CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1183	Date: FEBRUARY 9, 2007
	Change Request 5421

NOTE: Transmittal 1127, Change Request 5421, dated December 15, 2006 is rescinded and replaced by Transmittal 1183, dated February 9, 2007. An incorrect code was listed in the Business Requirements in 5421.2, and in the manual section 20.4. The correct code should be 880.00-887.7. All other material remains the same.

SUBJECT: Infrared Therapy Devices

I. SUMMARY OF CHANGES: On October 24, 2006, the Centers for Medicare & Medicaid Services announced a National Coverage Determination stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

NEW / REVISED MATERIAL
EFFECTIVE DATE: OCTOBER 24, 2006
IMPLEMENTATION DATE: January 16, 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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/20.4/Coding Guidance for Certain Physical Medicine CPT Codes - All Claims

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: 1183	Date: February 9, 2007	Change Request: 5421

NOTE: Transmittal 1127, Change Request 5421, dated December 15, 2006 is rescinded and replaced by Transmittal 1183, dated February 9, 2007. An incorrect code was listed in the Business Requirements in 5421.2, and in the manual section 20.4. The correct code should be 880.00-887.7. All other material remains the same.

SUBJECT: Infrared Therapy Devices

Effective Date: **October 24, 2006**

Implementation Date: January 16, 2007

I. GENERAL INFORMATION

A. Background: The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Currently there is no National Coverage Determination (NCD) concerning the use of infrared therapy devices, leaving the decision to cover, not cover, or leave up to local Medicare contractors.

B. Policy: Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce an NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5421.1	Effective for services performed on or after October 24, 2006, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) are non-covered as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin		X			X	X					DME PSC

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	
	and/or subcutaneous tissues.											
5421.2	Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes: 250.60-250.63 354.4, 354.5, 354.9 355.1-355.4 355.6-355.9 356.0, 356.2-356.4, 356.8-356.9 357.0-357.7 674.10, 674.12, 674.14, 674.20, 674.22, 674.24 707.00-707.07, 707.09-707.15, 707.19 870.0-879.9 **880.00-887.7** 890.0-897.7 998.31-998.32	X	X	X	X	X	X	X				DME PSC
5421.3	Contractors shall note that denial of infrared therapy claims for the indications listed in 5421.2 applies to all settings, and affects TOBs 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.		X	X		X	X	X				DME PSC
5421.4	Contractors shall use Medicare Summary Notice (MSN) 21.11 "This service was not covered by Medicare at the time you received it". Spanish translation: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."	X	X	X	X	X	X					DME PSC
5421.5	Contractors shall use Claim Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."	X	X	X	X	X		X				DME PSC
5421.6	Contractors shall not search claims with dates of service October 24, 2006 through January 2, 2007, but may adjust claims brought to their attention.	X	X	X		X	X					DME PSC
5421.7	Contractors shall advise physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs),	X	X	X	X		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	
	home health agencies (HHAs), and hospital outpatient departments, via a MedLearn Matters article, that they will be liable if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).											
5421.8	Contractors shall inform DME suppliers and HHA that they will be liable for the devices when they are supplied, unless the beneficiary signs an ABN.		X	X		X	X	X				DME PSC
5421.9	Contractors shall not search claims with dates of service October 24, 2006, through the implementation date of this CR. However contractors shall adjust any claim brought to their attention within this timeframe.	X	X	X	X	X	X					DME PSC

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	
5421.10	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	X	X	X	X	X	X					DME PSC

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	
	information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Karen Rinker (coverage), 410-786-0189, karen.rinker@cms.hhs.gov, Tracey Hemphill (DMERC claims), 410-786-7169, tracey.hemphill@cms.hhs.gov, Cindy Murphy (RHHI claims), 410-786-5733, cindy.murphy@cms.hhs.gov, April Billingsley (Part B claims), 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.

20.4 - Coding Guidance for Certain Physical Medicine CPT Codes - All Claims

(Rev. 1183, Issued: 02-09-07, Effective: 10-24-06, Implementation: 01-16-07)

The following provides guidance about the use of codes 96105, *97026*, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the Worker's Compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances. Further, we would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

- *CPT Code 97026*

Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Further coverage guidelines can be found in the National Coverage Determination Manual (Publication 100-03), section 270.6.

Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if the claim contains any of the following ICD-9 codes:

250.60-250.63

354.4, 354.5, 354.9

355.1-355.4

355.6-355.9

356.0, 356.2-356.4, 356.8-356.9

357.0-357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00-707.07, 707.09-707.15, 707.19

870.0-879.9

880.00-887.7

890.0-897.7

998.31-998.32

Contractors can use the following messages when denying the service:

- *Medicare Summary Notice # 21.11 "This service was not covered by Medicare at the time you received it."*
- *Reason Claim Adjustment Code #50 "These are noncovered services because this is not deemed a medical necessity by the payer."*

Advanced Beneficiary Notice (ABN):

Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHA), and hospital outpatient departments are lliable if the service is performed, unless the beneficiary signs an ABN.

Similarly, DME suppliers and HHA are liable for the devices when they are supplied, unless the beneficiary signs an ABN.