Local Coverage Article:
Billing and Coding for B-type Natriuretic Peptide (BNP) Testing (A56425)

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	STATE(S)
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

Article Information

General Information

Article ID
A56425

Article Title
Billing and Coding for B-type Natriuretic Peptide (BNP) Testing

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
10/01/2015

Revision Effective Date
N/A

Revision Ending Date
N/A

Retirement Date
N/A

AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

Article Guidance

Article Text:

This article gives guidance for billing, coding, and other guidelines in relation to local coverage policy L33943 B-type Natriuretic Peptide (BNP) Testing.

General Guidelines for Claims submitted to Part A or Part B MAC:

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-10-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. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

Advance Beneficiary Notice of Non-coverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier (“Waiver of Liability Statement Issued as Required by Payer Policy”) should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. 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 Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX ("Notice of Liability Issued, Voluntary Under Payer Policy") should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions other than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, will automatically be denied services.

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. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

Documentation Requirements

The patient's medical record should include but is not limited to:

- The assessment of the patient by the ordering provider as it relates to the complaint of the patient for that visit,
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)

Time Based Codes (if applicable)

- When billing time-based codes the CPT time rule applies
- Exact times MUST be documented in the medical record
    - The code reported should be selected based on the time closest to that indicated in the code descriptor
- Psychotherapy should not be reported if less than 16 minutes of therapy is provided
    - For psychotherapy sessions lasting 90 minutes or longer, the appropriate prolonged service code should be used (99354 – 99357). The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider MUST document the medical necessity for prolonged treatment.
- Many CPT codes for therapy modalities and procedures specify that direct (one-on-one) time spent in patient contact is 15 minutes. The time counted is the time the patient is treated using skilled therapy modalities and procedures, and is recorded in the documentation as "Timed Code Treatment Minutes." Pre- and post-delivery services are not to be counted when recording the treatment time. The time counted is the "intra-service" care that begins when the qualified professional/auxiliary personnel is directly working with the patient to deliver the service. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the

gym) and prepared to begin treatment. The intra-service care includes assessment. The time the patient spends not being treated because of a need for toileting or resting should not be counted. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time. Time spent "supervising" a patient performing an activity that is defined as a timed code, or for the patient to perform an independent activity, even if a therapist is providing the equipment, is considered unbillable time and these minutes should not be counted in the "Timed Code Treatment Minutes." Therapy timed services require direct, one-on-one patient qualified professional/auxiliary personnel contact, and by definition cannot be billed when performed in a supervised manner.
    - When determining the allocation of units, it is easiest to separate out each service first into "15-minute time blocks". For example:
        - 24 minutes 97112 = one 15-minute block + 9 remaining minutes
        - 23 minutes 97110 = one 15-minute block + 8 remaining minutes

- Each code contains one 15-minute block; therefore, each code shall be billed for at least 1 unit. Since the total minutes allows for 3 units, the third unit shall be applied to the service with the most "remaining minutes" (97112 has 9 remaining minutes, whereas, 97110 has 8 remaining minutes). The correct coding is 2 units 97112 + 1 unit 97110.

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 policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CODE	DESCRIPTION
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
014x	Hospital - Laboratory Services Provided to Non-patients
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
071x	Clinic - Rural Health
072x	Clinic - Hospital Based or Independent Renal Dialysis Center
073x	Clinic - Freestanding
077x	Clinic - Federally Qualified Health Center (FQHC)
085x	Critical Access Hospital

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 policy, 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 policy should be assumed to apply equally to all Revenue Codes.

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

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.

CODE	DESCRIPTION
030X	Laboratory - General Classification
0521	Freestanding Clinic - Clinic Visit by Member to RHC/FQHC
0522	Freestanding Clinic - Home Visit by RHC/FQHC Practitioner
0524	Freestanding Clinic - Visit by RHC/FQHC Practitioner to a Member in a SNF or Skilled Swing Bed in a Covered Part A Stay
0525	Freestanding Clinic - Visit by RHC/FQHC Practitioner to a Member in a SNF (not in a Covered Part A Stay) or NF or ICF MR or Other Residential Facility
0527	Freestanding Clinic - Visiting Nurse Service(s) to a Member's Home when in a Home Health Shortage Area
0528	Freestanding Clinic - Visit by RHC/FQHC Practitioner to Other non-RHC/FQHC site (e.g. Scene of Accident)
096X	Professional Fees - General Classification
0971	Professional Fees - Laboratory
0972	Professional Fees - Radiology - Diagnostic
0973	Professional Fees - Radiology - Therapeutic
0974	Professional Fees - Radiology - Nuclear
0975	Professional Fees - Operating Room
0976	Professional Fees - Respiratory Therapy

CODE	DESCRIPTION
0977	Professional Fees - Physical Therapy
0978	Professional Fees - Occupational Therapy
0979	Professional Fees - Speech Pathology
0981	Professional Fees - Emergency Room Services
0982	Professional Fees - Outpatient Services
0983	Professional Fees - Clinic
0984	Professional Fees - Medical Social Services
0985	Professional Fees - EKG
0986	Professional Fees - EEG
0987	Professional Fees - Hospital Visit
0988	Professional Fees - Consultation
0989	Professional Fees - Private Duty Nurse

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
83880	NATRIURETIC PEPTIDE

ICD-10 Codes that are Covered

Group 1 Paragraph:

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
I11.0	Hypertensive heart disease with heart failure
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

ICD-10 CODE	DESCRIPTION
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
I20.0	Unstable angina
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.700	Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris
I25.710	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
I25.720	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris
I25.730	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris
I25.750	Atherosclerosis of native coronary artery of transplanted heart with unstable angina
I25.760	Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
I25.790	Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris
I31.1	Chronic constrictive pericarditis
I42.0	Dilated cardiomyopathy
I42.5	Other restrictive cardiomyopathy
I42.8	Other cardiomyopathies
I42.9	Cardiomyopathy, unspecified

ICD-10 CODE	DESCRIPTION
I50.1	Left ventricular failure, unspecified
I50.20 - I50.23	Unspecified systolic (congestive) heart failure - Acute on chronic systolic (congestive) heart failure
I50.30 - I50.33	Unspecified diastolic (congestive) heart failure - Acute on chronic diastolic (congestive) heart failure
I50.40 - I50.43	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure - Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.9	Heart failure, unspecified
R06.00	Dyspnea, unspecified
R06.01	Orthopnea
R06.02	Shortness of breath
R06.09	Other forms of dyspnea
R06.2	Wheezing
R06.82	Tachypnea, not elsewhere classified
R06.9	Unspecified abnormalities of breathing

Group 2 Paragraph:

The following ICD-10-CM codes support medical necessity in non hospital setting.

Group 2 Codes:

ICD-10 CODE	DESCRIPTION
I11.0	Hypertensive heart disease with heart failure
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
I50.1	Left ventricular failure, unspecified
I50.20 - I50.23	Unspecified systolic (congestive) heart failure - Acute on chronic systolic (congestive) heart failure
I50.30 - I50.33	Unspecified diastolic (congestive) heart failure - Acute on chronic diastolic (congestive) heart failure
I50.40 - I50.43	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure - Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.9	Heart failure, unspecified

ICD-10 CODE	DESCRIPTION
R06.01	Orthopnea
R06.02	Shortness of breath
R06.2	Wheezing
R06.82	Tachypnea, not elsewhere classified
R06.9	Unspecified abnormalities of breathing

ICD-10 Codes that are Not Covered

N/A

Revision History Information

N/A

Associated Documents

Related Local Coverage Document(s)

N/A

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

Public Version(s)

Updated on 03/22/2019 with effective dates 10/01/2015 - N/A

Keywords

N/A