CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2629	**Date: January 4, 2013**
	Change Request 8123

NOTE: This CR was erroneously issued with the incorrect Transmittal number 1163. This CR is being reissued with the correct Transmittal number 2629. Date issued and all other information remains the same.

SUBJECT: Updating the VMAP/4D Table with B5 Ocularist Specialty Code

I. SUMMARY OF CHANGES: A new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Specialty Code for Ocularists was implemented on April 1, 2011 via CR 6891. This CR instructed VMS to recognize specialty B5 as a primary or secondary on a claim. However, there were not any HCPC codes included for updating with the B5 specialty. The information related to this RUN is found in Chapter 20, Sections 130.1, of Publication 100-04.

EFFECTIVE DATE: February 5, 2013
IMPLEMENTATION DATE: February 5, 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
R	20/130 - Billing for Durable Medical Equipment (DME) and Orthotic/ Prosthetic Devices
R	20/130.1 - Provider Billing for Prosthetics and Orthotic Devices

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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:

Recurring Update Notification
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

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EFFECTIVE DATE: February 5, 2013

IMPLEMENTATION DATE: February 5, 2013

I. GENERAL INFORMATION

A. Background: In August 2005, CR 3959 implemented front-end claim edits for certain orthotic and prosthetic (Oand P) items. Specifically, only the following specialties could be paid for these items: 51, 52, 53, 55, 56, 57, 65, 67, or any one of the Physician Specialty Codes. This CR was manualized in the IOM, 100-04, chapter 20, section 130.1. In April 2011, CR 6891 implemented a new specialty code of B5 for Ocularists. Prior to CR 6891, CMS had indicated specialty 56 for certified ocularists. The new specialty code B5 was never added to the list of acceptable specialty codes for any of the O and P HCPCS codes. The codes used by ocularists are being inappropriately denied for this reason, causing claims to be denied erroneously.

B. Policy: CMS specialty codes are used by DME MACs to ensure claims are processed and paid correctly. CMS developed specialty code B5 to categorize the specialty of Ocularist. VMS, the standard system for DMEPOS supplier claims processing, must be able to recognize and accept this specialty code for orthotics and prosthetics (O and P) claims processing and payment.

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	
8123.1	DME MACs shall add the specialty code B5 (Ocularist) to the VMAP/4D table for the applicable			X								

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	states for payable prosthetic and orthotic specialties.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

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): Kimberly McPhillips, 410-786-5374 or kimberly.mcphillips@cms.hhs.gov

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):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

130 - Billing for Durable Medical Equipment (DME) and Orthotic/ Prosthetic Devices

(Rev.2629, Issued: 01-04-13, Effective: -02-05-13, Implementation: 02-05-13)

See §01 for definition of provider and supplier.

130.1 - Provider Billing for Prosthetic and Orthotic Devices

(Rev.2629, Issued: 01-04-13, Effective: -02-05-13, Implementation: 02-05-13)

See § 01 for definition of provider.

These items consist of all prosthetic and orthotic devices excluding parenteral/enteral nutritional supplies and equipment and intraocular lenses.

Prosthetics and orthotic devices are included in the Part A PPS rate unless specified as being outside the rate. For SNFs, customized prosthetic devices that are not included in the Part A PPS rate and which may be billed separately are identified in the SNF HCPCS HELP file. Click here to access the file electronically. The file is updated as CMS determines appropriate. It describes HCPCS codes for services included in Part A consolidated billing, the services separately billable by the SNF or supplier under Part B for Part A and/or Part B inpatients, and services that may be billed by a supplier but not by SNF. If these latter services are billed by the SNF, no additional payment will be made. If the SNF or hospital wants also to be a supplier, they must enroll with National Supplier Clearinghouse and bill the DMERC. However, the DMERC will not separately pay for items of DME provided to a beneficiary in a Part A SNF stay.

Those items or services that are considered outside the PPS rate may be billed by the supplier in the case of a SNF or hospital to the FI, or if furnished by a qualified outside entity, that entity may bill its normal contractor.

The SNFs, hospitals, or other entities that furnish prosthetic and/or orthotic devices to their patients for whom Part A benefits are not payable (i.e., no Part A entitlement or benefits exhausted) may bill for such items, assuming other billing requirements are met.

NOTE: Items such as catheters and ostomy supplies are excluded from the fee schedule when billed by HHAs for patients under a plan of care. In this situation, HHAs bill for these items as supplies

under revenue code 0270. Effective with items furnished on or after January 1, 1994, the fee schedules for ostomy, tracheostomy, and urological supplies are calculated using the same method used to calculate the purchase fee schedules for inexpensive or other routinely purchased DME.

HCPCS codes A4214, A4310 through A4330, A4338 through A4359, and A5102 through A5114 are excluded from the fee schedule when billed by hospitals along with an ASC service. Hospitals bill for these items as supplies, under revenue code 0272. In addition, HCPCS codes A5119 through A5131 are excluded from the fee schedule unless they are submitted with ostomy related ASC procedure codes 44340 through 44346, 44380, 44382, 44388 through 44392, or 50953 through 50961.

In all other circumstances, including HHAs billing for patients not under a plan of care, SNFs, CORFs, OPTs, and hospitals bill these items as prosthetics and orthotics under code 0274, along with the relevant HCPCS code.

DMERCs only – For all states that have licensure/certification requirements for provision of prosthetics and/or orthotics, DMERCs shall process claims for Prosthetics and Certain Custom-Fabricated Orthotics only when the following specialty codes are forwarded to the DMERCs from the NSC. The specialty codes are:

- Medical Supply Company with Orthotics Personnel – Specialty Code 51;
- Medical Supply Company with Prosthetics Personnel – Specialty Code 52;
- Medical Supply Company with Orthotics and Prosthetics Personnel – Specialty Code 53;
- Orthotics Personnel – Specialty Code 55;
- Prosthetics Personnel – Specialty Code 56;
- Orthotics Personnel, Prosthetics Personnel and Pedorthists – Specialty Code 57,
- Physical Therapist – Specialty Code 65;
- Occupational Therapist – Specialty Code 67;
- *Ocularist – Specialty Code B5; and*
- All Physician Specialty Code listed in this manual [IOM] Chapter 26, §10.8.2

These specialties shall be licensed or certified by the state when applicable. These specialties shall bill for Medicare services when State law permits such entity to furnish a prosthetic or orthotic.

Claims billed by other specialty codes for prosthetics and certain custom-fabricated orthotics shall be denied.