CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1742	**Date: May 22, 2009**
	Change Request 6456

Transmittal 1731, dated May 8, 2009 is being rescinded and replaced by Transmittal 1742, dated May 22, 2009 to change the reason codes in Edits 1, 2, and 3. All other material remains the same.

Subject: Clarification of Chapter 32, Section 80.8 Billing of Routine Foot Care When Payment Ceases for Loss of Protective Sensation Evaluation and Management

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) is clarifying the requirement for podiatric treatment in Pub.100-04, Ch. 32, § 80.8. This clarification is necessary to support podiatric coverage requirements found in Pub.100-02, Ch. 15, § 290.

New / Revised Material
Effective Date: June 8, 2009
Implementation Date: June 8, 2009

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
N	32/80/80.8/Billing Requirements for Special Services

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1742	Date: May 22, 2009	Change Request: 6456

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SUBJECT: Clarification of Chapter 32, Section 80.8 Billing of Routine Foot Care When Payment Ceases for Loss of Protective Sensation Evaluation and Management

Effective Date: June 8, 2009

Implementation Date: June 8, 2009

I. GENERAL INFORMATION

A. Background: The Center for Medicare & Medicaid Services (CMS) is clarifying the requirement for podiatric treatment in Pub. 100-04, Chapter 32, §80.8. This clarification is necessary to support podiatric coverage requirements found in Pub. 100-02, Chapter 15, §290. Coverage policy found in Pub. 100-02, Chapter 15, §290 allows contractors to cover podiatric treatment based on additional case findings not included in Class A, Class B or Class C finding as determined by the contractor's medical staff and developed as necessary.

B. Policy: Contractors shall continue to process all claims in accordance to Pub.100-04, Chapter 32, §80.8.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6456.1	Contractors shall note the clarification to CMS Pub. 100-04, Ch. 32, Section 80.8.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
6456.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
None.	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Practitioner Claims Processing
Cynthia Thomas at 410-786-8169 or cynthia.thomas@cms.hhs.gov
Leslie Trazzi at 410-786-7544 or leslie.trazzi@cms.hhs.gov

Institutional Claims Processing
William Ruiz at 410-786-9283 or william.ruiz@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*: The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

80.8 - CWF Utilization Edits

(Rev. 1742, Issued: 05-22-09, Effective: 06-08-09, Implementation: 06-08-09)

Edit 1 - Should CWF receive a claim from an FI for G0245 or G0246 and a second claim from a *contractor* 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 *contractors* and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the contractors 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 same/similar procedure within set time frame.*

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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 *contractors* and FIs that will be identified in the CWF documentation. Based on this reject code, *contractors* 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 – *The related or qualifying claim/service was not identified on this 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, *per Pub 100-02, Chapter 15, §290.*

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 contractors and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the contractors 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 same/similar procedure within set time frame.*