Unna Boot - Supplemental Instructions Article (A47660)

Contractor Information

Contractor Name
National Government Services, Inc.

Contractor Number

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<th>Contractor Number</th>
<th>Contractor Type</th>
<th>Location</th>
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<tbody>
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<tr>
<td>13292</td>
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<td>NY – Part B</td>
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Contractor Type
MAC – Part A
MAC – Part B

Article Information

Article ID Number
A47660

Article Type
Article

Key Article
Yes
Article Title
Unna Boot - Supplemental Instructions Article

Primary Geographic Jurisdiction

<table>
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Secondary Geographic Jurisdiction
See “Other Comments”

Original Article Effective Date
07/18/2008

Article Revision Effective Date
Not applicable

Article Text
The information in this Supplemental Instructions Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination (LCD) for Unna Boot. The LCD can be accessed on our contractor Web site at www.NGSMedicare.com. It can also be found on the Medicare Coverage Database at www.cms.hhs.gov/mcd.

Coding Guidelines:

General Guidelines for claims submitted to Carriers or Intermediaries:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned.
to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

**Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services):**

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The -GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary, occurrence code 32 and the date of the ABN is required.

The -GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

CPT code 29580 represents the Unna Boot service or application only; it is not to be used for billing other strappings or dressing changes.

CPT code 29580 has a global period of 0 days. An evaluation and management (E&M) code can be billed in addition, when the **initial** evaluation of the condition leading to a decision to apply the Unna Boot is done. A **subsequent** E&M code for an established patient should not be billed when repeat Unna Boot application is done, unless an unrelated separately identifiable E&M service is performed. In this case, modifier -25 must be used with the E&M code.
When an Unna boot is applied to one extremity, use the appropriate RT or LT modifier to indicate which leg is affected.

When billing the Unna Boot for both legs, use the -50 modifier to indicate that this service is bilateral, and list 1 as number of service (modifiers RT and LT are not necessary in this situation). This will indicate that the Unna Boots are being applied to both legs.

**For claims submitted to the carrier:**

Claims for Unna Boot services are payable under Medicare Part B in the following places of service: office (11), home (12), assisted living facility (13), urgent care facility (20), inpatient hospital (21), outpatient hospital (22), ambulatory surgical center (24), skilled nursing home for patients in a Part A stay (31)*, nursing facility for patients not in a Part A stay (32)*, custodial care facility (33), independent clinic (49), inpatient psychiatric facility (51), psychiatric residential treatment center (56), comprehensive inpatient rehabilitation facility (61), state or local public health clinic (71).

*This place of service will be considered payable only when billed by a physician. When performed by an occupational or physical therapist in this place of service, payment will be denied.

**For claims submitted to the fiscal intermediary:**

**Hospital Inpatient Claims:**

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. *It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

**Hospital Outpatient Claims:**

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient’s symptom is reported. If the patient arrives without a referring
diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).

- The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

**Bill Type Guidelines**

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100(B) states that no type of technical services, such as...a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers...Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.

Per CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100(B), only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); ...telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment...: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100[B].)

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
• Is custodial in nature.

**Coverage Topic**
Surgical Services

**Coding Information**

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

11x Hospital-inpatient (including Part A)
12x Hospital-inpatient or home health visits (Part B only)
13x Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
18x Hospital-swing beds
21x SNF-inpatient, Part A
22x SNF-inpatient or home health visits (Part B only)
23x SNF-outpatient (HHA-A also)
71x Clinic-rural health
73x Clinic-independent provider based FQHC (eff 10/91)
85x Special facility or ASC surgery-rural primary care hospital (eff 10/94)

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal...
intermediary. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

Revenue codes 096X, 097X and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called Option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing professional services at the CAH may elect to bill their carrier or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill the FI using revenue codes 096X, 097X or 098X.

0360 Operating room services-general classification
0361 Operating room services-minor surgery
0369 Operating room services-other operating room services
0420 Physical therapy-general classification
0430 Occupational therapy-general classification
0439 Occupational therapy-other (may include restorative therapy)
0450 Emergency room-general classification
0456 Emergency room-urgent care (eff 10/96)
0510 Clinic-general classification
0516 Clinic-urgent care clinic (eff 10/96)
0520 Free-standing clinic-general classification
0700 Cast room-general classification
0761 Treatment or observation room-treatment room (eff 9/93)
0960 Professional fees-general classification
0969 Professional fees-other
0975 Professional fees-operating room
CPT/HCPCS Codes

29580 STRAPPING; UNNA BOOT

ICD-9 Codes that are Covered
Please see LCD.

ICD-9 Codes that are Not Covered
Not applicable

Other Information

Other Comments
These supplemental instructions apply within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

This Supplemental Instructions Article (SIA) is effective for Downstate New York – Part B on July 18, 2008; for Connecticut – Part B on August 1, 2008; for Upstate New York – Part B on September 1, 2008; for New York and Connecticut – Part A on November 14, 2008.

Revision History Explanation
Not applicable

Related Documents
LCD(s)
L28182 – Unna Boot