Program Memorandum
Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-02-158

DATE: NOVEMBER 8, 2002

CHANGE REQUEST 2444

SUBJECT: Common Working File (CWF), Fiscal Intermediary (FI), and Carrier Edits and Policy Clarification for Peripheral Neuropathy With Loss of Protective Sensation (LOPS) in People With Diabetes

This Program Memorandum (PM) corrects Transmittal AB-02-109, Change Request 2150, dated July 31, 2002, and only affects FIs; the only change is in the FI edit section. This section originally listed three edits for the FIs. It now only lists two. The original edit #2 has been eliminated. Edit #3 in the original PM has been renumbered and has become edit #2 in this PM.

Effective for claims with dates of service on or after January 1, 2003, FIs, carriers, and CWF must implement the following edits based on the policy in Transmittal AB-02-042, Change Request (CR) 2060, issued April 1, 2002, and the policy clarification in this transmittal.

Policy Clarification

The note directed to carriers at the end of the definition of G0245 in CR 2060, Transmittal AB-02-042, dated April 1, 2002, was incomplete. The note should read:

> For carriers, each physician or physician group of which that physician is a member may receive reimbursement only once for G0245 for each beneficiary. However, should that beneficiary need to see a new physician, that new physician may also be reimbursed once for G0245 for that beneficiary as long as it has been at least 6 months from the last time G0245 or G0246 was paid for the beneficiary, regardless of who provided the service.

Clarification of Billing Requirement for G0247

In order for CWF to process and edit LOPS claims correctly, G0247 must be billed on the same claim with the same date of service as either G0245 or G0246 in order to be considered for payment.

Code Definitions

G0245 - Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), which must include:

1. The diagnosis of LOPS;
2. A patient history;
3. A physical examination that consists of at least the following elements:
   (a) Visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) Evaluation of a protective sensation,
   (c) Evaluation of foot structure and biomechanics,
   (d) Evaluation of vascular status and skin integrity,
   (e) Evaluation and recommendation of footwear, and

4. Patient education

G0246 - Follow-up evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:

1. A patient history;
2. A physical examination that includes:
   (a) Visual inspection of the forefoot, hindfoot, and toe web spaces,
   (b) Evaluation of protective sensation,
   (c) Evaluation of foot structure and biomechanics,
   (d) Evaluation of vascular status and skin integrity,
   (e) Evaluation and recommendation of footwear, and
3. Patient education.

G0247 - Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:

1. Local care of superficial wounds,
2. Debridement of corns and calluses, and
3. Trimming and debridement of nails.

FI Edits

Edit 1 - Implement diagnosis to procedure code edits to allow payment only for the LOPS codes, G0245, G0246, and G0247 when submitted with one of the diagnosis codes 250.60, 250.61, 250.62, 250.63, or 357.2. Deny these services when submitted without one of the appropriate diagnoses.

Use the same messages you currently use for procedure to diagnosis code denials.

Edit 2 – Deny G0247 if it is not submitted on the same claim as G0245 or G0246.

Use MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.

Use RA claim adjustment reason code 107 - Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

Carrier Edits

Edit 1 - Implement diagnosis to procedure code edits to allow payment for the LOPS codes, G0245, G0246, and G0247 only when submitted with one of the diagnosis codes 250.60, 250.61, 250.62, 250.63, or 357.2. Deny these services when submitted without one of the appropriate diagnoses and use the same messages you currently use for procedure to diagnosis code denials.

Edit 2 - Deny the service if G0245 is submitted more than once per beneficiary per physician or group practice, per beneficiary lifetime and return the following messages.

> Medicare Summary Notice (MSN) 17.17 - Medicare already paid for an initial visit for this service with this physician, another physician in his group practice or a provider. Your doctor or provider must use a different code to bill for subsequent visits.

17.17 - Medicare ya pagó una visita inicial por este servicio con este médico, otro médico de su mismo grupo, o un proveedor. Su médico o proveedor debe usar un código distinto para facturar visitas subsiguientes.

Remittance advice (RA) claim adjustment reason code 96 – Non-covered charges, along with new remark code N113 – You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.

NOTE: As with any new remark code, notify potential recipients of the new code and its meaning prior to initial use in a remittance advice.

Edit 3 – Deny G0247 if it is not submitted on the same claim as G0245 or G0246 and return the following messages.

MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 107 - Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

CWF - General Information

Though G0245 and G0246 have no technical or professional components, for these codes, CWF will post FI claims for bill types 13X, 74X, and 75X as technical, and carrier claims as professional. For bill type 85X with revenue code 940, CWF will post as technical. For 85X bill type with revenue code 98X, (Method II), CWF will post as technical and professional. This will allow both the facility and professional service payments to be approved by CWF for payment when the code and date of service match. Therefore, should a claim from a carrier and an FI be received with the same code and same date of service for the same beneficiary, the second claim submitted will not be rejected as a duplicate.

Due to the billing and payment methodology of Rural Health Clinics - bill type 71X and Federally Qualified Health Centers - bill type 73X, CWF will post these claims as usual, which will correctly allow claims from these entities that are billed to the FI to reject as duplicates when the HCPCS code, date of service, and beneficiary Health Insurance Claim number are an exact match with a claim billed to a carrier.

Carriers and FIs must react to these duplicate claims as they currently do for any other duplicates.

CWF Utilization Edits

Edit 1

Should CWF receive a claim from an FI for G0245 or G0246 and a second claim from a carrier for either G0245 or G0246 (or vice versa) and they are different dates of service and less than 6 months apart, the second claim will reject. CWF will edit to allow G0245 or G0246 to be paid no more than every 6 months for a particular beneficiary, regardless of who furnished the service. If G0245 has been paid, regardless of whether it was posted as a facility or professional claim, it must be 6 months before G0245 can be paid again or G0246 can be paid. If G0246 has been paid, regardless of whether it was posted as a facility or professional claim, it must be 6 months before G0246 can be paid again or G0245 can be paid. CWF will not impose limits on how many times each code can be paid for a beneficiary as long as there has been 6 months between each service.

The CWF will return a specific reject code for this edit to the carriers and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the carriers and FIs must deny the claims and return the following messages:

MSN 18.4 -- This service is being denied because it has not been __ months since your last examination of this kind (NOTE**:** Insert 6 as the appropriate number of months.)

RA claim adjustment reason code 96 – Non-covered charges, along with remark code M86 – Service denied because payment already made for similar procedure within set time frame.

Edit 2

The CWF will edit to allow G0247 to pay only if either G0245 or G0246 has been submitted and accepted as payable on the same date of service. CWF will return a specific reject code for this edit to the carriers and FIs that will be identified in the CWF documentation. Based on this reject code, carriers and FIs will deny the claims and return the following messages:

MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 107 - Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

Edit 3

Once a beneficiary's condition has progressed to the point where routine foot care becomes a covered service, payment will no longer be made for LOPS evaluation and management services. Those services would be considered to be included in the regular exams and treatments afforded to the beneficiary on a routine basis The physician or provider must then just bill the routine foot care codes along with the appropriate modifier.

The CWF will edit to reject LOPS codes G0245, G0246, and/or G0247 when on the beneficiary's record it shows that one of the following routine foot care codes were billed and paid within the prior 6 months: 11055, 11056, 11057, 11719, 11720, and/or 11721.

The CWF will return a specific reject code for this edit to the carriers and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the carriers and FIs must deny the claims and return the following messages:

MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.

The RA claim adjustment reason code 96 – Non-covered charges, along with remark code M86 – Service denied because payment already made for similar procedure within set time frame.

Provider Notification

In their next regularly scheduled bulletins, carriers must notify physicians of the policy clarification and billing requirement for G0247 at the beginning of this program memorandum. FIs need only make notification of the billing requirement. As appropriate, this information should also be posted to carrier and FI Web sites and included on any list serves by 2 weeks from the date of this PM.

The *effective date* for this PM is January 1, 2003.

The *implementation date* for this PM is January 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.

If you have any questions, contact the appropriate regional office.