CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1164	**Date: JANUARY 26, 2007**
	Change Request 5462

Subject: Coding Change for Lumbar Artificial Disc Replacement (LADR)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to announce a coding change effective January 1, 2007 for LADR. A prior CR 5057, transmittal 992, issued on June 23, 2006 contains correct codes for services rendered in 2006. However beginning with services rendered on or after January 1, 2007 there are new coding changes.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: March 13, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	32/170.2/Carrier Billing Requirements

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1164	Date: January 26, 2007	Change Request: 5462

SUBJECT: Coding Change for Lumbar Artificial Disc Replacement (LADR)

Effective Date: January 1, 2007

Implementation Date: March 13, 2007

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to announce a coding change effective January 1, 2007 for LADR. A prior CR 5057, transmittal 992, issued on June 23, 2006 contains correct codes for services rendered in 2006. However beginning with services rendered on or after January 1, 2007 there are new coding changes. The instruction updates Publication 100-04, Chapter 32, § 170.2 to include new codes for 2007.

B. Policy: The CPT Category III code 0091T is being discontinued as of December 31, 2006. A new CPT Code 22857 replaces 0091T beginning January 1, 2007.

Also for January, CPT Category III code 0092T will no longer be applicable and new CPT Category III code 0163T should be used.

The National Coverage Determination issued under CR 5057 is not changing, only the codes that should be utilized have changed.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5462.1	Contractors shall accept codes 22857 in place of deleted code 0091T and/or 0163T in place of code 0092T for LADR billing when appropriate as specified in the Medicare National Coverage Determination Manual § 150.10 effective for dates of service on and after January 1, 2007. **NOTE:** These codes are in the 2007 Healthcare Common Procedure Coding System (HCPCS).	X			X							
5462.2	Contractors shall continue to deny claims submitted with 22857 and/or 0163T for dates of	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	service January 1, 2007 and after. (See Publication 100-03, Chapter 1, Section 150.10 for Coverage criteria.)											
5462.3	Contractors shall continue to use the appropriate messages and follow all other directions as instructed by CR 5057, transmittal 992.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5462.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): April Billingsley (410) 786-0140 April.Billingsley@cms.hhs.gov

Post-Implementation Contact(s): Appropriate RO

VI. FUNDING

A. *For TITLE XVIII Contractors,* use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

170.2 - Carrier Billing Requirements

(Rev.1164, Issued: 01-26-07, Effective: 01-01-07, Implementation: 03-13-07)

Effective for services performed on or after May 16, 2006 *through December 31, 2006*, carriers shall deny claims, for Medicare beneficiaries over 60 years of age, submitted with the following Category III Codes:

- 0091T Single interspace, lumbar; and
- 0092T Each additional interspace (List separately in addition to code for primary procedure.)

Effective for services performed on or after January 1, 2007, carriers shall deny claims, for Medicare beneficiaries over 60 years of age, submitted with the following codes:

- *22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace; and*
- *0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace.*

Carriers shall continue to follow their normal claims processing criteria for IDEs for LADR performed with an implant eligible under the IDE criteria.

Carriers shall allow claims submitted for approved IDEs/clinical trials submitted with 0091T or 0092T for services performed from May 16, 2006 through December 31, 2006 and 22857 or 0163T for services performed on or after January 1, 2007 with the modifier QA.