Program Memorandum Intermediaries/Carriers

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

Transmittal AB-02-042 **Date: APRIL 1, 2002**

CHANGE REQUEST 2060

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

Coverage

Presently, 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 six 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.

Applicable HCPCS Codes

- G0245 - Initial physician evaluation 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

NOTE: For Carriers, each provider or provider group of which that provider is a member, may only receive reimbursement once for G0245 for each beneficiary. However, should that beneficiary need to see a new provider, that new provider may also be reimbursed once for G0245 for that beneficiary.

- G0246 - Follow-up evaluation 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 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.

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

Short Descriptors

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

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.

Intermediary Payment Requirements

Payment is as follows:

- 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.

Intermediary - Applicable Bill Types

The applicable bill types are 13X, 23X, 71X, 73X, 74X, 75X, and 85X.

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).

Intermediary - Applicable Revenue Codes

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.

Carrier – Payment Requirements

These services, G0245 – G0247, may be furnished and billed by any Medicare provider licensed to provide such services. Deductible and coinsurance apply. These codes all have a type of service of 1.

Claims Editing Instructions for Carriers and FIs

Carrier and FI claims processing edits for this procedure are not being required at this time. Carriers and FIs may develop local edits for such claim(s) at their discretion as long as they do not conflict with national policy.

National carrier, FI, and CWF frequency and procedure to diagnosis code edits will be established at a later date.

Provider Notification

Contractors should notify providers of this new national coverage in their next regularly scheduled bulletin, on their web sites, and in routinely scheduled training sessions.

The *effective date* for this Program Memorandum (PM) is July 1, 2002.

The implementation *date* for this PM is July 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2003.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate carrier or intermediary.