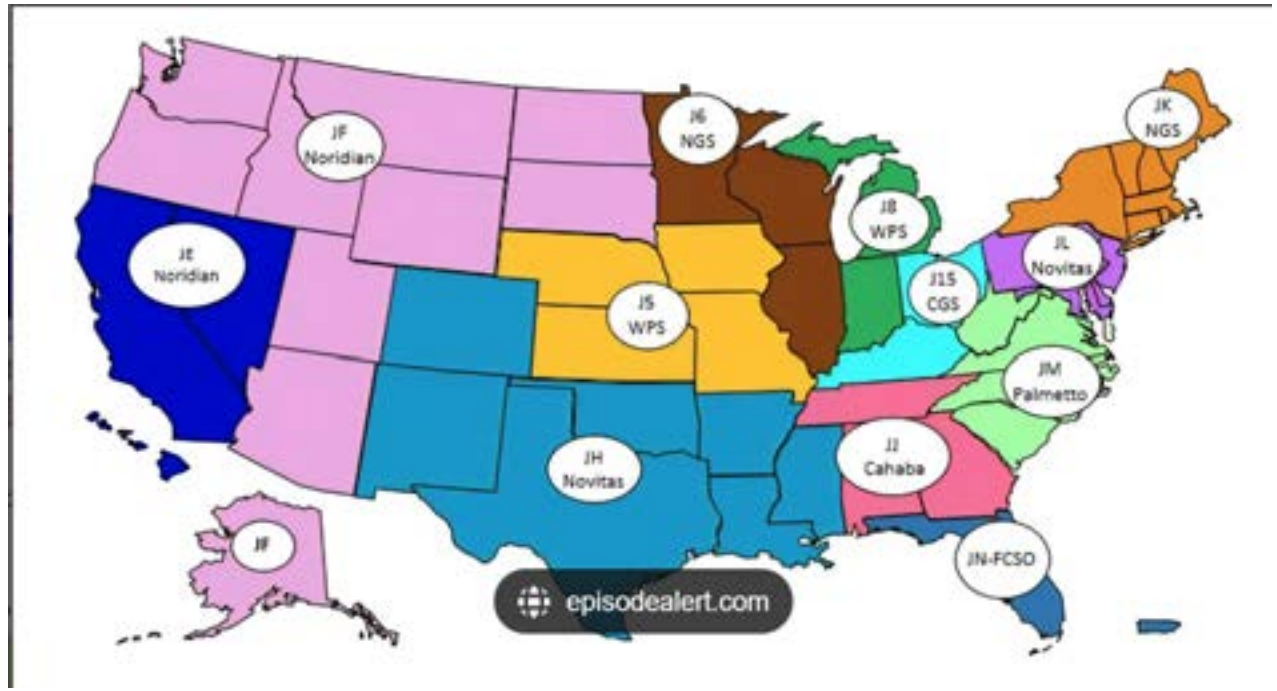
1. **Both the column 1/column 2 correct coding edits table and the mutually exclusive edits table for each of the codes.** For example, for CPT code pair 20550 and 29540, one should search for CPT code 20550 under column 1 of the column 1/column 2 correct coding edits table and column 1 of the mutually exclusive edits table to see if CPT code 29540 appears along with CPT code 20550 in column 2 of the two tables. Subsequently, look for CPT code 29540 under column 1 of the column 1/column 2 correct coding edits table and column 1 of the mutually exclusive edits table to see if CPT code 20550 appears along with CPT code 29540 in column 2 of the two tables.

2. **Modifier indicator "0" or "1".** Please note that modifiers should be appended to the column 2 codes only. From the CCI perspective, modifiers used to bypass edits are exceptions to the normal rule and should be used on code pairs with a "1" modifier indicator and when clinical circumstances warrant. Providers are expected to provide additional information to justify the use of a modifier and are responsible for applying the correct (and appropriate) modifiers to support the codes they report. Indiscriminate and inappropriate use of modifiers may lead to review of a provider's billing practices.

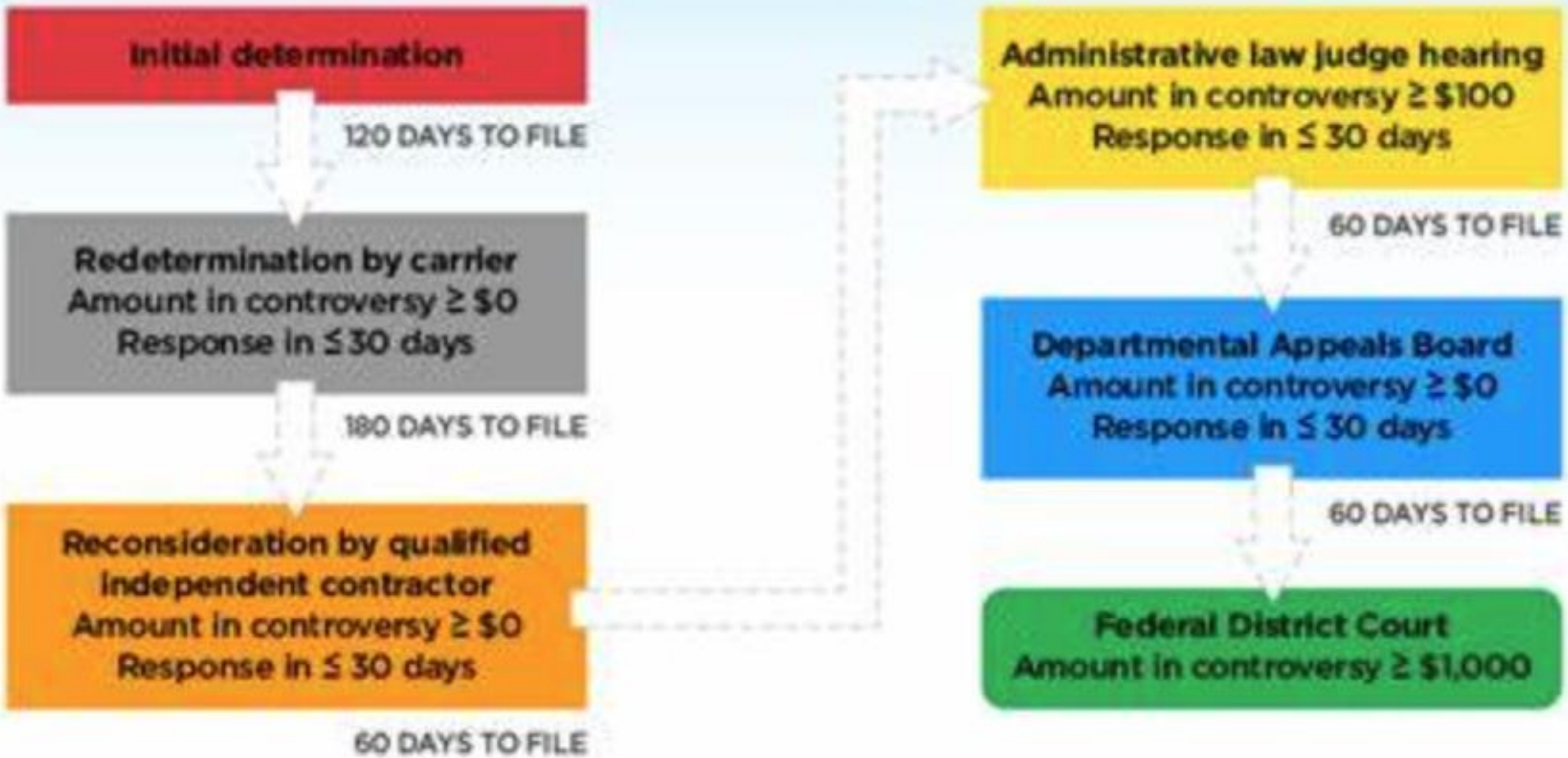
Audits for 2025

Regional Map

- TPE
- Noridian
- SMRC - Noridian National Contract
- RAC
- UPIC - Qlarant
- CERT


JF
Noridian
JE
Noridian
JH
Novitas
JJ
Cahaba
JM
Palmetto
JL
Novitas
JK
NGS
JN-FCSO
episodealert.com

ANATOMY OF THE MEDICARE APPEALS PROCESS



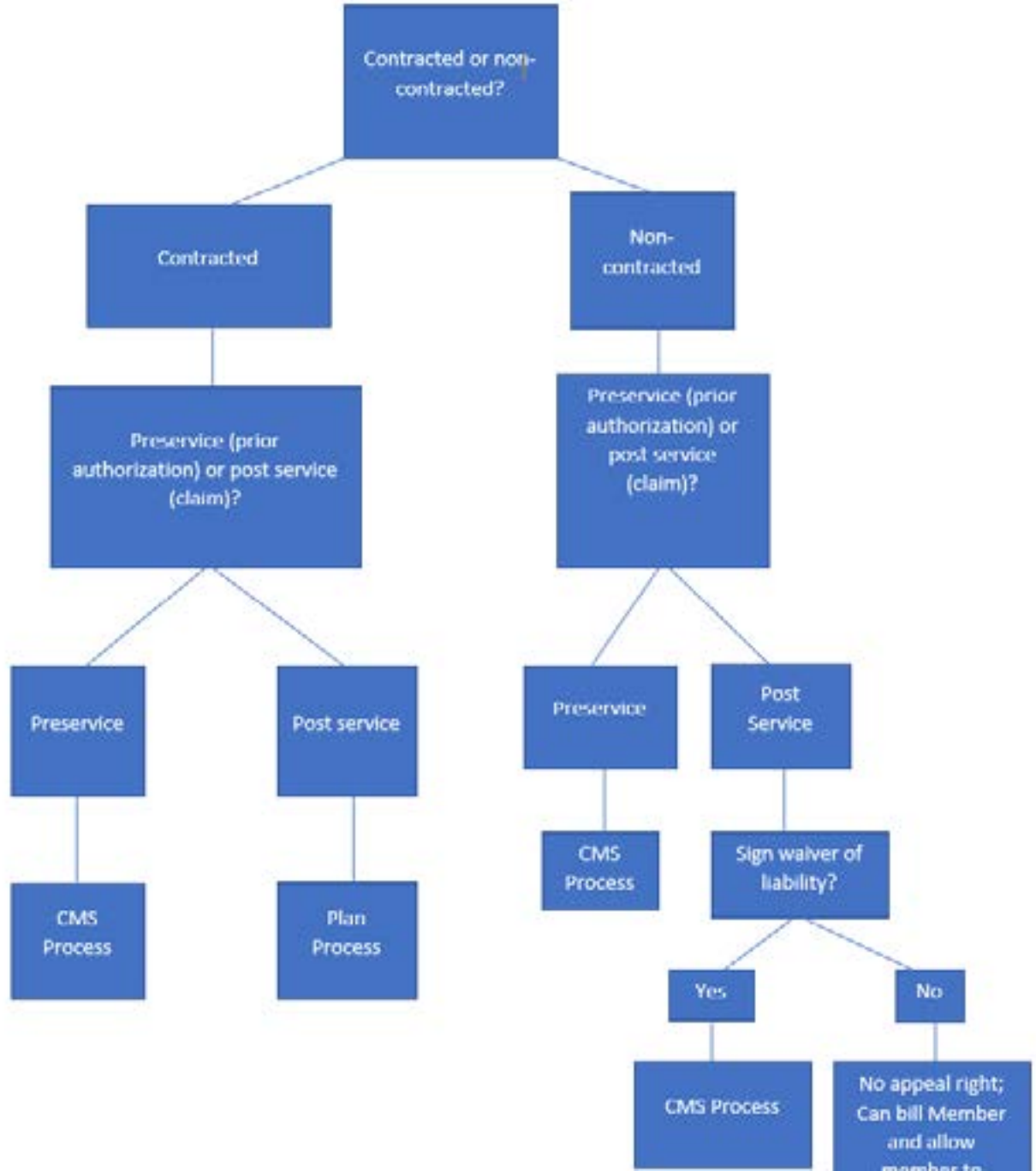
Medicare Advantage

Determinations and Appeals

Part C Services

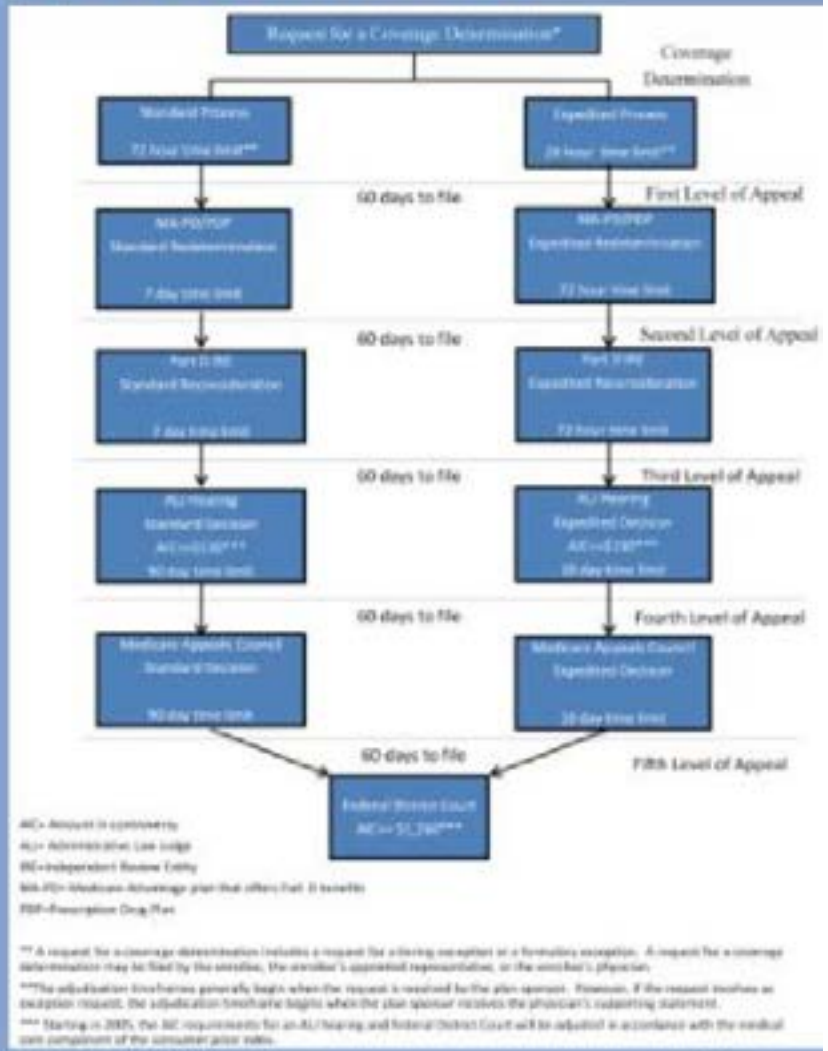
Regulatory Process[1]	**Plan Process**
Initial Decisions Claims payment determination – clean claims submitted by enrollees or non-contract providers must be paid in 30 days. All other claims submitted by non-contract providers must paid in 60 days. [42 CFR 422.520(a)] Pre-service organization determinations – Standard decisions must generally be made in 14 days.[2] [42 CFR 422.568] Expedited preservice organization determinations – Decisions must be made within 72 hours. An MAO must expedite a determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum. [42 CFR 422.572] Appeals[3] (1) Reconsideration – a reconsideration must be requested within 60 days of an adverse organization determination unless good cause is shown. [42 CFR 422.582(b) and (c)] Standard Reconsideration Decisions -- The plan must make a standard pre-service	Initial Decisions Claims payment determination – claim must be paid within the prompt payment timeframe set forth in agreement between the plan and provider. [42 CFR 422.520(b)] (Note that state prompt payment laws are preempted.) Appeals No process is prescribed by regulation. The plan process is determined by the relevant plan or by the parties through contract negotiations. Note that in reviewing Medicare Advantage plan policies, some of the largest plans (United, Humana and Anthem) offer two levels of internal appeals and no external appeals.

[1] Note that different (shorter) timeframes apply with regard to Part B drugs, but the process is the same. This chart does not address Part D drugs.


Contracted or non-contracted?
Contracted
Non-contracted
Preservice (prior authorization) or post service (claim)?
Preservice (prior authorization) or post service (claim)?
Preservice
Post service
Preservice
Post Service
CMS Process
Plan Process
CMS Process
Sign waiver of liability?
Yes
No
CMS Process
No appeal right; Can bill Member and allow

Medicare Part D Appeals Process

- Redetermination with the Part D plan (sponsor)
- Reconsideration with the independent review entity (IRE)
- Hearing with an administrative law judge (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Review by a federal district court



Medicare Appeals Process

- Level 1 – Redetermination
  - 120 days from demand to appeal
  - Appeal is to Medicare Administrative Contractor (MAC)
  - MAC has 60 days to review / respond
- Level 2 – Reconsideration
  - 180 days from date of MAC Determination
  - Appeal is to Qualified Independent Contractor (QIC)
  - QIC has 60 days to review / respond

Medicare Appeals Process

- Level 3 – Administrative Law Judge (ALJ)
  - 60 days from QIC Determination
  - Amount in controversy?
  - No new evidence
  - ALJ has 90 days to review / respond
- Level 4 – Departmental Appeals Board / Medicare Appeals Council
  - 60 days from ALJ Determination
  - DAB has 90 days to review / respond
- Level 5 – Judicial Review in US District Court
  - 60 days from DAB Determination
  - Need Legal Representation
  - Contested Claim Amount > $1,300


Browse by Topic
Browse by Specialty
Fees and News
Policies
Medical Review
Education and Outreach
Provider Enrollment
Forms
JE Part B > Medical Review
Medical Review
Documentation Requests: How, Who and When to Send
Documentation Requirements
How to Read an ADR
How to Respond to ADR
MR FAQs
MR Overview
MR Reopening
Medical Documentation Signature Requirements
Medical Record Review Results
Order Authentication Requirements
Prior Authorization
Post-Pay Reviews
Pre-payment Review
Targeted Probe and Educate (TPE)
Who Reviewed My Claim
Why Is My Claim Denied
Other Review Contractors
Comprehensive Error Rate Testing (CERT)
Office of Inspector General (OIG)
Quality Improvement Organization (QIO)
Recovery Auditor
Supplemental Medical Review Contractor (SMRC)
Unified Program Integrity Contractor (UPIC)
Medical Review
Documentation Requests: I and When to Send
Documentation Requireme
How to Read an ADR
How to Respond to ADR
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Post-Pay Reviews
Pre-payment Review
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ional materials, and provide education on claims denied
ucation webpage for details.
Review process, Noridian requests medical records for
on to Medicare
requested documentation
etails

Other Review Contractors

Comprehensive Error Rate Testing (CERT) - View program background, request and response timeline, communication used between Noridian and providers, Provider Corrective Actions, responding to a CERT request, contact details, and resources

Office of Inspector General (OIG) - View OIG information and access the OIG website.

Quality Improvement Organization (QIO) - View QIO functions and access state QIOs.

Recovery Auditor - View RA program details, contact information, types of reviews and the options available when receiving an RA decision.

Supplemental Medical Review Contractor (SMRC) - Access current and completed projects, the discussion/education period, documentation requests and hot SMRC topics.

Unified Program Integrity Contractor (UPIC) - View UPIC information, access the Midwest and Western UPIC websites and view UPIC functions and non-functions.

RAC

Recovery Audit Contractor

Cotiviti GOV Services

RAC

Region 3 Cotiviti LLC	AL, FL, GA, NC, SC, TN, VA, WV, Puerto Rico and U.S. Virgin Islands	https://www.Cotiviti.com/RAC	racinfo@cotiviti.com	1-866-360-2507
Region 4 Cotiviti GOV Services (formerly HMS)	AK, AZ, CA, DC, DE, HI, ID, MD, MT, ND, NJ, NV, OR, PA, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas	https://rac4info.cotiviti.com	rac4info@cotiviti.com	**Part A:** 1-87[illegible] 350-7992 **Part B:** 1-877-350-7993
Region 5 DME/HHE/Performant Recovery, Inc.	Nationwide for DMEPOS/HHA/Hospice	https://performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580

Feedback


Region 4: Cotiviti
GOV Services
Region 1: Performant
Recovery, Inc.
Region 3:
Cotiviti, LLC
Region 5: Performant Recovery, Inc.
DME/HHH Nationwide
Region 2: Performant Recovery Inc.
AK
HI
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
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ND
SD
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MI
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OH
KY
TN
MS
AL
GA
FL
SC
NC
VA
WV
PA
NY
VT
NH
ME
MA
CT
RI
NJ
DE
MD

Three types of RAC Reviews

- **Automated** (no medical record needed)
- **Semi-Automated** (providers are given the option to submit medical records but records are not required)
- **Complex** (medical record required)

Automated Reviews

- Recovery Auditors may perform automated reviews which occur when a Recovery Auditor makes a claim determination at the system level without review of medical records.
- Duplicate payment
- Charge for services after death
- Error in payment
- And others
- Scrubbing software

RAC Reviews

- Recovery Auditors may perform semi-automated and complex reviews and will send providers an Additional Development Request (ADR) for documentation. Providers have 45 days to respond to ensure proper review of documentation. Documentation must be sent directly to the Recovery Auditor not to Noridian

- The Recovery Auditor will not review a claim that has previously been reviewed by another entity. They analyze the claim data using their proprietary software and identify claims that clearly contain improper payments. If an improper payment is identified, a demand letter will be issued.

- Providers can identify claims that have been recouped by the Recovery Auditor by checking the remittance advice for the remark message code N432

Other Audit Contractors

Unified Program Integrity Contractor (UPIC)

UPICs were created to perform program integrity functions for Medicare Parts A, B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies, Home Health and Hospice, Medicaid and Medicare-Medicaid data matching. Medicare Part C and D program integrity efforts are handled separately by one national contractor known as the Medicare Drug Integrity Contractor (MEDIC). The UPICs and the MEDIC work under the direction of the Center for Program Integrity (CPI) in CMS.

UPIC Region	Contractor	Covered States/Territories
Western	Qlarant	Am. Samoa, Guam, N. Mariana Is., AK, AZ, CA, HI, ID, MT, NV, ND, OR, SD, UT, WA, and WY

UPIC Functions

- UPICs primary goal is to investigate instances of suspected fraud, waste, and abuse in Medicare or Medicaid claims. They develop investigations early, and in a timely manner, take immediate action to ensure Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC (Medicare Administrative Contractor). Actions the UPICs take to detect and deter fraud, waste, and abuse in the Medicare program include:
- Investigate potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conduct investigations in accordance with the priorities established by CPI's Fraud Prevention System;
- Perform medical review, as appropriate;
- Perform data analysis in coordination with CPI's Fraud Prevention System, IDR and OnePI;
- Identify the need for administrative actions such as payment suspensions, prepayment or auto-denial edits, revocations, postpay overpayment determination;
- Share information (e.g. leads, vulnerabilities, concepts, approaches) with other UPICs/ZPICs to promote the goals of the program and the efficiency of operations at other contracts; and
- Refer cases to law enforcement to consider civil or criminal prosecution

In performing these functions, UPICs may, as appropriate:

- Request medical records and documentation;
- Conduct interviews with beneficiaries, complainants, or providers;
- Conduct site verification;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit;
- Institute a provider payment suspension; and
- Refer cases to law enforcement.

- UPICs also support victims of Medicare identity theft. A provider or supplier who believes he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request their UPIC to investigate the case. The UPIC will then work with CMS to determine the appropriate remedial action to assist the provider. See the CMS Victimized Provider Project for guidance on how to avoid and report Medicare identity theft and information on current scams

UPIC AUDIT : QLARANT

Request for Records

General Documentation Request

- Name and telephone number of the contact person for facility.
- Complete account statement of all charges, payments, or adjustments for the claims identified in the review period:
  - Billing Forms (example: CMS 1500 or UB92).
  - Remittance Advice (evidence relating to payments and adjustments).
- List of all personnel billing services under your National Provider Identifier (NPI) and their credentialing, training, licensure, etc., during the review period.
- A list of all abbreviations and/or acronyms used, including definitions.
- Any documentation of prior audit, investigation, or review, and repayment or refund back to Medicaid/Medicare.

General Documentation Request

- List of staff, including licensing, certifications, qualifications, and background checks during the review period, if applicable.
- Organization chart.
- Policies and procedures for operations including personnel, billing, coding, etc.
- Signature attestation of all personnel providing services, if applicable.
- Prior Authorization form, if applicable.
- Waiver of non-covered services (if applicable).
- Any additional documentation that demonstrates the medical necessity of the services provided, if applicable.
- Beneficiary identification, Date of service and Provider of service shall be clearly identified on each page of the submitted documentation.
- Pictures where necessary

Wound Debridement Sampled Claims Documentation Request

- Place of Service Notes.
- Plan of Care/Treatment Plan.
- Office notes.
- Procedure reports.
- Operative reports.
- Physician’s orders and progress notes.
- History and physical reports.

Wound Debridement Sampled Claims Documentation Request

- Consultation reports.
- Nurses’ notes.
- Laboratory reports, if applicable.
- X-ray reports, if applicable.
- Pathology reports, if applicable.
- Nursing home notes, if applicable.
- Patient logs, appointment books or similar documents showing date and time, and the actual time spent with each patient.

Quality Improvement Organization (QIO)

- By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Based on this statutory charge, and CMS' Program experience, CMS identifies the core functions of the QIO Program as:
  - Improving quality of care for beneficiaries;
  - Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
  - Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.
- QIOs are private, mostly not-for-profit organizations, which are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.
  - California: HSAG
  - Hawaii, American Samoa, Guam, the Northern Mariana Islands: Mountain-Pacific Quality Health
  - Nevada: Health Insight
- QIO contracts are three years in length, with each three-year cycle referenced as an ordinal 'SOW.'

Office of Inspector General (OIG)

- Since its 1976 establishment, the Office of Inspector General of the U.S. Department of Health & Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs.
- OIG develops and distributes resources to assist the health care industry in its efforts to comply with the Nation's fraud and abuse laws and to educate the public about fraudulent schemes so they can protect themselves and report suspicious activities.
- Organizational Statement
- Work Plan
- Audit Findings
- Dental Services

SMRC
Supplemental Review Contractor

National

Noridian

Supplemental Medical Review Contractor (SMRC)

- Noridian Healthcare Solutions, LLC (Noridian) was selected by CMS to conduct nationwide medical reviews as directed by CMS. Noridian conducts nationwide medical reviews (Part A, Part B, and DME), in accordance with all applicable statutes, laws, regulations, national and local coverage determination policies, and coding guidance, to determine whether Medicare claims have been billed in compliance with coverage, coding, payment, and billing practices.
- Such reviews are assigned through CMS formal notifications and focus on analysis of national claims data issues identified by Federal agencies, such as the Office of Inspector General (OIG), Government Accountability Office (GAO), CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, and professional organizations, and/or analysis reports such as First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) report, and Program for Evaluating Payment Patterns Electronic Report (PEPPER).

SMRC Reviews Denied for No Documentation

- When a claim is denied for no receipt of documentation requested by the SMRC, the next step is to submit the documentation to the MAC that issued the demand letter for the overpayment. This must occur within 120 calendar days of the demand letter.
- This situation is considered a reopening and the MAC will send the submitted documentation to the SMRC for a re-review decision. The SMRC has up to 60 calendar days to make this decision. The SMRC will then mail a letter to the supplier with their findings, either to pay the claim or they will outline the reasons for denial.
- The SMRC will next notify the MAC of the payment or denial decision. The MAC will adjust the claim and a remittance advice with the adjustment results will be generated. The provider has the right to appeal the SMRC decision, if the claim remains denied.
- Based on the timeframes and steps listed above, please call the MAC about the status of the SMRC re-review only after at least 140 calendar days have passed from when documentation was sent.

California Wildfire Information

Active LCDs | Appeals | Claims

Fee Schedules | Noridian Medicare Portal (NMP) | Register for an Education Event

SYSTEM NOTICES

- All Systems Normal
  - Customer Service
  - NMP
  - IVR

Noridian Medicare Portal

Access Login | Registration Guide | User Manual

Provider Contact Center

Availability | Holiday Closures | Training Closures | IVR Guide

ALERTS

See All

There are currently no open alerts.

LATEST UPDATES

See All

Articles	Source	Posted
Travel Allowance Fees for Specimen Collection - 2025 Updates	CR13947	02/14/2025
HCPCS Codes Used for SNF CB Enforcement: April 2025 Quarterly Update	CR13945	02/14/2025
Ambulatory Surgical Center Payment Update - January 2025	CR13934	02/14/2025
MLN Connects - February 14		02/14/2025

Medical Review

Medical Review

02/19/25

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to Medicare

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MR Reopening - View information on how to request a Medical Review Reopening

Medical Documentation Signature Requirements - View signature requirement details

Order Authentication Requirements - View requirements as a condition of participation

Medical Review

Attend a Webinar

Documentation Requirements

02/19/25

Medical Review (MR)

The Medical Review (MR) mission is to reduce provider billing errors and ensure that Medicare claims are paid correctly while maintaining the Medicare Program integrity. To reduce claim submission (coverage/coding) and payment errors, and increase timely payments, data is gathered and errors are identified and addressed. It is our philosophy to educate early and often; therefore, the MR and Provider Outreach and Education (POE) team creates coverage and guideline related articles, informational materials, and provide education on claims denied through MR and/or other review contractors. View the CMS Medical Review and Education webpage for details.

Documentation Requests: How, Who and When to Send - As part of the Medical Review process, Noridian requests medical records for some services prior to completing claim processing.

Documentation Requirements - View reference guides for submitting documentation to Medicare

How to Read an ADR - View information about how to read an ADR Letter

How Do I Respond to an ADR? - Learn about the ADR process and how to submit requested documentation

MR FAQs - View frequently asked MR related inquiries and the answers to them

MR Overview - View the MR primary mission, plan and philosophy

MR Reopening - View information on how to request a Medical Review Reopening

Medical Documentation Signature Requirements - View signature requirement details

Order Authentication Requirements - View requirements as a condition of participation

Prior Authorization - Access Prior Authorization Program information

Medical Review

- Documentation Requests: How, Who and When to Send
- Documentation Requirements
- How to Read an ADR
- How to Respond to ADR
- MR FAQs
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- MR Reopening
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Access the Noridian SMRC website.

Review SMRC Current Projects

Last Updated Mar 25 , 2024

Educational Resources

Other Review Contractor Forms

CURRENT PROJECTS

Current Projects

CMS determines review topics and time frames, and assigns the focus project to the SMRC (Noridian) via a formal notification. Noridian sends affected providers/suppliers an Additional Documentation Request (ADR) letter and, upon receipt of returned medical records and/or supporting documents, conducts the review based on the analysis of national claims data and in accordance with statutory, regulatory and sub regulatory coverage, coding, payment, and billing requirements.

Project Review Types

- **Healthcare Fraud Prevention Partnership (HFPP) Support Review** – Review based on fraud, waste, and abuse trends identified by the HFPP
- **Program Integrity (PI) Support Review** – Claim review focused on possible falsification or other evidence of alterations of medical record documentation including, but not limited to: obliterated sections; missing pages, inserted pages, white out; and excessive late entries; evidence that service billed for was actually provided and/or provided as billed; or, patterns and trends that may indicate potential fraud, waste, and abuse
- **Provider Compliance Group (PCG) Review** – Claim review based on evaluation of beneficiary's information and supporting medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements

Access current projects below.

If the project is not listed, please see the Completed Projects.

Access current projects below.

If the project is not listed, please see the Completed Projects.

NOTE: At CMS discretion, not all projects will be made available on this website.

Project ID	Project Title
01-119	Home Health Second Certification Period
01-121	Nail Avulsions
01-123	Nerve Block Injections
01-125	Cataract Surgery
01-127	Outpatient Therapy Reviews Below the Threshold
01-130	Urinary Catheters
01-133	Knee Injections with Hyaluronic Acid
01-135	IRF Services
12-001	CAA Telehealth Services

COMPLETED PROJECTS

Completed Projects

When a project is completed, Noridian will forward the identified improper payments to CMS. CMS will direct the appropriate Medicare Administrative Contractor (MAC) to initiate the claim adjustments and/or overpayment recoupment actions.

Access completed projects below.

Project Number	Project Title	Error Rate
01-002	Kwashiorkor	4%
01-003	Hospital Outpatient Dental Services	91%
01-004	Specimen Validity	78%
01-005	Spinal Fusion	25%
01-006	Inpatient Bone Marrow and Stem Cell Transplant Procedures	86%
01-008	Electrodiagnostic Testing	58%
01-009	General Inpatient Hospice	36%

01-012	Emergency Ambulance	98%
01-013	Hospice Portfolio	38%
01-015	Non-Emergency Ambulance	79%
01-019	Spinal Cord Stimulator	36%
01-020	Outpatient Hyperbaric Oxygen (HBO)	38%
01-021	No Response Provider DME-DTS	86%
01-022	Emergency Ambulance	92%
01-024	Polysomnography	46%
01-025	Inpatient Rehabilitation Facility (IRF)	33%
01-026	Skilled Nursing Facility (SNF)	17%
01-027	Specimen Validity Part 2	42%
01-028	Therapeutic Shoes for Diabetics	70%
01-029	Intravenous Immune Globulin (IVIG)	56%
01-030	Botulinum Toxins	66%
01-031	DRG Thyroid, Parathyroid and Thyroglossal Procedures	12%

01-032	TENS	77%
01-034	Transforaminal Epidural Injection Phase I and Phase II	65%
01-036	Hospice Portfolio – Phase 2	29%
01-036	Hospice Portfolio – Phase 3	47%
01-038	Facility Chronic Care Management (CCM)	99%
01-043	DRG COVID 20% Add On Payment	1%
01-044	BBA Therapy Reviews	31%
01-045	Malnutrition	53%
01-046	Inpatient Rehabilitation Facility Stays (IRF) Longer Length of Stay (LOS)	54%
01-047	Electrodiagnostic Testing Axial Muscles and Spinal Levels	48%
01-049	Vitamin D Testing	96%
01-050	Podiatry	45%
01-054	Carotid Artery Screening	75%
01-055	Audio Only Telehealth Services During the PHE	60%
01-056	SNF 3-Day Stay Waiver PHE	36%




01-057	Potentially Unnecessary Surgeries	48%
01-058	Traditional Telehealth	88%
01-060	E&M No Response Providers DME Part II	59%
01-062	EDX Diabetes	56%
01-065	Total Joint Arthroplasty	20%
01-066	Schizophrenia in SNF	20%
01-067	Echocardiography	47%
01-069	Treatment of Chronic Venous Insufficiency	61%
01-071	E&M Dermatology Services	48%
01-072	Neurostimulator Implantation	53%
01-079	Dental Bone Grafting	100%
01-080	Vitamin B12 with Modifier 25	43%
01-081	Unspecified Outpatient Dental Services CPT 41899	95%
01-083	HBO for LE Diabetic Wounds	92%
01-084	Hospice General Inpatient (GIP) Level of Care	79%

01-085	IRF	37%
01-086	Home Health PDGM	66%
01-087	OIG Facet Joint Denervation	87%
01-088	SNF PDPM	19%
01-092	Cryosurgery of the Prostate	65%
01-093	Overlapping Claims – Hospital Transfers During the PHE	12%
01-095	Mohs Surgery	19%
01-096	Select Carotid Artery Screening	57%
01-099	Hospice 90 Day Stay	11%
01-103	Echocardiography Select Code	50%
01-106	OIG Psychotherapy Services	68%
01-108	OIG Genetic Testing	100%
01-109	Lumbar-Sacral Orthoses	69%
01-111	OIG Opioid Use Disorder Treatment Services	100%
01-113	Acupuncture	81%

01-116	OIG Epidural Steroid Injections	94%
01-118	Acute Hospital Care at Home (AHCaH) DRG Review	29%
01-301	Home Health	62%
01-302	Cataract Surgery	51%
01-303	Surgical Dressings	91%
01-304	Facet Joint Injections	92%
01-305	Inpatient Psychiatric Facilities	26%
01-306	Ostomy Supplies	68%
01-307	Orthopedic Footwear	69%
01-308	Outpatient Therapy	39%
01-309	Ophthalmology Injections	29%
01-310	Endomyocardial Biopsy with Right Heart Catheterization	60%

Option for Response – Appeal May be Available

Unless an overpayment demand letter has been sent to the provider/supplier from their respective MAC, an appeal request cannot be submitted.

Since SMRC does not handle appeal requests, requestors must address any overpayment recovery process or appeal rights with their MAC.

Last Updated Dec 6, 2024

TPE

Targeted Probe & Education

TPE

Documentation

Appeals

WE WILL DISCUSS

- **Medical review: TPE Process**
- **Documentation Tricks and Amending Records**

RE: Notice of Review - Targeted Probe and Education

Dear Medicare Provider:

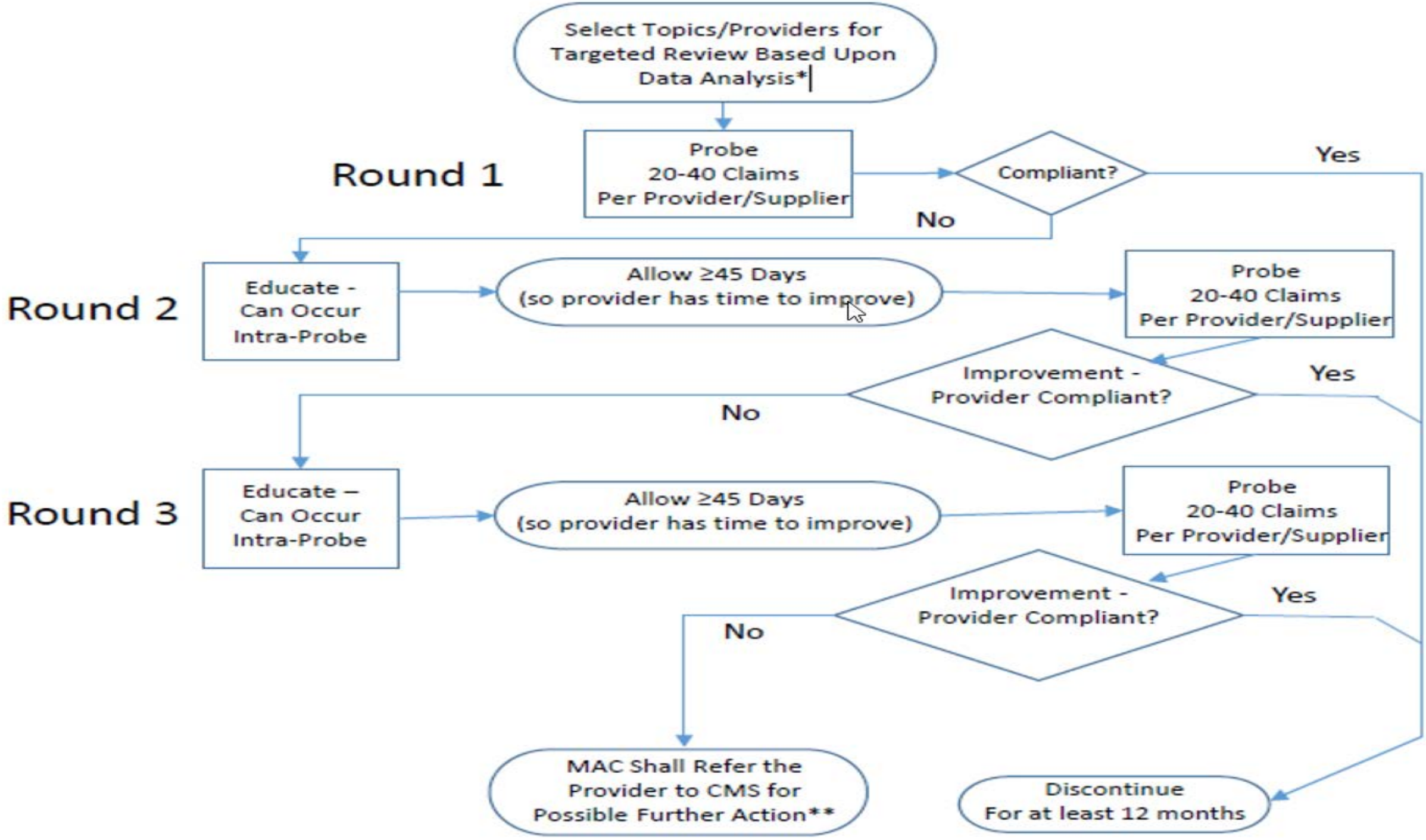
In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Noridian Healthcare Solutions, LLC, your Jurisdiction E Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Jurisdiction E to conduct the Targeted Probe and Educate (TPE) review process. The TPE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, Noridian will refer the provider to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason for Review

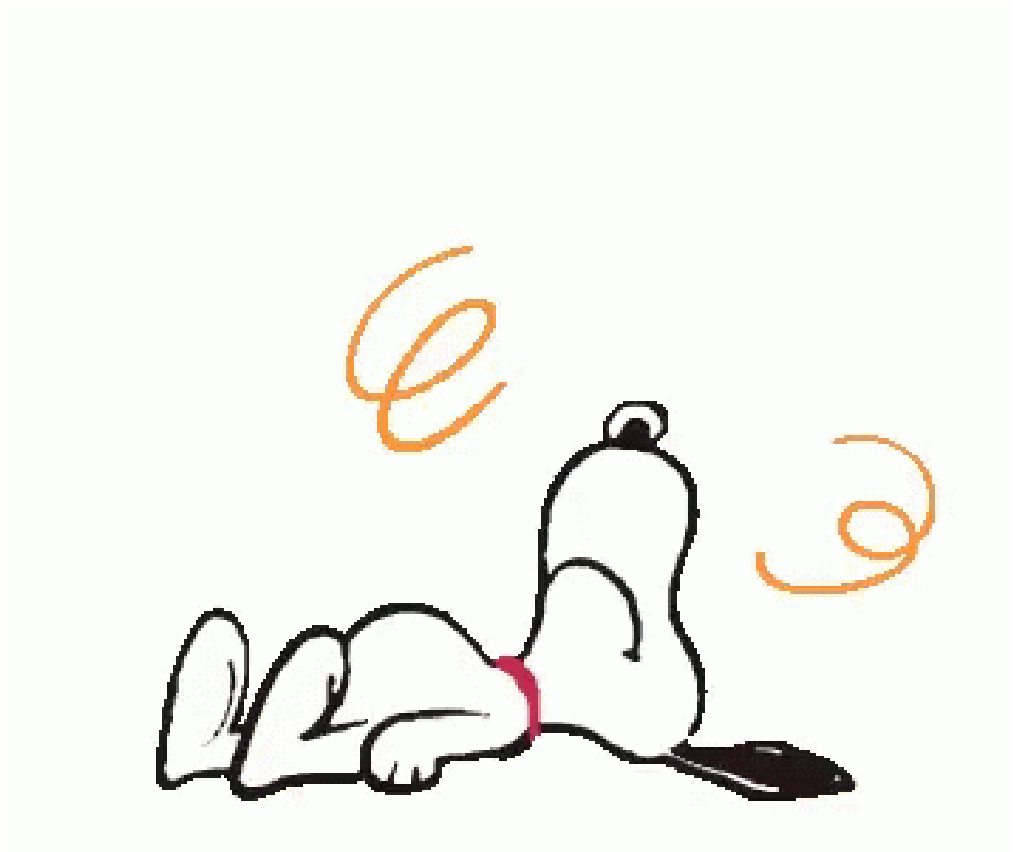
A prepayment review has been initiated to probe a sample of your claims billed with the following code(s):

Healthcare Common Procedure Coding System (HCPCS) code G0277


Select Topics/Providers for Targeted Review Based Upon Data Analysis*
Round 1
Probe 20-40 Claims Per Provider/Supplier
Compliant?
Yes
No
Round 2
Educate - Can Occur Intra-Probe
Allow ≥45 Days (so provider has time to improve)
Probe 20-40 Claims Per Provider/Supplier
Improvement - Provider Compliant?
Yes
No
Round 3
Educate – Can Occur Intra-Probe
Allow ≥45 Days (so provider has time to improve)
Probe 20-40 Claims Per Provider/Supplier
Improvement - Provider Compliant?
Yes
No
MAC Shall Refer the Provider to CMS for Possible Further Action**
Discontinue For at least 12 months

WHAT COMES NEXT

- You will get an e-mail asking for a specific patient, code and date of service-often every 3rd or 4th claim
- How are you and the code selected:
  - Outlier code/s compared to other states, or regions---specific code or groups of codes related
  - Outlier (higher frequency) numbers of claims for that code or series of codes by your office
  - Increased frequency of billing for those codes by your practice compared to prior time period
- You will be told where and when to send the chart information/documentation



Now pick yourself up from the floor
Find out which charts we are asking for
And please, please, please do not ignore
Sending them in is not a big chore

TOPICS UNDER TPE REVIEW JE/JF

- 0394T High dose rate electronic brachytherapy
- 11012 Debridement open fracture /dislocation skin, subcu tissue, muscle fascia, bone
- 11042-43-46 Debridement, various levels and depths
- 11102 Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
- 11106 Incisional biopsy skin (eg, wedge with simple closure, when performed); single lesion
- 11721 Debride nails 6 or more
- 11760 Repair of nail bed
- 13132 Repair, complex, forehead, chin cheeks, etc. 2.6-7.5 cm
- 14301 Adjacent tissue transfer / rearrangement, any area; defect 30.1 sq cm - 60.0 sq cm
- 15271 Application of skin substitute graft to trunk, arms, legs
- 17000 Destruction premalignant lesions (eg, actinic keratoses); first lesion
- 17003-4 Destruction premalignant lesions (2-14 and >15)
- 20553 Injection(s); single or multiple trigger point(s), 3 or more muscles
- 20604 Arthrocentesis, aspiration/injection, small joint or bursa, with permanent recording
- 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa without ultrasound
- 20611 Arthrocentesis, aspiration and/or injection, major joint or bursa with ultrasound
- 21025 Excision of bone (eg, for osteomyelitis or bone abscess)
- 21085 Computed tomography, abdomen and pelvis; without contrast material
- 21208-15 Dental / oral surgery codes

TOPICS UNDER TPE REVIEW JE/JF

- 21215 Graft, bone; mandible (includes obtaining graft)
- 22214 Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
- 22558 Arthrodesis, anterior interbody technique
- 22633 Arthrodesis, combined posterior or posterolateral…single interspace, lumbar
- 26055 Tendon sheath incision (eg, for trigger finger)
- 27130 Total hip arthroplasty
- 27447 Total knee arthroplasty
- 29581 Apply multi-layer compression system; leg (below knee), including ankle and foot
- 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair
- 31231 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
- 31295-98 Nasal/sinus endoscopy, surgical, with dilation frontal, sphenoid sinus / other ostia
- 36140 Introduction of needle or intracatheter, upper or lower extremity artery
- 36415 Routine Venipuncture
- 36473 Endovenous ablation therapy of incompetent vein, extremity,
- 36482 Endovenous ablation therapy of incompetent vein, extremity, 1st vein
- 37225 Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s),…
- 37229 Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral,
- 37233 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel;
- 43239 Esophagogastroduodenoscopy, flexible, with biopsy
- 43252 Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy

TOPICS UNDER TPE REVIEW JE/JF

- 43239 Esophagogastroduodenoscopy, flexible, with biopsy
- 43252 Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
- 45380-45385 Colonoscopy with biopsy-lesion removal
- 49450 Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous
- 51703 Insertion of temporary indwelling bladder catheter; complicated
- 52281 Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis
- 62322 Injection(s), diagnostic/therapeutic substance(s) including needle/catheter placement interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
- 63047 Laminectomy, facetectomy and foraminotomy...single vertebral segment; lumbar
- 63685 Insertion or replacement of spinal neurostimulator pulse generator
- 64405 Injection, anesthetic and/or steroid; greater occipital nerve
- 64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus
- 64455 injection(s), anesthetic agent(s) / steroid; plantar common digital nerve(s) Morton's
- 64479 Injection Anesthetic Agent (Nerve Block), Diagnostic / Therapeutic, somatic nerve
- 64483-4 Epidural lumbar/sacral

TOPICS UNDER TPE REVIEW JE/JF

- 64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment
- 64615 Chemodenervation muscle(s); chronic migraine)
- 64721 Neuroplasty and/or transposition; median nerve at carpal tunnel
- 64635-6 Destruction neurolytic agent, paravertebral facet nerves & additional joints
- 65778 Placement of amniotic membrane on the ocular surface; without sutures
- 66174 Transluminal dilation aqueous outflow canal; without retention of device or stent
- 66984 Cataract removal, insertion of IOL
- 67028 Intravitreal injection of a pharmacologic agent
- 68320 Conjunctivoplasty; with conjunctival graft or extensive rearrangement
- 68761 Closure of the lacrimal punctum; by plug, each
- 68840 Probing of lacrimal canaliculi, with or without irrigation
- CORF Comprehensive Outpatient Rehab Facility

TOPICS UNDER TPE REVIEW JE/JF

- IRF Inpatient rehabilitation facility claims /
- SNF Skilled nursing facility claims
- KX Modifier
- 70450 Computed tomography, head or brain; w/out contrast
- 71045-71046 Radiologic examination, chest; single view – 2 views
- 70496 CT angiography head with contrast angiography and non-contrast
- 71275 Computed tomographic angiography, chest (noncoronary), with contrast material(s)
- 72148 MRI lumbar spine without dye
- 72197 Magnetic resonance (eg, proton) imaging, pelvis; with and without contrast
- 73552 Radiologic examination, femur; minimum 2 views
- 74176 Computed tomography, abdomen and pelvis; without contrast material
- 74177 Computed tomography, abdomen and pelvis; with contrast material(s)
- 76857 Ultrasound, pelvic (nonobstetric), real time with image documentation
- 76700 Ultrasound, abdominal, real time with image documentation; complete
- 77014 CT for planning purposes
- 77063 Screening digital breast tomosynthesis, bilateral
- 77066 Diagnostic mammography inc. CAD when done bilaterally

TOPICS UNDER TPE REVIEW JE/JF

- 77080 Dual-Energy X-ray Absorptiometry axial skeleton
- 77525 Proton treatment delivery; complex
- 78431 Myocardial imaging, positron emission tomography (PET), perfusion study
- 78452 Myocardial perfusion imaging, tomographic (SPECT)
- 78608 Brain imaging, positron emission tomography (PET); metabolic evaluation
- 78815 Positron Emission Tomography (PET) skull base to mid-thigh
- 80061 Lipid Panel
- 80305-07 Drug test(s), presumptive, any # classes
- 81479 Unlisted molecular pathology procedure
- 82306 Vitamin D; 1, 25 dihydroxy, includes fractions
- 82607 Vitamin B-12
- 82746 Assay of folic acid
- 84402 Assay of free testosterone
- 84443 TSH
- 86003 Allergen specific IgE; quantitative / semiquantitative,

TOPICS UNDER TPE REVIEW JE/JF

- 90833-38 Psychotherapy 30-X minutes with E&M
- 90834-38 Psychotherapy
- 93342 Fluorescein angiography & indocyanine-green angiography (with multiframe imaging)
- 90868 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
- 90960-2 End Stage Renal Disease
- 92235 Fluorescein angiography with interpretation and report, unilateral or bilateral
- 92250 Fundus photography with interpretation and report
- 92285 External ocular photography w interpretation & report to document medical progress
- 92546 Sinusoidal vertical axis rotational testing
- 92550 Tympanometry and reflex threshold measurements
- 92570 Acoustic immittance testing, inc. tympanometry, acoustic reflex threshold testing,etc
- 92978 Endoluminal imaging coronary vessel or graft using IVUS or OCT
- 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
- 93005 EKG with at least 12 leads; tracing only, without interpretation and report
- 93016 Cardiograph stress test
- 93017 Cardiovascular stress test using maximal / submaximal treadmill or bicycle exercise, continuous monitoring, and/or pharmacological stress; tracing only,
- 93306 Echocardiography, transthoracic, real-time with image documentation (2D), includes spectral Doppler echocardiography, and with color flow Doppler echocardiography

TOPICS UNDER TPE REVIEW JE/JF

- 93248 External EKG 7-15 days continuous rhythm recording/storage; review /interpret
- 93306 Echocardiography, transthoracic, real-time, image documentation, M-mode
- 93350 Echo, TTE, real-time, includes M-mode recording, during rest and CV stress test
- 93351 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test
- 93454-58 Catheter placement in coronary artery(s) for coronary angiography, etc
- 93656 Tx atrial fibrillation, pulm vein isolation
- 93880 Duplex scan of extracranial arteries; complete bilateral study
- 93924 Noninvasive phys studies lower extremity art., rest/following treadmill stress testing
- 93925 Duplex scan lower extremity arteries/arterial bypass grafts; complete bilateral study
- 93951 Echo, transthoracic, real-time with image documentation (2D), includes M-mode recording, during rest and cardiovascular stress test with interpretation and report;
- 93970 Duplex scan extremity veins w responses to compression/maneuvers; bilateral study
- 95810-11 Polysomnography
- 95886 Muscle Test Done W/N Test Comp
- 95913 Nerve conduction studies; 13 or more studies
- 95819 Electroencephalogram (EEG); including recording awake and asleep
- 95826 Drain/Inject Joint//Bursa With Ultrasound
- 95939 Central motor evoked potential study-transcranial motor stim-upper and lower limbs

TOPICS UNDER TPE REVIEW JE/JF

- 96121 Neurobehavioral status exam
- 96127 Brief emotional/behavioral assessment with scoring and documentation,
- 96130-1 Psychological testing evaluation services,
- 96136-38 Psychological/neuropsych test admin & scoring, 2 or more tests; first 30 minutes
- 96365 IV infusion, for therapy, prophylaxis, or dx; up to 1hour
- 96374 Therapeutic, prophylactic, or dx injection; IV push
- 96413 Chemo infusion, up to1 hour
- 97010 Hot or cold pack therapy
- 97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes
- 97110-3 Physical therapy, Occupational therapy, SLP, each 15 minutes
- 97124 Massage therapy, each 15 min
- 97164 Re-evaluation of physical therapy established plan of care
- 97530 Therapeutic activities, direct (one-on-one) patient contact, each 15 minutes
- 97810 Acupuncture, 1 or more needles; w-out electrical stim, initial 15 minutes
- 98928 Osteopathic manipulative treatment (OMT); 7-8 body regions involved
- 99152 Moderate sedation services by the same physician or other qualified health care professional performing the diagnostic or therapeutic service
- 99183 Hyperbaric oxygen therapy
- 99487, 99489, 99490 Complex chronic care management services

TOPICS UNDER TPE REVIEW JE/JF

- A0425-28 Ambulance Codes; A0430-35-36 Fixed wing-Rotary wing-air transport
- C8925 Transesophageal echo (TEE) with or without contrast followed by with contrast
- G0277 Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
- G0283 Electrical stim (unattended), to one or more areas for indication(s) other than wound care,
- G0340 Image-guided robotic linear accelerator-based stereotactic radiosurgery
- G0444 Annual depression screening. 15 minutes
- G0480-G0483 Drug Tests 4-22+ drugs
- G0500 Moderate sedation endoscopy service >5yrs
- J0178 IMRT
- J0179 Injection, brolucizumab-dbll, 1 mg
- J0897 Injection Denosumab (Prolia and Xgeva)
- J1569 Gammagard liquid injection 500 mg

TOPICS UNDER TPE REVIEW JE/JF

- **J1944 Injection, aripiprazole lauroxil, (aristada), 1 mg**
- **J2350 Injection, ocrelizumab, 1 mg**
- **J3111 Romosozumab-aqqg 1 mg (Evenity)**
- **J3262 Injection, tocilizumab, 1 mg**
- **J3245 Injection, tildrakizumab, 1 mg**.
- **J7308 Aminolevulinic acid hcl for topical administration, 20%, single unit dosage form**
- **J9022 Injection, atezolizumab, 10 mg**
- **J9047 Injection, carfilzomib, 1 mg**
- **J9035 Injection, bevacizumab, (Avastin) 10 mg**
- **J9144 Daratumumab, hyaluronidase**
- **J9228 Injection, ipilimumab, (Yervoy) 1 mg**
- **J9271 Injection pembrolizumab (Keytruda)**
- **J9299 Injection, nivolumab, (Opdivo) 1 mg**
- **J9355** Inj trastuzumab excl biosimi
- **KX Modifier**

TOPICS UNDER TPE REVIEW JE/JF

- **G0277 Hyperbaric oxygen, whole body**
- **G0260 Injection sacroiliac joint-any substance**
- **G0340 Image-guided robotic linear accelerator-based stereotactic radiosurgery; 2-5 ses**
  G0482-3 Drug tests, definitive and screening
- **G0438-9 Initial wellness visit, Subsequent visit**
- **G0500 Moderate sedation GI endoscopy service, initial 15 min, age >5**
- **Q0138 Injection, ferumoxytol, for iron deficiency anemia, 1 mg (non-esrd use)**
- **Q4186 Epifix, per 1 square centimeter**
- **Q4196 Puraply am, per square centimeter**
- **Q5107 Bevacizumab-awwb, biosimilar,**
- **Q5117 Trastuzumab-anns, biosimilar**

REPORT ON RESULTS OF REVIEW

RE: Notice of File Closure - Targeted Probe and Educate

Dear Medicare Provider,

This letter is to inform you of the round 1 findings for the review initiated on January 4, 2022 for Current Procedural Terminology (CPT®) code 96374. This file is now closed.

An e-visit is not required given the low error rate for the round 1 file, however if you determine that one to one education would be beneficial, Noridian encourages your facility to contact me to set up an e-visit.

Claim Review Summary

Your facility had 20 claims selected for pre-payment review from January 4, 2022 through June 3, 2022 with an overall payment error rate of 2.8% and a claim error rate of 5%. The results are based on the documentation requests submitted by your facility. This review does not guarantee coverage and payment as the claims identified may be subject to other claim processing issues or reviews by other CMS contractors.

The formula to calculate the error rate, which is based on pre-payment decisions only, is the dollar amount of charges billed in error (minus any confirmed under-billed charges) divided by the total amount of charges for services medically reviewed. Individual claim correction is not required as the claims were reviewed on a pre-payment basis and processed per medical review determinations.

A summary of the claim determinations is as follows:

- 19 claims were accepted
- 0 claims required correct coding:
  - Documentation Supporting Infusion Units Billed
  - Therapeutic Administration Billing
  - Therapeutic Administration Billing Integral to a Procedure

Refer to the Claim Review Summary at the end of this letter for more detailed information on your individual claim determinations.

Education

This section provides education on errors found in the claims reviewed from your facility; it does not educate on all of CMS's guidelines required for this service. Furthermore, practitioner orders were not part of Noridian's scope of review and not incorporated in the error rate; however, orders are still required per Medicare

No mistakes or few mistakes and you need have no fear
Our requests for extra charts will stop and disappear
We won’t bother you for this code set for at least a year

Documentation

What you need to pass an Audit

WHAT SHOULD YOUR DOCUMENTATION SHOW

- **For Laboratory Tests:**
  - Signed and dated order exists in hospital and institutional charts
  - That office chart documentation shows that doctor wanted tests and (hopefully) for what reason tests were ordered
- **For imaging tests:**
  - Signed and dated order exists in hospital and institutional charts
  - Office documented shows that doctor wanted / needed the tests
- **Total time and what happened during office visit (E&M), or**
- **Decision making aspects of office visit (E&M)**
  - Potential problems, provider thoughts, rule outs help level of visit
  - What you are thinking at the time also helps…
  - Tests you plan and potential drug interactions also helps…

NATIONAL AND LOCAL COVERAGE DECISIONS

- **National Coverage Decisions:**
  - Made by CMS, must be followed as written
  - Areas not specifically mentioned (covered/ denied) may be covered or non-covered by local MACs
  - NCDs cannot be changed by MACs, QICs, even ALJs
- **Local Coverage Decisions**
  - Made by MACs locally or collaboratively
  - Can be asked for policy reconsiderations with reasons and literature sent in
  - Can be asked for individual consideration for individual patients for unusual or off label use with literature support
- **National and Local Coverage Decisions are posted in CMS Coverage Database**

DOCUMENTING REASONABLE & NECESSARY: NOT CHANGING

- **Only the actual physician who is treating the patient knows what is reasonable and necessary for that patient being evaluated and treated at that visit.**

- **The only way a Noridian reviewer can determine if something is (was) reasonable and necessary on a claim is to review the complete documentation submitted**

Send in the document you wrote
So all reviewers can read your note

FIGHTING BACK: RESPONDING TO ANY REQUEST FOR CHART RECORDS / DOCUMENTS

- **Have a set office process for dealing with Record Requests (from Medicare or any insurance or agency)**
- **Have 1 individual responsible for sending all records as part of set office process---experienced office manager or equivalent**
- **Have a check off sheet that includes:**
  - **Legibility of document and signature (can add typed / printed addendum to help us decipher)**
  - **Correct name, date, physician listed in request**
  - **Patient name, birthdate & date of service on every page submitted**
  - **Signature (signature sheet or attestation if needed)**
  - **Correct address for records to be sent (other entities may also want records)**
  - **Timeliness of records being sent**
- **Know how and where to get hospital /clinic records**
- **Send by certified mail (or equivalent) so you have proof it arrived**

MEDICARE APPEALS PROCESS

- Initial Determination from Noridian ($1)
- Redetermination from Noridian ($1)-120 days/file
- Qualified Independent Contractor (QIC) ($1)-180 days/file
- Administrative Law Judge (ALJ) ($180)-60 days/file
- Department Appeals Board (DAB) ($180)-60 days/file
- Federal Court ($1760)-60 days/file

AMENDED RECORDS

- Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, addendum or correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

  - Late Entry: supplies additional information that was omitted from original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

  - Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

AMENDED RECORDS

- **When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error.**

- **Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin.**

- **Document correct information on the next line or space with the current date & time, making reference back to the original entry.**

At-Risk & Pain Foot Care A Revenue Stream

GABRIEL HALPERIN, DPM, FACFAS, AENS

CAC REP

More Information on Coding for Routine Foot Care Painful & At-Risk

- 2021 Routine Foot Care lecture
- In the Supplemental Files

California Wound Healing Medical Group (323) 264-7796

Debridement Sheet

Facility:_____ Name: _____ ☐ M ☐ F DOB: _____ Date:_____

Chief Complaint:

Relevant History:

☐ Medication list on patient chart reviewed with no action needed

Questions
- ☐ DM
- ☐ Numbness
- ☐ Pain in limb
- ☐ Pain in foot
- ☐ Pain in nail
- ☐ Pain in callus/corn
- ☐ Infection
- ☐ Change of meds
- ☐ Coumadin
- ☐ Lovinox
- ☐ Heprin
- ☐ Hospitalizations
- ☐ Surgery
- ☐ Other:

Treating Doctor Name: NPI: Date Last Seen (within 6 months)

Callous – Painful
(Symptoms, Location, Size)
(Pain /burning / itching)

☐ Debride per S/P

Corns – Painful
(Symptoms, Location, Size)
(Pain /burning / itching)

☐ Debride per S/P

IPK – Painful Enucleated Keratosis
(Symptoms, Location, Size)
(Pain /burning / itching)

☐ Debride per S/P
☐ Size
☐ Defect left after debridement

NAIL PLATE	R 5	R 4	R 3	R 2	R 1	L 1	L 2	L 3	L 4	L 5
NORMAL										
PAIN ON PALPATION										
INCURVATED NEL										
PARONYCHIA										
INFLAMATION										
NAIL HYPERTHROPHY										
NAIL DYSTROPHY										
DISCOLORATION										
SUBUNGUAL DEBRIS										
ONYCHOLYSIS										
P. GRANULOMA										
PINCER SHAPE										

ROUTINE FOOT CARE
(Needs Dx, Systemic condition, and Q modifier for vasc Dx)

Right 1 2 3 4 5 Left 1 2 3 4 5

☐ All Nails

- ☐ Trimming 4Dx non-dystrophic nails (11719)
- ☐ Trimming of 4dx dystrophic nails
- ☐ Debridement of Dystrophic / Mycotic nails (11720 / 11721)
- ☐ Paring 4Dx corn or callous
  - ☐ 11055 ☐ 11056 ☐ 11057 (Needs location and size)
  - ☐ Corn ☐ Callus

Pulses

	Right 0 1 2 3 4	Left 0 1 2 3 4
DP	☐☐☐☐☐	☐☐☐☐☐
PT	☐☐☐☐☐	☐☐☐☐☐
Pop	☐☐☐☐☐	☐☐☐☐☐
Fem	☐☐☐☐☐	☐☐☐☐☐
Rad	☐☐☐☐☐	☐☐☐☐☐

Dx of Mycotic Nail

- 11720 (1-5) ☐
- 11721 (6-10) ☐
- Difficulty in walking ☐
- Pain in limb / toe ☐
- Paronychia of toe ☐

MYCOTIC NAILS

- Clinical evidence of mycosis ☐
- AND
- Marked limitation of ambulation ☐
- OR
- Pain due to the mycotic nail ☐
- OR
- Secondary infection ☐
- Due to the thickening and dystrophy of the infected toenail plate if left untreated ☐

CLASS FINDINGS FOR VASC COMPROMISED PATIENT

- Q7 : 1 class A ☐
- Q8 : 2 class B ☐
- Q9 : 1 class B & 2 class C ☐

CLASS B FINDINGS

- Absent Posterior Tibial Pulse ☐☐
- Absent Dorsalis Pedis Pulse ☐☐
- Advanced Trophic Changes: ☐

(three required)
- Hair Growth (decrease or absent) ☐
- Nail Changes (thickening) ☐
- Pigmented Changes (discoloration) ☐
- Skin Texture (atrophic, thin, shiny) ☐
- Skin Color (rubor or redness) ☐

★ Active foot care

☐ **Painful Ingrown Nails:**
☐ **Paronychia/ Inflammed**

Wedge Resection w/o Anesthesia per Standard Protocol

R1	☐ med	L1	☐ med
R2	☐ med	L2	☐ med
R3	☐ med	L3	☐ med
R4	☐ med	L4	☐ med
R5	☐ med	L5	☐ med

Fungal / Deformed / Dystrophic Thickened Nails: Reduction of Nail with Debulking with Bone Cutter and Electric Grinder per Standard Protocol

R1	☐ med	L1	☐ med
R2	☐ med	L2	☐ med
R3	☐ med	L3	☐ med
R4	☐ med	L4	☐ med
R5	☐ med	L5	☐ med

Systemic Conditions Justifying Routine Foot Care

- Diabetes Mellitus ★
- ASO ☐
- Buerger's Disease ☐
- Chronic Thrombophlebitis* ★
- Peripheral Neuropathy ★
- Malnutrition* ☐
- Uremic (Chron venous disease) ☐
- Anticoagulant ☐
- Immunodeficient ☐
- Coagulation disorder ☐
- Multiple Sclerosis ★

CLASS A FINDINGS

- Nontraumatic amputation of foot ☐
- Nontraumatic partial amputation ☐

CLASS C FINDINGS

- Claudication ☐
- Temperature changes (cold Feet) ☐
- Edema ☐
- Parasthesias ☐
- Burning ☐

Diagnosis of Routine Foot Care

- Corn & Callous ☐
- Disease of nail ☐
- Anomaly of nail ☐

Remarks:

Rev CWHMG 08272021

California Wound Healing Medical Group (323) 264-7796

Debridement Sheet

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- ☐ Heprin
- ☐ Hospitalizations
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- ☐ Other:

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(Symptoms, Location, Size)
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☐ Size
☐ Defect left after debridement

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PINCER SHAPE										

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(Needs Dx, Systemic condition, and Q modifier for vasc Dx)

Right: 1 2 3 4 5 ☐☐☐☐☐ Left: 1 2 3 4 5 ☐☐☐☐☐

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- ☐ Paring ASx corn or callous
  - ☐ 11055 ☐ 11056 ☐ 11057 (Needs location and size)
- ☐ Corn ☐ Callus

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Q8 : 2 class B ☐
Q9 : 1 class B & 2 class C ☐

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Absent Dorsalis Pedis Pulse ☐☐
Advanced Trophic Changes: ☐

(three required)

- Hair Growth (decrease or absent) ☐
- Nail Changes (thickening) ☐
- Pigmented Changes (discoloration) ☐
- Skin Texture (atrophic, thin, shiny) ☐
- Skin Color (rubor or redness) ☐

★ Active foot care

Pulses

	Right 0 1 2 3 4	Left 0 1 2 3 4
DP	☐☐☐☐☐	☐☐☐☐☐
PT	☐☐☐☐☐	☐☐☐☐☐
Pop	☐☐☐☐☐	☐☐☐☐☐
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Rad	☐☐☐☐☐	☐☐☐☐☐

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- **AND**
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- **OR**
- Pain due to the mycotic nail ☐
- **OR**
- Secondary infection ☐
- Due to the thickening and dystrophyof the infected toenail plate **if left untreated** ☐

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Wedge Resection w/o Anesthesia per Standard Protocol

R1	☐ med	☐ lat
R2	☐ med	☐ lat
R3	☐ med	☐ lat
R4	☐ med	☐ lat
R5	☐ med	☐ lat
L1	☐ med	☐ lat
L2	☐ med	☐ lat
L3	☐ med	☐ lat
L4	☐ med	☐ lat
L5	☐ med	☐ lat

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R2	☐ med	☐ lat
R3	☐ med	☐ lat
R4	☐ med	☐ lat
R5	☐ med	☐ lat
L1	☐ med	☐ lat
L2	☐ med	☐ lat
L3	☐ med	☐ lat
L4	☐ med	☐ lat
L5	☐ med	☐ lat

Systemic Conditions Justifying Routine Foot Care

- Diabetes Mellitus ☐★
- ASO ☐
- Buerger's Disease ☐
- Chronic Thrombophlebitis* ☐★
- Peripheral Neuropathy ☐★
- Malnutrition* ☐
- Uremic (Chron venous disease) ☐
- Anticoagulant ☐
- Immunodefficient ☐
- Coagulation disorder ☐
- Multiple Sclerosis ☐★

CLASS A FINDINGS

- Nontraumatic amputation of foot ☐
- Nontraumatic partial amputation ☐

CLASS C FINDINGS

- Claudication ☐
- Temperature changes (cold Feet) ☐
- Edema ☐
- Parasthesias ☐
- Burning ☐

Diagnosis of Routine Foot Care

- Corn & Callous ☐
- Disease of nai ☐
- Anomaly of nail ☐

Remarks:

Options for Covered Routine Foot Services

Painful Condition

- Debridement of Painful Mycotic/ Dystrophic Nail
- Debridement of Painful Callus
- Debridement of Painful Corn

- **No 60 Day Rule**
- **Document the pain**

- Debride / wedge resection of painful normal nail --- E/M code

At-Risk Condition

- Debridement of Mycotic/Dystrophic nails
- Trimming of normal nails
- Debridement of Callus
- Debridement of Corn

- **60-Day Rule applies**

At-Risk Routine Foot Care

- G0127 pays much higher than the 11719
  - G0127- $24.14 = Trimming of dystrophic nail
  - 11719 - $15.80 = Trimming of non-dystrophic nails
- At-risk trimming of dystrophic nails,
  - Only one nail trimmed allows the use of the code
- You will use the G0127 along with the 11720, at 50%

2024 Fees for 'Covered' Foot Care (Pain & 'At-Risk')

	2023	**2024**	**2025**
99212	$63.20	$61.99	$61.40
99213	$99.89	$98.61	$98.19

- 99213
- 98.61 / 99.89 = 0.987 = 99
- Ave 1% reduction E/M Codes

- 97597
- 110.88 / 113.64 = 0.972
- Ave 2.5-3% reduction on Surgical Codes

	2022	2023	**2024**	2025
11055	$85.71	$84.05	$81.43	78.90
11056	$97.66	$96.19	$93.81	91.13
11057	$106.61	$104.31	$101.89	98.89
11720	$37.05	$37.21	$36.62	36.17
11721	$49.91	$49.82	$49.04	48.83
11719	$15.78	$15.90	$15.80	15.61
G0127	$27.17	$27.15	$27.14	26.81
97597	$118.81	$116.28	$113.64	110.88

OP E/M Encounters – 2024 Fees

CPT	–2022	-	2023	**2024**	**2025**
99201	Deleted				
99202	$81.63	-	$80.67	$78.89	$77.71
99203	$124.29	-	$123.47	$120.37	$119.68
99204	$184.35	-	$182.44	$179.36	$178.34
99205	$243.48	-	$240.37	$235.95	$234.86

OP E/M Encounters – 2024 Fees

CPT –2022	2023	**2024**	**2025**
99211 $26.71	$26.70	$26.31	$25.99
99212 $63.41	$63.20	$61.99	$61.40
99213 $101.00	$99.89	$98.61	$98.19
99214 $142.31	$140.90	$138.66	$137.58
99215 $199.76	$196.82	$194.34	$192.53

Potential Reimbursement

- 99213 $98.19

- **Total** **$**98.19

- Significant documentation
- Possible repayment if found to be routine foot care, qualified or not

- 11055 $78.90
- 11720 $36.17
- G0127 $26.81 (13.40)

- **Total** **$128.47**

- Relatively easy documentation
- Easy to sched on a 61 day basis
- Keep the $
- Buy a car

Potential Reimbursement

- 99212 $61.40

OR

- 97597 $110.88
- 11056 $91.13 (45.57)
- 11720 $36.17
- G0127 $26.81 (13.40)

- Total $206.02

Potential Reimbursement

- 11721 $48.83
- OR
- 99212 $61.40

The E/M visit is difficult to repeat as often as the Routine Foot Care

OR

- 11720 $36.17
- G0127 $26.81 (13.40)

- Total $49.57

- Difference
  - Minimal documentation
  - Under the radar

-59 Modifier & CCI Edits

- To break a CCI edit that bundled normally separate procedures
- Seen often in Routine Foot Care
- APMA CRC is my resource in coding
- The 2 CPT codes are entered. And listed in tablet form
- The secondary code is the CPT code to place the -59 modifier

- We can not bill for a callous and a nail if they are on the same toe.
- Everything else should be codes with the -59 or the -XS modifier to identify the services performed in separate anatomical locations

LCD & LCA

2025 LCD & LCA

- No change to the listed LCD list
- Proposed LCD & LCA for Application of Skin Substitutes / TCPs for Diabetic Ulcers and Venous Leg Ulcers (DFU & VLU)
- LCA Coding & Billing for Routine Foot Care
  - Not new but re-evaluated in 2024

LCD & LCA 2024

Wound Care	LCD L38902 (2021)	LCA A58565 (01/2024) **NEW**
Trigger Points	LCD L34211 (2019)	LCA A57701 (2021)
Treatment of Varicose Veins	LCD L34209 (2019)	LCA A57706 (01/2023) **NEW**
Spinal Chord Stimulator for Chronic Pain	LCD L35136 (2019)	LCA A57791 (01/2024) **NEW**
PRP Injections for Non-Wound Injections	LCD L39058 (1/2022)	LCA A58788 (2022)
Plastic Surgery	LCD L35163 (2019)	LCA A57221 (10/2023) **NEW**
Peripheral Nerve Stimulation	LCD L34328 (2019)	LCA A55530 (01/2024) **NEW**
Nerve Conduction Studies	LCD L36524 (2019)	LCA A54969 (01/2024) **NEW**
Nerve Blockade for Chronic Pain & Neuropathy	LCD L35456 (9/2022)	LCA A56034 (01/2024) **NEW**
Mol Dx Molecular Syndrome Panel for Infectious Disease	LCD L39001 (2022)	LCA A58720 (01/2024) **NEW**
Injections – Tendon – Ligament – Ganglion Cyst - Tunnel Syndromes & Morton's Neuroma	LCD L34218 (2019)	LCA A57079 (2019)
Benign Skin Lesion Removal (not Actinic Keratosis or Mohs)	LCD L34233 (2019)	LCA A57161 (01/2024) **NEW**
Amniotic & Placental derived Product Injection and other applications for Musculoskeletal Indications; Non wound "Non-Coverage Policy"	LCD L39116 (11/2023) **NEW**	LCA A58865 (11/2023) **NEW**

Nerve Blockade for Chronic Pain & Neuropathy (L35456)

- **PERIPHERAL NEUROPATHY**

  • Nerve blockade and/or electrical stimulation are non-covered for the treatment of **metabolic** peripheral neuropathy. The peer-reviewed medical literature has not demonstrated the efficacy or clinical utility of nerve blockade or electrical stimulation, alone or used together, in the diagnosis and/or treatment of neuropathic pain.
  • The use of imaging guidance (i.e. ultrasound, CT, or fluoroscopic guidance) in conjunction with these non-covered injections is also considered not medically necessary.
  • The use of electrostimulation alone for the treatment of multiple neuropathies or peripheral neuropathies caused by underlying systemic diseases is not medically reasonable and necessary. These procedures are considered investigational. Medical management using systemic medications is clinically indicated for the treatment of these conditions.
- **Utilization Guidelines**
  Treatment protocols utilizing multiple injections per day on multiple days per week for the treatment of multiple neuropathies or peripheral neuropathies caused by underlying systemic diseases are not considered medically necessary.
- A peripheral nerve injection may be allowed during the reconsideration process if the medical record supports a medically necessary service. (Not associated with metabolic disease [Diabetes])

NORIDIAN Medicare

Medicare

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Jurisdiction E

Medicare Part A	Medicare Part B
Noridian Medicare Portal	Noridian Medicare Portal
Active LCDs	Active LCDs
Latest Updates	Latest Updates
Molecular Diagnostic Services (MolDX)	Molecular Diagnostic Services (MolDX)
Education & Outreach	Education & Outreach
Fee Schedules	Fee Schedules
Audit and Reimbursement	Provider Enrollment
Provider Enrollment	Contact
Contact	Forms
Forms	EDI
EDI	Tools
Tools	

Jurisdiction F

Medicare Part A	Medicare Part B
Noridian Medicare Portal	Noridian Medicare Portal
Active LCDs	Active LCDs
Latest Updates	Latest Updates
Molecular Diagnostic Services (MolDX)	Molecular Diagnostic Services (MolDX)
Education & Outreach	Education & Outreach
Fee Schedules	Fee Schedules
Audit and Reimbursement	Provider Enrollment
Provider Enrollment	Contact
Contact	Forms
Forms	EDI
EDI	Tools
Tools	

Jurisdiction A

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
- Education & Outreach
- Fee Schedules
- Contact
- Forms
- CEDI - EDI Contractor
- NPE East - National Provider Enrollment Contractor
- PDAC - Pricing, Data Analysis and Coding Contractor

Jurisdiction D

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
- Education & Outreach
- Fee Schedules
- Contact
- Forms
- CEDI - EDI Contractor
- NPE West - National Provider Enrollment Contractor
- PDAC - Pricing, Data Analysis and Coding Contractor

SMRC

Supplemental Medical Review Contractor

- Current Projects
- Completed Projects
- Documentation Requests
- Discussion & Education Period
- Contact

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Jurisdiction E

Medicare Part A

- Noridian Medicare Portal
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- Latest Updates
- Molecular Diagnostic Services (MolDX)
- Education & Outreach
- Fee Schedules
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- Provider Enrollment
- Contact
- Forms
- EDI
- Tools

Medicare Part B

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
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- Education & Outreach
- Fee Schedules
- Provider Enrollment
- Contact
- Forms
- EDI
- Tools

Jurisdiction F

Medicare Part A

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
- Molecular Diagnostic Services (MolDX)
- Education & Outreach
- Fee Schedules
- Audit and Reimbursement
- Provider Enrollment
- Contact
- Forms
- EDI
- Tools

Medicare Part B

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
- Molecular Diagnostic Services (MolDX)
- Education & Outreach
- Fee Schedules
- Provider Enrollment
- Contact
- Forms
- EDI
- Tools

Jurisdiction A

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
- Education & Outreach
- Fee Schedules
- Contact
- Forms

Jurisdiction D

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

- Noridian Medicare Portal
- Active LCDs
- Latest Updates
- Education & Outreach
- Fee Schedules
- Contact
- Forms

SMRC

Supplemental Medical Review Contractor

- Current Projects
- Completed Projects
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About Noridian

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P.O. Box 39
Lawrence, KS 66044

Website
Medicare.gov

Policies

- Local Coverage Determination (LCD)
  - **Active LCDs**
  - Proposed LCDs
  - Retired LCDs
  - Open Public Meeting
- Clinician's Corner
- Medicare Coverage Articles
- Molecular Diagnostic Services
- National Coverage Determination (NCD)
- Noridian Medical Directors
- Self Administered Drugs (SADs)

Educational Resources

Policy Related Forms

Active LCDs

All LCDS are the same for each state within a Jurisdiction and are accessible from the table below.

Access LCD or Article: Select the LCD or Article number in the table below to view the policy or article on the Medicare Coverage Database (MCD).

Print the LCD or Article: Select the LCD or Article number in the table below to view the policy or article on the Medicare Coverage Database (MCD).

1. Click on the blue download arrow on the right side of page when LCD or Article appears.
2. Click the print when PDF opens.

View the ICD-9 to ICD-10 LCD number crosswalk.

Once you access the LCD, the "Coding Guidelines" can be found under the heading, "LCD Attachments" near the end of the document. Note: All CPT/HCPCS codes listed are mentioned in the LCD, but are not necessarily subject to diagnosis codes or coverage criteria.

Search for an LCD Type here to filter...

LCD Title	LCD Number	Billing and Coding Companion Article	CPT / HCPCS Codes Referenced
Allergy Testing	L34313	A57181	86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95076, 95079

2. Click the print when PDF opens.

View the ICD-9 to ICD-10 LCD number crosswalk.

Once you access the LCD, the "Coding Guidelines" can be found under the heading, "LCD Attachments" near the end of the document.
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Search for an LCD Type here to filter... ×

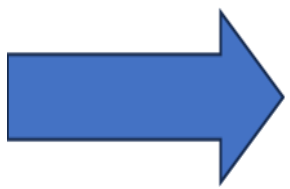
LCD Title	LCD Number	Billing and Coding Companion Article	CPT / HCPCS Codes Referenced
Allergy Testing	L34313	A57181	86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95076, 95079
Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-cell or T-cell Origin	L39396	A59175	38240
Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound	L39116	A58865	Q4112, Q4139, Q4145, Q4149, Q4155, Q4162, Q4168, Q4171, Q4174, Q4177, Q4185, Q4189, Q4192, Q4206, Q4212, Q4213, Q4215, Q4230, Q4231, Q4233, Q4240, Q4241, Q4242, Q4244, Q4245, Q4246
Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)	L39881	A59769	0623T, 0624T, 0625T, 0626T
B-type Natriuretic Peptide (BNP) Testing	L35526	A57083	83880
BDX-XL2	L37054	A57356	0080U
Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)	L34233	A57161	11200, 11201, 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, 11313, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 17110, 17111

(I-CGM)			
Injections-Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma	L34218	A57079	20526, 20527, 20550, 20551, 20612, 26341, 28899, 64455, 64632
Intraosseous Basivertebral Nerve Ablation	L39642	A59466	64628, 64629
In Vitro Chemosensitivity & Chemoresistance Assays	L37628	A56071	84999, 89240, 0564T, 0083U
Lab: Bladder/Urothelial Tumor Markers	L36678	A55028	86294, 86316, 86386, 88120, 88121
Lab: Coenzyme Q10 (CoQ10)	L37066	A55769	82542
Lab: Cystatin C Measurement	L37616	A57643	82610
Lab: Flow Cytometry	L34215	A57689	88182, 88184, 88185, 88187, 88188, 88189, 86053, 86355, 86356, 86357, 86359, 86360, 86361, 86363, 86367
Lab: Special Histochemical Stains and Immunohistochemical Stains	L36351	A57611	88312, 88313, 88341, 88342, 88344, 88360, 88361
Lumbar MRI	L34220	A57206	72148, 72149, 72158, A9585, Q9953
Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor	L37729	A57512	0398T

			0349U, 0350U, 0355U, 0356U, 0362U, 0363U
MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing	L39001	A58720	87631, 87636, 87637,87801,0240U, 0241U, 87505, 87483, 87154, 8151381514, 87800, 87999, 0352U, 0353U, 87632, 87633, 0115U, 0202U, 0223U, 0225U, 87506, 87507, 87468, 87469, 87471, 87472, 87475, 87476, 87478, 87480, 87481, 87482, 87484, 87485, 87486, 87487, 87490, 87491, 87492, 87493, 87495, 87496, 87497, 87498, 87501, 87502, 87503, 87510, 87511, 87512, 87516, 87517, 87520, 87521, 87522, 87525, 87526, 87527, 87528, 87529, 87530, 87531, 87532, 87533, 87534, 87535, 87536, 87537, 87538, 87539, 87540, 87541, 87542, 87550, 87551, 87552, 87555, 87556, 87557, 87560, 87561, 87562, 87563, 87580, 87581, 87582, 87590, 87591, 87592, 87593, 87623, 87624, 87625, 87634, 87635, 87640, 87641, 87650, 87651, 87652, 87653, 87660, 87661, 87662, 87797, 87798, 87799, U0001, U0002, U0003, U0004, U0005
MolDX: Molecular Testing for Solid Organ Allograft Rejection	L38629	A58168	81479, 81595, 81599, 0118U

Nerve Blockade for Treatment of Chronic Pain and Neuropathy	L35456	A56034	62281, 62324, 62325, 64405, 64408, 64415, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450, 64451, 64461, 64462, 64463, 64505, 64510, 64517, 64520, 64530, 64620, 64640, 64999, 64450, 76881, 76882, 76942, 76999, 97032, 97139, G0282, G0283
Nerve Conduction Studies and Electromyography	L36524	A54969	95873, 95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95933, 95937, 95999, G0255, 51785, 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95874, 95885, 95886, 95887
Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease	L38613	A58095	0501T, 0502T, 0503T, 0504T
Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)	L34228	A56572	22510, 22511, 22512, 22513, 22514, 22515
Peripheral Nerve Stimulation	L34328	A55530	64553, 64555, 64561, 64569, 64570, 64575, 64581, 64585, 64590, 64595, 64999

Plastic Surgery	L35163	A57221	15780, 15781, 15782, 15783, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, 19380, 19396, 30400, 30410, 30420, 30430, 30435, 30450
Platelet Rich Plasma Injections for Non-Wound Injections	L39058	A58788	86965, G0460, G0465, M0076, P9020, 0232T
Polysomnography and Other Sleep Studies	L36861	A57697	G0398, G0399, G0400, 95782, 95783, 95800, 95801, 95803, 95805, 95806, 95807, 95808, 95810, 95811
ProMark Risk Score	L36704	A57515	81479



Skin Substitutes Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers	L39760	A59626	15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278, A2001, A2002, A2004, A2005, A2006, A2007, A2008, A2009, A2010, A2011, A2012, A2014, A2015, A2016, A2018, A2019, A2020, A2021, A2022, A2023, A2024, A2025, C5271, C5272, C5273, C5274, C5275, C5276, C5277, C5278, C9358, C9360, C9363, C9364, Q4101, Q4102, Q4103, Q4104, Q4105, Q4106, Q4107, Q4108, Q4110, Q4111, Q4112, Q4113, Q4114, Q4115, Q4116, Q4117, Q4118, Q4121, Q4122, Q4123, Q4124, Q4125, Q4126, Q4127, Q4128, Q4130, Q4132, Q4133, Q4134, Q4135, Q4136, Q4137, Q4138, Q4139, Q4140, Q4141, Q4142, Q4143, Q4145, Q4146, Q4147, Q4148, Q4149, Q4150, Q4151, Q4152, Q4153, Q4154, Q4155, Q4156, Q4157, Q4158, Q4159, Q4160, Q4161, Q4162, Q4163, Q4164, Q4165, Q4166, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, Q4174, Q4175, Q4176, Q4177, Q4178, Q4179, Q4180, Q4181, Q4182, Q4183, Q4184, Q4185, Q4186, Q4187, Q4188, Q4189, Q4190, Q4191, Q4192, Q4193, Q4194, Q4195, Q4196, Q4197, Q4198, Q4199, Q4200, Q4201, Q4202, Q4203, Q4204, Q4205, Q4206, Q4208, Q4209, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4222, Q4225, Q4226, Q4227, Q4229, Q4230, Q4231, Q4232, Q4233, Q4234, Q4235, Q4236, Q4237, Q4238, Q4239, Q4240, Q4241, Q4242, Q4245, Q4246, Q4247, Q4248, Q4249, Q4250, Q4251, Q4252, Q4253, Q4254, Q4255, Q4256, Q4257, Q4258, Q4259, Q4260, Q4261, Q4262, Q4263, Q4264, Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, Q4271, Q4272, Q4273, Q4274, Q4275, Q4276, Q4278, Q4279, Q4280, Q4281, Q4282, Q4283, Q4284, Q4285, Q4286, Q4287, Q4288, Q4289, Q4290, Q4291, Q4292, Q4293, Q4294, Q4295, Q4296, Q4297, Q4298, Q4299, Q4300, Q4301, Q4302, Q4303, Q4304, Q4305, Q4306, Q4307, Q4308, Q4309, Q4310




Spinal Cord Stimulators for Chronic Pain	L35136	A57791	63650, 63655, 63663, 63664, 63685
Total Hip Arthroplasty	L34163	A57683	27130, 27132, 27134, 27137, 27138
Total Knee Arthroplasty	L36575	A57685	27445, 27447, 27486, 27487
Transcranial Magnetic Stimulation (TMS)	L37086	A57692	90867, 90868, 90869
Transurethral Waterjet Ablation of the Prostate	L38705	A58227	C2596, 0421T
Treatment of Males with Low Testosterone	L36538	A57615	11980, 84410, 96372, J1071, J3121, J3145, J3490
Treatment of Varicose Veins of the Lower Extremities	L34209	A57706	36299, 36465, 36466, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 37799, 93970, 93971
Trigger Point Injections	L34211	A57701	20552, 20553
Urine Drug Testing	L36668	A55001	80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659
Vitamin D Assay Testing	L36692	A57718	82306, 82652
Wound and Ulcer Care	L38902	A58565	11000, 11001, 11004, 11005, 11006, 11008, 11010, 11011, 11012, 11042, 11043, 11044, 11045, 11046, 11047, 11055, 11056, 11057, 29445, 29580, 29581, 97597, 97598, 97602, 97605, 97606, 97607, 97608, 97610

Wound Care LCD & Documentation

Local Coverage Determination (LCD)

Wound and Ulcer Care

L38902

Expand All | Collapse All

Contractor Information

LCD Information

Document Information

LCD ID
L38902

LCD Title
Wound and Ulcer Care

Proposed LCD in Comment Period
N/A

Source Proposed LCD
DL38902

Original Effective Date
For services performed on or after 11/28/2021

Revision Effective Date
For services performed on or after 11/28/2021

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Local Coverage Determination (LCD)

Wound and Ulcer Care

L38902

Expand All | Collapse All

LCD Information

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LCD ID
L38902

LCD Title
Wound and Ulcer Care

Proposed LCD in Comment Period
N/A

Source Proposed LCD
DL38902

Original Effective Date
For services performed on or after 11/28/2021

Revision Effective Date
For services performed on or after 11/28/2021

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
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LCD Reference Article | Billing and Coding Article

Billing and Coding: Wound and Ulcer Care

A58565

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General Information

Article ID
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Article Title
Billing and Coding: Wound and Ulcer Care

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Billing and Coding

Original Effective Date
11/28/2021

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10/01/2024

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Revision History Information

REVISION HISTORY DATE **REVISION HISTORY NUMBER** **REVISION HISTORY EXPLANATION**

01/01/2024 R5

Per 2024 CPT/HCPCS Updates:

Either the short and/or long code description was changed for the following code(s). **Please Note:** Depending on which descriptor was used, there may not be any changes to the code display in this document: 11000, 11001, 11004, 11005, 11006, 11008,
11042, 11043, 11044, 11045, 11046, 11047, 11055, 11056, 11057, 97597, 97598,
97605, 97606, 97607, 97608.

This update is effective 01/01/2024.

02/03/2022 R4

Updated to indicate this article is an LCD Reference Article.

02/03/2022 R3

Under Revision History Number 2: Correcting the sentence, "This section of the NCCI Manual was updated 01/01/2021" to "This section of the NCCI Manual was updated 01/01/**2022**."

02/03/2022 R2

Effective 11/28/2021 under **Debridement, Total Contact Casting and Unna boot**, the statement “The National Correct Coding Initiative (NCCI) Policy Manual for Medicare