Utilizing the CMS Website for Additional Coding Direction

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By Megan DeVoe, CCS

Editor's Note: This is the final article in a three-part series on how to master the information available on the Centers for Medicare and Medicaid Services website.

Have you ever wondered how a code becomes a code? Thinking about this question can easily bring to mind the *Schoolhouse Rock* classic "I'm Just a Bill." If you become inspired to write your own rendition of "I'm Just a Code," you can find all the information you need to do so on the Centers for Medicare and Medicaid Services (CMS) website. The ICD-10 Coordination and Maintenance Committee meets twice a year to discuss code changes. These meetings are streamed live and worth taking the time to watch. It is incredibly interesting to see the key stakeholders discuss new technologies, procedures, and clinical issues. Not only do they discuss code changes in these meetings, but the history and reasoning behind the changes are presented as well. It often happens that a doctor will provide detailed information on conditions and procedures that would be difficult to find elsewhere. It is so helpful to understand what you are coding and why it is important to select the most appropriate code. Even better, you can get free CEUs for watching.

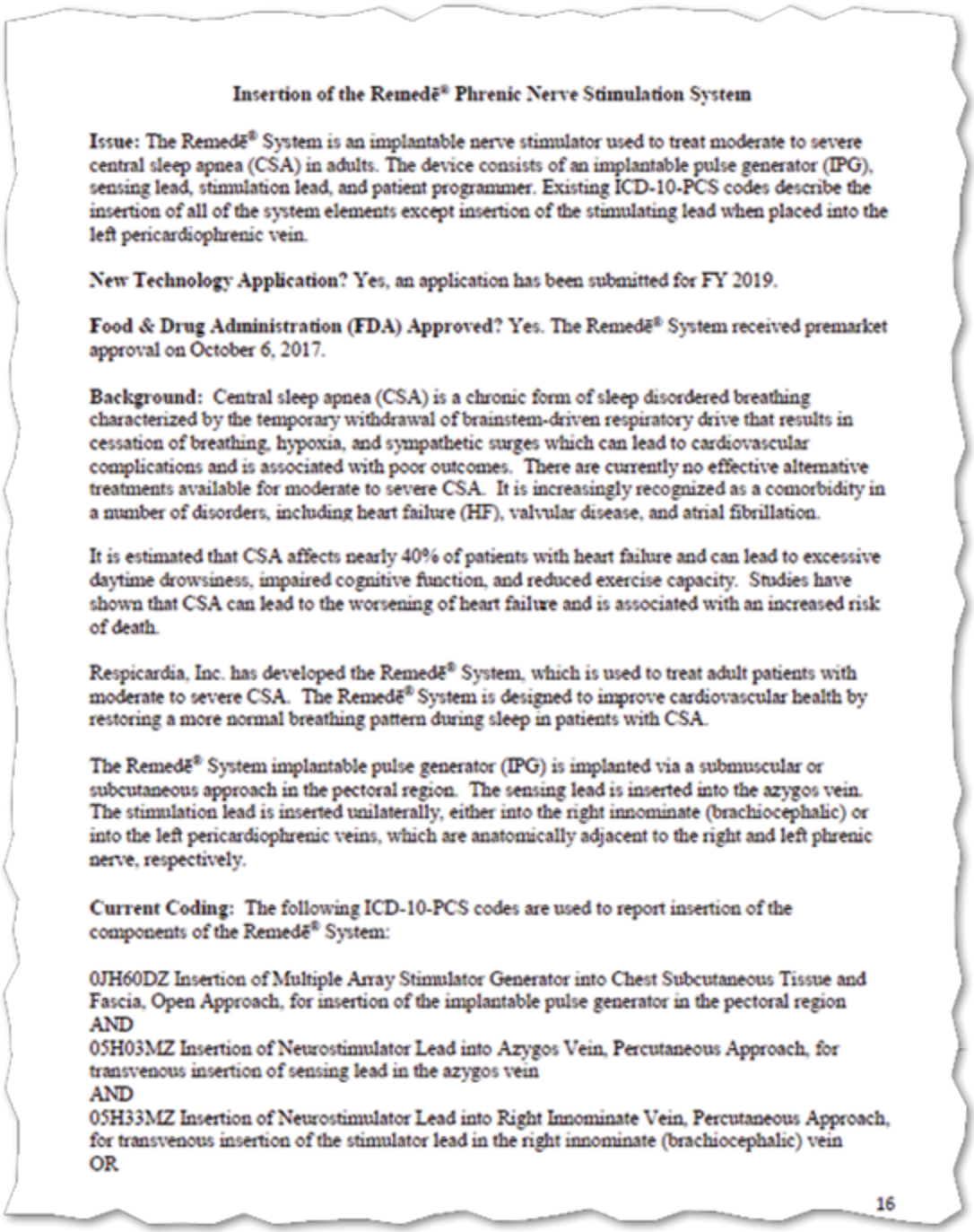
CMS handles the ICD-10-PCS code process and the Centers for Disease Control and Prevention (CDC) handles the ICD-10-CM code process. Both agencies do a great job of crosslinking their websites so it is easy to access the meeting information. To review meeting materials for the ICD-10 Coordination and Maintenance Committee (C&M), go to the page titled "ICD-10 C and M Meeting Materials" at www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html. Do not be alarmed when you see that the URL still has "ICD-9-CM" in it. It will still take you to the listing of the ICD-10 meeting materials.

For each meeting you will find an agenda and handouts in the downloads section of the web page. Each agenda contains detailed information on the codes proposed during that meeting as well as important dates relating to the C&M and the ICD-10-PCS codes. ICD-10-PCS index and table information for the upcoming October changes may also be included.

The screenshot in Figure 1 below shows the March 2018 C&M meeting materials page and where you can find the handouts, as well as an excerpt from the agenda for a meeting.

Figure 1: ICD-10 C and M Meeting Materials Web Page and Agenda Excerpt


Home | About CMS | Newsroom | Archive | Share Help
CMS.gov
Centers for Medicare & Medicaid Services
Learn about your health care options
type search term here
Medicare
Medicaid/CHIP
Medicare-Medicaid Coordination
Private Insurance
Innovation Center
Regulations & Guidance
Research, Statistics, Data & Systems
Home > Medicare > Transition from ICD-9-CM to ICD-10 > ICD-9-CM C and M Meeting Materials Items > Details for title: 2018-03-06
Transition from ICD-9-CM to ICD-10
Return to List
Details for title: 2018-03-06
Date
2018-03-06
Subject
March 6, 2018 Meeting Materials
Tube videos of the meeting:
March 6, 2018 Morning Session
March 6, 2018 Afternoon Session
March 7, 2018 Morning Session
March 7, 2018 Afternoon Session
Downloads
March 6, 2018 Agenda and Handouts - Revised (Updated March 8, 2018) [PDF, 1MB]
Help with File Formats and Plug-Ins



Insertion of the Remedē® Phrenic Nerve Stimulation System

Issue: The Remedē® System is an implantable nerve stimulator used to treat moderate to severe central sleep apnea (CSA) in adults. The device consists of an implantable pulse generator (IPG), sensing lead, stimulation lead, and patient programmer. Existing ICD-10-PCS codes describe the insertion of all of the system elements except insertion of the stimulating lead when placed into the left pericardiophrenic vein.

New Technology Application? Yes, an application has been submitted for FY 2019.

Food & Drug Administration (FDA) Approved? Yes. The Remedē® System received premarket approval on October 6, 2017.

Background: Central sleep apnea (CSA) is a chronic form of sleep disordered breathing characterized by the temporary withdrawal of brainstem-driven respiratory drive that results in cessation of breathing, hypoxia, and sympathetic surges which can lead to cardiovascular complications and is associated with poor outcomes. There are currently no effective alternative treatments available for moderate to severe CSA. It is increasingly recognized as a comorbidity in a number of disorders, including heart failure (HF), valvular disease, and atrial fibrillation.

It is estimated that CSA affects nearly 40% of patients with heart failure and can lead to excessive daytime drowsiness, impaired cognitive function, and reduced exercise capacity. Studies have shown that CSA can lead to the worsening of heart failure and is associated with an increased risk of death.

Respicardia, Inc. has developed the Remedē® System, which is used to treat adult patients with moderate to severe CSA. The Remedē® System is designed to improve cardiovascular health by restoring a more normal breathing pattern during sleep in patients with CSA.

The Remedē® System implantable pulse generator (IPG) is implanted via a submuscular or subcutaneous approach in the pectoral region. The sensing lead is inserted into the azygos vein. The stimulation lead is inserted unilaterally, either into the right innominate (brachiocephalic) or into the left pericardiophrenic veins, which are anatomically adjacent to the right and left phrenic nerve, respectively.

Current Coding: The following ICD-10-PCS codes are used to report insertion of the components of the Remedē® System:

0JH60DZ Insertion of Multiple Array Stimulator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach, for insertion of the implantable pulse generator in the pectoral region
AND
05H03MZ Insertion of Neurostimulator Lead into Azygos Vein, Percutaneous Approach, for transvenous insertion of sensing lead in the azygos vein
AND
05H33MZ Insertion of Neurostimulator Lead into Right Innominate Vein, Percutaneous Approach, for transvenous insertion of the stimulator lead in the right innominate (brachiocephalic) vein
OR

16

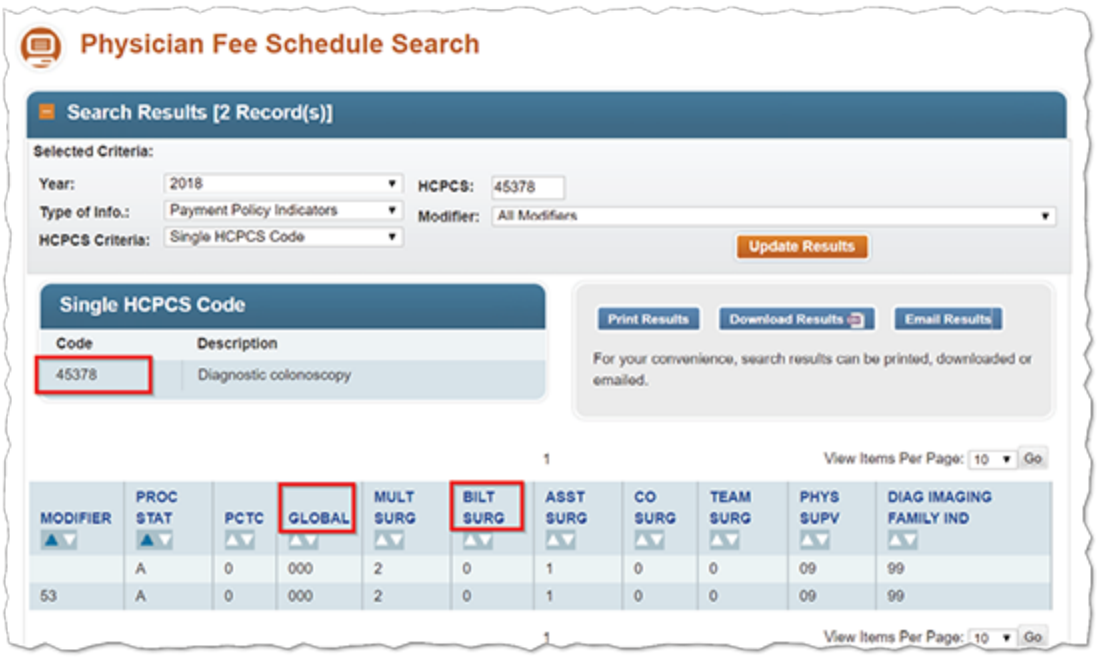
Source: Centers for Medicare and Medicaid Services. ICD-10 C and M Meeting Materials web page. www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials-Items/2018-03-06-MeetingMaterials.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.

The May 2018 Coding Notes article “Understand CMS Outpatient Hospital Edits in 10 Minutes or Less” discussed the National Correct Coding Initiative (NCCI) hospital procedure to procedure (PTP) edits. There are also practitioner PTP edits. Those edits can be found using the same URLs mentioned in that article. Each quarter, a new version of the edits is released, available at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html. When coding for physician services, these are the PTP edits coding professionals will want to use to help decide when CPT/HCPCS codes may or may not be assigned together.

CMS also provides the Medicare Physician Fee Schedule files and a handy look-up tool on their physician fee schedule web page at www.cms.gov/apps/physician-fee-schedule/overview.aspx. In the look-up tool, a coding professional can search by code to find code information relating to the fee schedule.

For example, the screenshot of the look-up tool in Figure 2 below provides information on laterality, global period, and modifier usage.

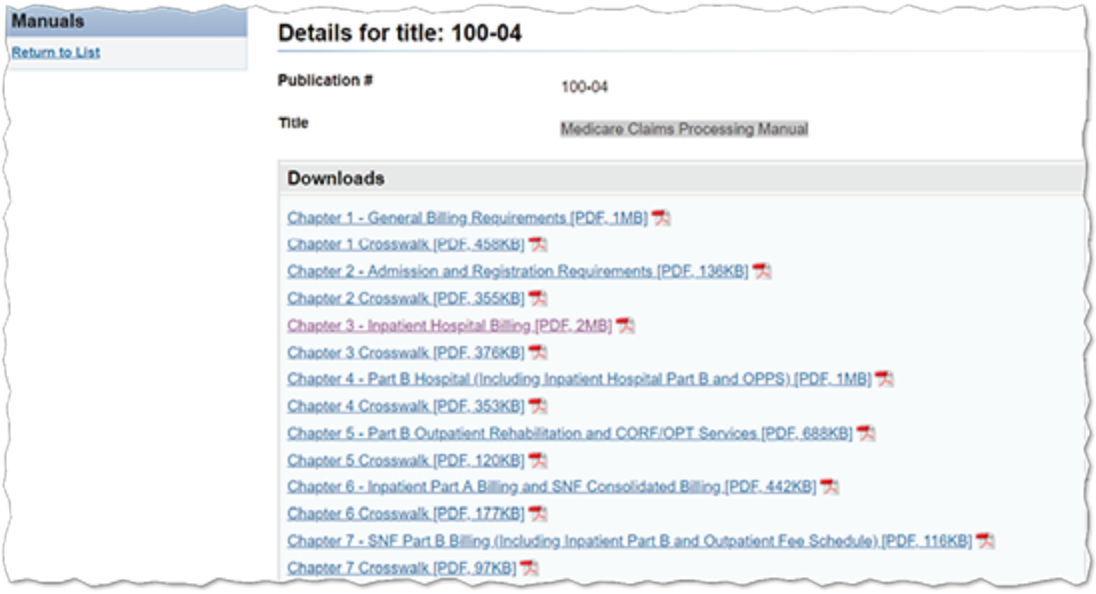
Figure 2: Screenshot of Look-up Tool



Source: Centers for Medicare and Medicaid Services. Physician Fee Schedule Search web page. www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=1&HT=0&H1=45378&M=5.

Along with all the information above and in the previous articles of this Coding Notes series, CMS provides yet another fantastic resource—the Medicare Claims Processing Manual. This manual explains the history of instruction for hospital and provider services. There are 38 chapters, each dealing with a different service or instruction. The screenshot in Figure 3 below is a sampling of the chapters available in the manual.

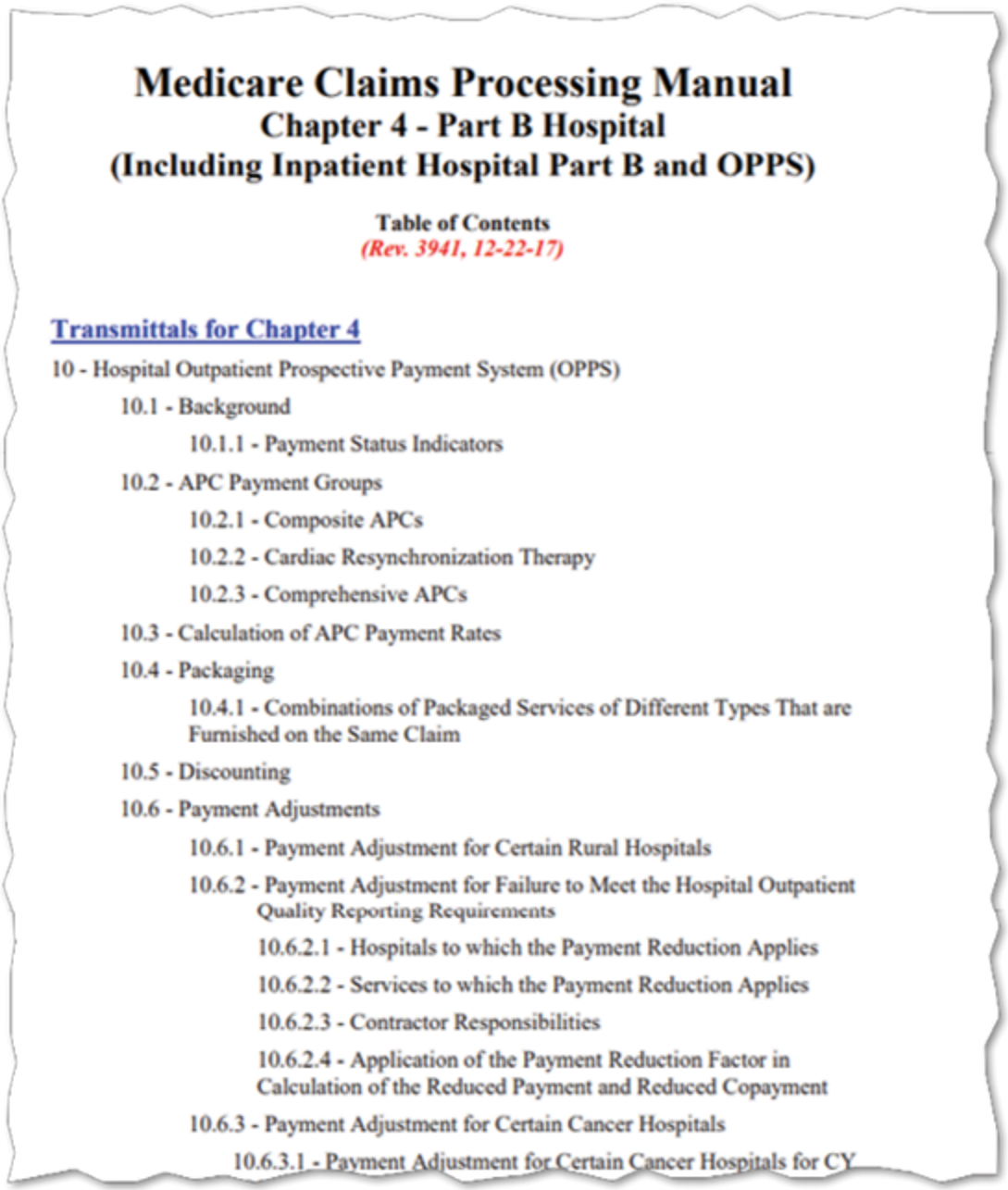
Figure 3: Sample of Chapters Available in Medicare Claims Processing Manual



Source: Centers for Medicare and Medicaid Services. Details for title: 100-04 web page. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html.

The chapters will provide very specific information for the chapter topic and links to applicable transmittals for that chapter. They include coding and modifier direction as well as claims processing information. Bookmark these manuals rather than downloading them so you can be sure you are looking at the most recent information. The screenshot in Figure 4—below—shows an excerpt from Chapter 4 – Part B Hospital.

Figure 4: Excerpt from Medicare Claims Processing Manual



Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 3941, 12-22-17)

Transmittals for Chapter 4

10 - Hospital Outpatient Prospective Payment System (OPPS)

10.1 - Background

10.1.1 - Payment Status Indicators

10.2 - APC Payment Groups

10.2.1 - Composite APCs

10.2.2 - Cardiac Resynchronization Therapy

10.2.3 - Comprehensive APCs

10.3 - Calculation of APC Payment Rates

10.4 - Packaging

10.4.1 - Combinations of Packaged Services of Different Types That are Furnished on the Same Claim

10.5 - Discounting

10.6 - Payment Adjustments

10.6.1 - Payment Adjustment for Certain Rural Hospitals

10.6.2 - Payment Adjustment for Failure to Meet the Hospital Outpatient Quality Reporting Requirements

10.6.2.1 - Hospitals to which the Payment Reduction Applies

10.6.2.2 - Services to which the Payment Reduction Applies

10.6.2.3 - Contractor Responsibilities

10.6.2.4 - Application of the Payment Reduction Factor in Calculation of the Reduced Payment and Reduced Copayment

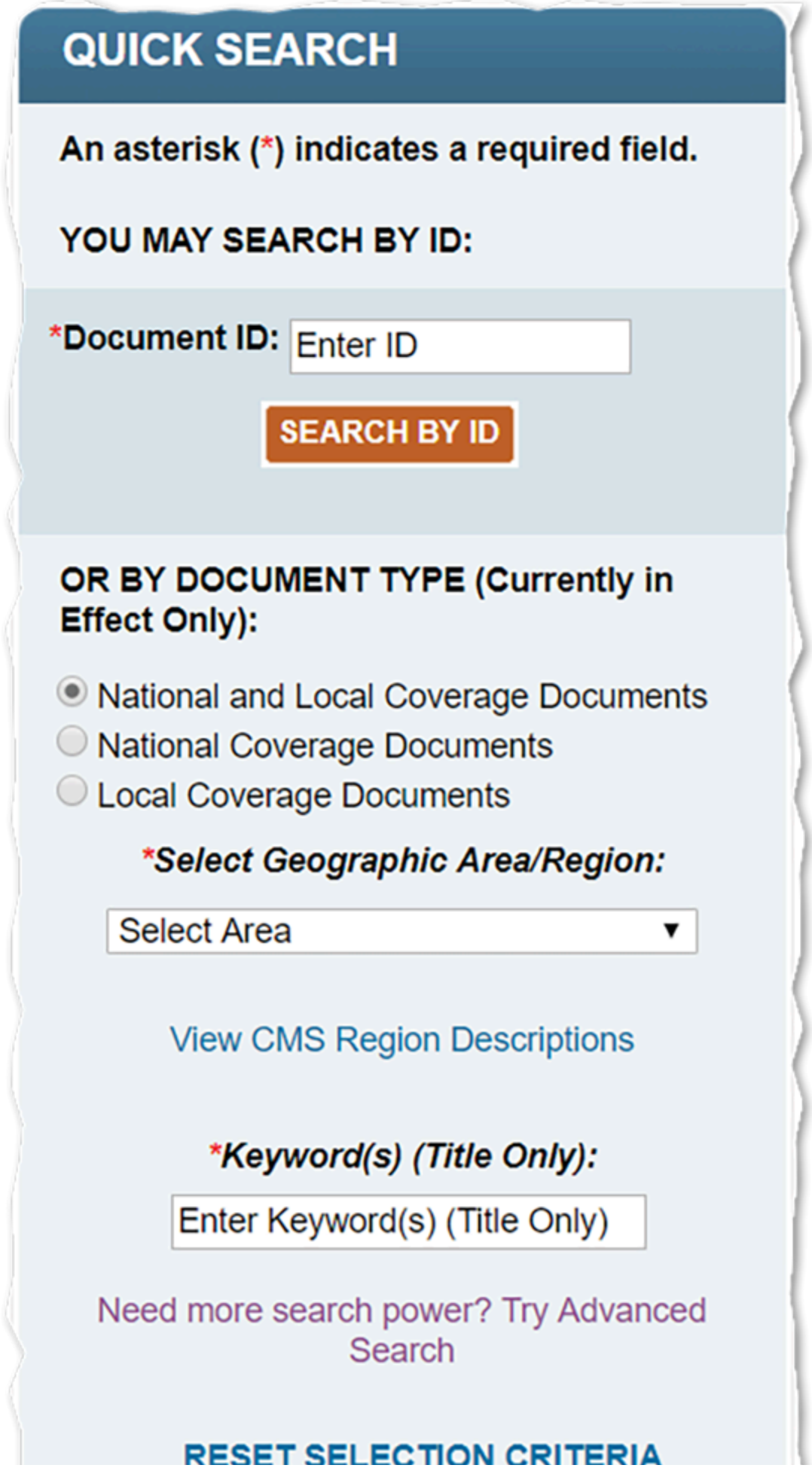
10.6.3 - Payment Adjustment for Certain Cancer Hospitals

10.6.3.1 - Payment Adjustment for Certain Cancer Hospitals for CY

Source: Centers for Medicare and Medicaid Services. "Medicare Claims Processing Manual. Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)." www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

Finally, let's talk about medical necessity. CMS provides all Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and local coverage articles on the Medicare Coverage Database web page. On this page you can search by document ID or document type. There is also an advanced search where you can search using multiple parameters. The screenshot in Figure 5—below—shows the Quick Search function.

Figure 5: Quick Search Function on Medicare Coverage Database Web Page

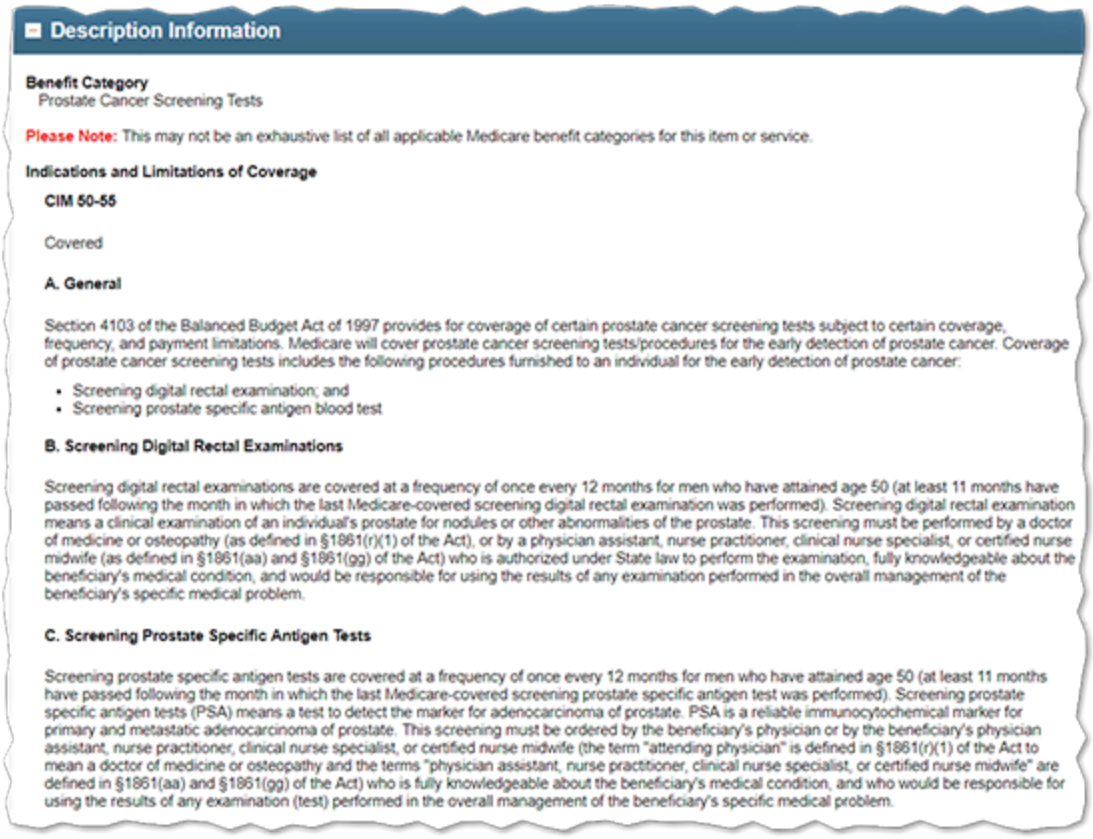

QUICK SEARCH
An asterisk (*) indicates a required field.
YOU MAY SEARCH BY ID:
*Document ID:
Enter ID
SEARCH BY ID
OR BY DOCUMENT TYPE (Currently in Effect Only):
National and Local Coverage Documents
National Coverage Documents
Local Coverage Documents
*Select Geographic Area/Region:
Select Area
View CMS Region Descriptions
*Keyword(s) (Title Only):
Enter Keyword(s) (Title Only)
Need more search power? Try Advanced Search
RESET SELECTION CRITERIA

Source: Centers for Medicare and Medicaid Services. Medicare Coverage Database web page. www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

The NCDs provide direction on the national level for Medicare services. You can view the NCDs alphabetically or by chapter/section. Each NCD section will describe the section service, indications and limitations of coverage, and any non-covered indications. NCDs generally do not provide coding instruction but do provide links to the appropriate LCDs, coverage transmittals, and change requests. Also contained in the NCDs are any frequency limitations and age restrictions.

For example, the screenshot in Figure 6 below shows the indications and limitations of coverage for Prostate Cancer Screening Tests defined in the NCD for Prostate Cancer Screening Tests (210.1), which are covered at a frequency of once every 12 months for men who have attained age 50 (when at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen test was performed). Since the NCDs provide indications for coverage, this can help providers ensure their documentation will sufficiently represent the need for the service.

Figure 6: Prostate Cancer Screening Tests



Description Information

Benefit Category
Prostate Cancer Screening Tests

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Indications and Limitations of Coverage

CIM 50-55

Covered

A. General

Section 4103 of the Balanced Budget Act of 1997 provides for coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations. Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- Screening digital rectal examination; and
- Screening prostate specific antigen blood test

B. Screening Digital Rectal Examinations

Screening digital rectal examinations are covered at a frequency of once every 12 months for men who have attained age 50 (at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed). Screening digital rectal examination means a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act), or by a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (as defined in §1861(aa) and §1861(gg) of the Act) who is authorized under State law to perform the examination, fully knowledgeable about the beneficiary's medical condition, and would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

C. Screening Prostate Specific Antigen Tests

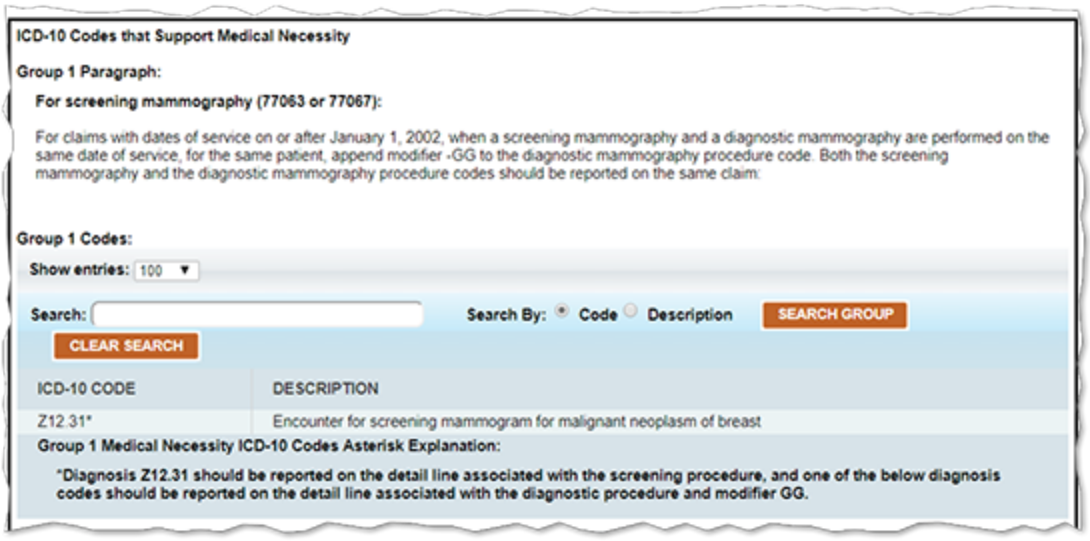
Screening prostate specific antigen tests are covered at a frequency of once every 12 months for men who have attained age 50 (at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen test was performed). Screening prostate specific antigen tests (PSA) means a test to detect the marker for adenocarcinoma of prostate. PSA is a reliable immunocytochemical marker for primary and metastatic adenocarcinoma of prostate. This screening must be ordered by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (the term "attending physician" is defined in §1861(r)(1) of the Act to mean a doctor of medicine or osteopathy and the terms "physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife" are defined in §1861(aa) and §1861(gg) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination (test) performed in the overall management of the beneficiary's specific medical problem.

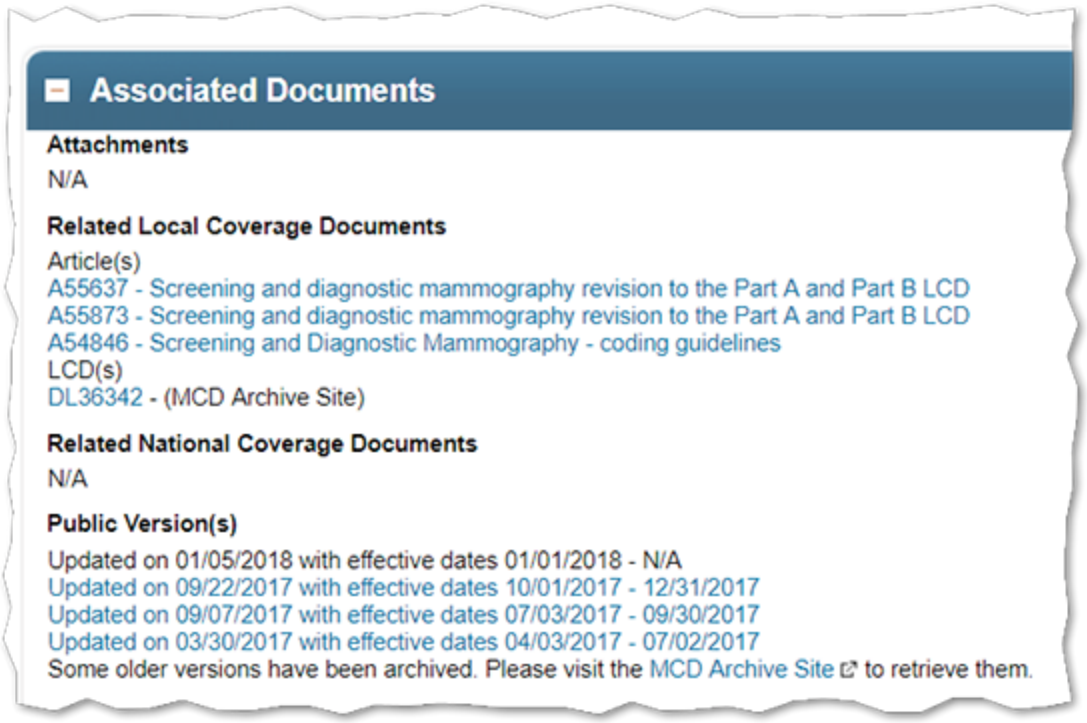
Source: Centers for Medicare and Medicaid Services. National Coverage Determination (NCD) for Prostate Cancer Screening Tests (210.1) web page. www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=268&ncdver=2&bc=AAAAQAAAAAAA&.

LCDs are policy decisions made by Medicare contractors for their geographic area where a NCD does not exist or needs clarification. LCDs do provide procedure codes and may indicate which diagnosis codes will meet medical necessity. Along with LCDs, contractors may provide local coverage articles to communicate additional local coverage information. Like

NCDs, LCDs provide a description of the service and any limitations. They can even include which revenue code and bill type to use. Again, documentation requirements are listed and links provided to any related local coverage documents. The screenshot in Figure 7 below shows the codes that meet medical necessity for screening mammograms defined in L36342, as well as the related local coverage documents.

Figure 7: Codes that Meet Medical Necessity for Screening Mammograms and Related LCDs





Source: Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD): Screening and Diagnostic Mammography (L36342) web page. www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36342&ver=31&DocType=Active&bc=AAIAAAAAAAAA&.

This article series has discussed how to use the information publicly available on the CMS website to enhance and substantiate coding decisions. While several key areas were covered, this series barely scratches the surface. Coding professionals are

encouraged to get familiar with the information available on this website and get curious. It is important to understand what is being coded and why it needs to be coded that way. As instruction, technology, and medicine evolve, we must keep pace and embrace change. Never a dull moment, right?

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