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Part B Insider (Multispecialty) Coding Alert

TRANSMITTAL ROUNDUP: The Faster You Answer Development Letters, The Sooner The 45-Day Clock Restarts

3 pump codes no longer covered in SNFs

Carriers should process -other-than-clean- claims within 45 days, the **Centers for Medicare & Medicaid Services** (CMS) says in Transmittal 1173 (CR 5355). These claims require -investigation or development- outside of the contractor's Medicare operation on a prepayment basis.

If the contractor sends the physician a request for additional information five days after receiving the claim, the contractor will only have 40 days left to finish processing the claim and notify the provider of the result, CMS adds.

But the 45-day clock stops when the carrier sends the development letter and resumes when the carrier receives a response, CMS explains. -Other-than-clean- claims don't include those that have been delayed by a glitch in the Common Working File (CWF).

In other transmittals:

- Medicare won't cover infrared therapy for the treatment of diabetic or non-diabetic peripheral sensory neuropathy, CMS says in Transmittal 1183 (CR 5421).

- Medicare will no longer cover three chemotherapy administration codes separately in a skilled nursing facility (SNF). CMS updates the list of codes included in SNF consolidated billing in Transmittal 1182 (CR 5502), and now they include pump implantation and maintenance codes 96521 (portable) and 96522 (implantable). The list now also includes 96523 (Irrigation of implanted venous access device for drug delivery systems).

- Starting July 1, your carrier will include a -denotation mark- on your claims for imaging services to note which codes were subject to the technical component (TC) cap that limits them to Outpatient Prospective Payment System (OPPS) levels. The carrier or other contractor will include the letter -C- in the -NOTE- field next to the procedure code, which means -payment for the TC is capped at the OPPS amount,- according to Transmittal 1171 (CR 5476).

- Contractors must develop a system for differentiating between mass adjustments and other kinds of adjustments of claims, says Transmittal 1179 (CR 5472). Mass adjustments may be due to the Medicare Physician Fee Schedule (MPFS) or other reasons, CMS explains. Carriers process mass adjustments using special software, such as Super-Op Events or Express Adjustments, to make -monetary changes to a high number of claims.-

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