CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2231	**Date: May 27, 2011**
	Change Request 7401

SUBJECT: Phase 3 of Manual Revisions to Reflect Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items as a Result of the DMEPOS Competitive Bidding Program and the Deficit Reduction Act of 2005

I. SUMMARY OF CHANGES: This chapter has been developed to provide policies and instructions for the DMEPOS Competitive Bidding Program. This update of Chapter 36 is to provide additional information for Medicare Contractors and suppliers on the Round One Rebid Implementation.

EFFECTIVE DATE: August 28, 2011
IMPLEMENTATION DATE: August 28, 2011

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
R	R 36/Table of Contents
R	36/50.3/ Billing for Items in Multiple Product Categories
N	36/50.10/ Claims Submitted for Hospitals Who Furnish Competitively Bid Items
N	36/50.11/ Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan
N	36/50.12/ Claims for Repairs and Replacements
N	36/50.13/Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap
N	36/50.14/ Purchased Accessories and Supplies for Use With Grandfathered Equipment
N	36/50.15/ Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge

III. FUNDING:

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.

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: 2231	Date: May 27, 2011	Change Request: 7401

SUBJECT: Phase 3 of Manual Revisions to Reflect Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items as a Result of the DMEPOS Competitive Bidding Program and the Deficit Reduction Act of 2005

Effective Date: **August 28, 2011**
Implementation Date: August 28, 2011

I. GENERAL INFORMATION

A. Background:

This chapter has been developed to provide policies and instructions for the DMEPOS Competitive Bidding Program. This update of Chapter 36 is to provide additional information for Medicare Contractors and suppliers on the Round One Rebid Implementation.

B. Policy:

Currently, Medicare payment for most DMEPOS is based on fee schedules. However, §302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which amended §1847 of the Social Security Act (Act), mandates a competitive bidding program to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items subject to competitive bidding under this statute. The statute also mandates that the competitive bidding program be phased in beginning in 2007. The Centers for Medicare & Medicaid Services (CMS) has issued the regulation for the competitive bidding program, which was published on April 10, 2007 (72 Federal Register 17992). Round One of the National Competitive Bidding (NCB) Program was implemented on January 1, 2011 and this Change Request (CR) provides additional instructions on changes since the previous implementation of the DMEPOS Competitive Bidding Program.

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	
7401.1	Medicare Contractors shall continue to apply all existing instructions for DMEPOS items as applicable, unless otherwise noted in this chapter.	X	X	X	X	X					
7401.2	Medicare Contractors shall be knowledgeable that hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a bid and being awarded a contract.	X	X	X	X	X					
7401.3	Medicare Contractors shall be knowledgeable that if a beneficiary resides in a CBA and elects to leave their Medical Advantage (MA) plan or loses his/her coverage	X	X	X	X	X					

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	
	under this plan, the beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program.										
7401.4	Medicare Contractors shall be knowledgeable that any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA.	X	X	X	X	X					
7401.5	Medicare Contractors shall be knowledgeable that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment.	X	X	X	X	X					
7401.6	Contractors shall be aware of all other changes applicable to the Round One Implementation as specified in Chapter 36 of the IOM.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

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	
7401.7	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.	X	X	X	X	X					

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	
	Medicare 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. Medicare Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): For claims processing questions contact Bobbett Plummer at Bobbett.Plummer@cms.hhs.gov or (410) 786-3321. For policy questions contact Michelle Peterman at Michelle.Peterman@cms.hhs.gov or (410) 786-2591 or Hafsa Bora at Hafsa.Bora@cms.hhs.gov or (410) 786-7899.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Carriers (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Medicare 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.

Medicare Claims Processing Manual
Chapter 36 – Competitive Bidding

Table of Contents
(Rev.2231, Issued: 05-27-11)

Transmittals for Chapter 36

50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items
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50.12 – Claims for Repairs and Replacements
50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap
50.14 - Purchased Accessories & Supplies for Use With Grandfathered Equipment
50.15 - Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge

50.3 - Billing for Items in Multiple Product Categories
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

New HCPCS modifiers were developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. For example, HCPCS code E0981 (Wheelchair Accessory, Seat Upholstery, Replacement Only, Each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category shall submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category shall use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are used in Round I of the competitive bidding program and the KU and KW modifiers are reserved for future program use.

50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Under DMEPOS Competitive Bidding, hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a bid and being awarded a contract. The DME items that a hospital may furnish as part of the exception are limited to: crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. Payment for items furnished under this exception will be made based on the single payment amount for the item for the CBA where the beneficiary resides. Separate payment is not made for walkers and related accessories furnished by a hospital on the date of admission because payment for these items is included in the Part A payment for inpatient facility services. Refer to Pub. 100-04, the Medicare Claims Processing Manual, Chapter 1, 10.1.1.1 for instructions for submitting claims.

50.11 - Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Under DMEPOS Competitive Bidding, if a beneficiary resides in a CBA and elects to leave their MA plan or loses his/her coverage under this plan, the beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program. However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier; meet the Medicare FFS coverage criteria and documentation requirements; and must elect to become a grandfathered supplier. All competitive bid grandfathering rules apply in these situations.

50.12 – Claims for Repairs and Replacements
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Under the DMEPOS Competitive Bidding Program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for claims for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment, that are submitted with the RB modifier, will be based on the single payment amount for the part if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.

The replacement of an entire item, as opposed to the replacement of a part for repair purposes, which is subject to the DMEPOS Competitive Bidding Program, must be furnished by a contract supplier. Medicare payment for the replacement item would be based on the single payment amount for the item in the beneficiary's CBA. Refer to Pub. 100-04, the Medicare Claims Processing Manual, Chapter 20, 10.2 for instructions on submitting claims for repairs and replacements.

50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment. This requirement continues to apply under the Medicare DMEPOS Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a CBA).

Should a beneficiary travel or temporarily relocate to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.

The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides

outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.

50.14 - Purchased Accessories & Supplies for Use With Grandfathered Equipment
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:

- *Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562*
- *Hospital Beds and Related Accessories – E0271, E0272, E0280, and E0310*
- *Walkers and Related Accessories – E0154, E0156, E0157 and E0158*

Grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

50.15 - Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge
(Rev.2231, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on

the same day that they submit the claim for the walker to ensure timely and accurate claims processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier to claims submitted for these items.

The J4 modifier should not be used by contract suppliers.