CMS Manual System

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

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CHANGE REQUEST 3580

SUBJECT: Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

I. SUMMARY OF CHANGES: This instruction manualizes Change Requests 2060, 2150, 2184, 2269 2444 and 2734

NEW/REVISED MATERIAL - EFFECTIVE DATE*: N/A
IMPLEMENTATION DATE: N/A

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	32/ Table of Contents
N	32/80 Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes
N	32/80/1 General Billing Requirements
N	32/80/2 Applicable HCPCS Codes
N	32/80/3 Diagnosis Codes
N	32/80/4 Payment
N	32/80/5 Applicable Revenue Codes
N	32/80/6 Editing Instructions for Fiscal Intermediaries (FIs)
N	32/80/7 CWF General Information
N	32/80/8 CWF Utilization Edits

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev. 498, 03-11-05)

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80-Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

Coverage Requirements - Peripheral neuropathy is the most common factor leading to amputation in people with diabetes. In diabetes, peripheral neuropathy is an anatomically diffuse process primarily affecting sensory and autonomic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal, or chemical sources. When foot lesions are present, the reduction in autonomic nerve functions may also inhibit wound healing.

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule (see 42 C.F.R. §411.15(l)(l)(i)). Foot exams for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 1, 2002, Medicare covers, as a physician service, an evaluation (examination and treatment) of the feet no more often than every 6 months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of 5 tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

80.1 General Billing Requirements *- Follow the general bill review instructions in §3604.*
(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

The following providers of service may bill you for these services:

> *Hospitals;*
> *Rural Health Clinic;*
> *Free-Standing Federally Qualified Health Clinic (FQHC);*
> *Outpatient Rehabilitation Facility (ORF);*

Comprehensive Outpatient Rehabilitation Facility (CORF); and
Critical Access Hospitals

80.2 Applicable HCPCS Codes

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

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 physician 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 LOPS to include if present, at least the following:

(1) local care of superficial (i.e., superficial to muscle and fascia) wounds;

(2) debridement of corns and calluses; and

(3) trimming and debridement of nails.

NOTE: *Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.*

The short descriptors for the above HCPCS codes are as follows:

G0245 – INITIAL FOOT EXAM PTLOPS
G0246 – FOLLOWUP EVAL OF FOOT PT LOP
G0247 – ROUTINE FOOTCARE PT W LOPS

80.3 Diagnosis Codes

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

Diagnosis Codes.--Providers should report one of the following diagnosis codes in conjunction with this benefit: 250.60, 250.61, 250.62, 250.63, and 357.2.

80.4 Payment

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

- *Hospital outpatient departments - OPPS*
- *Critical Access Hospital (CAH) - Method I -- Reasonable cost; Method II -- Technical - reasonable cost, Professional -- 115 percent of the fee schedule*
- *Comprehensive Outpatient Rehabilitation Facility - Medicare physician fee schedule (MPFS)*
- *Skilled Nursing Facility - MPFS*
- *Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) - All inclusive rate.*

Deductible and coinsurance apply.

Examples of Payment calculation:

Part B Deductible Met: $900 (MPFS allowed amount) x 20 percent (co-insurance) = $720 (Medicare reimbursement). Beneficiary is responsible for $180.

Part B Deductible Not met: $900 (MPFS allowed amount) - $100 (Part B deductible) = $800 x 20 percent (co-insurance) = $640 (Medicare reimbursement). Beneficiary is responsible for $260.

Part B Deductible Met: $800 (actual charged amount) x 20 percent (co-insurance) = $640 (Medicare Reimbursement), beneficiary is responsible for $160 co-insurance.

Part B Deductible Not Met: $800 (actual charged amount) - $100 (Part B deductible) = $700 x 20 percent (co-insurance) = $560 (Medicare reimbursement). Beneficiary is responsible for $240, ($100 Part B deductible and $140 co-insurance).

Services are paid at 80 percent of the lesser of the fee schedule amount or the actual charges.

This service, when furnished in an RHC/FQHC by a physician or non-physician, is considered an RHC/FQHC service. RHCs/FQHCs bill you under bill type 71X or 73X with revenue code 940 and HCPCS G0245, G0246, and G0247.

Payment should not be made for this service unless the claim contains a related visit code. Therefore, install an edit in your system to assure payment is not made for revenue code 940 unless the claim also contains a visit revenue code (520 or 521).

80.5 Applicable Revenue Codes

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

The applicable revenue code is 940, except for hospitals.
This service can be performed in other revenue centers such as a clinic (510) for hospitals. Therefore, instruct your hospitals to report these procedures under the revenue center where they are performed.

80.6 Editing Instructions for Fiscal Intermediaries (FIs)

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

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.

80.7 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.

80.8 CWF Utilization Edits

(Rev. 498, Issued: 03-11-05, Effective/Implementation: N/A)

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.