CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1184	**Date: February 8, 2013**
	Change Request 8181

SUBJECT: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) National Competitive Bidding (NCB): Using the "KY" Modifier to Bill for Accessories for Non-NCB Wheelchair Base Units

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to implement claims billing and processing instructions allowing DMEPOS suppliers to bill and DME Medicare Administrative Contractors (DME MACs) to process and pay claims for standard power wheelchair and manual wheelchair accessories furnished for use with non-competitively bid wheelchair base units and to a beneficiary who permanetly resides in a competitive bid area.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's 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 obliged 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:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new Competitive Bidding Program for certain Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid. On January 1, 2011, CMS launched the first phase of Medicare's competitive bidding program in nine different areas of the country for nine product categories.

MIPPA also required the competition for Round Two to occur in 2011 in 70 additional metropolitan statistical areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act of 2010 expanded the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016.

CMS is required by law to re-compete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except mail-order diabetic supplies expires on December 31, 2013.

B. Policy: Standard Power Wheelchairs and Manual Wheelchairs are included in the Round 2 Standard (Power and Manual) wheelchairs, scooters, and related accessories product category. Since some of the accessories included in this product category can also be used with non-competitively bid wheelchair base units, a non-contract supplier providing an accessory for a non-competitively bid wheelchair base unit to a beneficiary who permanently resides in a competitive bid area (CBA) will need to use the "KY" informational modifier in order for the claim for the item to price correctly.

Since MIPPA mandated a 9.5% fee schedule reduction for items included in Round 1 of the Competitive Bidding Program, the “KE” modifier was used to differentiate wheelchair accessory codes used with both competitive bid and non-competitive bid wheelchair base units. The “KE” modifier identifies accessories used with a non-competitive bid base unit and not subject to the fee schedule reduction.

See the conditions below for scenarios based on each of the types of base unit and competitive bid inclusion or exclusion.

NOTE: This CR provides instructions for using the “KY” informational modifier to bill for accessories for non-competitively bid wheelchair base units only. Other payment scenarios described below have been addressed in previously issued instructions.

Under Round 2

Chair Bases bid: Manual (K1, K2, K3, K4, K6, K7) and standard power wheelchairs

Example: billing accessory code E0950 used with a:

- Manual wheelchair (K0001 - K0004, K0006, K0007) - Base code competitive bid status = Bid in Round 2; not bid in Round 1

- If a claim is for a beneficiary who permanently resides in a CBA, then bill the item without a KE or KY modifier. The payment basis is the single payment amount (SPA).

- If claims are for a beneficiary who permanently resides outside of a CBA, then bill the item with a KE modifier. The payment basis is the fee schedule (5%).

- Standard power wheelchair (K0813 thru K0829) - Base code competitive bid status = Bid in Round 1 and Round 2.

- If a claim is for a beneficiary who permanently resides in a CBA, then bill the item without a KE or KY modifier. The payment basis is the single payment amount (SPA).

- If claims are for a beneficiary who permanently resides outside of a CBA, then bill the item without a KE modifier. The payment basis is the fee schedule (-9.5%).

- Complex Rehabilitative Group 2 Power Wheelchair (K0835 thru K0843) and Complex Rehabilitative Group 3 Power Wheelchair (K0848 thru K0864) - Base code competitive bid status = Bid in Round 1; not bid in Round 2.

- If a claim is for a beneficiary who permanently resides in a CBA, then bill the item with a KY modifier. The payment basis is the fee schedule (-9.5%).

- If a claim is for a beneficiary who permanently resides outside of a CBA, then bill the item without a KE modifier. The payment basis is the fee schedule (-9.5%).

- Manual Wheelchair (K0005, K0009) or Miscellaneous Power Wheelchair (K0898) - Base code competitive bid status = Not bid in Round 1 or Round 2

- If a claim is for a beneficiary who permanently resides in a CBA, then bill the item with a KE modifier. The payment basis is the fee schedule (5%).

- If claims are for a beneficiary who permanently resides outside of a CBA, then bill the item with a KE modifier. The payment basis is fee schedule (5%).

Since the “KY” modifier indicates that the accessory is used with a non-competitively bid base unit, if the claim is billed without the “KY” modifier, claims submitted by a non-contract supplier will be denied and claims submitted by a contract supplier will be reimbursed based on the single payment amount.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8181.1	Contractors shall ensure that their systems are programmed to accept the “KY” modifier on claims from non-contract suppliers for accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with non-competitively bid wheelchair base units, effective for claims with dates of service of July 1, 2013 and later.			X						X		
8181.1.1	Contractors shall pay claims for wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with non-competitively bid wheelchair base units at the fee schedule rate, when billed by a non-contract supplier with a “KY” modifier.			X						X		
8181.1.2	Contractors shall deny claims for wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with non-competitively bid wheelchair base units, when billed by a non-contract supplier without a “KY” modifier.			X						X		
8181.1.2.1	When denying claims according to the instructions in 8181.1.2, contractors shall use the following remittance advice messages, Medicare Summary Notice messages, and group code: CARC 4: The procedure code is inconsistent with the modifier used or a required modifier is missing. RARC M114: This service was processed in accordance with rules and guidelines under the			X						X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. RARC MA13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code. RARC N565: Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed. MSN 9.2: This item or service was denied because information required to make payment was missing. MSN 9.2: Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida. Group Code: CO											
8181.2	Contractors shall pay claims for wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent rounds) CBA for use with non-competitively bid wheelchair base units at the single payment amount, when billed by a contract supplier with a “KY” modifier.			X						X		
8181.3	Contractors shall return claims as unprocessable when the KY modifier is submitted by suppliers for accessory items for beneficiaries in a CBA for wheelchairs that are not identified by the HCPCS ranges K0835 - K0843 and K0848 - K0864.			X						X		
8181.3.1	When returning claims as unprocessable according to the instructions in 8181.3, contractors shall use the following remittance advice messages and Group Code:			X						X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	CARC 4: The procedure code is inconsistent with the modifier used or a required modifier is missing. RARC M114: This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. RARC MA13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code. RARC MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. Group Code: CO											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8181.4	MLN Article : 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. Contractors shall post this			X				

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	article, or a direct link to this article, on their Web sites 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 the contractor's next regularly scheduled bulletin. 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: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Eric Coulson, Eric.Coulson@cms.hhs.gov (for claims processing questions), Janae James, janae.james@cms.hhs.gov (for policy questions)

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

VI. FUNDING

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