DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters®

Official Information Health Care Professionals Can Trust

The "World of Medicare" Web-Based Training (WBT) course has been revised (as of January 2011). It is designed for healthcare professionals who want to understand the fundamentals of the Medicare program, and covers Medicare Part A, Part B, Part C, and Part D; identifying Medicare beneficiary health insurance options; eligibility and enrollment; as well as recognizing how Medigap and Medicaid work with the Medicare program. This WBT course offers continuing education credits; please see the course description for details. To access the training course, visit **http://www.CMS.gov/MLNGenInfo** on the Centers for Medicare & Medicaid Services (CMS) website, scroll to "Related Links Inside CMS," select "Web-Based Training (WBT) Modules," and then select "World of Medicare (Developed: January 2010 / Revised January 2011)" from the list of trainings provided.

MLN Matters® Number: MM7401

Related Change Request (CR) #: 7401

Related CR Release Date: May 27, 2011

Effective Date: August 28, 2011

Related CR Transmittal #: R2231CP

Implementation Date: August 28, 2011

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

Note: This article was revised on May 26, 2015, to add a reference to MLN Matters® Article **MM9059** that alerts DMEPOS suppliers that when billing for DMEPOS items for Medicare beneficiaries who reside in a Competitive Bidding Area, suppliers should only apply modifiers KG and KK. Modifiers KU and KW are not currently authorized. All other information is unchanged.

Provider Types Affected

This article is for Medicare DMEPOS suppliers that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part

A/B Medicare Administrative Contractors (A/B MACs) for DMEPOS that they refer or order for Medicare beneficiaries.

What You Need to Know

Change Request (CR) 7401, from which this article is developed, is the third installment of, and adds information to, Chapter 36 DMEPOS Competitive Bidding Program in the "Medicare Claims Processing Manual" and provides additional information for Medicare contractors and suppliers on the Round One Rebid Implementation. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The phase one MLN Matters® article CR5978 is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM5978.pdf** on the Centers for Medicare & Medicaid services (CMS) website. CR 6119 provided the second installment of Chapter 36 and details the second phase of the manual revisions to this program. The related MLN Matters® article CR6119 is available at **http://www.cms.gov/MLNMattersArticles/Downloads/MM6119.pdf** on the CMS website.

Background

The Medicare payment for most DMEPOS was traditionally based on fee schedules. When section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) was amended, a competitive bidding program was implemented to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

CMS issued the regulation for the competitive bidding program on April 10, 2007 (72 Federal Register 17992). Round One of the National Competitive Bidding (NCB) Program was implemented on January 1, 2011. CR 7401 provides additional instructions on changes under the DMEPOS Competitive Bidding Program. This regulation is available at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid** on the CMS website.

Key Points of CR7401

There are seven additions to section 50 of Chapter 36 of the "Medicare Claims Processing Manual"; one is an update and the other six are new additions:

- Section 50.3 is updated to include new HCPCS modifiers 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 must submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category must 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.

The six sections added to Chapter 36: 50.10 through 50.15 as follows:

- 50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items;
    - 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 Competitive Bidding Area (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 are included in the Part A payment for inpatient facility services. Refer to the "Medicare Claims Processing Manual", Chapter 1, 10.1.1.1 for instructions for submitting claims at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf** on the CMS website.
- 50.11 - Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan;
    - 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 Fee-For-Service 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;
    - 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 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 the "Medicare Claims Processing Manual", Chapter 20, 10-2 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf** for instruction for submitting claims for repairs and replacements.
- 50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap;
    - 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 (that is, 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; and
    - 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, E0310; and
    - 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.
    - 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 as 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.

Additional Information

If you have any questions, please contact your Medicare Carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

The official instruction associated with this CR7401, issued to your Medicare MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2231CP.pdf** on the CMS website.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at **http://www.cms.gov/DMEPOSCompetitiveBid/** on the CMS website. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.