



Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prosthesis Healthcare Common Procedure Coding System (HCPCS) Code – JA6743

Related CR Release Date: April 29, 2010

Date Job Aid Revised: May 12, 2010

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

Key Words	MM6743, CR6743, R686OTN, Jurisdiction, Tracheo, Esophageal, Prosthesis, HCPCS, L8509
Contractors Affected	<ul style="list-style-type: none"> • Medicare Carriers • Medicare Administrative Contractors (MACs) • Durable Medical Equipment MACs (DME MACs)
Provider Types Affected	Provider types affected are physicians, non-physician practitioners and suppliers submitting claims to Medicare Carriers, MACs, and/or DME MACs for tracheo-esophageal voice prostheses provided to Medicare beneficiaries.



- Change Request (CR) 6743 changes the claims filing jurisdiction for HCPCS code L8509, which describes a tracheo-esophageal voice prosthesis inserted by a licensed health care provider, any type. This device is inserted in a physician's office or other outpatient setting.
- Effective for dates of service on or after October 1, 2010, claims for HCPCS code L8509 must be submitted to the A/B MAC or Part B carrier (as applicable) instead of the DME MAC.
- This jurisdictional policy does not apply to tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting (HCPCS code L8507). The filing jurisdiction for these claims remains with the DME MACs.

Provider Needs to Know...	<ul style="list-style-type: none"> • Effective for dates of service on or after October 1, 2010, DME MACs will deny claims containing HCPCS code L8509 as not payable under the contractor's claims jurisdiction area. • When Medicare denies such claims, the provider will receive these messages: <ul style="list-style-type: none"> • Remark code N418 (Misrouted claim. See the payer's claim submission instructions.), and • Reason code 109 (Claim not covered by this payer/contractor. You must send the
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claim to the correct payer/contractor.).

- Effective for dates of service on or after October 1, 2010, the A/B MACs and Part B carriers will accept HCPCS code L8509 for processing.
 - The A/B MACs and Part B carriers will cover claims for HCPCS code L8509 as a prosthetic device.
 - The A/B MACs and Part B carriers will base the Medicare allowed payment amount on the lower of the actual charge or the fee schedule amount for HCPCS code L8509.
- Tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting are billed using HCPCS code L8507 (tracheo-esophageal voice prostheses, patient inserted, any type, each) and are eligible for coverage under the prosthetic device benefit. The filing jurisdiction for these claims remains with the DME MACs.
- Medicare does not cover the item if it is shipped or dispensed to the beneficiary, who then takes the item to their physician's office for insertion.
- The A/B MACs or Part B carriers will deny claims in these instances, as described in Chapter 15, Section 120 in the *Medicare Benefit Policy Manual*, which states:

“Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient’s condition.”

Background

- Currently claims for tracheo-esophageal voice prostheses (HCPCS code L8509) are being submitted to the DME MACs.
- Tracheo-esophageal voice prostheses are inserted by licensed health care providers in a physician's office or other outpatient setting.
- In general, Medicare requires that claims for DME Prosthetics, Orthotics, and Supplies that are implanted or inserted by a physician be billed to the A/B MAC or Part B carrier because these contractors also handle the claims for the professional services related to inserting or implanting the device.
- In order to be consistent with this jurisdictional requirement, the Centers for Medicare & Medicaid Services (CMS) is changing the claims filing jurisdiction for this code from the DME MACs to the A/B MACs/Part B carriers, effective October 1, 2010.

Operational Impact	N/A
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Reference Materials	<p>The related MLN Matters® article can be found at http://www.cms.gov/MLN MattersArticles/downloads/MM6743.pdf on the CMS website.</p> <p>The official instruction (CR6743) issued regarding this change may be found at http://www.cms.gov/Transmittals/downloads/R686OTN.pdf on the CMS website.</p>
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